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Blackpool Council

25 November 2014

To: All Members of the Health and Wellbeing Board

The above members are requested to attend the:

HEALTH AND WELLBEING BOARD

Wednesday, 3 December 2014 at 3.00 pm
At the Solaris Centre, New South Promenade

A G E N D A

1   DECLARATIONS OF INTEREST

Members are asked to declare any interests in the items under consideration and in doing so state:

(1) the type of interest concerned; and

(2) the nature of the interest concerned

If any member requires advice on declarations of interests, they are advised to contact the Head of Democratic Governance in advance of the meeting.

2   MINUTES OF THE LAST MEETING HELD ON 22ND OCTOBER 2014   (Pages 1 - 6)

To agree the minutes of the last meeting held on 22nd October 2014 as a true and correct record.

3   STRATEGIC COMMISSIONING GROUP UPDATE   (Pages 7 - 16)

To receive an update on the work of the Strategic Commissioning Group.

4   PRESENTATION ON THE BETTER START AND HEADSTART INITIATIVES (Pages 17 - 104)

To receive a presentation on the Better Start and Headstart initiatives.

5   END OF LIFE UPDATE   (Pages 105 - 116)

To receive a presentation on End of Life initiatives.

6   BETTER CARE FUND   (Pages 117 - 234)

To receive an update on the revised submission of the Better Care Fund and Action Plan developed following the National Consistent Assurance Review.

7   DEVELOPMENT OF NEW MODELS OF CARE- EXTENSIVIST   (Pages 235 - 292)

To provide an update on the development and progress against plans to deliver New Models of Care.

8   CHILDREN'S IMPROVEMENT BOARD UPDATE   (Pages 293 - 308)

To receive an update on the Children's Improvement Plan.

9   DATES OF FUTURE MEETINGS

To note the dates of future meetings as follows:

28th January 2015
4th March 2015
10th June 2015

Venue information:

First floor meeting room (lift available), accessible toilets (ground floor), no-smoking building.

Other information:

For queries regarding this agenda please contact ,Lennox Beattie, Executive and Regulatory Manager , Tel: 01253 477157, e-mail Lennox.beattie@blackpool.gov.uk

Copies of agendas and minutes of Council and committee meetings are available on the Council's website at www.blackpool.gov.uk.

MINUTES OF HEALTH AND WELLBEING BOARD MEETING - WEDNESDAY, 22 OCTOBER 2014

Present:

Councillors Clapham, Rowson and I Taylor

Board Members:

Delyth Curtis, Director for People, Blackpool Council
Dr Arif Rajpura, Director for Public Health, Blackpool Council
Karen Smith, Deputy Director for People, Blackpool Council
David Bonson, Blackpool Clinical Commissioning Group
Richard Emmess, Blackpool Council for Voluntary Services
Roy Fisher, Blackpool Clinical Commissioning Group
Jane Higgs, NHS England
Dr Leanne Rudnick, Blackpool Clinical Commissioning Group

In Attendance:

Lennox Beattie, Executive and Regulatory Support Manager, Blackpool Council
Venessa Beckett, Corporate Development and Policy Officer, Blackpool Council
Scott Butterfield, Corporate Development Officer, Blackpool Council
Neil Jack, Chief Executive, Blackpool Council
Carmel McKeogh, Deputy Chief Executive, Blackpool Council
Liz Petch, Public Health Specialist, Blackpool Council
Val Raynor, Head of Commissioning, Blackpool Council
Wendy Swift, Blackpool, Fylde and Wyre Teaching Hospitals Trust
Rachel Swindells, Public Health Practitioner, Blackpool Council

Apologies:

Councillors Blackburn and Collett

Gary Doherty, Blackpool, Fylde and Wyre Teaching Hospitals Trust

Dr Amanda Doyle, Blackpool Clinical Commissioning Group

Joan Rose , Healthwatch Blackpool

Heather Tierney-Moore, Lancashire Care Trust

1 APPOINTMENT OF CHAIRMAN

In the absence of the Chairman and Vice-Chairman, the Board considered the appointment of a Chairman for the meeting.

Resolved:

That Roy Fisher be appointed Chairman for the meeting.

2 DECLARATIONS OF INTEREST

Richard Emmess declared a prejudicial interest in Item 6- Social Isolation Update as his organisation may consider bidding for the provision of services.

3 MINUTES OF THE LAST MEETING HELD ON 3RD SEPTEMBER 2014

Resolved:

That the minutes of the meeting held on the 3rd September 2014 be approved as a correct record.

4 STRATEGIC COMMISSIONING GROUP UPDATE

The Board received an update on the work of the Strategic Commissioning Group including the notes of the meeting held on the 25th September 2014.

It was noted that a number of items were dealt with elsewhere on the agenda.

Resolved:

To note the update and the notes of the meeting held on the 25th September 2014.

5 BETTER CARE FUND SUBMISSION

The Board received an update on the Better Care Fund from David Bonson (Blackpool CCG). It was noted that the submission had informally received positive feedback that the submission would be assured with conditions.

The Board held a discussion under this item, the Operational Resilience Plan and the Due North regarding the extreme budgetary pressures on Blackpool Council and the impact that this would have on the ability to deliver the Board's and the Government's key objectives and it was agreed that a letter be sent by the Board to Central Government on these issues. This was agreed as a resolution under Item 12.

Resolved:

To note the update on the revised Better Care Fund submission.

6 TOBACCO CONTROL STRATEGY AND ACTION PLANS 2014-2016

The Board considered three documents the Tobacco Free Lancashire Strategy 2014-2016, the Pan-Lancashire Smoking in Pregnancy Action Plan and the Blackpool Tobacco Control Strategy.

Liz Petch presented the documents and highlighted the key priority areas of prevention, protection and cessation. It was noted that reducing smoking was a key driver to improve health outcomes and reduce health inequality.

It was noted that the full version of the Blackpool Tobacco Control Strategy had yet to be circulated but it was noted that the key principles were in line with the other documents and that the document would be agreed in principle with the full document to be circulated and any comments on the full document to be forwarded to Liz before the end of November 2014.

Resolved:

1. To endorse the Tobacco Free Lancashire Strategy 2014 – 2016. This pan-Lancashire document having already been agreed by the Lancashire and Blackburn with Darwen Health and Wellbeing Boards.

2. To receive the Pan-Lancashire Smoking in Pregnancy Action Plan and agree to work to develop local solutions to the actions identified.

3. To agree in principle that the Blackpool Tobacco Control Strategy and Action Plan 2014 – 2016 focuses on a range of actions across three priority themes as we believe these to be the areas of greatest opportunity where the greatest differences can be made:

- *Prevention* - creating an environment where (young) people choose not to smoke

- *Protection* - protecting people from second-hand smoke

- *Cessation* - helping people to quit smoking

7 SOCIAL ISOLATION UPDATE

Further to the meeting on the 4th June 2014 of the Board and the thematic debate on Social Isolation, the Board received an update report from Val Raynor on the work undertaken and proposed future actions. It was agreed that the proposed actions could be achieved in cooperation with the Fairness Commission which had already undertaken some work in that area.

Resolved:

1. To, in conjunction or through the Fairness Commission, commission a third sector organisation to engage with the community, public and private sector to develop a vision and strategy to reduce isolation of people in Blackpool.

- The lead organisation will develop a partnership to work collaboratively to develop the plan.

- The partnership will comprise of third sector representatives and other stakeholders that may have a strong understanding of the needs of isolated people.
- There will be meaningful and genuine community engagement with groups representing isolated people.
- The strategy will produce a plan and recommendations to meet priority outcomes identified.

2. To report back to a future meeting on the appointment process.

8 PUBLIC HEALTH ANNUAL REPORT

The Board received the Public Health Annual Report. The report was completed by Dr Arif Rajpura, the Director of Public Health who has a statutory duty to write an annual report on the health of the local population.

Resolved:

To receive the Public Health Annual Report 2013.

9 QUALITY PREMIUM

David Bonson presented a report on the Board on the Blackpool CCG's Quality Premium intentions for 2014/2015 and on that body's proposal for the chosen target for the Friends and Family test score for patients in the stroke unit.

Resolved:

1. To note the Clinical Commissioning Group's Quality Premium goals for 2014

2. To support the Clinical Commissioning Group with their choice of local metric for the Friends and Family Test element of Quality Premium

10 OPERATIONAL RESILIENCE PLAN

The Board received an update on Operational Resilience and Winter Planning from David Bonson Chief Operating Officer from Blackpool CCG.

The Board noted the update on the steps that were being undertaken to plan for winter and that the Fylde Coast Operational Resilience plan had been signed off the Local Area Team and that monitoring procedures were in place through the Clinical Commissioning Group. It further noted that funding would be transferred from NHS England in October.

The Board continued to express the concern regarding the risks outlined in Item 5 and also later under Item 12.

Resolved:

That the update be noted.

11 ADULT SOCIAL CARE- SECTION 256 MONIES TRANSFER

The Board considered an update on the proposed services and values in respect of the funding transfer for Adult Social Care from NHS England to Blackpool Council from Karen Smith, Deputy Director for People, Blackpool Council.

It was highlighted that the specified amount for Blackpool would be £4,141,888 in total as a transfer from NHS England to Blackpool Council under Section 256 of NHS Act 2006. It was noted that the funding must be used to support Adult Social Care services in each Local Authority which also has a health benefit. There will be a responsibility to link the funding proposals to joint commissioning plans with regard also to the joint strategic needs assessment for our local population.

The Board noted that the schedule attached to the agenda meet these requirements and had already been approved by the Blackpool Clinical Commissioning Group.

Resolved:

To accept the proposed schedule from the funding transfer, which was in accordance with the joint working of Health and Social Care services

12 DUE NORTH REPORT

The Board received a presentation on the Due North report from Dr Arif Rajpura, Director for Public Health on the Due North report.

The Board noted the report as a key piece of evidence on health inequality. It endorsed the key actions outlined in the report and suggested that this Board and its partners and other Health and Wellbeing Board across the region lobbied government regarding these issues.

The Board had also agreed under a previous item to write a letter lobbying the government with its concerns regarding the reduction in funding and the impact

Resolved:

1. To note the Due North report.

2. That the Deputy Chief Executive, Blackpool Council, following consultation with the Chairman of the Health and Wellbeing Board, writes a letter to the Secretary of State for Education and the Secretary of State for Communities and Local Government expressing the Board's concern on the impact on the reduction of

funding for Local Government services on health issues particularly health inequality.

13 DATE OF NEXT MEETING

The Board noted that the date of the next meeting as the 3rd December 2014 at 3pm in the Solaris Centre

Chairman

(The meeting ended at 5.10pm)

Any queries regarding these minutes, please contact:
Lennox Beattie, Executive and Regulatory Manager
Tel: 01253 477157
E-mail: Lennox.beattie@blackpool.gov.uk

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Delyth Curtis, Director of People, Blackpool Council
Relevant Cabinet Member	Councillor Eddie Collett, Cabinet Member for Public Health
Date of Meeting	3rd December 2014

STRATEGIC COMMISSIONING GROUP UPDATE

1.0   Purpose of the report:

1.1   To receive a verbal update on issues related to the Strategic Commissioning Group.

2.0   Recommendation(s):

2.1   To note the update

3.0   Reasons for recommendation(s):

3.1   The Board has as a key responsibility to receive regular updates on the work programme of the Strategic Commissioning Group and to review future actions. The notes of the meeting of the Strategic Commissioning Group on 6th November 2014 are attached for information at Appendix 3a.

3.2a   Is the recommendation contrary to a plan or strategy adopted or approved by the Council?   No

3.2b   Is the recommendation in accordance with the Council's approved budget?   Yes

3.3   Other alternative options to be considered:

There are no alternative options to be considered

4.0   Council Priority:

4.1   The relevant Council Priority is

"Improve health and well-being especially for the most disadvantaged"

5.0 Background Information

5.1 The Strategic Commissioning Group has a responsibility to regularly update the HWB on progress against its work programme and future planned activity. The notes of the meeting of the Strategic Commissioning Group on 6 November 2014 are attached for information at Appendix 3(a).

5.2 Some of the items considered at the meeting include an update on Better Start and Headstart; an update on the Better Care Fund submission; an update on the transfer of 0-5 years commissioning arrangements; and a report on governance and partnership arrangements.

5.3 Considerable time was spent considering the Health and Wellbeing Board Performance Dashboard and updates on relevant performance indicators. Health and Wellbeing Board strategy action plans were also discussed (see minutes attached); the Strategic Commissioning Group can give assurance to the Board that progress is being made in delivering the action plans, with no serious cause for concern about any of the actions.

5.4 Does the information submitted include any exempt information?   No

5.5 **List of Appendices:**

Appendix 3a – Strategic Commissioning Group Notes and Actions 6th November 2014

6.0 Legal considerations:

6.1 None

7.0 Human Resources considerations:

7.1 None

8.0 Equalities considerations:

8.1 None

9.0 Financial considerations:

9.1 None

10.0   Risk management considerations:

10.1   None

11.0   Ethical considerations:

11.1   None

12.0   Internal/ External Consultation undertaken:

12.1   None

13.0   Background papers:

13.1   None

Strategic Commissioning Group
Notes and Actions
6 November, 2 – 3.30pm
Conference Room 3 A, Bickerstaffe House

Present	Delyth Curtis, Director of People, Blackpool Council (Chair)
	Dr Amanda Doyle (OBE), Chief Clinical Officer, Blackpool CCG
	Liz Petch, Public Health Specialist, Blackpool Council
	Dr Arif Rajpura, Director of Public Health, Blackpool Council
	Gary Raphael, Chief Finance Officer, Blackpool CCG
	Steve Thompson, Director of Resources, Blackpool Council
	Judith Mills, Public Health Specialist, Blackpool Council
	Lynn Donkin, Public Health Specialist, Blackpool Council
	Andy Roach, Director of Integration and Transformation, Blackpool CCG
	Helen Lammond-Smith, Head of Commissioning, Blackpool CCG
	Wendy Swift, Director of Strategy/Deputy Chief Executive, Blackpool Teaching Hospitals NHS Foundation Trust
Also present	Venessa Beckett, Corporate Development and Policy Officer, Blackpool Council
	Sarah Lambert, Better Start Manager, NSPCC
	Pauline Wigglesworth, Manager, Early Help for Children and Families, Blackpool Council
	Claire Grant, Integrated Commissioning Manager, Blackpool Council
	Martin Birch, LAC Service Manager, Blackpool Council
	Lennox Beattie, Democratic Governance Manager, Blackpool Council
	Karen Nolan, Business Intelligence Officer, Blackpool Council
Apologies	David Bonson, Chief Operating Officer, Blackpool CCG
	Scott Butterfield, Corporate Development Manager, Blackpool
	Jane Higgs, NHS England

	Apologies Apologies were noted.
	Welcome and Introductions. Del welcomed everyone to the meeting.
2.	**Notes and actions from previous meeting.** Notes from the previous meeting were agreed.

	Actions from previous meeting: **Item 3:** Better Start was to be discussed on the agenda **Item 5:** David Bonson attended the Children's Partnership as an additional CCG representative **Item 6:** The Improvement Plan actions are being incorporated into the Forward Plans for the HWB and SCG; these will be brought to a future meeting **Item 8:** Social Isolation was discussed at the HWB on 22 November **Item 9:** BCF update given to HWB and on SCG agenda **Item 10:** Development session planned for 12 December 2014
3.	**Better Start Commissioning Process** Sarah Lambert attended to present the item, advising that the commissioning work will be led by the Council's Commissioning Team and with strong liaison with the CCG and Teaching Hospitals to ensure that all are involved and informed. A discussion regarding the commissioning process ensued, with the need for a joint commissioning overview group identified into which operational groups would feed in. There was further discussion regarding the role and remit of the SCG, which was becoming increasingly broad. **Action:** A small group to be convened to consider the membership and terms of reference for the SCG with a view to the group focusing on commissioning and resource issues for Blackpool; this would report back to a future meeting. (Venessa Beckett to convene group)
4.	**HeadStart update** Pauline Wigglesworth attended to present the item, giving an overview of the pilot so far. There was some discussion regarding the projects chosen and whether these are the types of things we would choose to deliver, part of the pilot's purpose is to determine the effectiveness of the projects, and we have already benefitted from some learning of what works as a result of earlier intervention. Questions arose regarding the choice of schools, which was due to historical deprivation clusters as well as some of the primary schools being 'feeder schools' for the secondary schools identified. It was highlighted that Lancs Care Trust are involved strategically and a co-production approach is being taken, with young people involved at every level.
5.	**Governance and Partnerships report**

	Venessa Beckett presented the report, briefly outlining the content and advising that some consideration of the sub-groups identified as reporting to the HWB (e.g. YOT Board) required some reconsideration. The substructures of the Board may also require reconsidering as part of the refresh of the priorities and strategy, which would take place at a later date. The report gives a current overview of the governance arrangements, which are complex and likely to change. Discussion relevant to this item had taken place at item 3 so further work on the HWB substructures will be taken forward by the small group **Action:** An updated report will be presented to the HWB Board in December for information and discussion, and an updated version presented following the work of the small group.
6.	**Performance Dashboard update** Karen Nolan attended to present the performance dashboard; she advised that updates were available for five of the indicators. Karen also discussed the dashboard as a whole and that some of the indicators were not up due date as they were national indicators therefore did not accurately reflect Blackpool or accurately measure ongoing work. It was agreed that the performance framework and monitoring arrangements would be reviewed as part of the refresh of the strategy. Karen reported the following changes to national data: • NEET: there had been a reduction from 8.1% to 6.8% in 2013 • Chlamydia diagnosis rate: this had reduced • Successful treatment of drug treatment (alcohol): this had improved – a discussion followed regarding how alcohol progress is tracked and the effectiveness of the measure, Judith advised that a new measure is being developed to track long term progress. • Children in care: the figure given was the national *rate*, however actual *number* of looked after children is monitored monthly, which for September 2014 is 459.
7.	**Action Plan updates** i) **Alcohol Action Plan** Judith Mills presented the Alcohol Action Plan update, advising that a new plan had been developed and the majority of actions were on track. ii) **Sexual Health Action Plan** Judith gave a progress update on the sexual health action plan; all Blackpool secondary schools have signed up in full or in part to the PSHE good practice scheme. iii) **Healthy Weight Action Plan**

	Lynn Donkin updated on progress against the action plan, most actions are on track however some challenges have been identified around work within schools which the Healthy Weight Steering Group is working to explore how to address.
	### iv) Mental Health Action Plan
	Helen Lammond-Smith presented an overview of progress against the plan. Since July, 523 people (over 50) have taken part in memory screening and of those 200 referred back to their GP with significant cognitive issues for further investigation. The remaining 300+ people have been given information about keeping healthy and how to reduce chances of developing such problems.
	### v) LAC Action Plan
	Martin Birch presented the update, advising that the new Children's Improvement Plan in response to the Ofsted inspection report was currently in development and would be presented to the HWB in December following the Children's Improvement Board on 14 November.
	Martin asked that the SCG consider in particular areas of the plan that are relevant to partners in particular CAMHS and other health services for looked after children (LAC). Discussion followed regarding suitability of CAMHS, Claire Grant suggested that a systems change is needed to redesign service delivery at Tier 1 and 2 to prevent escalation.
	Arif asked if there were high numbers of LAC with Foetal Alcohol Syndrome and discussion on this followed with Martin agreeing to follow it up.
8.	**BCF Programme Board update** Andy Roach advised that confirmation had been received from NHS England that the revised submission had been approved with support. The next stages included the allocation of a relationship manager from the local area team. We are also awaiting publication of the 2015/16 mandate.
9.	**0-5 Commissioning** Lynn Donkin presented a report outlining that commissioning responsibility for health visiting and family nurse partnership services would transfer to the local authority in Oct 2015. We are currently awaiting the indicative allocations before feedback can be given to the Dept of Health. A transitions group has been set up to consider some of the issues regarding the amount we expect to receive which is considerably less and does not include the CQUIN payment. Further updates will be brought as appropriate.
10.	**AOB**

	Claire Grant had brought the consultation on the Commissioning Strategy but this was deferred to the next meeting due to time constraints.
11.	**DATES OF FUTURE MEETINGS** All meetings will run 1:30-3:00pm as follows : • Thurs 11 Dec 14 (Boardroom, Stadium) • Thurs 29 Jan 15 (Boardroom, Stadium) • Thurs 26 Feb 15 (Boardroom, Stadium)

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Report to:	**Health and Wellbeing Board**
Relevant Officer:	Merle Davies, Head of Early Help for Children and Families
Relevant Cabinet Member :	Cllr Ivan Taylor, Cabinet Member for Children's Services
Date of Meeting:	3rd December 2014

PRESENTATION REGARDING THE BETTER START AND HEADSTART INITIATIVES

1.0   Purpose of the report:

1.1   Blackpool recently successfully submitted 2 'Big Lottery' bids. The first, Better Start, was £45 million over ten years to transform services for 0-3 year olds; the second, Headstart, is a £500,000 pilot aimed at building the resilience of 10-14 year olds to reduce the likelihood of them developing mental health problems in the future.

1.2   Two reports were presented to the Strategic Commissioning Group on 6 November 2014, outlining the two bids and the implications and these are attached at Appendices 4a to 4f.

2.0   Recommendation(s):

2.1   To note the presentation on Better Start and Head Start

3.0   Reasons for recommendation(s):

3.1   A presentation on both initiatives will be made to the Board.

3.2a   Is the recommendation contrary to a plan or strategy adopted or approved by the Council?   No

3.2b   Is the recommendation in accordance with the Council's approved budget?   Yes

3.3   Other alternative options to be considered:

None, the presentation are for information only

**4.0	Council Priority:**

4.1	The relevant Council Priorities are:
- Tackle child poverty, raise aspirations and improve educational achievement
- Safeguard and protect the most vulnerable
- Improve health and well-being especially for the most disadvantaged
- Deliver quality services through a professional, well-rewarded and motivated workforce

**5.0	Background Information**

5.1	**Better Start**
The Better Start Partnership is led by the NSPCC and involves as key partners; Council, Health, and Police.

5.2	The strategy has 4 components, which are:
1. A public health approach - shifting the curve for the whole population
2. Evidence based interventions - providing more intensive help for those who need it
3. Systems transformation - building shared understanding and shared action
4. Building and sharing learning - creating the Blackpool Centre for Early Child Development

5.3	**Headstart**
The Headstart partnership is led by the Council and involves a range of partners. In addition, Headstart has a steering group of young people who advise the partnership and co-produce the strategy.

5.4	The pilot has 4 elements of support to young people, these are;
1. Work in schools
2. In the Home
3. Community Activities
4. Digital Platform

5.5	The pilot will run until December 2015, after this a further submission can be made for a £10 million project over five years.

5.6	Does the information submitted include any exempt information?			No

5.7	**List of Appendices:**

Appendix 4a: Report on Better Start to the Strategic Commissioning Group on 6 November 2014
Appendix 4b: Better Start Executive Summary
Appendix 4c: Better Start Commissioning Plan
Appendix 4d: Better Start Strategy

Appendix 4e: Better Start Implementation Plan
Appendix 4f: Report on Headstart to the Strategic Commissioning
Group on 6 November 2014

6.0   **Legal considerations:**

6.1   None

7.0   **Human Resources considerations:**

7.1   None

8.0   **Equalities considerations:**

8.1   None

9.0   **Financial considerations:**

9.1   None

10.0   **Risk management considerations:**

10.1   None

11.0   **Ethical considerations:**

11.1   None

12.0   **Internal/ External Consultation undertaken:**

12.1   None

13.0   **Background papers:**

13.1   None

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Strategic Commissioning Group　　　　　　　　**Agenda Item 3**

Better Start Blackpool

Date: 6th November 2014

Matter for consideration: Better Start Commissioning Process

Recommendation: For discussion

Relevant Officer: Sarah Lambert

1.0　　Background

1.1　　In June 2014 Blackpool was one of five LA's to successfully be awarded £45 million funding from the Big Lottery Fund. This will focus on the conception to three years age group and a population of between 40 and 50 thousand.

1.2　　The funding is for seven wards in Blackpool – Brunswick, Park, Claremont, Victoria, Clifton, Talbot, Bloomfield. However, although the funding from the Big Lottery can only be used in these wards it is intended to roll out the learning and programmes across Blackpool using the leveraged funds. This will create a whole system change by developing stronger partnership working that delivers collaborative services organised around the needs of Blackpool children aged pre-birth to three, securing strong social, emotional and physical health foundations for children, leading to better educational and economic achievement, which is sustained over time.

1.3　　There will be four main areas of approach:
- a public health approach – producing universal campaigns e.g. breastfeeding, drinking in pregnancy etc;
- evidence based intervention – making a changing for those with additional and complex needs;
- Reframing and System Transformation – Building a shared understanding and shared action;
- Centre for Early Child Development – Building and sharing learning about the projects delivered;

1.4　　Families will be instrumental in the project development. Community based engagement and accountability will increase service quality and commitment among voluntary and statutory agencies for identifying, assessing and supporting children and families in need and understanding the impact creating a better future for all our children.

2.0   Supporting Information

2.1   Effective commissioning is at the heart of the service redesign.

2.2   It is agreed that the commissioning work will be led by Blackpool Council's Commissioning Team and with strong liaison with the CCG and Teaching Hospitals to ensure that all are involved and informed.

2.3   The Commissioning Strategy has been shared with the Executive, Operational and Community Boards

3.0   Key Issues

3.1   How is the Better Start Commissioning going to be overseen?

3.2   How will joint commissioning be undertaken?

3.3   How can we ensure gaps are closed and positive outcomes for children and families are achieved?

4.0   Recommendations and Next Steps

4.1   For discussion on the way forward for Better Start commissioning

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Background papers:

Appendix (i) Blackpool Better Start Strategy paper
Appendix (ii) Blackpool Better Start Executive Summary
Appendix (iii) Blackpool Better Start Implementation Plan
Appendix (iv) Draft Better Start Commissioning Strategy

A Better Start – A Better Future for Blackpool's Children

EXECUTIVE SUMMARY

> The overall aim of Blackpool Better Start is simple – to give every new baby in Blackpool a better start in life.

The benefit will be felt by all children of 3 and under in Blackpool: Lottery funding will enable us to focus on seven priority wards, whilst leveraged funding will spread the benefit across the whole town.

Children growing up in Blackpool face some of the toughest challenges seen anywhere in the country. Blackpool is the sixth most deprived local authority in England, with a low-skill, low-pay economy based on a seasonal tourist trade. Thirty per cent of babies born in Blackpool experience poverty. And we have the highest levels of looked after children in the country.

There are high rates of teenage pregnancy and incidence of unhealthy gestation and birth. Large numbers of babies are exposed to parental problems of mental illness, drug and alcohol abuse and domestic abuse. 30% of mothers continue to smoke, while only 56% of mothers try breastfeeding and only half of those continue after 6-8 weeks. Not surprisingly, child development outcomes are poor and many children start school ill-equipped to learn.

We want to achieve a generational shift, ensuring that today's babies enjoy the early care and nurture they need for healthy development and to be ready for school. And that in turn, as they grow up and become parents themselves, they will pass on the Better Start legacy to the next generation.

OUR BLUEPRINT FOR CHANGE HAS FOUR PARTS

- **A public health approach**, 'shifting the curve' for the whole population
- **Evidence based interventions**, providing more intensive help for those who need it
- **System transformation**, building shared understanding and shared action
- **Building and sharing learning**, creating Blackpool Centre for Early Child Development

Throughout our programme, we will focus on what we know about the particular challenges in Blackpool, and what research tells us about the most important risk and protective factors for us to address:

- *Tackling key risks:* drugs and alcohol, mental ill-health, relationship conflict and domestic abuse, and social isolation
- *Empowering parents and communities:* promoting good parenting, healthy parent-child relationships, self-efficacy and social cohesion.

1. A public health approach

At the universal level we aim to address factors that most influence children's outcomes, and to build a sense of collective responsibility for their wellbeing.

We will measure success against key developmental outcomes: *healthy gestation and birth;* and *readiness for school*. Social and emotional development; healthy and nutrition; and language and communication skills are 'golden threads' that run throughout our programme.

Our public health activity will have two prongs:

- *Rolling out universally resources and programmes of proven effectiveness*, including those that promote physical health, diet and nutrition, social and emotional development, and language and communications skills
- *Creating a series of parent education campaigns* focussed on risk factors evident in Blackpool. The first will be on the impacts of parental alcohol misuse.

2. Evidence based interventions

We will deploy evidence-based and science-based interventions to bring about change for those children and parents with additional or specialist needs.

The centre-piece of our portfolio will be the expansion of the *Family Nurse Partnership*, a proven nurse-led home visiting programme, to all parents under 20.

Among other interventions will be *Parents Under Pressure*, a 20-week intensive programme for parents in receipt of drug or alcohol treatment; and *Baby Steps*, supporting people in the transition to parenthood, nurturing healthy relationships and promoting child development.

We will also research and develop new interventions designed to address critical gaps in current support, such as our work on domestic abuse in pregnancy and infancy.

3. System transformation

We are going to bring about the changes needed throughout local service provision, underpinned by a shared understanding of the problem and a cohesive approach that unites community and professionals from all agencies.

Our partnership brings together all players – voluntary, community, private and public - who can make a difference. We have a strong track record of partnership working, but now we need to develop shared core values, common understanding and a shared language, build local capabilities and share what we learn. So we will deliver an integrated *cross-workforce* training and development programme.

We will actively engage *families and communities*, giving them a formal voice and power. We will recruit and train volunteers to act as community champions, and build on the success of the Family

Nurse Partnership with a new mentoring service provided by those who have been through the programme themselves.

We will make our services more *accessible*, in places like GP clinics and at convenient times of day. We will target known weaknesses in service take-up, including engagement with dads and take-up of free nursery places for 2 year olds.

The partnership on the ground will be underpinned by a *ring-fenced fund* comprising the Big Lottery grant and a further £30 million of funds leveraged from local partners, and managed through an integrated commissioning framework.

We will also ensure that *other policies* (such as transport, environment, housing and welfare) are carefully aligned with the goals of *A Better Start*.

4. Building and sharing learning

We will establish the *Blackpool **Centre for Early Child Development,*** to help build local capacity and expertise.

The Centre will provide leadership and strategic direction for Blackpool Better Start, planning and implementing campaigns and interventions, carrying out research, evaluating outcomes, supporting the workforce and sharing learning.

A dedicated and expert local team will enjoy a close relationship with the NSPCC's national programme on pregnancy and babyhood. As part of a wider community of learning that includes other successful Better Start areas across the country, the Early Intervention Foundation, Dartington Social Research Unit and WAVE Trust, it will become an internationally-renowned centre of expertise.

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Blackpool
Better Start

Commissioning Plan

Foreword

Our vision is:

> *To give every new baby in Blackpool a better start in life, helping them enjoy the early care and nurture they need for healthy development and to be ready for school*

The commitment to all Blackpool's families from Better Start:

- We will transform the way local services are delivered, putting children and families first
- Every expectant mum and dad will have access to high quality antenatal education
- Every new parent will have opportunities to meet other parents in safe attractive community spaces
- Every new parent will have the information and advice they need to foster good health and readiness for school
- Every mum under twenty will be able to access the Family Nurse Partnership
- We will increase access to early help services for babies in families affected by drug and alcohol, mental illness and domestic abuse problems
- We will radically reduce the risks of abuse and neglect of babies
- We will become a national beacon for early child development

Blackpool's Better Start shares with all its partners a responsibility to constantly find more effective ways of making the Better Start and public money deliver better outcomes for our children.

Commissioning is the process for deciding how to use the total resources available in order to improve outcomes in the most efficient, effective, equitable and sustainable way. Commissioning is one of the most effective tools we can use to support us make robust and effective decisions on how we deliver the Better Start programme in Blackpool.

Excellence in procurement and contract management are integral to our Commissioning Strategy. They will provide Blackpool Better Start (BBS) with a foundation and a framework for pursuing a transformative agenda. It sets out how we are going to work together; what governance will apply; what information and processes do we need; how will we work with providers and service-users and what new skills and behaviours do we need to learn.

Setting out our commissioning approach is particularly important for joint working across the partnership. A commitment to excellent commissioning starts with our obsession with achieving great outcomes but it also includes developing relationships with providers to achieve our shared business requirements, identifying providers that will assist with transformation, securing contracts that are value for money.

Finally, innovation is as much about stopping doing something as it is starting or developing something else. This may mean changing or 'decommissioning' existing services to reinvest in a different, better approach and means confronting fundamental questions about the 'right' way to deliver what the communities need. This Commissioning Strategy will help us to be robust about both the evidence for decision-making and the processes needed to enable decommissioning.

1   Introduction

1.1 This Strategy sets out our principles and framework the Blackpool Centre for Early Child Development will use for commissioning. For partners and providers, it is intended to raise awareness of the business opportunities, to give the market time to prepare for tenders, and to guide sub-contracting opportunities. It also offers a basis on which to engage with stakeholders about needs, outcomes and possible solutions.

1.2 This Strategy will be reviewed on an annual basis. Consultation on the review will take place as part of our ongoing dialogue with stakeholders, and the reviewed document will be approved through the Blackpool Better Start governance mechanisms.

2   Blackpool Better Start – strategic priorities

2.1   Blackpool Better Start has three overarching outcomes:

- All babies in Blackpool are born healthy
- Blackpool's children are ready for school
- Families in Blackpool feel more included in their community

2.2 Whilst delivering a balanced budget, the **key strategic priorities** for Blackpool Better Start are:

- Tackling poor parental health and unhealthy gestation and birth
- Safeguarding and protecting the most vulnerable children and families
- Tackling poor mental health and well-being
- Enabling our youngest children to enter school ready and able to learn and reach their full potential
- Delivering quality services through a committed, professional and motivated workforce.

2.3   Blackpool Better Start Key Principles

2.4   Children, young people and their families will be **at the heart of everything we do;**

1. There will be "**no wrong door**" – equitable service will be accessed no matter which agency is first contacted

2. Service will be delivered in and through the **universal services** rather than through separate specialist services

3. We will "**hold the baton**" – the service will work with the family rather than just refer them on.

4. Relationships will be at the centre of our work – **relationships before tasks**

5. "**Services for people, not people for services**" – services will be flexible enough to meet need wherever and whenever children and families need them.

6. Services will be experienced as "**seamless**" by children and parents.

7. There will be a **single point of contact** - children and families will not be required to struggle through the maze of services, but will have a named individual contact.

8. There will be clear, **simple lines of accountability.**

3   Commissioning Principles

3.1.   Our strategic intentions are firstly, to ensure service specifications, contracts and contract monitoring arrangements reflect Better Start outcomes and are evidence based. Secondly, to work with providers to ensure services are designed to meet the needs of parents and residents.

3.2   The Better Start Partnership has agreed a set of principles that underpin our approach to commissioning. Commissioning will be based on:

- Ensuring all commissioned activity contributes to achieving the BS priority outcomes

- Using evidence to understand what works – either through the use of evidence based interventions or those with a science base

- Robust evaluation that both meets Better Start performance requirements and enables commissioners to assess impact, and where necessary, to decommission services which are inefficient, ineffective, inequitable or unsustainable

- Sharing the learning widely on what works, including what works in implementation

- Building sustaining stable relationships between key practitioners and vulnerable families

- Ensuring the views of children, young people and families shape commissioning decisions.

- We are committed to developing innovative ways of engaging service users, for example, through co-design and co-production.

- using open and transparent processes that build confident partnerships

- using commissioning not just to retain existing services or commission new ones but, taking account of value for money in all decisions and encouraging a more diverse provider market in order to stimulate quality and choice

- use of shared processes such as lead professional arrangements and the Blackpool Getting it Right Framework and associated assessment paperwork

3.3   Together these principles contribute to the local commissioning framework. These will be shared with and understood by all who provide services for young children under the Better Start banner.

Governance and Decision Making

4.1   The tender process will be undertaken in line with Blackpool Council's Contract Procedure rules which are written in accordance with EU legislation. This will ensure an equitable process in the procurement of services.

4.2   All commissioning activity will reflect the Commissioning Cycle

Full Needs Assessments will be undertaken alongside a continuous cycle of reviewing performance and monitoring outcomes. The needs of the community, through consultation and feedback, will be reflected as part of the commissioning cycle.

4.3   Outcomes will be measured against Key Performance Indicators to ensure a positive impact for babies, young children and their families.

4.4   Community voice will be a 'golden thread 'throughout the commissioning cycle.

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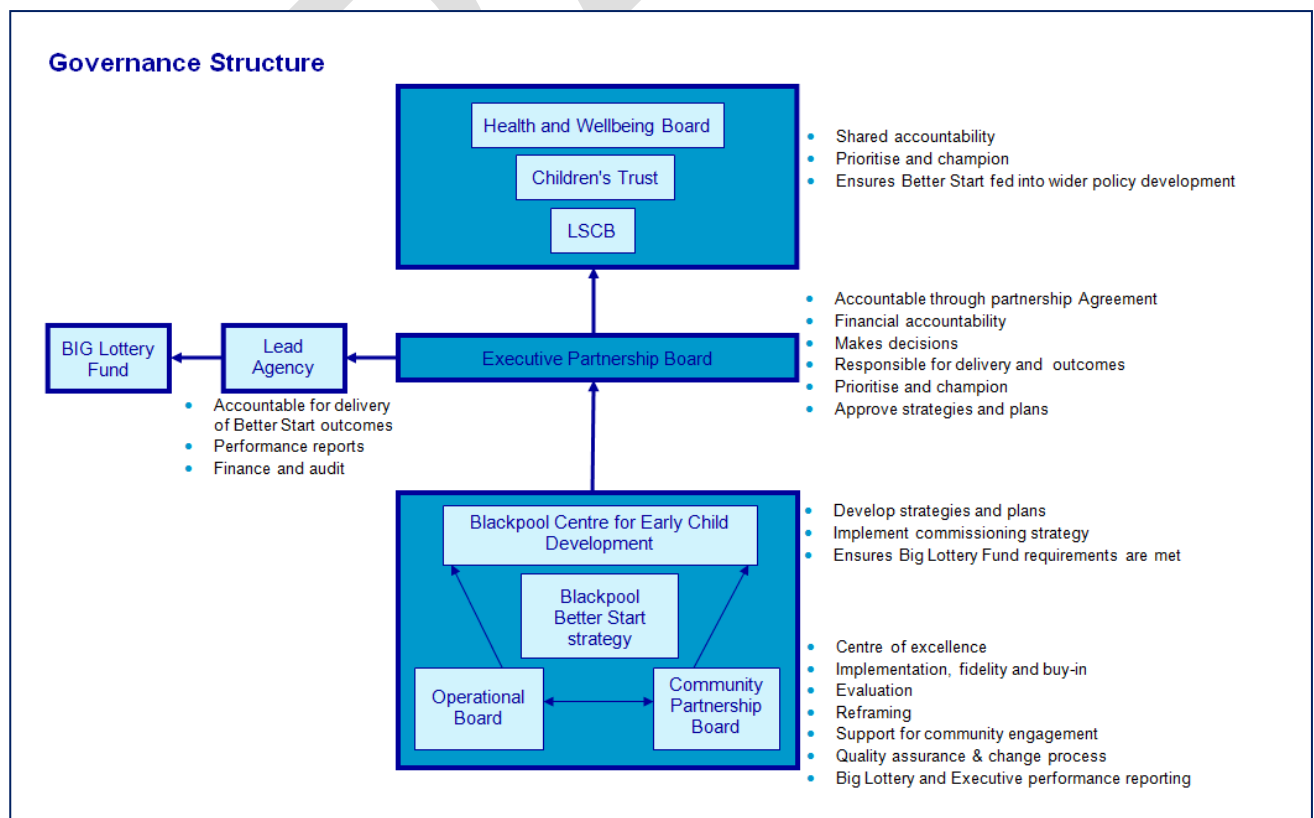
4.6   The Better Start Blackpool Executive Board was created in September 2013. The role of the Executive is to:

- Provide a robust evidence base for decision-making.

- Offer a strategic and integrated view of need.

- Ensure the best and most cost effective providers are sourced

- Develop markets and alternative delivery models.

- Derive maximum value from procurement.

- Ensure the performance of service providers is managed well.

- Use performance information and business intelligence to improve and learn lessons.

- Challenge the status quo and to drive innovation and improvement.

4.7   The Blackpool Centre for Early Child Development will work with local authority and health commissioners to ensure:

- that expertise and experience is shared

- Procurement efficiency

- Good relationships with providers and suppliers

5   Informing the Market of Commissioning Opportunities

5.1   How we will communicate and engage with provider markets

We want to BBS to be a project that providers want to do business with, and whenever we tender contracts, we want to get them right for all parties involved.

5.2   Often we will place Prior Information Notices [PINs] in the Official Journal of the European Union [OJEU], on our websites, in the specialist media, and on capital E-sourcing [when available] that will alert providers to our intention to tender a contract in the near future. We may invite providers to an event to hear more about it, and for us to hear their views. Of course, we realise providers might not want to share their ideas openly with potential competitors, so we might also ask them to complete a confidential questionnaire on some of the key issues to get their feedback. Where the market is small and specialised, we may invite providers to have one to one meetings with us.

5.3   We are keen to improve the method and quality of our engagement with providers. We aim to foster a dialogue with providers in order to facilitate continuous service improvement and to achieve better outcomes for babies, young children and their families.

5.4   In order to develop collaborative and mutually beneficial relationships with providers, we will:

- Appoint designated commissioners to act as the key contacts with providers, facilitating a means of communicating their concerns, ideas and wishes.

- Ensure that our key priorities and projects are communicated to providers via the designated contacts and at provider forums.

- Keep abreast of significant policy and market developments and communicate these to providers.

- Organise events that will bring together key stakeholders across the sector in order to promote relations between organisations and to facilitate an open conversation on priorities, partnership working, and gaps in services.

- Offer opportunities for greater involvement with providers in the design of services, acknowledging their invaluable expertise and practical knowledge.

6   Contract Management

6.1   Over the course of the next year we aim to develop a contract monitoring and management system. The Framework will be based on the following principles:

- We will ensure that standards and methods for assessing performance and quality are detailed in the service specification/contract.

- We recognise that contract monitoring can be resource intensive for both provider and commissioner. We will therefore ensure that the methods used are proportionate to outcomes, contract price, and the level of risk.

- Contract monitoring will focus on the delivery of outcomes rather than just inputs or outputs. We will establish key performance indicators linked to outcomes, and work with providers to address performance variations and under-performance.

- Evaluation will be a key part of the delivery of all contracts and providers will be required to work with BS evaluation teams.

- Where we can, we will collate information from already existing sources.

- We will consistently manage supplier relationships across the contracts we hold, and we will make use of provider's own quality assurance and self assessment systems.

- There will be a named commissioning officer for each contract.

6.2   Finding out what works is a key part of the Better Start initiative. All projects will be evaluated and where they are shown to be effective, using criteria agreed in advance by the BBS Executive, a business case will be made to take them to scale drawing on leveraged funding.

6.3   Performance information indicating that services are inefficient, ineffective or unsustainable will help inform commissioners' decisions both to support and challenge the provider to improve, or to de-commission it and seek alternative provision to meet need. The first stage in addressing failing performance will usually be to work with providers to agree what action they will take to improve their performance. We will agree timescales for improvement and be clear about the consequences of failing to make the agreed improvements. We will agree a protocol for intervention with poorly performing or failing providers, and set up systems for remedial action where needed.

7   De-Commissioning

7.1   De-commissioning, the process of discontinuing a service procured from an external or internal provider, may be necessary when:

- A provider is failing to deliver the required outcomes, and has been unable to improve in a reasonable timeframe.

- Evaluation shows the service is ineffective.

- A thorough needs assessment shows a particular service is no longer needed.

- Funding is no longer available or the provision is no longer a priority.

7.2 Decommissioning is part of the commissioning cycle and should be undertaken in a planned way to ensure that the most effective services are delivered, making best use of the resources available. In some instances service reviews will lead to a process of ending a service or part of a service and a smooth transition to a new or alternative service delivery model in order to achieve the right outcomes for people. This will enable investment in new services in accordance with our strategic commissioning plans.

7.3 The principles we have set out for commissioning apply equally to de-commissioning. However, in addition we will endeavour to apply the following principles:

- Strong internal and external engagement and communications.

- Minimised political, individual and social impacts.

- Sensitivity to the impact on organisations and markets.

- A strong narrative underpinning the changes.

- Effective validation of solutions prior to implementation.

- Strong and auditable governance.

- Strong follow-through to ensure outcomes are met.

Appendix A Priority Commissioning projects 2014/15/16

2014/2015
[Include list of deliverables, from the bid, for the first 12-18 months with the budget, key agency responsible where relevant and/or whether there will be a procurement. This should include all budget workstreams.]

Project	Key agency responsible [BBS Centre, LA, CCG, NHS England]	Procurement [y/n]	Budget
FNP	NHS England		

Blackpool Better Start
Commissioning and Contracting Governance

1.   Introduction

Decision making on spend for Better Start needs to satisfy the requirements of Big Lottery and partner organisations in line with their Standing Orders. The following is proposed for making decisions on spend for Better Start in Blackpool and is based on the need to identify an efficient, streamlined and rigorous approval process. The proposal applies to both Big Lottery and leveraged funding. Governance arrangements will evolve as Better Start is established and alongside other partnership arrangements.

The Blackpool Centre for Early Child Development would oversee all commissioning and contract activity.

2.   Proposal for contract approval structure in Blackpool Better Start

2.1 The Blackpool Centre for Early Child Development will be the single agency with authority to oversee and approve the delivery and implementation of all Better Start strategies and their consequent procurements and contract management, prior to submission to the Blackpool Better Start (BBS) Executive for approval as required under the BBS Partnership Agreement.

2.2 The Centre draws on commissioning expertise from the Local authority and Clinical Commissioning Group Commissioning Team. Finance and legal advisers will be invited where particular items require it.

2.3 Reports should be submitted to the Executive within agreed formats which ensure that appropriate inputs have been obtained prior to submission, including consideration of the workforce, property and equalities implications, Community Voice, user involvement and stakeholder consultation, and legal and financial sign off. A sample template is attached in Annex C.

2.4 Decisions will be tracked through the Blackpool Centre for Early Child Development to ensure the timely conclusion of procurements. A sample template for keeping track of all commissioning and contracting activity to ensure priority outcomes and budget considerations are being met is attached in Annex D.

2.5 The Centre will raise any issues of concern with the Operational Board and, if necessary, through the relevant Partnership Executive Board member.

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Blackpool Better Start
Commissioning

Terms of Reference for the Blackpool Centre for Early Child Development in relation to commissioning

Aim

To provide oversight of, and approval for, the delivery and implementation of Better Start commissioning plans, their procurement stages and their ongoing contract management. To meet the governance requirements of the BBS Partnership.

Objectives

To manage and review a Forward Plan of procurement and agree the scheduling to achieve a clear link to shared strategic priorities and savings plans with partner organisations. There is also to be a link to the Strategic Commissioning Group which is part of the HWB

To ensure that statutory requirements, Better Start values, safeguarding considerations and Big Lottery standards are adhered to.

To involve the Operational Board and Community Voice in all decisions.

To ensure appropriate resource is committed to each commissioning project and procurement process to deliver in a timely fashion.

Procedures

Reports will be presented to the BBS Executive Board for consideration and approval based on a standard template (see Annex C) which can be amended by report authors to meet specific subject matter requirements.

Papers, with appropriate legal, financial, and corporate property, IT, and HR implications signed off, will be circulated five days in advance of BBS Executive meetings to ensure that Board members have time to study them. Tabled papers will not be accepted. In exceptional circumstances papers can be approved by email between meetings.

Decision Making & Accountability

The BBS Executive Board will approve, inter alia:

- commissioning/contracting strategies which require procurement and contract management,
- procurement initiation, specifications, service levels, service user involvement and procurement timetables,
- approval of preferred and reserve bidders and post tender clarification/negotiations,
- award of contract and contract start up,
- contract variations,
- contract extensions,
- reporting of any issue of concern and/or safeguarding matter that may arise in any contracted service,
- and any other relevant commissioning and contracting matter that may arise.

For large projects the Centre will carry out a gateway function for all stages of procurement and ongoing contract management matters.

Above agreed thresholds, reports will be submitted to the BBS Executive for approval.
Criteria for papers to come to the BS Executive Board

a. Initiatives which result in Better Start incurring significant spend – with a financial thresholds of £10,000

b. Initiatives which result in spend drawn from partners leveraged funds
c. Significant in terms of its effects on communities living or working in Blackpool.
d. Significant in terms of its effects on the Better Start Partnership

Process

Projects will be presented to the board at three key stages:

1)   to agree the strategy decision. This will require a paper setting out the approach and to agree key principles

2)   Agreement to service levels, spend and spec

3)   Contract award decision

Before presenting papers to the board the following should be included:

- Confirmation from finance on the budget for the project, including where the money is coming from (BS, leverage, other) and any other financial or resource implications.
- Clearance from legal
- Views of the community
- Timeline
- Political governance process

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Blackpool Better Start Executive Decision Report

Decision maker(s) and date of Executive meeting	*Insert meeting details as appropriate* Date of decision: *[insert]*
Report title (decision subject)	*Insert, IN CAPITALS*
Project lead	*Insert name here*
Decision	Yes or No
Access to information classification	*Insert* 'Confidential/exempt' or 'public'
Executive sign-off details	*Report authorised: [insert]* *Date: [insert]*

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[Please note that, in normal circumstances:

(i) Reports should normally be no longer than four sides with ancillary information in appendices

(ii) Paragraph numbering should normally be limited to two levels, i.e. 1 and 1.1 but not 1.1.1 etc.

(iii) Sub-headings should normally be lower-case bold and that underlining should be avoided throughout the report.]

1. EXECUTIVE SUMMARY

Include here a brief summary of the purpose of the report.

2. RECOMMENDATIONS

You should include here precisely, but briefly, what you want agreed.

3. REASONS FOR DECISION

The reason for the recommendation must be included here.

4. BACKGROUND, INCLUDING POLICY CONTEXT, AND ANALYSIS OF OPTIONS

This part of the report should set out the main consideration(s) for the decision maker. This is where you demonstrate that all relevant options have been weighed-up and how the recommendation has been arrived at. All relevant factors (see Appendix A for list of standard considerations) should be taken into account here.

Use relevant sub-headings (lower case bold please) to assist with clarity.

Other Implications

[The report author should consider, and include paragraphs on the following as appropriate within this separate appendix, unless these considerations are sufficiently important and relevant as to justify being included within the body of the report itself.]

1. Business Plan

2. Risk Management

3. Evaluation

4. Outcomes

5. Health and Wellbeing, including Health and Safety Implications

6. Staffing

7. Sustainability

8. Communications

6. **EQUALITY IMPLICATIONS**

Any key/relevant equalities issues must be included here, in the body of the report.

6. **LEGAL IMPLICATIONS**

This section should include the legal power relevant to the proposal must be set out together with any future possible legal implications. Unless circumstances dictate that a legal input from each authority is required, it will normally be sufficient for the Legal Officer at the authority originating the report to comment.

7. **FINANCIAL AND RESOURCES IMPLICATIONS**

Details of the current and future financial implications must be set out here. It is the responsibility of the report author to ensure this happens.

8. **CONSULTATION**

*The report author will be expected to ensure all necessary consultation (including external consultation where appropriate) has taken place **before** this report is submitted to the BBS Executive.*

Background papers used in the preparation of this report

Contact person(s): *[Insert name, post title, organisation and both email/telephone contact details. The contact person should be the report author or someone who is able to answer questions about the report.]*

Appendix D Sample contracts tracker

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A Better Start – A Better Future for Blackpool's Children

Strategy

Our community is united in our ambition to give every new baby in Blackpool a better start in life. We do not underestimate the scale of the challenges we face. But we are determined to seize this moment to make a decisive change and to transform the life chances of our youngest children and families.

> Our vision is that Blackpool will be a place in which families raise happy, healthy children who grow up to take pride in belonging to the community. Through Better Start, every new baby in Blackpool will enjoy the early care and nurture they need for healthy development and to be ready for school

EXCEPTIONAL ABILITY TO DELIVER

We are confident we will be able to deliver this vision and have a lasting impact beyond the life of the programme because we have:

- **Strong partnerships:** all key players from the voluntary, statutory, private and community sectors are united behind a shared vision and a shared plan for delivering change. This proposal builds on a long track record of successful partnership working

> *"The only way we can change things is by working together.".*
>
> Parent

- **Bold plans for system transformation:** all partners are committed to whole system change, underpinned by financial, structural, cultural and workforce changes.
- **Effective and inclusive governance:** our governance structure ensures effective and strong leadership, including a dynamic and robust role for the community to shape services and activities.
- **Compact unitary authority:** two-thirds of children live in the target wards and we are committed to rolling out the learning and activity across the whole borough. Common boundaries between local authority and the clinical commissioning group make joint planning and alignment of activities straightforward and effective.
- **Policy alignment:** the Better Start Approach is clearly aligned with the wider regeneration agenda. Blackpool's aim to become a great place to live and Britain's number one holiday destination and to make its offer to the resort relevant to today's visitor. Its investments in the environment and heritage of the town alongside a plan to boost availability of good quality family housing all reinforce the goals of A Better Start.
- **Public health approach:** we believe in change at the population level (through universal services and public health campaigns) with more intensive intervention for those identified as needing extra help

- **Exceptionally strong portfolio of evidence based interventions:** We have a carefully tiered approach to addressing need across the population and a track record of delivering evidence based interventions
- **£30 million of local investment:** we have agreed to leverage £30 million of real investment for conception to threes across the 10 years of the programme. We will create a 'Bank of Blackpool' to pool resources.
- **Role of the NSPCC:** we are in a unique position to have the NSPCC as the voluntary sector lead for this bid.   They bring to this strategy not only the size and reputation of the leading child protection charity, but also in-depth knowledge and experience of evidence-based interventions – including a major national programme of work on pregnancy and infancy.
- **Access to international expertise:** We have established links with national and international experts who can enhance our knowledge base and capacity to share cutting edge learning and development
- **Blackpool Centre for Early Child Development:** This new centre demonstrates our commitment to building local expertise and capacity in the design and delivery of evidence based interventions. It also signals our bold ambition to make a difference to children's lives and to share the learning.

> *"We want to be a place where people from around the world come to see how things should be done".*
>
> Neil Jack, Chief Executive, Blackpool Council

CONTEXT: THE CHALLENGES FOR BLACKPOOL

Blackpool, a seaside resort on the North West coast, is the sixth most deprived local authority in England.   Our population of 142,000 people is predominantly White British. Our main industry is the tourist trade which is obviously seasonal and must compete in a global market for visitors. We have problems with high levels of poverty, poor quality housing and a low-skill, low-pay economy. Employment opportunities are difficult to create, given our geography and lack of available development land, and 'out of work' benefit levels are at almost twice the national average. Blackpool suffers major health inequalities, with life expectancy for men and women respectively the lowest and third lowest in England. Many local families feel socially isolated. What is more, these challenges are compounded by low aspirations and expectations, and a sense of almost resignation amongst some in our community.

Every year around 750 babies are born in the Better Start wards of Bloomfield, Brunswick, Claremont, Clifton, Park, Talbot and Victoria. And in total there are around 2,650 children aged up to 3 in these wards – almost 40% of all those in Blackpool as a whole. Park and Clifton are fringe of town estates, dominated by social housing. The other five wards form a continuous area around Blackpool's town centre and are characterized by dense housing, with some accommodation converted from former Bed and Breakfast stock into multi-occupancy flats and houses.

Blackpool's children face high levels of disadvantage. 30% of children in our town experience poverty; and a

> "There is an on-going generational cycle of poverty in Blackpool that is very difficult to break."
>
> Joseph Rowntree Foundation

half of those in poverty live in the Better Start wards. We have the highest levels of Looked After Children in England. In fact, 78 of our 434 children in care, are under 3 and from the Better Start area. Large numbers of babies in our town are exposed to parental problems of mental illness, drug and alcohol abuse and domestic abuse. Women's risk of suffering domestic abuse, for example, is estimated to be nearly four times the national average.

Blackpool has high teenage pregnancy rates, with around one in twenty girls aged 15-17 conceiving each year. One in five babies in Better Start wards experienced an unhealthy gestation and birth (measured by low birth weight, prematurity or use of drugs/alcohol/tobacco by their mother in pregnancy). 30% of mothers in Blackpool continue to smoke when their babies are born (twice the national level). 44% of mothers choose not to try breastfeeding. And among those that do try, only half persist after 6-8 weeks.

Not surprisingly given these levels of disadvantage, child development outcomes are poor. One in twenty children aged 6 months to 5 years has poor speaking or listening skills. Around one in five children in Better Start wards are affected by hyperactivity or ADHD; and results across the Early Years Foundation Stage profile compare poorly against the national average.

Against this backdrop of disadvantage it would be easy to become fatalistic and write off the children and families of Blackpool. On the contrary, it is precisely because of the scale of the challenge, that we are so united in our determination to turn things around.

OUR BLUEPRINT FOR CHANGE

Delivering our bold vision requires a **cohesive and committed partnership** and a **strategic programme of action**.

Our partnership brings together all players – voluntary, community, private and public - who can make a difference to young children's lives. We want to achieve change for a whole generation and we knew this could only be achieved by building a genuinely inclusive and cohesive alliance. Our approach started with the needs of children and families themselves and is underpinned by meaningful engagement with the community. We are in this together - for the long run.

Delivering the vision requires rigour and a strategic framework for prioritising those activities that will make most impact on the outcomes we care about most. It requires careful implementation and systems that help – not hinder - what we need to do. We have a strong track record of partnership working, but we also recognise we need to invest time in developing common understanding and a shared language. We need to build local capabilities and to develop the infrastructure for learning and sharing what we learn with others. Better Start provides us with an exceptional opportunity to make this transformation and we are determined to deliver real and sustainable change in the way we do things.

In Blackpool, we have developed a blueprint for our Better Start programme based around 4 pillars, which we believe provide exceptionally strong foundations for our work over the next ten years and beyond.

First of all, our programme of action is grounded in a **public health approach**, and starts with an understanding of needs across the whole population. Secondly, for those with additional needs, we

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have crafted a programme of science and **evidence based interventions** designed to provide more intensive services, focussed on achieving clear priority outcomes. The third pillar of our approach is **systems transformation**, which refers to the change we need to see at all levels of our local services and systems. We believe this type of reform can only be successfully implemented if it is underpinned by a shared understanding (or 'framing') of the problem we face and a cohesive approach that unites community and professionals from all agencies. And our fourth pillar – **the Blackpool Centre for Early Child Development** – provides the dedicated locus for driving the strategy, programme implementation and research. The centre will build local capacity and expertise and become internationally renowned as a centre of innovation and learning.

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| Pillar 1 | **PUBLIC HEALTH:** *Change for a population* |

Blackpool Better Start takes a public health approach. This means we emphasise: the needs of the whole population; the underlying socio-economic and wider determinants of children's outcomes; and collective responsibility and partnerships with all those who contribute to the wellbeing of young children and families.

Our overall strategy for the Blackpool Better Start programme is a developmental one. Based on extensive analysis of local data and a careful review of the research literature on early child development, we have prioritised two key outcomes: **healthy gestation and birth**; and **readiness for school**

A developmental strategy

| Social & Emotional Development | Communication & Language | Health & Nutrition |

Key Developmental Outcome 1:
Healthy gestation and birth

Key Developmental Outcome 2:
Readiness for school

These outcomes were selected not only because baseline data show particular challenges for our community, but also because they pinpoint important developmental milestones and provide rich composite measures of developmental progress. We fully embrace the Big Lottery Fund's three domains of: social and emotional development; language and communication; and diet and nutrition. We see these as crucial 'golden threads' that run right throughout our programme.

We have an important responsibility to ensure the Better Start investment is targeted where it can achieve the greatest impacts.

In Blackpool, there is a high degree of consistency between the issues of greatest concern to the community and the areas that stand out most in our local needs analyses and the survey data from Dartington. We have combined these data about local needs and priorities with what research
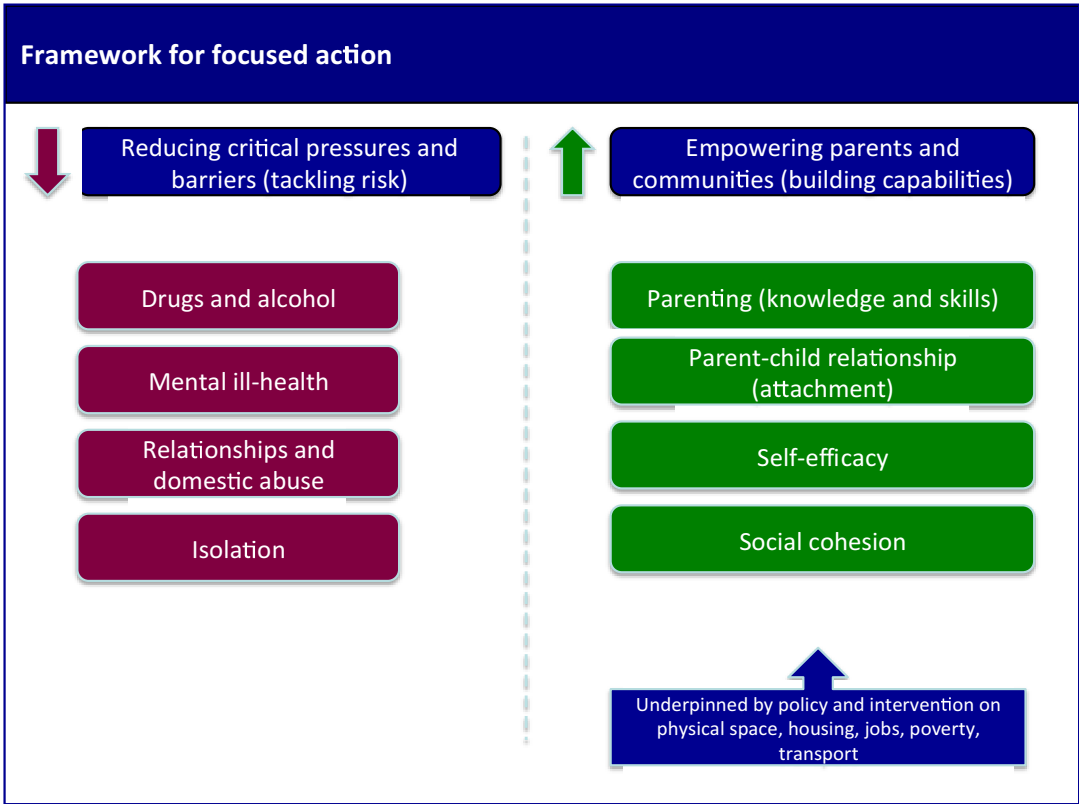
6

evidence tell us about the factors that matter most for achieving our desired outcomes for babies and young children.

We have used these data to create a 'Framework for focussed action' in our Better Start programme, based around:

- Reducing critical pressures and barriers (tackling risk)
- Empowering parents and communities (building capabilities)

The chart below sets out on the left-hand side the four key risks/barriers we aim to reduce through our programme. And on the right-hand side it lists the key ways in which we will empower parents and the community (our 'mechanisms for change'):

Framework for focused action

Reducing critical pressures and barriers (tackling risk)	Empowering parents and communities (building capabilities)
Drugs and alcohol	Parenting (knowledge and skills)
Mental ill-health	Parent-child relationship (attachment)
Relationships and domestic abuse	Self-efficacy
Isolation	Social cohesion

Underpinned by policy and intervention on physical space, housing, jobs, poverty, transport

We have designed an integrated programme of activities spanning all levels of the government's Healthy Child Programme policy framework.

Building on our strong local universal health and children's services provision, we will ensure that new parents have access to a suite of **universal health promotion** resources, directly addressing:
- Diet and nutrition
- Language and communication
- Social & Emotional Development

[Details of the specific resources can be found in Annex C]

Over the course of the ten years, we expect to develop and deliver four public health campaigns. The first will be on the impacts of parental alcohol misuse. Our campaigns will each have a clear theory of change based on latest scientific research and they will be informed by original ethnographic research helping us to better understand local values, attitudes and behaviours that

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might inhibit or motivate change. Campaign executions will be carefully designed and pre-tested locally. Evaluations of awareness, recall and attitudinal and behavioural change will help us measure the impacts of these campaigns; and also create an evidence base for their potential replication elsewhere.

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Pillar 2 **EVIDENCE BASED INTERVENTION:**
Change for those with additional needs

We propose a tiered model of provision, spanning different levels of need across the Healthy Child Programme framework:

A tiered model of provision

Universal Partnership Plus	Family Nurse Partnership
	Parents Under Pressure
	Parent-Infant Psychotherapy — Survivor Mums*
	Safecare — Domestic Abuse* — Pre-birth assessment*
Universal Plus	Baby Steps — Video Interaction Guidance
	Hanen & REAL — Triple P for toddlers
	Early Learning with Families
Universal	Health Promotion resources and 4 new Public health campaigns
	Maternity and community health — Children's Centres
Community	Beach school — Food Dudes — FNP Graduate Mentors
	Safe space and play fund

*projects marked with an asterisk are innovation projects

Each of these programmes has been identified on the basis of a careful assessment of: its current evidence base; fit with our priority outcomes; fit with our local needs; feasibility and suitability for our workforce and context; fit within the wider programme of activity; resource implications and value for money; potential for sustainability and replication; as well as its potential for new learning and impacts. Further details on the programmes can be found Annex C.

We have adopted a staged approach to implementation; identifying three broad categories of activity.

1. Development or expansion of existing services and 'quick wins'
- full expansion of the **Family Nurse Partnership** programme to reach all under-20s in the town
- development of a **new FNP graduate mentoring service**, provided by local FNP graduates to other mums
- full expansion of the **Baby Steps** group parent education programme to reach all those not on FNP
- increasing access to **Triple P** parenting programme, for parents of 2-3 years olds

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- full expansion of **Food Dudes** health and nutrition programme
- development of **Early Learning for Families**, supporting language development and learning
- creation of the **Beach School,** providing community led space for learning
- creation of the **Improving safe space and play,** community led fund

2. Introduction to Blackpool of interventions successfully developed elsewhere*

- **Parents Under Pressure**, for families with drug and alcohol problems
- **Video Interaction Guidance,** increasing parental sensitivity in families with attachment problems
- **Safecare,** structured home visiting for families at risk of, or reported for, maltreatment
- **Parent Infant Psychotherapy,** addressing critical mental health and attachment needs
- **Hanen & REAL,** improving language and communication skills

3. Innovation and research projects$

- **Domestic abuse in pregnancy and infancy,** attachment based service where families stay together
- **Pre-birth assessment,** a new model where harm is suspected about an unborn child
- **Survivor mums companion,** tackling abuse-related trauma triggered in pregnancy
- **Alcohol abuse in pregnancy**, developing an early intervention service

* Three of these programmes have already been successfully implemented in other areas of the UK by the NSPCC. And we have strong existing links with the providers of the other identified programmes

$ The first two of these projects are already underway, led and funded by the NSPCC and their collaborators. Our close partnership with the NSPCC means the opportunity to help shape and inform these new services as they are being designed; and it means opportunities to pilot and deliver services that are relevant to our needs locally. The NSPCC has a strong track record in attracting funding for service development projects and research. We are currently awaiting the outcome of a bid to the NIH in the USA to fund the Survivor Mums Companion work.

We will make the most of our relationship with the NSPCC and their experience of developing and testing evidence based programmes specifically in pregnancy and the early years. They have extensive knowledge of the evidence base and are skilled at identifying opportunities for science-based innovation. Together we will identify the gaps in the evidence and take a thoughtful and considered approach to innovation, always building on the work of others and working with programme developers to ensure a good fit with our specific local context.

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Pillar 3	**REFRAMING AND SYSTEM TRANSFORMATION:** *Building shared understanding and shared action*

We will not achieve the step-change in the outcomes we desire, through evidence-based interventions alone. A key pillar of our blueprint is systems reform, which means change at all levels and pulling everyone together behind our shared vision.

Children in our target wards make up two thirds of the conception-to-threes in the town. We can't re-design part of the system for such a large proportion of children, so we are ready to completely reform public services for all conception to threes. We have already started the work of transforming our local systems, in part stimulated by large cuts in public expenditure, but also because we recognise the strategic importance of investing in the early years and prevention.

System transformation
- Investment, leadership and accountability
- Workforce development
- Engaging families and communities
- Reframing
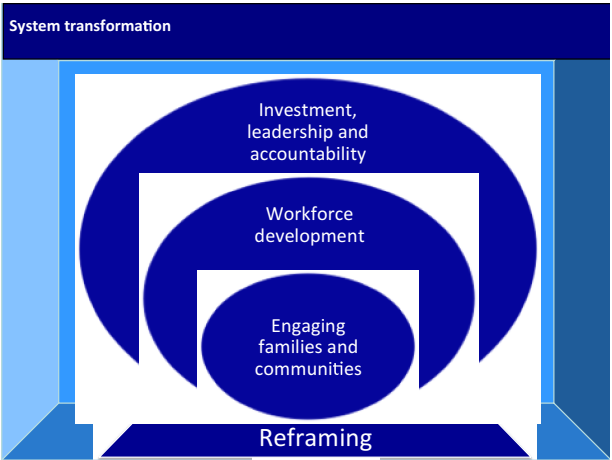
Reframing

We want to give everyone: professionals, volunteers and parents, a common language for communicating about children's needs. Inspired by the success of the *Alberta Child Wellbeing Initiative* in Canada, we plan to deliver a cross-workforce training and development programme in partnership with the US based *FrameWorks Institute*.

In Alberta, the Initiative has worked with a range of leading child well-being experts and the *FrameWorks Institute* to build a cohesive workforce bound by a common language and shared experiences.

The purpose of the reframing programme is to:

- Develop a shared understanding of child development across the community and across the children's workforce ('what do children need?' and 'how can we help them?')
- Develop a shared language for articulating these needs
- Through sharing the experience of learning, break down professional and professional-citizen boundaries and build trust and confidence, creating a culture of integrated working

The reframing work will be the essential bedrock for our ambitious programme of system reform. We have identified key systems challenges at three main levels of our systems. These are set out in the table below, together with our programme of action to turn things around:

Engaging families and communities	
Key challenges:	• Many families in Blackpool are poorly connected to their communities • Parents want safe space to meet other new families • Service access and engagement is often poor • Trust in professionals is often low • Parents want more say in the design and delivery of services • Parents would like to be more informed about child development • Parents would like to be more in control and to have greater agency to help

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	children themselves
Our approach:	1. **Strengthening our understanding and skills** Building on the Well-Being data, we will work with researchers to get a deeper understanding of how Blackpool's families think about children and how they see their needs. This research will feed directly into the 'Reframing' work; and it will also provide important insight for our public health campaigns described earlier. 2. **Delivering our pledges on service accessibility** In our community consultation, parents asked us to make our services more accessible by putting them in places where people currently go, like their GP clinics and children's centres. We will operate them at times that suit the community, not just between 9am and 5pm. Parents also want our services to have 'one front door' so that families' needs are met without multiple referrals and so that information is shared in a way that means families need only tell their story once. 3. **Nurturing community champions** A volunteer academy will be established to recruit, mentor and support a group of community champions. Building on the existing Community Champion initiative in Blackpool. They will work in communities to actively promote the use of services and highlight to the partnership where changes are needed. 4. **Creation of 'FNP Mentoring Service'** Building on the local success of the Family Nurse Partnership, we will develop a new mentoring service, provided by local graduates of the programme. Building trust and engagement are major challenges for public services in Blackpool. We believe that by training and supporting FNP graduates as mentors/befrienders to other parents, we will not only overcome barriers to service engagement, but also help to build the skills, confidence and work-readiness of the graduate volunteers themselves. 5. **Empowering 'Community Voice'** *Community Voice*, our community engagement board provides a solid foundation on which to build a group of empowered service users with formal structural links to the governance of the Better Start Partnership. [Further details on how we will ensure they have meaningful inluence in our governance arrangements can be found in Annex M.] We will coach and support this group through the stages of engagement. They will be our touchstone for when we're getting things right – and wrong 6. **Targetting known weaknesses** We have identified areas where our current user engagement is particularly poor and we will target these areas for special attention: engaging dads; take-up of free nursery places for 2 year olds; and help in a crisis. We have included budget for specialist workers whose role will be to address these

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critical issues, drawing on research and development insights brought together by the *Blackpool Centre for Early Child Development.*

7. **Real projects with budgets and impact**
   Community Voice and other bodies that will be developed over time will be given control of budgets and have real decision making authority. We have already identified two totemic projects that *Community Voice* will take lead responsibility on: **Beach School** and **Improving safe space and play**. [These are described in Section C]

Workforce development	
Key challenges:	• We have a partial picture of development needs across the Better Start workforce as a whole • Professionals want tools and approaches for better engaging families • Professionals want access to evidence based methods of practice and opportunities to share learning • Some practitioners need specialist training in evidence based programmes • There are opportunities for increased multi-agency working • Professionals want more opportunities for reflective practice • There are opportunities to increase professional confidence in decision-making
Our approach:	1. **Establishment of the 'Better Start Workforce Development Group'** This inter-agency body will oversee the production and delivery of the workforce development strategy. It will bring together senior managers from the partner agencies with the authority to reshape workforce development according to a common Better Start design. 2. **Core values, competency framework and skills audit** We will develop a set of 'core values' to guide professional practice and provide a common frame of reference between staff from different disciplines. The group will develop a shared 'competency framework' for staff and volunteers and undertake an audit of the current skills, experience and competencies of the workforce. Findings will be used to prioritise needs and to plan specific training and development activities. 3. **'Core training' programme** Definition of the core training programme is likely to include child development, roll out of approaches for engaging families (such as Motivtional Interviewing) as well as issues such as safeguarding, perinatal menal health awareness, domestic abuse, drug and alcohol misuse and data protection. 4. **Specialist training for specific professionals** The Workforce Development Strategy will also capture the specialist training needs identified by individual services or professions.

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	5. Specialist training in evidence based programmes The *Blackpool Centre for Early Child Development* will oversee the planning and delivery of specialist training in our newly-introduced evidence based programmes such as Video Interaction Guidance and Safecare. Many of these new programmes will involve increased multi-agency and inter-professional working **6. Video enhanced reflective practice (VERP)** We will explore the potential to pilot the use of Video Enhanced Reflective Practice, an approach involving the use of video technology to film supervision sessions; and joint discussion of the films between managers and practitioners to help review interaction and promote reflective practice.

Investment, leadership and accountability	
Key challenges:	• There is a need to redirect investment towards early years intervention and prevention • There may be opportunities to increase outside investment in services from pregnancy to three • There can be competing priorities between different agencies, reflecting different government agendas • There are gaps between systems (between health and children's services; adults' and children's services; maternity and child health; voluntary, statutory and private; and between prevention and protection). • We need to ensure commissioning decisions are made on the basis of 'what works' and 'what doesn't' – as well as evidence of value for money
Our approach:	**1. £30m of local investment to Better Start** In addition to the Big Lottery funding, the Delivery Partners agree to ring fence and make available over the ten years of the Better Start programme £30,000,000 (thirty million pounds) from existing budgets. This additional investment underscores the seriousness of our commitment and provides resources to enable re-design of service delivery and expansion of services demonstrated to be effective and provide good value for money. **2. Creation of the 'Bank of Blackpool'** The 'Bank of Blackpool' is the vehicle through which we will pool and ring-fence resources from partner agencies for our Better Start programme. Blackpool Local Authority has a history of pooling and aligning budgets to improve outcomes, create economies of scale, and work in closer partnership with other organisations. Most recently the Local Authority have pooled budgets with health and local voluntary organisations on Learning Disabilities and created a joint NHS commissioning pooled budget for substance misuse services. During the first twelve months of the programme, the Delivery Partners will obtain legal and financial advice as to the most appropriate vehicle for holding such funds. This could be holding the monies in a joint bank account, on trust, or in accordance with any other structure as may be agreed by the parties.

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The Bank of Blackpool will also provide an important and highly visible symbol of our Better Start investment; and we will exploit this to profile to attract further funding and outside investment.

3. Integrated Commissioning Framework

We will develop a new integrated commissioning framework, ensuring a shared, transparent and effective approach to commission across the partnership. This process will include a joint commissioning sub group that will manage the mechanics of any commissioning process and ensure conflicts of interest are effectively managed. It will also include a critical friend role from the *Blackpool Centre for Early Child Development*, helping ensure that commissioning draws on the best and most current evidence and science base.

4. Effective and inclusive governance

We have established robust governance structures so that decision-making processes are fair and transparent. Roles and responsibilities are clearly defined across the partnership. Further details on governance arrangements can be found in Annex M.

The community will have a clear influence on decision making through the newly developed 'Community Voice' – a group of parents with an elected member sitting on the Operational Board. As *Community Voice* grows in confidence it is hoped that other members will take a more active role in developing Better Start. To give community members real power and influence over outcomes they will be supported by the *Blackpool Centre for Early Child Development* and they will have their own budgets for flagship projects such as the Beech School. Further details on community engagement can be found in Annex N.

5. The Better Start policy test

Better Start has backing at the very highest levels in all our partner organisations. Senior Officers and politicians will ensure that Better Start is a long-term priority for the town by acting as champions for the programme and sending out clear and consistent signals that we mean business. We will also ensure that wider policy developments – such as in housing, transport and regeneration - all take into account the goals of the Better Start programme. When new policies are being formulated, we will ask whether the proposals pass the 'Better Start test'.

6. Clear accountability

The Executive will ultimately be accountability for leadership of the change agenda and for delivery of Better Start outcomes.   Senior local leaders commit to working together to build consensus around the Better Start vision and to drive sustained commitment towards its goals.

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Pillar 4	**BLACKPOOL CENTRE FOR EARLY CHILD DEVELOPMENT:**
	Building and sharing learning

The final pillar of our distinctive Better Start approach will be establishment of the *Blackpool Centre for Early Child Development*. The centre will play a crucial role in driving Better Start strategy and overseeing delivery and learning from the programme. Our ambition is that the centre should become an internationally recognised and renowned source of expertise and innovation in services and systems from pregnancy to three.

Functions of the Centre

- Leadership and strategic direction for the Blackpool Better Start programme as a whole
- Planning and implementation of the public health campaigns and new evidence based interventions, working in partnership with other providers
- Chairing the operational partnership group
- Communications and marketing, including the FrameWorks approach
- Managing community development contracts and projects
- Research and development of new services
- Support and challenge to the Executive around systems transformation
- Support and challenge to the Workforce Development Group
- Local evaluation of process, impacts and costs to inform service improvement and commissioning
- Data capture for the programme
- Support and challenge to the Bank of Blackpool and commissioning board on quality of evidence
- Capturing and sharing learning

How it will work

We will establish a **dedicated and expert local team**:

- **The Director** of the Centre will provide overall leadership of Better Start in Blackpool and be accountable to the Executive Partnership Board. He/she will be a key ambassador for the programme across the partnership and externally. The Director of the Centre will be a high profile role and we expect this to be filled by a recognised expert in the sector.
- **Development Managers** will each be responsible for leading implementation of several evidence based programmes, liaising as appropriate with other partners and providers. They will also have a role in managing research and innovation projects and in workforce development and training.
- **Evaluation Officers** will be responsible for local evaluation at individual and population levels.
- A **Community Development Officer** will manage the community engagement contracts and projects, support the *Frameworks* project and be the key link between the Centre and *Community Voice*.
- A **Senior Communications Officer** will manage all marketing and communications activities, including materials for new services and management of the *Frameworks* project.

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There will be a dedicated and experienced **Business Manager** to oversee day-to-day operations of the programme. There will also be **Administrative** posts, a **Data Analyst** and a part time **Finance Officer** to ensure smooth running of the programme and business operations, to organise events and to meet reporting requirements expected by partners, funders and the accountable body.

We will develop a **'special relationship' with the NSPCC's programme on pregnancy and babyhood**, led by Chris Cuthbert (Head of Strategy & Development at the NSPCC) and his team, providing:

- **Communities of practice** with practitioners from over thirty other NSPCC service centres providing evidence-based interventions specifically for pregnancy to threes
- **Local opportunities to collaborate** with NSPCC's established and fully staffed local service centre in Blackpool
- **National experience** and advice on developing, implementing and rigorously evaluating science and evidence based programmes
- **Policy and influencing** at national level, such as NSPCC's *All Babies Count* campaign and Spotlight reports on issues such as perinatal mental illness, drug and alcohol misuse, homelessness and babies in the criminal justice system
- **Opportunities for 'buddying'** with Development Managers, Evaluation Officers, Policy & Public Affairs Officers, Communications Specialists and Fundraisers at the NSPCC's national offices
- **Advice on replication and dissemination**
- **Advice on research ethics**

The NSPCC has a unique contribution to bring to the *Blackpool Centre for Early Child Development*. The 0-3 life stage is a strategic priority nationally for the NSPCC and over the past two and a half years the NSPCC has invested £11.5 million in evidence based programmes specifically focussed on this life stage. We have a track record of implementing programmes as well as undertaking rigorous, science based innovation, including robust experimental evaluation. This capacity will have direct benefit for Blackpool as the only site supported by the NSPCC in the Better Start programme. Furthermore, any learning from Better Start will have a wider benefit, since NSPCC operates in 43 sites across the UK and has a strong influence in national policy.

We will create a **virtual network of national and international experts** to keep abreast of latest research, policy and practice and to share findings from our own programme**.**

The *Blackpool Centre for Early Child Development* will become part of a wider community of learning that includes other successful Better Start areas across the country, the Early Intervention Foundation, Dartington Social Research Unit, WAVE Trust and other centres of expertise in this important field.   Internationally, we will look to build on existing links with organisations like the Yale Child Study Centre and the University of Colorado Blueprints programme.

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HOW THE STRATEGY WAS DEVELOPED

The strategy builds on a 12-year history of successful partnership between local agencies. Our proposal is the result of over six months of work by public services, the voluntary sector and the communities themselves, to maximise the involvement of all members the community.

We engaged with 210 families who have children aged pre-birth to three - 30 in each ward, and 50 families with older children. We also collected and analysed data to inform our priorities, so that our strategy was based on the best available information.

It was essential to remove barriers so that the most vulnerable and seldom heard residents were able to feed their views in, so we designed a variety of community engagement activities that enabled the local residents to also have their say.

Once we felt confident that all families knew about Better Start, we held consultation events that they were invited to attend to share their views about services for children and the changes they wanted to see.

The Social Research Unit aimed to collect data on 600 children from across Blackpool by door knocking to find eligible families to participate in a survey. Despite extensive advertising to inform people about the survey, the interviewers were not able to get sufficient responses in the time available. The sample was 'topped up' by engaging families using the Children's Centres. The struggle to engage people in the survey seemed to echo the experience of services, which also struggle to reach and engage some of the more vulnerable families in the town.

The commitment of all our partners was evident at our two-day Strategy meeting on 15th - 16th January 2014, when 49 people from statutory bodies (including the Local Authority, Health and Police) , the voluntary and community sector, and parents, came together to generate the content behind this document.

CONTINGENCY PLAN

We are committed to changing the way we do business across Blackpool to improve the life chances and health outcomes of our babies, children and families. But we are ambitious for faster and greater improvements and with the Big Lottery Fund's help we know we can do more.

There is a strong commitment from all levels, to the systems change element and for the Bank of Blackpool to still proceed even if we do not get the funding. The Partnership and Governance arrangements would remain in place and move forward. We would have to revise our plans in terms of timescales, as without the Big Lottery funding the programmes we have planned would not be able to go ahead within the timescales set. Our plan is to front load the project using the Big Lottery Funds between years one and five and then the funds from the Public Sector and fundraising would start to come on board.

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We would have to rationalise our projects where that could be done and set up a new timescale. Our plan would stand but it would be slower to be realised. We would have to manage the expectations of the community and ensure that they were fully involved in the new more modest plans. Some of the community work around isolation and social cohesion could still take place. We will continue to work with communities who will drive our system change and be accountable to them for delivering outcomes. The development of the green spaces and park would be built in to the revised timescales.

We would not have the resources to go ahead with the Blackpool Centre of Early Child Development. We would still want the commissioning framework to be in place and this would lead the monitoring and learning. The services for birth to threes would be reorganised as part of the systems change. We would continue too with the Healthy Child Programme and other initiatives that can go ahead with small pots of funding. The commitment to pooling budgets and the Bank of Blackpool means that some funds would come on stream in the future and our plans would adapt to this.

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Attendees at Blackpool Better Start
Strategy Days: 15th and 16th January 2014

Role and organisation if appropriate	Name
Blackpool CEO	Neil Jack
Director of Children's Services	Sue Harrison
CEO NSPCC	Peter Wanless
Divisional Commander Western and Northern Divisions, Lancashire Constabulary	Richard Baley
Borough Treasurer (Blackpool Council)	Steve Thompson
Managing Director for Community Development, Blackpool Teaching Hospital NHS Foundation Trust	Wendy Swift
Head of Families Division (Blackpool Teaching Hospital NHS Foundation Trust)	Pauline Tschobotko
Chief Clinical Officer of the Clinical Commissioning Group (CCG)	Dr Amanda Doyle
NHS England	Jane Cass
NHS England	Carol Ann McElhone
Senior Manager Public Health	Lynn Donkin
Portfolio Holder for Children's Services	Ivan Taylor
Head of Early Help	Merle Davies
Senior Manager Early Years and Family Support	Sarah Lambert
Regional Head of Service for North West and Cumbria NSPCC	Bernadette Oxley
Projects Co-ordinator for North West and Cumbria NSPCC	Annette Algie
Associate Head for Strategy NSPCC	Joanne Hay
Head of Strategy and Development for Children Under One and Neglect NSPCC	Chris Cuthbert
CEO Blackpool Coastal Housing	Peter Jefferson
Lancashire Police	Steve Hodgkins
Representative of Pre-school provision	Joan Harris
Blackpool Corporate Development Manager	Scott Butterfield
Blackpool Council Researcher	John Patterson (for data section only)

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Role and organisation if appropriate	Name
Aiming Higher Trustee	Bruce Ainge
Groundworks	Rachael Hesketh
Empowerment	Claire Powell
One Blackpool	Vicky Wells
Children's Centres	Sara McCartan
Volunteer Centre	Claire Mashiter
Communicate	Joanne Burr
Head Teacher Mereside Primary School	Susan Diver
CPEA	Robin Currie
Kaleidoscope	Julie Housby
Parent	Cheryl Hole
Parent	Nicola Hitchon
Parent	Stephanie Bradley
Parent	Simone Moore
Parent	Louise Chennells
Parent	Darren Downs
Parent	Dave Bannister
Parent	Teresa Cornwell
Parent	Kelly Rayner
Parent	Josephine Morbury
Parent	Martina Draycott
Parent	Clare Sampson
Parent	Aileen Lyons
Parent	Peggy Bannister
Parent	Lisa Roberts
Parent	Vanessa Beckett

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A Better Start – A Better Future for Blackpool's Children

Project Plan
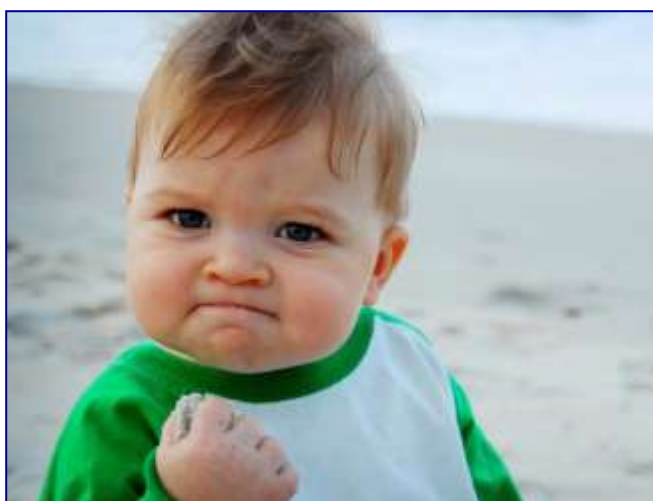## Annex C: Project Implementation

> Our vision is to give every new baby in Blackpool a better start in life, helping them enjoy the early care and nurture they need for healthy development and to be ready for school

This section covers our 'blueprint for change' in Blackpool, describing the four pillars of our distinctive Better Start approach and setting out the detail of our plans for programme delivery.

Our community is united in our ambition to give every new baby in Blackpool a better start in life. We do not underestimate the scale of the challenges we face. But we are determined to seize this moment to make a decisive change and to transform the life chances of our youngest children and families.

OUR COMMITMENTS TO THE CHILDREN AND FAMILIES OF BLACKPOOL

- We will transform the way local services are delivered, putting children and families first
- Every expectant mum and dad will have access to high quality antenatal education
- Every new parent will have opportunities to meet other parents in safe attractive community spaces
- Every new parent will have the information and advice they need to foster good health and readiness for school
- Every mum under twenty will be able to access the Family Nurse Partnership
- We will increase access to early help services for babies in families affected by drug and alcohol, mental illness and domestic abuse problems
- We will radically reduce the risks of abuse and neglect of babies
- We will become a national beacon for early child development

"Babies born in Blackpool face some of the highest levels of adversity seen anywhere in the country. Yet there is a striking passion and determination in the local community to turn things around. I am excited and inspired by the possibility for change".

Peter Wanless, Chief Executive, NSPCC

"The only way we can change things is by working together."

Parent

"We are committed to developing innovations that can be scaled out across the world. We want to be a place where people come to see how things should be done."

Neil Jack, Chief Executive, Blackpool Council

A BETTER START FOR BLACKPOOL: OUR BLUEPRINT FOR CHANGE

Delivering our bold vision requires a **cohesive and committed partnership** and a **strategic programme of action**.

Our partnership brings together all players – voluntary, community, private and public - who can make a difference to young children's lives. We want to achieve change for a whole generation and we knew this could only be achieved by building a genuinely inclusive and cohesive alliance. Our approach started with the needs of children and families themselves and is underpinned by meaningful engagement with the community. We are in this together - for the long run.

Delivering the vision requires rigour and a strategic framework for prioritising those activities that will make most impact on the outcomes we most care about. It requires careful implementation and systems that help – not hinder - what we need to do.   We have a strong track record of partnership working, but we also recognise we need to invest time in developing common understanding and a shared language. We need to build local capabilities and to develop the infrastructure for learning and sharing what we learn with others. Better Start provides us with an exceptional opportunity to make this transformation and we are determined to deliver real and sustainable change in the way we do things.

In Blackpool, we have developed a blueprint for our Better Start programme based around 4 pillars, which we believe provide exceptionally strong foundations for our work over the next ten years and beyond.

4 Pillars of the Blackpool Better Start approach

1. Public Health
change for a population

2. Evidence Based Intervention
change for those with additional needs

3. Reframing & System Transformation
Building shared understanding and shared action

4. Centre for Early Child Development
Building and sharing learning

First of all, our programme of action is grounded in a **public health approach**, and starts with an understanding of needs across the whole population. Secondly, for those with additional needs, we have crafted a programme of science and **evidence based interventions** designed to provide more intensive services, focussed on achieving clear priority outcomes. The third pillar of our approach is **systems transformation**, which refers to the change we need to see at all levels of our local services and systems. We believe this type of reform can only be successfully implemented if it is underpinned by a shared understanding (or 'framing') of the problem we face and a cohesive approach that unites community and professionals from all agencies. And our fourth pillar – **the Blackpool Centre for Early Child Development** – provides the dedicated focus for driving the strategy, programme implementation and research. The centre will build local capacity and expertise and become internationally renowned as a centre of innovation and learning.

Pillar 1	**PUBLIC HEALTH:** *Change for a population*

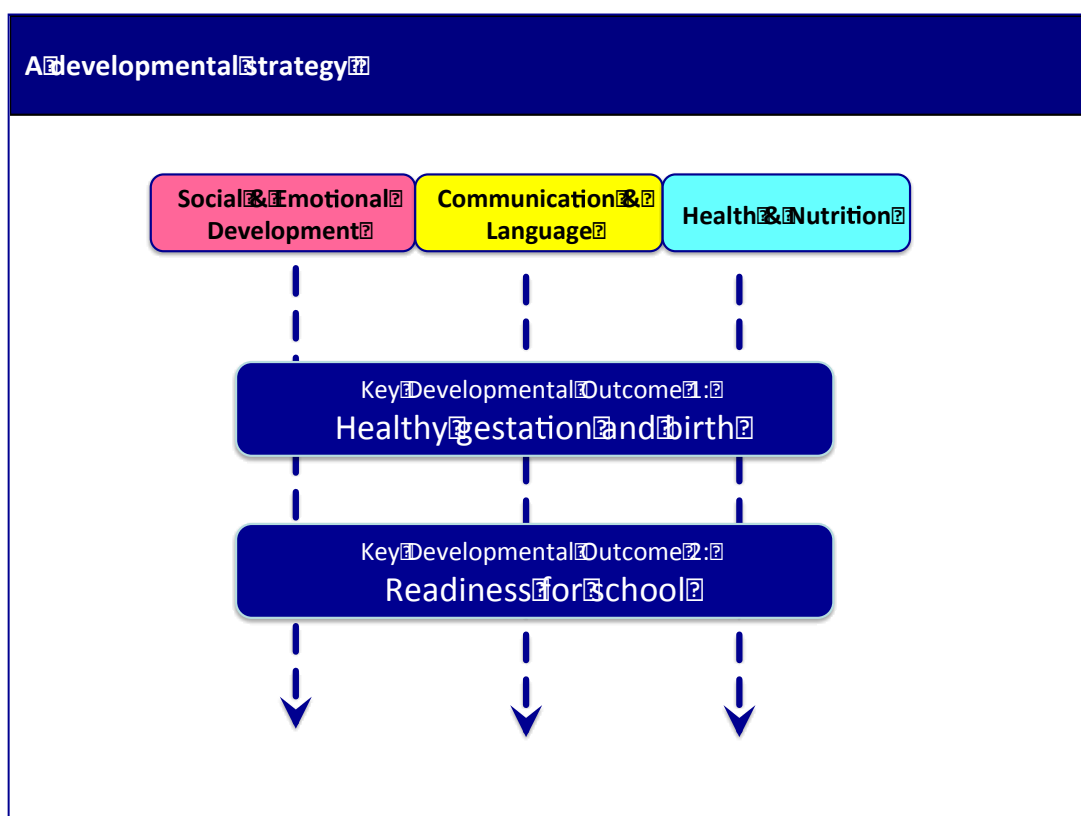*Blackpool Better Start* takes a public health approach. This means we emphasise:

- the needs of the whole population
- the underlying socio-economic and wider determinants of children's outcomes
- collective responsibility and partnerships with all those who contribute to the wellbeing of young children and families.

A public health approach can be defined by a four step-process:

1. Defining the key outcomes of concern
2. Determining the key risk and protective factors
3. Developing and implementing interventions across the population
4. Measuring effectiveness and capturing learning

Defining the key outcomes

Our overall strategy for the Blackpool Better Start programme is a developmental one. Based on extensive analysis of local data and a careful review of the research literature on early child development, we have prioritised two key outcomes: **healthy gestation and birth**; and **readiness for school**

A developmental strategy

Social & Emotional Development	Communication & Language	Health & Nutrition

Key Developmental Outcome 1:
Healthy gestation and birth

Key Developmental Outcome 2:
Readiness for school

These outcomes were selected not only because baseline data show particular challenges for our community, but also because they pinpoint important developmental milestones and provide rich composite measures of developmental progress. We fully embrace the Big Lottery Fund's three domains of: social and emotional development; language and communication; and diet and nutrition. We see these as crucial 'golden threads' that run right throughout our programme and which will be instrumental to achieving 'healthy gestation and birth' and 'school readiness'.
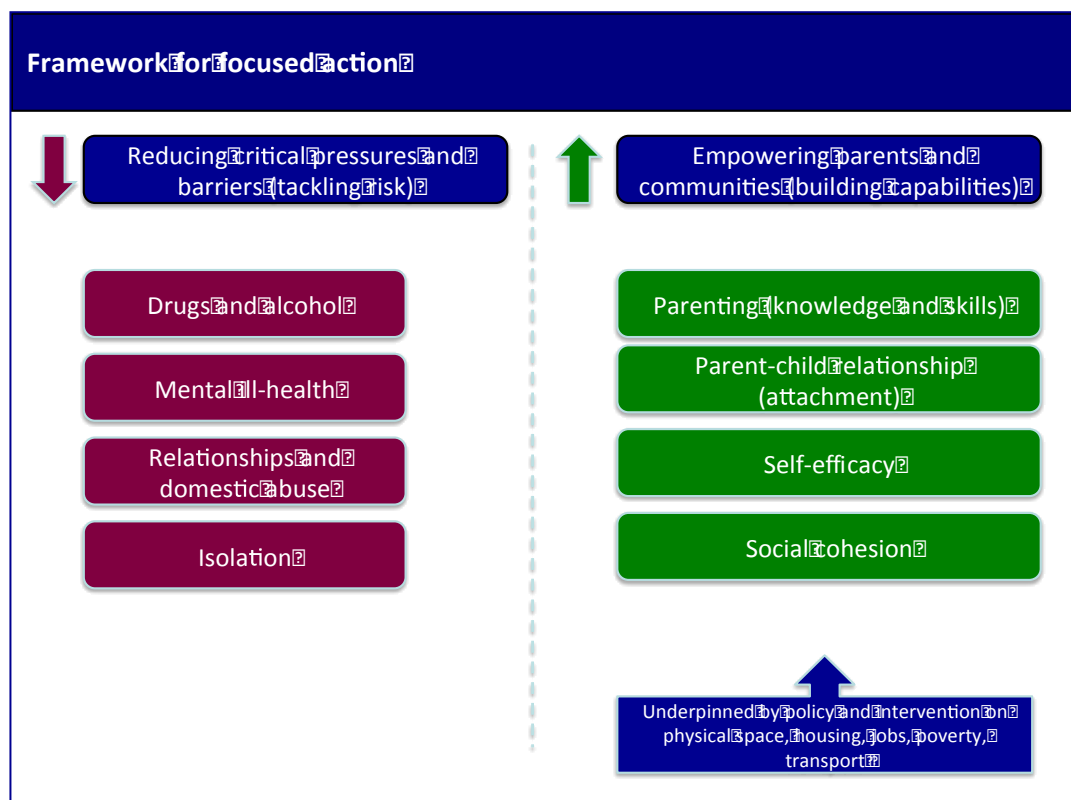
Determining the key risk and protective factors

In Blackpool, there is a high degree of consistency between the issues of greatest concern to the community and the areas that stand out most in our local needs analyses and the survey data from Dartington. We have combined these data about local needs and priorities with what research evidence tell us about the factors that matter most for achieving our desired outcomes for babies and young children.

We have used these data to create a 'Framework for focussed action' in our Better Start programme, based around:

- Reducing critical pressures and barriers (tackling risk)
- Empowering parents and communities (building capabilities)

The chart below sets out on the left-hand side the four key risks/barriers we aim to reduce through our programme. And on the right-hand side it lists the key ways in which we will empower parents and the community (our 'mechanisms for change'):

Framework for focused action

Reducing critical pressures and barriers (tackling risk)	Empowering parents and communities (building capabilities)
Drugs and alcohol	Parenting (knowledge and skills)
Mental ill-health	Parent-child relationship (attachment)
Relationships and domestic abuse	Self-efficacy
Isolation	Social cohesion

Underpinned by policy and intervention on physical space, housing, jobs, poverty, transport

The Better Start programme is a once in a lifetime opportunity to turn things around for Blackpool's youngest children. We believe we have an important responsibility to ensure that this new investment is very carefully targeted where it can achieve greatest impacts. That is why we propose to use this framework to guide our commissioning, mapping activities against it to help maximise the prospects of achieving our desired goals.

We will also ensure that other Blackpool policies and initiatives (such as transport, unemployment, environment, housing and welfare) are carefully aligned with the goals of *A Better Start* and that there is an on-going forum for ensuring policy development that supports expectant and new families with babies. But we are absolutely clear that the Better Start investment must be explicitly focussed on addressing the risk and protective factors identified in this framework.

Developing and implementing interventions across the population

The Government's Healthy Child Programme (HCP) provides a well-established and highly respected framework for planning support across different levels of need within the population:

The Healthy Child Programme

Universal Partnership Plus

Community

Universal Plus
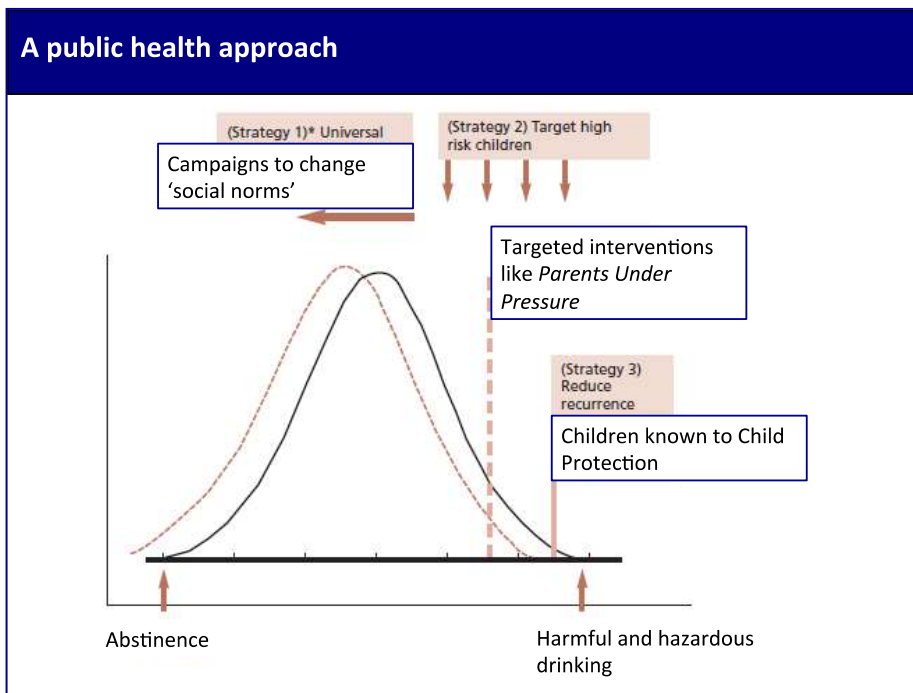
Community

Universal
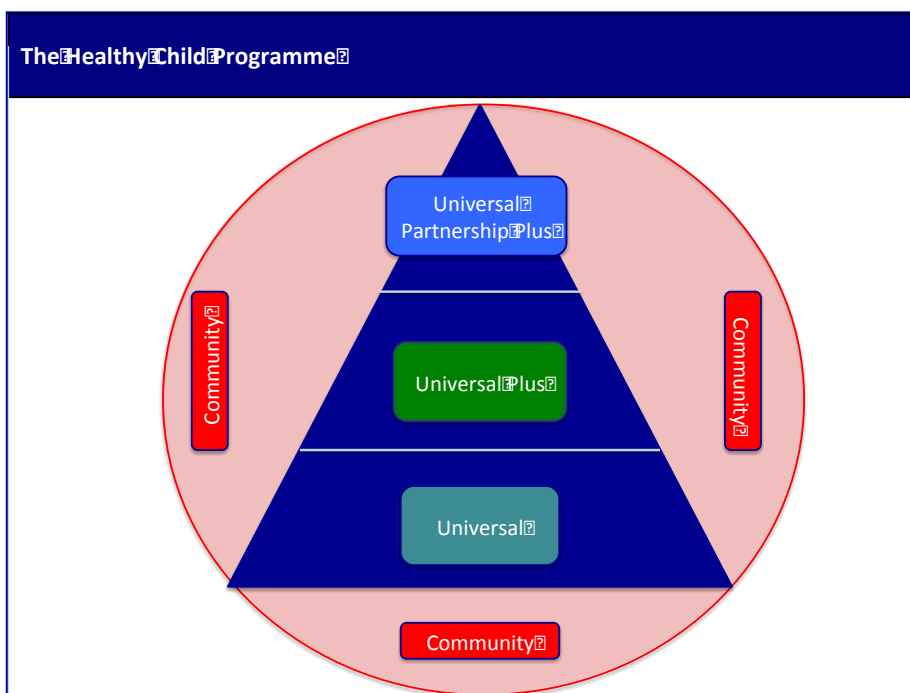
Community

We have developed a robust programme of action, spanning each of these different levels.

Further details on the targeted interventions (at 'community' 'universal plus' and 'universal partnership plus') can be found in the following section of this proposal (Pillar 2 – Evidence based Interventions).

But first we set out our plans for universal level public health campaigning.

The public health approach emphasises that many outcomes of concern, such as harmful and hazardous drinking are the extreme ends of a distribution (in the case of alcohol spanning less serious levels of alcohol consumption right through to abstinence). The key insight here is that by influencing social norms and patterns of behaviour *across the whole population* of parents it may be possible to 'shift the entire curve'.

A public health approach

Campaigns to change 'social norms'

(Strategy 1)* Universal

(Strategy 2) Target high risk children

Targeted interventions like *Parents Under Pressure*

(Strategy 3) Reduce recurrence

Children known to Child Protection

Abstinence

Harmful and hazardous drinking

Our public health approach is important because changing social norms helps change the context even for those with the most complex problems requiring more intensive interventions. In this way, we change the social context and improve the chances of successful intervention with the most complex families too.

For Blackpool this type of population level approach is also important because many of our social problems are widespread, affecting large proportions of local children.

Adapted from Woodman J & Gilbert R (2013) Child maltreatment: moving towards a public health approach. BMA

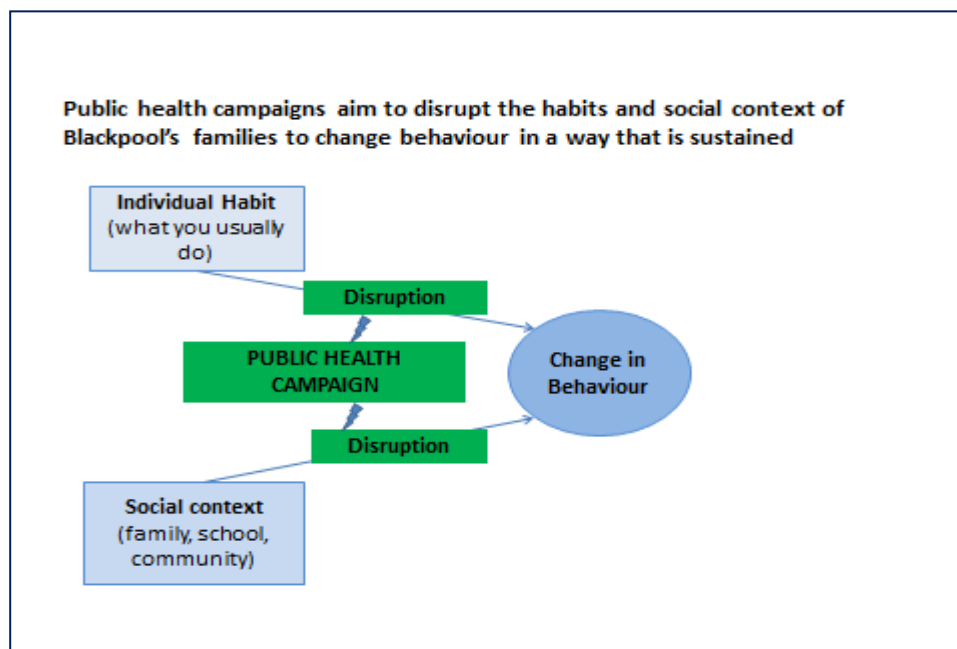## Track record in public health

Blackpool already has solid foundations on which to build our public health work for the Better Start programme. For example, we have run successful programmes on **safe sleeping** (with the Lullaby Trust) and breastfeeding (we have UNICEF Baby Friendly Level 3 status) as well as a recent campaign 'What's your Number, Know your Risk', which resulted in a huge increase in people **taking up blood pressure tests**. All of these campaigns have involved strong partnership working between public health, the local authority and a range of partners in the private and voluntary and community sectors.

Blackpool is one of 22 maternity hospitals across the UK piloting an innovative parent education DVD designed to help new parents **cope with infant crying**. Developed by the NSPCC and experts from Great Ormond Street Children's Hospital, this programme draws inspiration from a similar public health intervention in North America that led to a 47% reduction in non-accidental head injurie. A major study into the implementation and effectiveness of this intervention is underway with publication of early findings due later in the year.

NSPCC is also currently working with the Design Council on research into the information and advice needs of **expectant and new dads**. We aim to learn more about how to provide information to dads in a way that appeals to them and supports them in the transition to parenthood, and we'll also learn about how small changes to maternity services might influence dads' perceptions of their role and how valued they are. The resources designed as part of this programme will be made freely available to Blackpool to use with local dads.

Behaviour Change

We know that behaviour change in the product of changes in the social context and individual's habits and our activities will seek to influence both. This diagram illustrates our model of change.

Public health campaigns aim to disrupt the habits and social context of Blackpool's families to change behaviour in a way that is sustained

Our experience – and the research – teaches that successful public health activities are not simply a matter of providing information and sitting back and watching it work. We know that it is critical to work alongside parents to enable them to put into practice the information. Behaviour change comes about when people have the opportunity to practice new habits and learn by doing. There are 3 basic steps to achieving change:

1. Provide good, accessible information = increase awareness of a problem & solution
2. Ensure repeated exposure to the information = increase awareness of a problem & solution
3. Provide opportunities to practise using the new awareness & knowledge = increase understanding & capability

Our campaigns would move through each of these 3 steps so that people develop the capabilities they need to make sustained changes. By 'campaign' we mean everything from billboards and social media to targeted programmes to support high risk families. Our partnership has experience in this approach. For example, in our programme to help new parents cope with crying, we have ensured they receive the information at a time and place when they are receptive and able to form new habits. We have given then information in way that is emotionally powerful. And we have made staff available to support parents in thinking about how they will respond to the messages.

Universal health promotion resources

Local needs analyses highlight widespread challenges around adoption of healthy behaviours in pregnancy and with new babies. The antenatal period is a critical moment of opportunity for

building awareness and understanding of healthy development for mums, dads and babies. It is also an important time for preparing parents to think about their own relationships with one another and with their new baby.

Through funding from Better Start and our network of maternity, community health and children's centre provision, we will ensure right from the start, that expectant and new parents know where to go and take advantage of a suite of high quality resources to support **physical health, diet and nutrition**:

- The Pregnancy Book, proving authoritative and comprehensive guide to health and development
- NHS Parent Information Service, providing online access to NHS educational films and advice
- NHS Diet resources
- Best Beginning's *Bump to Breastfeeding* DVD, promoting breastfeeding initiation
- Best Beginning's *Baby Buddy App, helping parents get to know their baby and understand her development*

Food Dudes
Many of our attitudes to health and food consumption patterns are established early in life and so it is very important that any attempts to produce long-term improvements in the nation's diet should start with young children. Food Dudes has been designed to increase consumption of fruit and vegetables in early years children and will be rolled out across all early years and childcare settings in Blackpool – as well as in the new 'Beach School'. Parents also receive Food Dudes packs with tips and materials to enable them to continue running the programme at home in an effective way, Better Start will fund the 7 target wards; and Public Health the others, ensuring a whole population approach to healthy eating across the town.

Maternal obesity is an issue in Blackpool as more overweight women become pregnant. Health professionals will help women to understand the health risks of being overweight or obese during pregnancy and the importance of achieving a healthy weight prior to pregnancy, but also advise them not to try to lose weight while they are pregnant the risk will be managed by the health professionals caring for them during their pregnancy. These women will also be offered a referral to a dietician for assessment and personalised advice on healthy eating and how to be physically active. After pregnancy there will be encouragement to lose weight.

In Blackpool every mother has their BMI screened at booking in for maternity care. This is between 10 and 12 weeks of pregnancy. If their BMI is over 30 they are tested for gestational diabetes
If the BMI is between 35 and 39 they are referred to Consultant led care and if the BMI is over 40 they are referred to a special obesity clinic which involves prescribing or monitoring of specific treatment required for the individual from anaesthetics, dieticians, medical consultants etc.

All of the above are reviewed at 36 weeks gestation in preparation for labour.

To support breastfeeding we will continue Star Buddies, volunteer breastfeeding champions who support new mums in the hospital and at home to initiate and continue breastfeeding. Since the introduction of this initiative initiation rates at 6-8 weeks have gone up from 15% in 2007/08, to 25%

in recent years. The initiative involves Maternity Services, Health Visiting and Children's Centres The hard work and achievements were acknowledged by the achievement of the UNICEF stage 3 Baby Friendly Award jointly for the then PCT Community and Children's Centre staff. We are currently working with the acute trust to achieve the same status across the NHS Trust and Children's Centres.

In terms of **social and emotional development**, we will ensure parents have access to:

- Brazelton's *Neonatal Behavioural Observation (NBO)* training for midwives, helping midwives demonstrate new-born social and communication skills
- NSPCC's *Coping with Crying* DVD, providing expert and peer-to-peer advice on coping with infant crying and prevention of non-accidental head injuries
- Lullaby Trust, *Safe Sleeping* resources, helping to prevent infant deaths
- Warwick University's *Getting to know your baby* app, providing science-based information on child development and with films on reading babies' cues. Parents can also video their own baby in interaction and share this with their midwife, health visitor or children's centre worker
- One-Plus-One's *Couple Connection* game, a free online game helping new parents understand and enhance relationship skills
- Best Beginning's *Baby Express,* tailored specially for Blackpool's new parents and highlighting sources of information and advice as well as local events and groups and services

Without solid foundations in **language and communication skills**, children run the risk of school failure, low self-esteem and poor social skills. Yet many of Blackpool's young children are starting school without these vital skills.

Our **public health approach** to language and communication reflects:

- The scale of children's poor communication in Blackpool
- The need for earlier identification and response
- The importance of skills development for the entire children's workforce.
- The crucial role of parents themselves as agents of change

Our approach will include:

- *Supporting Speech, Language and Communication in the early Years*, our established Universal Communication training package will become mandatory across the Better Start workforce.
- *All Aboard*, a programme to support families where English is an Additional Language.
- *Tatty Bumpkins* & *Baby Bumpkins*, a multisensory approach to communication offered in children's centres.
- *Rhyme Challenge* and other reading programmes, run with Book Start
- *Dialogic Book Talk*, an evidenced based programme encouraging adults to prompt children with questions and engage them in discussions while reading.
- *ICAN,* parent resources and practitioner accreditation

Every child deserves the best possible start in life and the support that enables them to fulfil their potential. Children develop quickly in the early years and a child's experiences between birth and

age five have a major impact on their future life chances. A secure, safe and happy childhood is important in its own right. Good parenting and high quality early learning together provide the foundation children need to make the most of their abilities and talents as they grow up.

The Early Years Foundation Stage (EYFS) sets the standards that all early years providers must meet to ensure that children learn and develop well and are kept healthy and safe. It promotes learning and teaching to ensure children's 'school readiness' and gives children the broad range of knowledge and skills that provide the right foundation for good future progress through school and life. To ensure this is promoted in Blackpool we aim to ensure that our early years and childcare provision is of the highest quality. In Blackpool we are committed to developing the best quality early years settings in partnership with the parents. It is established in research that high quality provision leads to improved outcomes for young children and that poor quality provision add no value at all. By focusing on continued high quality improvement we will make sure that all young children in our settings get a high quality experience.

To do this we intend supporting the early years workforce to gain further qualifications and to update and develop their practice. In Blackpool we have an early years interactive learning environment where practitioners can put in to practice the theory they have learnt on the training. In this way they can learn from each other and see how to implement practice in a 'safe' environment. We also intend supporting the early years workforce with the core skills including child development.

A series of new parent education campaigns

Given the scale and nature of some of the problems in our community, such as alcohol abuse, domestic abuse and perinatal mental ill-health, we believe there is a strong case for action to address these barriers at a population level. We will build a series of parent education campaigns focused on our priority risk factors and around key 'touch points' during the transition from pregnancy to age 3. Over the course of the ten years, we expect to develop and deliver four campaigns. The first in the series will be on the impacts of parental alcohol misuse. The choice of future public education campaigns will be shaped by the community's own concerns, which might include child protection. Our parent education campaigns will each have a clear theory of change based on latest scientific research and they will be designed to reinforce our direct services.

They will each be informed by ethnographic research and behavioural insight, helping us better understand local values and attitudes as well as the factors that inhibit and motivate behaviour change. We will adopt a simple research and development methodology underpinned by three basic principles:

- Involving parents in every step of the process is vital
- We don't want to reinvent the wheel and will build on expert knowledge
- We will start with a wide lens and narrow our focus

Research will also be used to segment our audience groups and to identify the most effective formats and channels for reaching and influencing local parents.
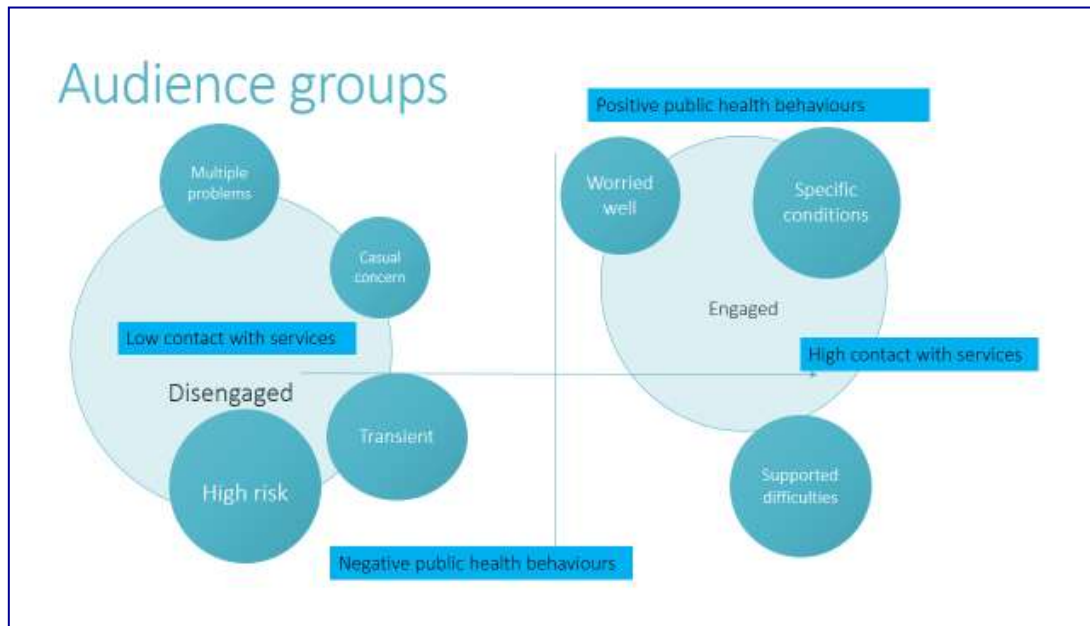
Campaign executions will be carefully designed and pre-tested locally. As well as extensive local expertise in public health, we will also have the benefit of advice from the NSPCC's national Communications and media department. Evaluations of awareness, recall and attitudinal and behavioural change will help us to measure the impacts of these campaigns across the town. More on 'measuring effectiveness and learning' can be found on page X (Pillar 4 – Blackpool Centre for Early Child Development).

Pillar 2	**EVIDENCE BASED INTERVENTION:** *Change for those with additional needs*

Our ultimate aim for this pillar of the programme, is to build outstanding science and evidence based support for families with additional needs - what the Healthy Child Programme calls the '**Universal Plus'** and **'Universal Partnership Plus'** levels. Our local needs analyses and community consultation point to clear gaps in current specialist provision. In particular, the Blackpool Better Start programme aims to build our capacity to respond effectively to issues such as parent education for disadvantaged groups, drug and alcohol misuse, mental ill-health and domestic abuse.

The chart below provides an overview of the range of direct service provision we propose to develop through our Better Start programme, based around the different levels of need in the Healthy Child Programme[1].

A tiered model of provision

Universal Partnership Plus
- Family Nurse Partnership
- Parents Under Pressure
- Parent-Infant Psychotherapy
- Survivor Mums*
- Safecare
- Domestic Abuse*
- Pre-birth assessment*

Universal Plus
- Baby Steps
- Video Interaction Guidance
- Hanen & REAL
- Triple P for toddlers
- Early Learning with Families

Universal
- Health Promotion resources and 4 new Public health campaigns
- Maternity and community health
- Children's Centres

Community
- Beach school
- Food Dudes
- FNP Graduate Mentors
- Safe space and play fund

In this section we focus primarily on describing the portfolio of science and evidence based interventions we propose at the levels of **Universal Plus** and **Universal Partnership Plus**.

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* projects marked with an asterisk are 'innovation' projects, involving original research and development to design and develop new interventions, rather than the introduction of services already developed elsewhere

We have already described - under Pillar 1 - how we will build on the foundation of our strong **universal** maternity, community health and children's centre services, through a programme of public health campaigns and resources.

Later – under Pillar 3 – we describe the specific **community led programmes** we believe will be essential to building social cohesion, tackling isolation among new parents and breaking down the barriers to effective engagement that is such a challenge in Blackpool. [More details on our approach to community engagement can be found in Annex N]

UNIVERSAL PLUS SERVICES

Baby Steps

Maternity services in Blackpool have been working with the NSPCC since 2011 to provide this innovative parent education programme. We propose to roll out the Baby Steps programme to be available to all expectant parents in Blackpool, who are not enrolled on the Family Nurse Partnership.

Originally developed by the NSPCC in partnership with Warwick Medical School, Baby Steps is a new science-based programme that helps mums and dads to make a successful transition to parenthood. The programme aims to:

- support men and women to negotiate the **emotional and physical transition** to parenthood;
- nurture **healthy relationships** by encouraging listening and conflict resolution skills;
- encourage the development of **sensitive, reflective relationships with the infant** from the ante-natal period onwards;
- promote **healthy child development** within a network of supportive relationships

Baby Steps is a 9 session group-based programme designed explicitly to engage parents who might not respond well to traditional 'didactic' antenatal education.   Home visits are used to build trust and programme activities and materials have been carefully co-designed to be engaging and support reflection and learning. For example, video of parents' interactions with their new-borns is used to identify sensitive caregiving and promote secure attachment.

Formative evaluation shows that this programme is very successful in achieving its goals around engagement of disadvantaged mums and dads and quantitative results are expected later this year from a multi-site evaluation study. Practitioners delivering this service in Blackpool will be part of a national community of practice involving colleagues from other locations across the country.

Support from the Big Lottery will allow us to take this important prevention service to full scale across Blackpool. The expansion process will be carried out in two cohorts, given the need to train twenty-eight practitioners in total (though it should be noted that for most of these practitioners, delivery of the groups will only be a relatively small part of their roles).

Triple P for toddlers

The Area Wellbeing data showed that child behaviour was an issue with over 27% of children having poor social and emotional development, including self regulation, compliance and empathy for others. There was also quite high incidence of early onset of poor behaviour, which will affect a child's readiness for school. Blackpool's nationally renowned 'Springboard' Families in Need service has been delivering the Triple P Parenting Programme for over ten years. Triple P is positive parenting programme that uses practical parenting strategies. There is a strong body of evidence to support the efficacy of the Triple P programme in a wide range of different settings and across a range of different population groups. Triple P has been chosen in Blackpool because of its success in providing parenting and family support for behavioural and emotional problems in children.

We intend building on this successful track record of delivering Triple P, by extending our remit to work with parents of 2-3 year olds. We will fund 2 new posts to deliver Triple P and training for 6 staff in total.

Video Interaction Guidance

VIG is a powerful approach for enhancing communication within family relationships. VIG is a particularly powerful tool in increasing parental sensitivity in families where there are attachment difficulties. It works by capturing short pieces of video of a parent interacting with their child. In the process of standing back and looking at themselves on screen, parents are able to analyse what they were doing when things were going 'better than usual'. Parents are supported to become more sensitive to children's communication attempts and to develop greater awareness of how they can respond in an attuned way. VIG is a particularly good fit with Blackpool's goals of empowering parents and communities, because it is built on a conviction that the power and responsibility for change resides within families themselves.

VIG has solid scientific foundations, building on the rich legacy of Professor Colwyn Trevarthen and on rigorous intervention studies in Holland [Ref]. The NSPCC has experience of implementing the programme in other locations across the UK and will be able to facilitate training, accreditation and supervision through our established collaboration with the programme's developer Dr Hilary Kennedy. Practitioners working on this service will be able to benefit from being part of a community of practice with other VIG practitioners across the country.

We will create a multi-agency team comprising practitioners from NSPCC (2FTE) and the Families in Need team (1FTE). Better Start will fund 2 of these posts and the costs of clinical supervision. NSPCC will fund 1 post.

Targeted communication and language services (Hanen and REAL)

Effective oral language skills are the building blocks on which subsequent literacy and numeracy development are based. We intend to provide a comprehensive programme of evidence and science based programmes to promote communication and language skills. Our targeted provision will be delivered through the Speech and Language Health Service and – as described earlier - this will be underpinned by a public health approach including strong links health visiting and children's centres. Targeted provision will comprise:

Hanen
- *It Takes Two to Talk* – a programme designed specifically for parents of young children (birth to 5 years of age) who have been identified as having a language delay
- *More Than Words* – a programme designed for young children from 18 months who are identified as a late talker and will support the children to develop vocabulary
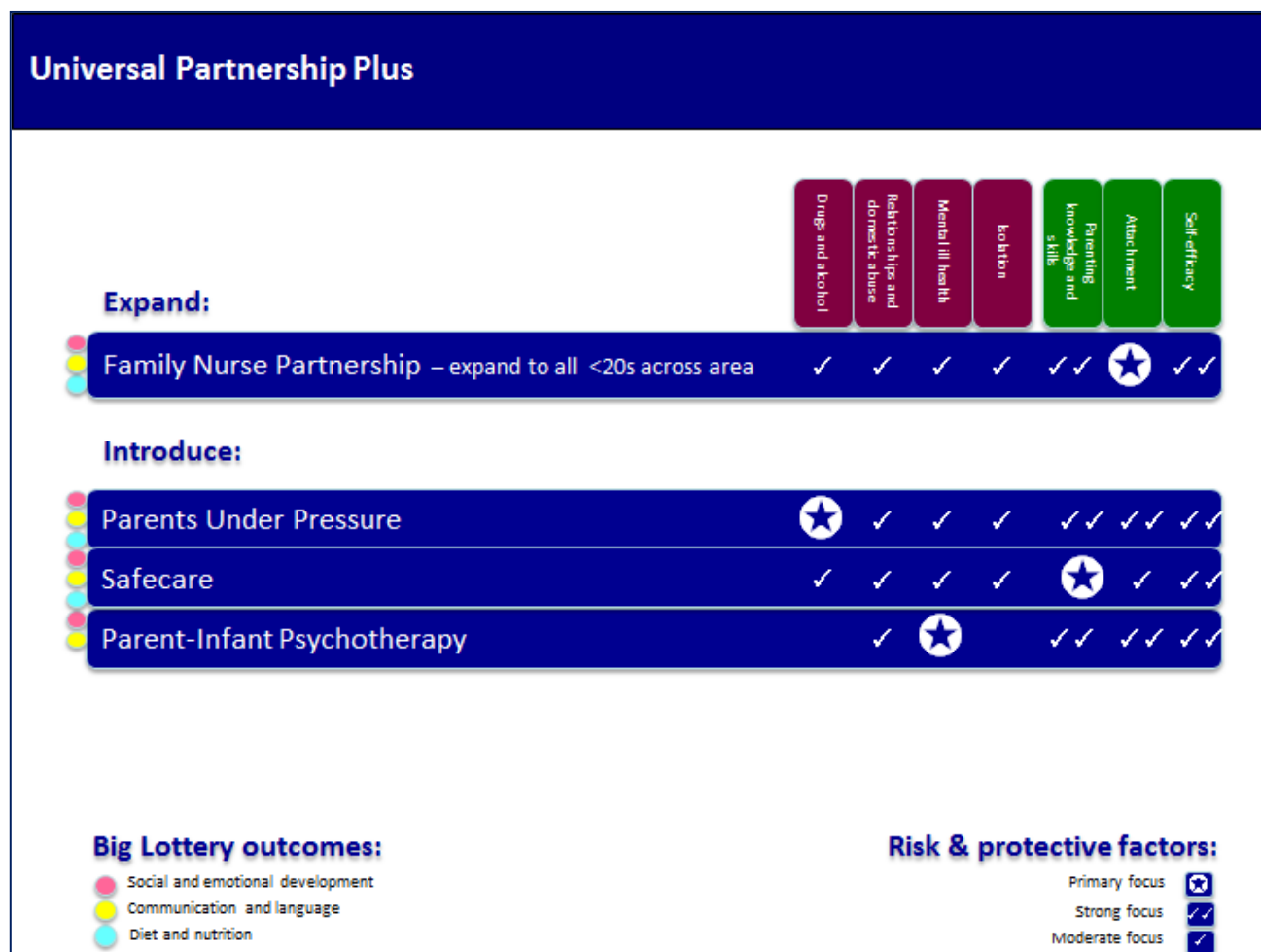
Raising Early Achievement in Literacy (REAL)
- An evidenced programme working with early years settings and parents in the home to support young children's oral language, early reading and writing and awareness of environment print

Early Learning with Families (ELF)

Public Health Public Health

UNIVERSAL PARTNERSHIP PLUS SERVICES

Family Nurse Partnership

We see full expansion of the Family Nurse Partnership programme to reach all under-20s in the town as a cornerstone of our Better Start programme. The Family Nurse Partnership in Blackpool is one of the earliest established FNPs in the country and has an excellent track record and reputation both locally and nationally.   This nurse led home visiting programme has a very strong evidence base, pinpointing outcomes that are central to the goals of our programme; and its established position within local maternity services provides a strong backbone to our pathway of provision for vulnerable young mothers and their families.

Blackpool Clinical Commissioning Group has already committed to increasing the number of family nurses from 4 to 6. With investment through our Better Start programme, we will increase this to 10

nurses in total by 2017, ensuring we have the capacity to offer this vital service to **all eligible mothers across Blackpool**.

Parents Under Pressure

We propose to introduce Parents Under Pressure (PUP)**,** a twenty-week intensive parenting programme, which specifically targets parents in receipt of drug or alcohol treatment. Originally developed in Australia, the programme was shown as part of a randomised controlled trial [Dawe & Harnett, 2007] to achieve reductions in parenting stress, in child behaviour problems and in the risks of child abuse.

PUP has been transported to the UK by the NSPCC and is currently being evaluated in a multi-site evaluation led by Professor Jane Barlow at Warwick University. The programme is delivered in the home. It addresses the psychological functioning of family members, the parent-child relationship and social contextual factors such as social isolation, accommodation and financial issues. The key mechanisms for achieving change are a holistic approach, therapeutic relationship with parents and a focus on mindfulness to help parents to manage their emotions.

This PUP programme fits really well with Blackpool's identified priorities around tackling drug and alcohol misuse. The Blackpool Better Start team will be able to benefit form NSPCC's experience in implementing this evidence based service in eleven other locations across the UK. We have well established working relationship with the programme's developer, Professor Sharon Dawe. Practitioners delivering the programme will have the benefit of access to high quality training and accreditation, expert clinical supervision, an established programme database and membership of a national community of practice alongside the other NSPCC service centres across the UK.

In order to ensure strong referral levels and sustainability, we will make this service available to parents of 0-5 year olds. We will create a multi-agency team comprising practitioners from NSPCC (2FTE) and the Local Authority Families in Need Team (1FTE). Better Start will fund 2 of these posts and the costs of clinical supervision. NSPCC will fund 1 post.

Safecare

Safecare is a programme that works with parents of children aged 0-5 at risk of, or reported for, maltreatment. Given the very high level of babies in Blackpool who are taken into care, we believe it is particularly important to include this evidence based safeguarding programme in our portfolio of services.

Delivered in the home over twenty weeks by trained family support workers, Safecare comprises 4 modules: Parent-Child Interaction; Home Safety; Child Health Care; and Counselling and problem solving skills. Evidence from a large-scale trial in Oklahoma demonstrates the programme's positive impacts on reducing repeat referrals to child protection services and the programme has also demonstrated a strong benefit-to-cost ratio of 2.07:1.

The NSPCC has experience of implementing this home visiting programme in a range of UK settings and will be well placed to facilitate training, coaching and on-going connections with the programme developers at Georgia State University. We will create a multi-agency team comprising practitioners from NSPCC (2FTE) and Families in Need (1FTE). Better Start will fund 2 of these posts and the costs of clinical supervision. NSPCC will fund 1 post.

Parent-Infant Psychotherapy

As part of the development of the Blackpool perinatal mental health pathway, we want to enhance the level of specialist provision for mothers during pregnancy and following the birth of their child in order to address critical mental health and attachment needs. We propose to introduce Parent-Infant Psychotherapy, a model which focuses on restoring ruptured bonds between mother and baby.

The therapist's role is as an observer and an interpreter of the interaction between the infant and the parent. He might share some of his thoughts about the behaviour of the child with the parent and by doing so offering the parent an alternative way of experiencing the child. This technique helps the parent to resolve issues with his or her own infancy-experiences in order to restore secure attachment with the infant. And it helps lower the risk for psychopathological developments of the child in the future.

Overseas evidence on the use of parent-child psychotherapy is promising and results from a UK-based trial are awaited later this year [Sleed & Fonagy]. We will work closely with partners at OXPIP and the Anna Freud Centre who have been successfully delivering this service for a number of years in the UK; and we will work with the national replication charity PIPUK, to develop proposals for implementation in Blackpool. We believe that there are reasonably good prospects of attracting matched funding from PIPUK to support replication of the service here. It will be important to ensure that this service is well integrated within the perinatal mental health pathway; and that there are strong links with existing psychiatry services for addressing the most acute needs.

We will work carefully to plan and prepare implementation of this new component of the perinatal mental health pathway and we do not anticipate this service going live until at least year 3. It is envisaged that Better Start funding will be used to fund a Clinical Director (parent-infant psychotherapist) and 3 infant mental health specialists.

UNIVERSAL PARTNERSHIP PLUS – RESEARCH AND INNOVATION

Universal Partnership Plus – Research & Innovation

Research and innovate:	Drugs and alcohol	Relationships and domestic abuse	Mental ill health	Isolation	Parenting knowledge and skills	Attachment	Self-efficacy
Domestic abuse in pregnancy and infancy	✓	★	✓	✓	✓✓	✓✓	✓✓
Pre-birth risk assessment	✓	✓	✓		✓	✓	✓
Survivor Mums Companion (PTSD)		✓	★	✓	✓✓	✓✓	✓✓
Alcohol in pregnancy		★			✓✓	✓	✓✓

Big Lottery outcomes:
- 🔴 Social and emotional development
- 🟡 Communication and language
- 🔵 Diet and nutrition

Risk & protective factors:
- Primary focus ★
- Strong focus ✓✓
- Moderate focus ✓

Nationally, the NSPCC has made pregnancy and babyhood one of it priority themes. Over the past four years the charity has embraced evidence-based practice and is collaborating with leading experts from around the world on the development and evaluation of new services, designed to tackle key gaps in practice.

In Blackpool, our close partnership with the NSPCC means the opportunity to help inform and shape these new services as they are being co-designed; and it means opportunities to pilot and test those services which are most relevant to our needs here in Blackpool.

Below we describe examples of the service development work already underway, which Blackpool will help to shape and which we might pilot as part of our innovation work stream. Through this process of collaboration with the NSPCC and their partners, we will build expertise and capacity for undertaking research and development work locally through the Blackpool *Centre for Early Child Development*.

Domestic abuse in pregnancy and infancy

Domestic abuse is a major priority in Blackpool. Domestic abuse often begins in pregnancy and is associated with premature labour and low birth weight. International research suggests that 4-8% of all pregnant women are victims of domestic abuse, with homicide by a spouse or partner being the number one cause of death for pregnant women.

The limited evaluation material available for the UK suggests that existing perpetrator programmes have high rates of recidivism and attrition. There is no evidence in the UK of effective intervention with women who are pregnant and no services that specifically target intervention at this life stage, other than screening during antenatal procedures. Interventions with children are usually post separation to help children recover from adverse effects of domestic abuse. There are particular knowledge gaps and a lack of service provision around the options for effective child protection where the mother, child and perpetrator remain together

The NSPCC nationally has recently agreed a new project to research, develop and pilot test a new home-based model of intervention to reduce domestic abuse. The service will focus on the pregnancy-5 age range and it will seek to build on best available research from a range of models internationally.

This development project will dovetail neatly with local research in partnership with the charity CAADA (Coordinated Action Against Domestic Abuse) following up the experiences of Blackpool families subject to MARAC (Multi-Agency Risk Assessment Conference) procedures. We will also liaise with Professors David Olds and Harriet McMillan to monitor findings and implications from their current Canadian trial looking at the impacts of new components of the Family Nurse Partnership designed to better address domestic violence within that programme.

Pre-birth assessment

Analyses of Serious Case Reviews have repeatedly shown that high proportions of cases of serious abuse involve babies. A recurrent finding is that babies may not have died or been seriously injured if a protection plan had been formulated prior to birth. Ofsted has highlighted concerns about failure to conduct pre-birth assessments, as well as serious shortcomings in the timeliness and quality of many assessments that were carried out.

This project is funded by the Department for Education and is being carried out in a partnership between the NSPCC, Loughborough and Warwick Universities. The aim of the project is to develop a robust new model for undertaking Pre Birth Assessments where the risk of significant harm is identified about an unborn child.
Given the very high numbers of babies taken into care in Blackpool, this new assessment services is likely to be of particular value to practitioners here. We hope that Blackpool could be involved as a partner in wider testing of the model.

Survivor mums companion

During pregnancy, women with a childhood maltreatment history have a 12-fold increased risk of Post-Traumatic Stress Disorder (PTSD). Although awareness of the need for trauma-informed care

is increasing, there are no front-line programmes for the childbearing year that address maltreatment-related PTSD.

The Survivor Mums Companion is a ten-module self-study programme that aims to disrupt the intergenerational cycle of abuse and psychiatric vulnerability. It works by improving affect regulation; reducing interpersonal reactivity; and supporting PTSD symptom management, despite the presence of triggers. Mums are recruited through maternity services (at booking with midwifery) and they work through the self-study modules (either in workbook, online or MP3 formats) and then after each session they receive the support of a tutor/counsellor to help them process the materials they have gone through. A rigorous pilot study led by Professor Julia Seng at the University of Michigan in the US has demonstrated positive results of the programme.

NSPCC has joined with the researchers from the University of Michigan, who developed the Survivor Mums Companion and with researchers from Australia to put forward a research bid to the US National Institute of Health to replicate the programme in UK settings as part of a three-country research study. If the bid is successful, then Blackpool could be considered as one of the UK research sites.

Alcohol abuse in pregnancy

Blackpool has established links with internationally renowned alcohol expert Prof Barry Carpenter. We propose to work with Professor Carpenter to develop and test an early intervention service to address alcohol misuse in pregnancy. This will run alongside the public health campaigns and work on alcohol across the town as well as our preventative work in schools. It will complement our intensive home visiting programme Parents Under Pressure. This project will feed directly into the Health & Wellbeing Board as a major contribution to the Blackpool Alcohol Strategy.

A staged approach to implementation

Above we have outlined a sophisticated multi-level programme of science and evidence based interventions as well as setting out our ideas for innovation and new service development. We have extensive experience of implementation of new services and we know the importance of a very carefully staged approach and of rigorous programme management, monitoring and communications.

From an operational and implementation perspective, we have categorised our science and evidence based interventions into three broad types of activity, mapped in the table below:

1. Development or expansion of existing services and 'quick wins'

Universal Partnership Plus
- full expansion of the *Family Nurse Partnership* programme to reach all under-20s in the town

Universal Plus

- full expansion of the *Baby Steps* group parent education programme to reach all those not on FNP
- increasing access to *Triple P* parenting programme, for parents of 2-3 years olds
- development of *Early Learning for Families,* supporting language development and learning

Our community-led programmes, *Beach School* and *Safe Space & Play* (described under 'Pillar 3'), will also fit under this category of activity, demonstrating swift and visible changes to the community

2. Introduction to Blackpool of interventions successfully developed elsewhere*

Universal Partnership Plus
- *Parents Under Pressure*, for families with drug and alcohol problems
- *Safecare*, structured home visiting for families at risk of, or reported for, maltreatment
- *Parent Infant Psychotherapy*, addressing critical mental health and attachment needs

Universal Plus
- *Video Interaction Guidance*, increasing parental sensitivity in families with attachment problems
- *Hanen* & *REAL*, improving language and communication skills

3. Innovation projects$

Universal Partnership Plus
- *Domestic abuse in pregnancy and infancy*, attachment based service where families stay together
- *Pre-birth assessment*, a new model where harm is suspected about an unborn child
- *Survivor mums companion*, tackling abuse-related trauma triggered in pregnancy
- *Alcohol abuse in pregnancy*, developing an early intervention service with Prof Barry Carpenter

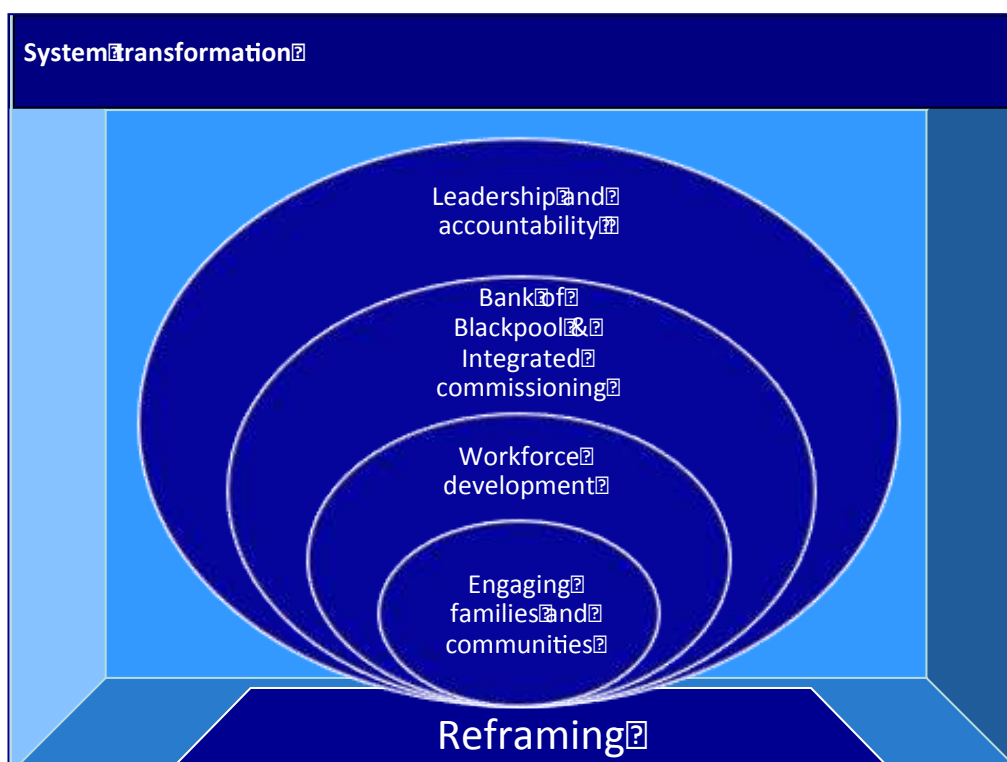| Pillar 3	**REFRAMING AND SYSTEM TRANSFORMATION:** *Building shared understanding and shared action*

Children in our target wards make up two thirds of the conception-to-threes in the town. We can't re-design part of the system for such a large proportion of children, so we are ready to completely reform public services for all pregnancy to threes. We have already started the work of transforming our local systems, in part stimulated by large cuts in public expenditure, but also because we recognise the strategic importance of investing in the early years and prevention.

We will not achieve the step-change in outcomes we desire, through evidence-based interventions alone. A key pillar of our blueprint is systems reform, which means **change at all levels.** Below we describe our model for reforming local services and systems.

It is an approach that starts with the need to **'reframe' the problem** we face and pull everyone together behind a **shared understanding** of:

- Child development and local children's needs
- The critical barriers we face in Blackpool
- The roles we can each play
- The work we need to do together to turn things around.

It is only by building this shared frame of understanding across everyone – families, community and professionals from all agencies – that we will be able to achieve sustainable change in the way we work together at all levels of our system. The diagram below illustrates the different levels of our model for systems transformation – each of which is underpinned by this essential 'reframing' work.

System transformation

Leadership and accountability

Bank of Blackpool & Integrated commissioning

Workforce development

Engaging families and communities

Reframing

'Reframing': building shared understanding

We want to give everyone: families, the community, volunteers and professionals a common language for communicating about children's needs. Inspired by the success of the *Alberta Child Wellbeing Initiative* in Canada, we plan to deliver a cross-workforce training and development programme in partnership with the US based *FrameWorks Institute*.

In Alberta, the Initiative has worked with a range of leading child well-being experts and the *FrameWorks Institute* to build an effective integrated, collaborative workforce bound by a common language and shared experiences. This is delivering real benefits for the people of Alberta. They have achieved this through a structured long-term programme that incorporates content and communications learning.

The purpose of reframing programme is to:
- Develop a shared understanding of child development across the community and across the children's workforce – a key explanatory tool in describing what children need and how we can help them
- Develop a shared understanding and competence in talking about child development
- Through sharing the experience of learning, break down professional and professional-citizen boundaries and build trust and confidence, creating a culture of integrated working

The NSPCC and its partners are uniquely well placed to deliver this programme, having worked with the Frameworks Institute since 2011 to pioneer a set of tools to support professionals to talk about child development in the UK. These tools have already been empirically tested for use in the UK. We will build on this pioneering partnership to put into practice the latest findings from child development and the science of communications.

Our model, illustrated in the diagram below, has been developed from the Alberta approach. It will be integral to our systems reform programme and it will be a central plank of the Workforce Development Strategy.
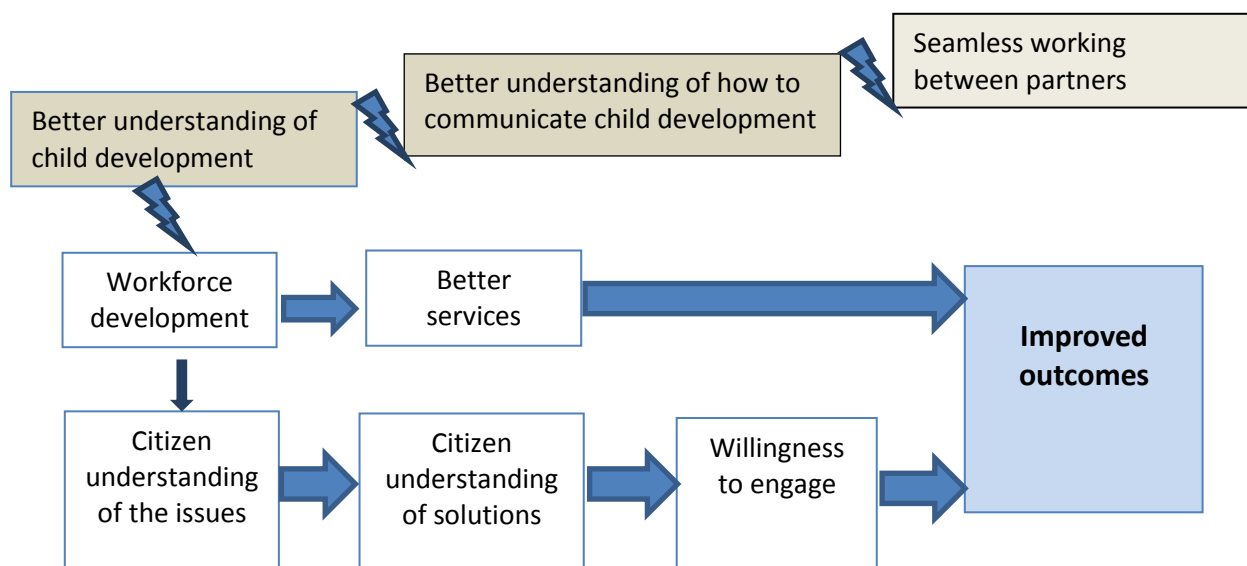
The Reframing programme will run throughout the duration of the Better Start project: it is not a one-shot solution, but an on-going programme of continuous improvement and partnership building. It will involve significant numbers of professionals from a wide range of backgrounds and across all levels of seniority and community members (up to around 150 people at one time).

This initiative will be led and coordinated through the Blackpool Centre for Early Child Development. Key activities will be to:

- Identify a cohort of interested people
- Hold an annual residential symposium to share latest thinking on this life stage. Drawing on the NSPCC network of national and international experts
- Support professionals to work differently and hold an annual follow up event.

Introducing and assessing the impact of this innovative approach across an integrated workforce will be a key and the learning will be used to influence and direct the on-going systems change.

Engaging Families & Communities

Effectively engaging with our service users, or potential service users, is a significant challenge for Blackpool's Better Start. It is an area where we know there is lots of scope to innovate and opportunity to improve. Through our community consultation work we have pinpointed a number of **key challenges in engaging families and communities:**

- Many families in Blackpool are poorly connected to their communities
- Parents want safe space to meet other new families
- Service access and engagement is often poor
- Trust in professionals is often low
- Parents want more say in the design and delivery of services
- Parents would like to be more informed about child development
- Parents would like to be more in control and to have greater agency to help children themselves

In response to this challenge we have begun the process of developing a different approach to involving citizens and we plan to develop and build on this through Better Start to radically change the way we work with Blackpool's children and families. Our ambition is **to go on a journey with our service users and – over time – increase the role that they play in the decision making processes so that we reach a point where we have geniune and sustained engagement with increasing number of Blackpool's citizens** as shown in the final two columns of the diagram – collaboration and empowerment. We will know we have succeeded when future waves of Area Well-Being data are produced (Year 3) and instead of doors being shut in the face of the researchers, we get begin to get signs of greater engagement and trust.
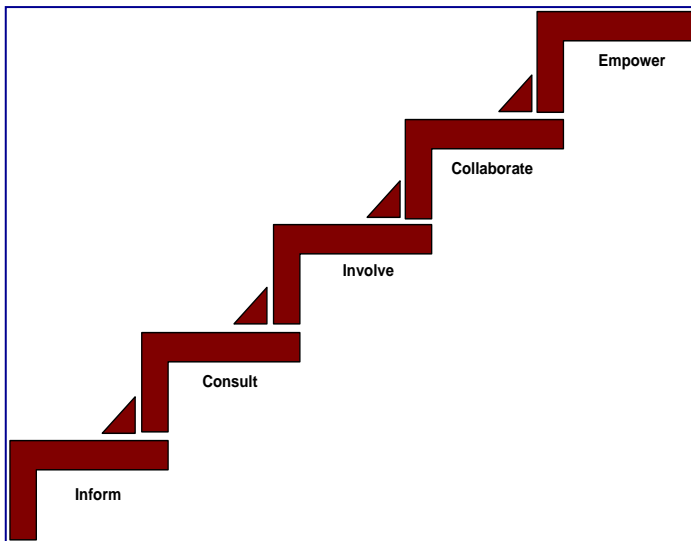
We have no romanticism about the challenges of meaningful community engagement, particularly in a community facing such stark levels of deprivation and fragmentation as ours. We therefore believe it is necessary to put in place a robust infrastructure to support the process of building confidence and capability. We recognise that this will be a long term endeavour. We know the importance of being able to demonstrate swift and visible impacts early on, so that local parents can see they are being heard and that their concerns are being addressed.

We have therefore developed a number of key strands to our programme of engagement:

1. **Strengthening our understanding and skills**
   Building on the Well-Being data, we will work with researchers to get a deeper understanding of how Blackpool's families think about children and how they see their needs. This research will feed directly into the Child Development 'Reframing' work; and it will provide important insight for our public health campaigns described earlier.

2. **Delivering our pledges on service accessibility**
   In our community consultation, parents asked us to make services more accessible by putting them in places where people currently go, like their GP clinics and children's centres, at times that suit the community, not just between 9am and 5pm. Parents also want our services to have 'one front door' so that families' needs are met without multiple referrals and so that information is shared in a way that means families need only tell their story once.

3. **Nurturing community champions**
   A Volunteer Academy will be established to recruit, mentor and support a renewing group of community champions. Building on and expanding the community champion initiative in Blackpool. They will work in communities to actively promote the use of services and highlight to the partnership where changes are needed.

4. **Creation of 'FNP Mentoring Service'**
   Building on the local success of the Family Nurse Partnership, we will work with the FNP National Unit to develop a new mentoring service, provided by local graduates of the programme. Building trust and engagement are major challenges for public services in Blackpool. We believe that by training and supporting FNP graduates as mentors/befrienders to other parents, we will not only overcome barriers to service engagement, but also be help to build the skills, confidence and work-readiness of the graduate volunteers themselves.

5. **Empowering 'Community Voice'**

   Our community engagement board provides a solid foundation on which to build a group of empowered service users from all parts of the community with formal structural links to the governance of the Better Start Partnership. [Further details on how we will ensure they have meaningful inluence in our governance arrangements can be found in Annex M.] We will coach and support this group through the stages of engagement. They will be our touchstone for when we're getting things right – and wrong.

6. **Targetting known weaknesses**

   We have identified areas where our current user engagement is particularly poor and we will target these areas for special attention: engaging Dads, take-up of free nursery places for two year olds and help in a crisis. We have included budget for specialist workers, employed from the community, whose role will be to address these critical issues, drawing on research and development insights brought together by the Centre for Early Child Development.

7. **Real projects with budgets and impact**

   Community Voice and other bodies that will be developed over time will be given control of budgets and have real decision making authority. We have already identified two totemic projects that Community Voice will take lead responsibility on: **Beach School** and **Improving safe space and play**, and we expect the Community Voice will develop other projects.

Beach School

Blackpool has 11 miles of coastline and beach, which is an unexplored environment for many of our young children. Taking inspiration from the successful 'Forest Schools' approach, local parents have set out their ambition to create their own Beach School. There is scope for outdoor play and learning on the shore and the beach offers a unique environment for children's discovery and learning. That could mean getting in the water, living out desert island fantasies, creating amazing sand sculptures, lighting fires, driftwood structures or just as simple as feeling the sand between your toes! We've always got our fair share of pirates and smugglers too. This would link in with the Heritage Lottery bid project *Creative People and Places* which is developing activities around Blackpool's coastal and marine past.

As well as building strong social networks, a key focus of the Beach School will be on building communication and language skills, promoting healthy nutrition and building social and emotional skills. We intend working very closely with parents to encourage talk in everyday activities to promote effective communication skills and sensitive interaction with new babies and toddlers. Responding to parents requests to help other parents, we will set up a group of 'Community Communication Champions', trained parents and volunteers who will promote communication to other parents in their community. The beach school will be an important setting for our broad public health approach, allowing parents to access information, support and advice and helping to build their confidence and sense of self-efficacy.

Improving safe space and play (community fund)

A consultation with the community has already taken place about the development of the green spaces in Blackpool. These projects will not only enable young children and their families enjoy the outdoors more but also encourage physical exercise (an important issues highlighted in our

wellbeing data).   Our needs analysis highlighted social isolation as a very salient issue in Blackpool and a core role of this fund will be about helping to build social networks and places where new families can meet.

These projects are not about expensive equipment, but about making the most of available space and resources.

They will take in to account the need to reclaim the space for positive community use. Many of the these projects are to join up with other projects across the parks to ensure best value for money but also that the longer term maintenance costs and implications have been taken in to account. The spaces will be used to grow flowers, trees, fruit and vegetables and play areas. The community will be starting a birth tree scheme where each month a tree is planted for the new babies born that month. All new-borns will be notified about their tree and encouraged to visit it at least once a year!

Management of both the Beach School and Improving safe space and play (community fund) will be supported by Groundworks, a local charity with great expertise in community engagement and delivering successful community development projects.   Better Start will fund a community development worker from Groundworks to support these projects and ensure local parents have real ownership.

Workforce Development

We have pinpointed our **key challenges around workforce development:**

- We have a partial picture of development needs across the Better Start workforce as a whole
- Professionals want tools and approaches for better engaging families
- Professionals want access to evidence based methods of practice and opportunities to share learning
- Some practitioners need specialist training in evidence based programmes
- There are opportunities for increased multi-agency working
- They want more opportunities for reflective practice
- Opportunities to increase professional confidence and autonomy for decision-making

Generally we have a wide definition of the 'Better Start workforce', encompassing parents and volunteers – as well as professionals to ensure we connect with the widest range of providers. Our approach to building the capacity and capabilities of parents and volunteers is described in the preceding two sections on 'reframing' and on 'engaging families and communities' (and also in Annex N). In this section we focus primarily on the development of the professional workforce.

In Appendix G8 we set out our draft workforce strategy, which will be refined and finalised during the first six months of the Better Start programme, giving us more time to capture crucial baseline data. The key planks of our workforce development strategy will be:

1. Establishment of the 'Better Start Workforce Development Group'
This inter-agency body will oversee the production and delivery of the workforce development strategy. It will bring together senior managers from the partner agencies with the authority to

reshape workforce development opportunities according to a common Better Start design. They will ensure that profesional development and training opportunities are prioritised and that staff are rewarded for their commitment to the Better Start programme (for example through end of year appraisals).

2. Core values, competency framework and skills audit

This Better Start Workforce Development Group will lead on the development of a set of '*core values'* which will help to guide professional practice and provide a common frame of reference between staff from different professional disciplines. The group will also develop a shared '*competency framework'* for staff and volunteers. They will also undertake an audit of the current skills, experience and competencies of the workforce and use this data to prioritise needs and to plan specific training and development activities.

3. 'Core training' programme

Building on the work with the *Frameworks Institute*, training in child development will be the central component of the 'core training' programme for all of the Better Start workforce. Definition of the core training programme is also likely to include roll out of successful approaches for engaging families (such as Motivtional Interviewing, which has already been widely adopted in our FNP and Health Visiting teams) as well as issues such as safeguarding, perinatal menal health awareness, domestic abuse, drug and alcohol misuse and data protection.

The NSPCC has developed *'Breakdown or Breakthrough?'* a series of five ground-breaking films with Dr Amanda Jones which cover key topics all professionals working across the perinatal period need to be aware of, such as 'the social brain', 'the forgotten father', 'emotional breakdown' and 'domestic abuse.'

Delivery of the 'core training' programme will be a priority across the entire Better Start workforce and will require careful programme management and senior level buy-in.

4. Specialist training for specific professionals

The Workforce Development Strategy will also capture the specialist training needs identified by individual services or professions. For example, maternity services have committed to training midwives in the Brazelton *Neonatal Behavioural Observation*. And Children's Centre workers will be trained in *Supporting Speech, Language and Communication in the early Years.*

5. Specialist training in evidence based programmes

The Centre for Early Child Development will oversee the planning and delivery of specialist training in our newly-introduced evidence based programmes such as Video Interaction Guidance and Safecare. Many of these new programmes will involve increased multi-agency and inter-professional working. Given the multi-agency nature of many of the interventions, the Centre will need to liaise very closely with all partner providers. We have designed a staggered approach to implementation to avoid bottlenecks when large amounts of training are going on at the same time. We have also anticipated the need for back-fill training when practitioners leave or go on maternity leave. The Centre will also hold the relationships with new external programme developers, providing a clear and single point of contact between frontline practitioners and the organisations who originally developed the interventions.

6. Video enhanced reflective practice (VERP)

As part of our Workforce Development Strategy, we will explore the potential to pilot the use of Video Enhanced Reflective Practice. This approach has been successfully pioneered in a range of different contexts, including a small local pilot among NSPCC practitioners already delivering Video Interaction Guidance in Peterborough. This approach involves the use of video technology to film supervision sessions; and joint discussion of the films between managers and practitioners to help review interaction and promote reflective practice.

The 'Bank of Blackpool' and integrated commissioning

We have identified several significant **challenges to resourcing** of support from conception to three, as well as **barriers to integrated commissioning**:

- Need to redirect investment towards early years intervention and prevention
- Little outside investment in services from pregnancy to three
- Competing priorities between different agencies
- Gaps between systems (between health and children's services; adults' and children's services; maternity and child health; voluntary, statutory and private; and between prevention and protection).
- Need to inform commissioning decisions on the basis of 'what works' and 'what doesn't' – as well as evidence of value for money

Blackpool Better Start is committed to whole system change and the development of the **Bank of Blackpool** and **pooling of budgets** for conception to 3 are central to this change. Partners are committed to creating a pooled budget for Big Lottery money, with £30 million of funds leveraged from the public system.

In addition to the Big Lottery funding, the Partners agree to ring fence and make available over the ten years of the Better Start programme £30,000,000 (thirty million pounds) from existing budgets. During the first 12 (twelve) months of the term, the Partners will obtain legal and financial advice as to the most appropriate vehicle for holding such funds. This could be holding the monies in a joint bank account, on trust, or in accordance with any other structure as may be agreed by the parties.

The Bank is expected to have three elements:

- **Effective governance** – delivered through the structure outlined above – crucially the community have a clear, consistent and robust voice into this through the newly developed community partnership and also through the more established and embedded Fairness Commission (terms of reference attached).
- **A pooled budget** – partners have committed to pooling £30 million of resources to enable re-design of service delivery and expansion of services which are demonstrated to be effective and provide good value for money. The current commitments are based on financial projections, which are based on known resource allocations. Partners have the right to revise this if their resource allocation changes.

- **An integrated commissioning framework,** which ensures that the Executive sets the strategic direction and that commissioning is delivered in an effective and legal way. This process will include a joint commissioning sub group that will manage the mechanics of any commissioning process and ensure conflicts of interest are effectively managed. It will also include a critical friend role from the *Blackpool Centre for Early Child Development*, helping ensure that commissioning draws on the best and most current evidence and science base.

Blackpool Local Authority has a history of pooling and aligning budgets to improve outcomes, create economies of scale, and work in closer partnership with other organisations. Most recently the Local Authority have pooled budgets with health and local voluntary organisations on Learning Disabilities and created a joint NHS commissioning pooled budget for substance misuse services. In addition the Families in Need team have aligned budgets from health (mental health and substance misuse) and the Police to create a multi-agency team of professionals together all line managed by the Local Authority. This has led to families receiving a holistic response to their needs. We intend to build on this track record of managing pooled resources.

Our governance arrangements have been designed to support community commissioning. By this we mean parents and residents having a central role in the commissioning of local services, making collective decisions on how to get the very best outcomes from available resources. This could include, integrating services, participatory budgeting and personalisation.

We will build local evaluation expertise located within the new *Blackpool Centre for Early Child Development*; and we will ensure that evidence is central to decisions about commissioning, decommissioning and expansion of services.

Leadership and accountability

We aspire to be recognised leaders in combining the power of local communities and public systems to radically improve outcomes for babies and young children. Delivering our vision requires governing in a different way with families and communities to reshape services.

The key **challenges for leadership and accountability** are:

- Early Intervention and prevention require a long-term and sustained commitment
- Policy silos
- Giving the community real power and influence over outcomes

Our **new approach will be characterised** by:

- Strong leadership and clear accountability
- Authentic partnerships built around shared outcomes
- Building relational public services

To achieve this, in Blackpool we are building on strong foundations with an established track record for partnership working across the local authority, health and voluntary sectors. The community is at

the heart of the Better Start Partnership with representatives on each of the boards. Our governance arrangements are designed to enable parents, residents and services to tackle shared problems together through systems that are interconnected and decentralised. By working in this way we aim to build more relational public services.

We will ensure that Better Start is a long-term priority and ensure wider policy developments are based on the needs of families by:

- Building cross party, long term consensus on the Better Start goals.
- Senior Officers and Political Leaders sharing accountability and leadership of the change agenda by prioritising, championing and being accountable for the delivery of outcomes for pre-birth to 3 years,
- Policy development based on the needs of families to ensure their needs are taken into account in other initiatives (e.g. economic development, environment and housing)

A Community Partnership Board is responsible for developing and implementing the Better Start strategy for Blackpool. Sitting alongside this is *Community Voice* – a group of parents with an elected member sitting on the Operational Board. As *Community Voice* grows in confidence it is hoped that other members will take a more active role in developing Better Start. Through the governance arrangements, community and voluntary groups, parents and residents will participate at a range of levels – from providing advice to co-designing the process and from undertaking some aspects of the engagement to delivering projects to meet some of the outcomes.

To give the community real power and influence over outcomes they be supported by the *Blackpool Centre for Early Child Development* and will have their own budgets for particular projects such as the Beech School and developing play spaces. Further engagement activity, detailed in Section N, will support community collaboration and empowerment.

While we are ambitious, we recognise there will be challenges. We have taken a staged approach at a pace that is realistic based on the NSPCCs experience of implementing evidence based programmes. We will support implementation of the programme through the *Blackpool Centre for Early Child Development* described below.

Pillar 4	**BLACKPOOL CENTRE FOR EARLY CHILD DEVELOPMENT** *Building and sharing learning*

The final pillar of our distinctive Better Start approach will be establishment of the *Blackpool Centre for Early Child Development*. The centre will play a crucial role in driving Better Start strategy and overseeing delivery and learning from the programme. Our ambition is that the centre should become an internationally recognised and renowned source of expertise and innovation in services and systems from pregnancy to three.

Functions of the Centre

- Leadership and strategic direction for the Blackpool Better Start programme as a whole
- Planning and implementation of the public health campaigns and new evidence based interventions, working in partnership with other providers
- Managing the part
- Communications and marketing, including the Child Development 'reframing' approach
- Managing community development contracts and projects
- Research and development of new services
- Support and challenge to the Executive around systems transformation
- Support and challenge to the Workforce
- Local evaluation of process, impacts and costs to inform service improvement and commissioning
- Central IT systems and data capture for the programme
- Support and challenge to the Bank of Blackpool and commissioning board on quality of evidence
- Capturing and sharing learning

How it will work

We will establish a **dedicated and expert local team**:

- **The Director** of the Centre will provide overall leadership of Better Start in Blackpool and be accountable to the Executive Partnership Board. He/she will be a key ambassador for the programme across the partnership and externally. The Director of the Centre will be a high profile role and we expect this to be filled by a recognised expert in the sector.
- **Development Managers** will each be responsible for leading implementation of several evidence based programmes, liaising as appropriate with other partners and providers. They will also have a role in managing research and innovation projects and in workforce development and training.
- **Evaluation Officers** will be responsible for local evaluation at individual and population levels.
- A **Community Development Officer** will manage the community engagement contracts and projects, support the *Frameworks* project and be the key link between the Centre and the *Community Voice*.

- A **Senior Communications Officer** will manage all marketing and communications activities, including materials for new services and management of the *Frameworks* project.

There will also be a dedicated and experienced **Business Manager** to oversee day-to-day operations of the programme. There will also be **Administrative** posts, a **Data Analyst** and a part time **Finance Officer** to ensure smooth running of the programme and business operations, to organise events and to meet reporting requirements expected by partners, funders and the accountable body.

We will develop a **'special relationship' with the NSPCC's programme on pregnancy and babyhood**, led by Chris Cuthbert (Head of Strategy & Development at the NSPCC) and his team, providing:

- **Communities of practice** with practitioners from over thirty other NSPCC service centres providing evidence-based interventions specifically for pregnancy to three
- **Local opportunities to collaborate** with NSPCC's established and fully staffed local service centre in Blackpool
- **National experience** and advice on developing, implementing and rigorously evaluating science and evidence based programmes
- **Policy and influencing** at national level, such as NSPCC's *All Babies Count* campaign and Spotlight reports on issues such as perinatal mental illness, drug and alcohol misuse, homelessness and babies in the criminal justice system
- **Opportunities for 'buddying'** with Development Managers, Evaluation Officers, Policy & Public Affairs Officers, Communications Specialists and Fundraisers at the NSPCC's national offices
- **Advice on replication and dissemination**
- **Advice on research ethics**

The NSPCC has a unique contribution to bring to the *Blackpool Centre for Early Child Development*. The pre-birth to 3 life stage is a strategic priority nationally for the NSPCC and over the past two and a half years the NSPCC has invested £11.5 million in evidence based programmes specifically focussed on this life stage. We have a track record of implementing programmes as well as undertaking rigorous, science based innovation, including robust experimental evaluation. This capacity will have direct benefit for Blackpool as the only site supported by the NSPCC in the Better Start programme. Furthermore, any learning from Better Start will have a wider benefit, since NSPCC operates in 42 sites across the UK and has a strong influence in national policy.

The Blackpool Centre for Early Child Development will create a **virtual network of national and international experts** to keep abreast of latest research, policy and practice and to share findings from our own programme. Below are examples of the kinds of expertise we will seek to bring into the network:

- Implementation Science: Michael Little, David Olds, George Hosking
- Child Development: Pasco Fearon, Lynne Murray
- Perinatal Mental Health: Alain Gregoire, Susan Pawlby, Tessa Baradon
- Drugs and Alcohol: Sharon Dawe; Paul Harnett; Barry Carpenter

- Domestic Abuse: Gene Feder; Harriet McMillan; Gwynne Rayns
- Parent Education: Angela Underdown; Sally Hogg; Mary Nolan
- Children's Centres and Child Care: Naomi Eisenstadt; Kathy Sylva
- Language and communication: Jean Gross; AN OTHER
- Child Health and practice: Kate Billingham; Cathy Warwick; Cheryll Adams
- Public Health: Mitch Blair; Jane Barlow
- Child protection: Ruth Gilbert; Julie Taylor; Phillip Noyes
- Community engagement; Nesta
- Research and evaluation: Richard Cotmore; Leon Feinstein
- Finance and fundraising: Elly Decker; Paul Farthing

The *Blackpool Centre for Early Child Development* will become part of a wider community of learning that includes other successful Better Start wards across the country, the Early Intervention Foundation, Dartington Social Research Unit, WAVE Trust and other centres of expertise in this important field.

We fully recognise the importance of recruiting a high calibre team and that we will require excellent business infrastructure if the Centre and its staff are going to be able to deliver on our ambitious programme. We will invest time in bringing in the right team and establishing robust systems. We fully expect the Director to be a recognised expert in the sector. And our work plan is carefully staged, recognising the kind of pace that will be realistic based on our previous experience of implementing evidence-based programmes.

Strategic Commissioning Group **Agenda Item 4**

HeadStart Blackpool

Date: 6th November 2014

Matter for consideration: HeadStart Commissioning Process

Recommendation: For discussion

Relevant Officer: Merle Davies

1. Background

1.1 Blackpool was one of 12 Local Authorities identified by the Big Lottery Fund (BLF) to apply for the HeadStart funding as part of their fulfilling lives programmes. HeadStart is aimed at building the resilience of young people aged 10-14 years to reduce the likelihood of them developing mental health conditions in the future. The funding is a three stage process, Blackpool has been successful in both stage one (10K for project development) and stage two (500K to deliver an 18 month pilot project).

1.2 Clear guidance was given by BLF regarding what they wanted to see in the pilot project. This included an element of both universal and targeted approaches and had to cover young people's experiences at school, in the family home and in the community. The use of digital technology also needed to be included in the pilot.

1.3 The BLF have acknowledged that there is very little evidence available regarding what works in building young people's resilience. This has led to their decision to utilise the pilots as test and learn projects and have encourages each area to be innovative and risk taking in their approach to project design.

1.4 BLF have been clear that young people must be at the heart of project development and Blackpool has and continues to facilitate wide ranging participation and co-production opportunist to fulfil this objective.

1.5 Blackpool has developed the delivery model for this stage two pilot, consisting of two clusters of school, each containing one secondary school and two feeder primaries. A range of commissioned projects were agreed, based on feedback form young people and where possible, existing processes to access support have been utilised i.e. school processes, GIR, CAMHS etc. to avoid confusion and duplication.

1.6 Governance for the project is provided by an operational group and a steering group that then feed into CLT, the children's trust and health and well being board.

1.7 BLF are looking for a step change in the way that mental health services are designed and delivered. The ability to achieve this step change will greatly affect the chances of being successful at Stage three of the funding process.

1.8 The timescale for the pilot project is July 14 to December 15, and we are currently

waiting for confirmation from BLF regarding the deadline for the stage three submission; however this will not be before December 2015.

2. Supporting Information

2.1 Blackpool Council Commissioning Team have been involved in the project development and are represented on the operational and steering groups for HeadStart

2.2 Funding has been made available for the commissioning work will be led by Blackpool Council's Commissioning Team and commissioning processes are currently underway to procure the HeadStart programmes. It is estimated that this will be completed and contracts awarded by the end of the year.

2.3 It is accepted that this is a pilot and that if Blackpool is successful in stage three, that will provide 10 million over 5 years, and then a full commissioning strategy will be developed.

3. Key Issues

3.1 For a number of different reasons, the pilot project is currently running approx 12 weeks behind schedule. Therefore the commissioning process needs to be facilitated swiftly as any further delay may compromise Blackpool's chances of being successful in stage three.

3.2 Young people will be involved in all aspects of project delivery, including commissioning and monitoring. It is imperative that we ensure that their involvement is supported, for example times, dates and locations of meetings.

3.3 What processes can the project agree to ensure that all learning from this current commissioning process is recorded and utilised for the stage three submission.

3.4 Discussions regarding future re design of services will need to take place sooner rather than later to ensure that any possible future decisions regarding the re design of mental health services for young people can be achieved within the required timescale.

4. Recommendations and Next Steps

4.1 HeadStart and the model for the commissioning and delivery of young people's mental health services to be discussed at all relevant forums and with all appropriate partners.

4.2 Robust evaluation of all interventions must be in place to ensure effective evidence for the stage three submission.

Background papers:

HeadStart Stage two submission form
HeadStart Delivery Model
HeadStart Integrated Working Model

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Jeannie Harrop, Blackpool Clinical Commissioning Group
Relevant Cabinet Member:	Councillor Eddie Collett, Cabinet Member for Public Health
Date of Meeting:	3rd December 2014

UPDATE ON END OF LIFE INITIATIVES

1.0   Purpose of the report:

To provide an update on End of life initiatives for Blackpool Health and Wellbeing Board including Hospice at Home pilot, education and training, DNACPR, Gold Standard Framework for care homes, and Care of the Dying Pathway.

2.0   Recommendation(s):

2.1   To note the update presentation on end of life initiatives.

3.0   Reasons for recommendation(s):

3.1   To update the Health and Wellbeing Board on the current initiatives for end of life care.

3.2a   Is the recommendation contrary to a plan or strategy adopted or approved by the Council?   No

3.2b   Is the recommendation in accordance with the Council's approved budget?   Yes

3.3   Other alternative options to be considered:

None, the presentation is to provide an update.

4.0   Council Priority:

4.1   The relevant Council Priorities are:

- Safeguard and protect the most vulnerable
- Improve health and well-being especially for the most disadvantaged
- Encourage responsible entrepreneurship for the benefit of our communities
- Deliver quality services through a professional, well-rewarded and motivated workforce

5.0   Background Information

5.1   Background and details of the initiatives has been provided in the attached presentation.

5.5   Does the information submitted include any exempt information?   No

5.3   **List of Appendices:**

Appendix 5a: Presentation

6.0   Legal considerations:

6.1   None

7.0   Human Resources considerations:

7.1   None

8.0   Equalities considerations:

8.1   None

9.0   Financial considerations:

9.1   None

10.0   Risk management considerations:

10.1   None

11.0   Ethical considerations:

11.1   None

12.0   Internal/ External Consultation undertaken:

12.1   None

13.0   Background papers:

13.1   None

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Update on End of Life Care initiatives

Hospice at Home pilot

- The pilot started on 1 September 2014.

- An event was held in November 2012 to identify the gaps for end of life care, and due to the lack of sufficient evening provision this was prioritised.

- The pilot is funded by Blackpool and Fylde and Wyre CCGs and Trinity Hospice. The provision is over 7 days between the hours of 10pm and 8am and the service works closely with the other established out of hours services including Marie Curie and Blackpool Council.

- The pilot aims to improve the quality of services for patients at the end of life, enabling them to be cared for and die in the place of their choice and avoiding inappropriate hospital admissions.

Hospice at Home pilot

Details of what the service provides :-

- Via a community care plan, Hospice at home trained nurses and healthcare assistants can help support patients and families overnight to manage care at home, monitor the patient's condition and deal with any changes that occur. They can assist with a range of nursing needs such as breathing management, nausea and pain, and the management of medication issues including setting up syringe pumps

- Hospice at Home trained nurses are able to administer prescribed medications to alleviate symptoms, whilst the senior healthcare assistants can assist with all aspects of personal care.

- The Hospice at Home team provides practical advice and emotional or psychological support to patients and those caring for them.

- Patients will be handed back to the usual caring team in the morning.

- Where complex specialist palliative care needs are apparent the patient will be referred to the Trinity Clinical Nurse Specialist team.

Hospice at home activity

Hospice at Home week commencing 15th September 2014
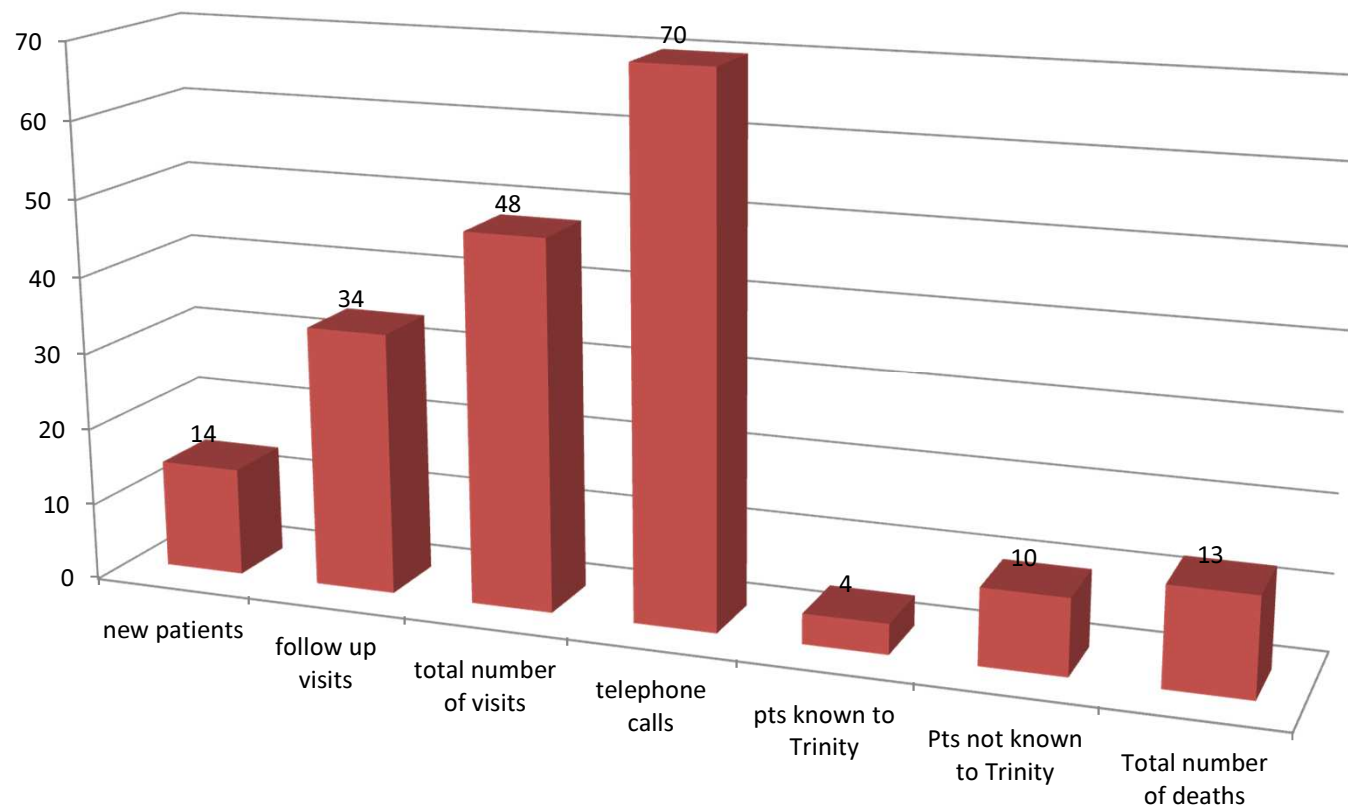
Education and Training

- Two successful bids have been submitted for multi-professional education and training monies (MPET) for 2013/14 and 2014/15.

- The funding for 2013/14 was used for a range of education programmes including bereavement and listening skills training for learning disability teams, to develop a rolling programme on end of life prescribing to support pharmacists and non medical prescribers, to deliver Mental Capacity Act, advanced care planning and DOLS training for community and primary care staff, end of life updates for GPs and practice staff including an education event.

- The aim for 2014/15 funding is to recruit a nurse based in the community to in reach into A&E and the wards. They will link with the community teams, including rapid response, GP practices and hospice at home teams to enhance community care.

- An educational rolling programme has been developed which can be accessed by health, social care, care homes and voluntary sector staff.

DNACPR forms

- New Do not attempt cardio- pulmonary resuscitation (DNACPR) forms have been developed across Blackpool and the Fylde Coast.

- They are available to be used in any health care setting.

- The forms are transferable between health care settings.

Gold Standard Framework (GSF) for care homes

- This is a national programme of education for Care Homes.

- 23 homes are registered on the education programme in Blackpool and have completed the educational workshops.

- To date 10 homes have successfully completed the GSF national accreditation process and now recognised nationally as a GSF accredited home.

- A further two homes are in the process of accreditation with the results due in March 2015 and if successful will take the total of accredited homes in Blackpool to 12. The remaining 11 homes whilst not completing the formal accreditation process are at various levels of implementation of GSF and follow the process of best practice.

- A further 24 care homes in Blackpool have received end of life training via the less informal Blackpool model based on the national document 'Routes to Success'.

Care of the Dying Pathway

- Following the public consultation on the Liverpool Care Pathway (LCP), 'The More Care Less Pathway' document recommended the withdrawal of the LCP in July of this year.

- On the Fylde Coast the Individualised Care of the Dying Person was developed for cross boundary use.

- A pink checklist has been developed giving prompts for the 5 recommended priorities of care, the pink check list is placed in the patients notes and acts as a marker for the transition of care.

- To support the implementation of the new documentation a robust training programme has been developed and delivered in all care settings including community, acute hospital and Trinity Hospice.

- Supportive documentation has been developed and available including guidance for Doctors and nurses, an end of life information leaflet for families and carers.

- A communication diary that is offered to families and carers was recommended in the report is currently under development.

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Andy Roach, Blackpool Clinical Commissioning Group
Relevant Cabinet Member	Councillor Eddie Collett, Cabinet Member for Public Health
Date of Meeting:	3rd December 2014

BETTER CARE FUND SUBMISSION UPDATE

1.0   Purpose of the report:

1.1   To provide an update on the revised submission of the Better Care Fund and Action Plan developed following the National Consistent Assurance Review.

2.0   Recommendation(s):

2.1   To note the current status of the revised Better Care Fund submission.

3.0   Reasons for recommendation(s):

3.1   The Board has a key role in monitoring the submission of the revised Better Care Fund.

3.2a   Is the recommendation contrary to a plan or strategy adopted or   No
        approved by the Council?

3.2b   Is the recommendation in accordance with the Council's approved   Yes
        budget?

3.3   Other alternative options to be considered:

        None, the item is for information to keep the Board informed as to the Better Care Fund's progress.

4.0   Council Priority:

4.1   The relevant Council Priorities are:

- Safeguard and protect the most vulnerable
- Improve health and well-being especially for the most disadvantaged

5.0   Background Information

5.1   The £3.8bn Better Care Fund (BCF) was announced in the June 2013 spending review. The key ambition of the Fund seeks to transform local services to ensure people are provided with better integrated care and support – which is joined-up, personalised and provided closer to home.

5.2   In order to access the Better Care Fund, every local area developed a locality plan aligned to the two-year operational and five year strategic plans of their Clinical Commissioning Group. Plans must also meet certain national conditions including a commitment to seven day working, better sharing of information and protection of social care services. Draft and final plans were approved by Health and Wellbeing Boards in February and April 2014 respectively before being take forward for ministerial sign off.

5.3   Following a ministerial review in April 2014 it was recognised that whilst many plans reflected the ambition of the Fund, certain aspects required further development as follows:
   • More evidence of financial risk and performance metrics;
   • Sufficient provider engagement and agreement on the impact of plans;
   • Greater clarity around the alignment of the Better Care Fund plan to wider plans and policies, such as how Better Care Fund schemes will align with and work alongside primary care;
   • More evidence of robust finance and analytical modelling underpinning plans.

5.4   To address these requirements, NHS England published updated guidance, revised plan templates and extended the timetable for revising and submitting locality plans.

5.5   Further to the previous update in October, the final submission and supporting action plan will be presented to update the Board on the status of the Better Care Fund Plan following the National Consistent Assurance Review

5.6   Does the information submitted include any exempt information?   No

5.7   **List of Appendices:**

Appendix 6a: Better Care Fund Final Submission

Appendix 6b: Better Care Fund Action Plan

6.0   Legal considerations:

6.1   None

7.0   Human Resources considerations:

7.1   None

8.0   Equalities considerations:

8.1   None

9.0   Financial considerations:

9.1   None

10.0   Risk management considerations:

10.1   None

11.0   Ethical considerations:

11.1   None

12.0   Internal/ External Consultation undertaken:

12.1   None

13.0   Background papers:

13.1   None

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Better Care Fund planning template – Part 1

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

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

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

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- PLAN DETAILS

  o   Summary of Plan

Local Authority	Blackpool Council
Clinical Commissioning Groups	Blackpool CCG
Boundary Differences	Blackpool Council and CCG are co-terminus, however some of the population registered with Blackpool GPs live within Lancashire County Council and vice versa
Date agreed at Health and Well-Being Board:	03/09/2014
Date submitted:	19/09/14
Minimum required value of BCF pooled budget: 2014/15	£7,530,000
2015/16	£14,081,000
Total agreed value of pooled budget: 2014/15	£0
2015/16	£15,230,000

  o   Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Blackpool CCG
By	Dr Amanda Doyle OBE
Position	Chief Clinical Officer
Date	19/09/14

Signed on behalf of the Council	Blackpool Council
By	Delyth Curtis
Position	Director Adult Social Services
Date	19/09/14

Signed on behalf of the Health and Wellbeing Board	Blackpool Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Cllr Simon Blackburn
Date	19/09/14

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

No.	Document or information title	Synopsis and links
1	**Unscheduled Care Strategy**	The Unscheduled care strategy was developed in 2011 by the shadow CCG in collaboration with social care and our major health care providers. The 5 year strategy is now approaching its 3rd year. Many of the schemes delivered as part of this strategy support the vision of the BCF. Unscheduled Care Strategy Fylde Coast
2	**BCF Programme Board Project Initiation Document**	This document provides a summary of local arrangements to implement the Better Care Fund including the rationale for carrying it out, the outcomes it is seeking to achieve and how it will be managed. It also describes the governance arrangements to ensure that groups have all the information necessary to manage the project. It will also provide a baseline against which the progress of the project can be measured. Better Care Fund PID v2.doc
3	**Health and Wellbeing Board JHWS & Performance Framework**	Blackpool HWBB's key focus is on improving health and wellbeing outcomes and reducing inequalities through every stage in people's lives, and to enable local commissioners to plan and commission integrated services that meet the needs of the whole community, in particular for the most vulnerable individuals and the groups with the worst health outcomes. Blackpool HWBB has developed a Joint Health and Wellbeing Strategy which sets out its vision, goals and priorities over the next two years. This strategy was informed by the Joint Strategic Needs Assessment (JSNA) and through public consultation. www.blackpool.gov.uk/hwb Blackpool HWBB has also developed a local performance framework to quality assure the delivery of its strategic priorities. Performance Framework v1.pdf
4	**NHS Blackpool & Blackpool Council: Adult Health, Social Social Care and Housing Related Support Community Services Towards 2015: A New Commissioning Strategy**	This strategy has been informed by the work of the Commissioning leads in Blackpool CCG, Blackpool Council and the Practice Based Commissioning Consortium (at the time). It is the culmination of a series of service reviews, consultation and engagement with a wide range of stakeholders especially patients, users of care and support services and their carers.

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		Joint-Adult-Health-Social-Care-and-Housing http://www.blackpool.gov.uk/Your-Council/Documents/Joint-Adult-Health-Social-Care-and-Housing-Related-Support-Commissioning-Strategy-20102015.pdf
5	**Blackpool Joint Strategic Needs Assessment (JSNA)**	The JSNA core documents are a joint venture by Blackpool CCG and Blackpool Council that aim to promote a common understanding of health and wellbeing and the causes of poor health within Blackpool. This common understanding is the first step in enabling suitable services to be commissioned that will improve the health of the people of Blackpool. http://blackpooljsna.org.uk/
6	**Healthwatch Blackpool presentation and Feedback**	Healthwatch Blackpool facilitated a public event on the 31 January 2014 to explain the BCF and gather thoughts and opinions. This was completed in a questions and answers session with a voting system. BCF Health Watch.pptx Blackpool Better Care Event Voting Re
7	**Blackpool HWBB presentation**	This was the last of a series of presentations given to the HWBB prior to submission of the first draft of this template, to keep the board informed and gather opinion from the membership on the vision, context and content of the draft BCF plan. Later presentations were given following the revised guidance to ensure ongoing support Better Care Fund Jan 2014 HWBB presc
8	**Blackpool Strategic Commissioning Group (SCG)**	The SCG is a sub-group of Blackpool HWBB with the delegated accountability for the development and oversight of the implementation of the BCF. SCG FINAL Terms of Reference June13.dc
9	**NHS Blackpool 5 Year Strategic Plan 2014-2019**	The 5 year plan was submitted to NHS England on 19th June 2014. It describes Blackpool CCG's vision for improving the health for all sections of our population. Blackpool Strategic Plan FINAL.PDF
10	**Fylde Coast Operational Resilience Plan**	The Resilience Plan has been jointly developed with key partners across Fylde Coast to manage surges of activity. Fylde Coast Operational Resilience

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11	**Project Brief New Models of Care**	The Project Brief which outlines the Extensivist and Enhanced Primary Care Models Project Plan OOH New Models of Care.(
12	**Blackpool CCG Prospectus**	http://blackpoolccg.nhs.uk/about-blackpool-ccg/who-we-are/blackpool-ccg-prospectus/
13	**Blackpool Teaching Hospitals NHS FT Plan on a Page**	BTH POAP_30 04 14.pdf
14	**Care Plan Proforma**	Attached is an example of 'the perfect care plan' used by NHS Wyre and Fylde CCG for individuals with COPD, end of life and risk of admission, which is available to practices via the GP plus scheme. Perfect care plan.docx
15	**Information and Data Sharing Codes of Practice and Protocol**	We are co-signatories to the North West Information Sharing Framework which is in three parts. Tier 0 – is signed by the Chief Executive to agreeing in principle to share information responsibly the detail set out in: Tier 1 – which sets out the legislation that is specific to this particular sharing and what we need to share in terms of the data Tier 2 – describes how we will share the data (e.g. encrypted emails, portal uploads etc) and what operational processes we will put in place Tier 0 North West Statement 2012 Tier 1 Info Sharing Code of Practice Tier 2 Info Sharing Protocol The protocol will be amended to meet local requirements as the BCF project develops.
16	**Carers Services Specification – Carers Grant, GP support and Acute Carers workers**	Carers Specification

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2) VISION FOR HEALTH AND CARE SERVICES

   a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/2020

By 2019 we will have created a truly integrated and effective health and social care system that maintains people's health, wellbeing and independence for as long as possible, by providing the highest quality of care.

Our vision is that:

'Together we will have made Blackpool a place where all people can live longer,
happier and healthier lives by 2019'

Our vision will be achieved by:
- Integrating local health and social care commissioning
- Pooling budgets across organisations
- Creating a neighbourhood / locality model with co-located integrated teams based around groups of GP practices coordinating out-of-hospital/ community care and social care
- Ensuring we have a thriving hospital providing appropriate in-hospital care when needed

Our vision derives from the bold ambition set out in Health and Wellbeing Board's Joint Health and Well-being Strategy 2013-15, which seeks to make **Blackpool a place where ALL people can live long, happy and healthy lives**. The strategy outlines a process of thinking differently and a framework for the future commissioning of health, social care and broader wellbeing services which will be more focused, better co-ordinated and provided closer to home. The strategy focuses on three interdependent themes of **healthy lifestyles**, **health and social care** and **wider determinants**. Each theme is comprised of specific priority areas which the Board has determined it can most influence and effect as a partnership. Underpinning the strategy are four cross cutting themes, which reinforce the aims and ambition set out in our BCF plan:

1. **Safeguards and protects the most vulnerable**
   Ensure all agencies work together to prevent harm and to identify and protect children and adults living in abusive and neglectful situations.
2. **Integrates services**
   Maximise opportunities and outcomes by drawing together existing resources and aligning expertise.
3. **Focuses on prevention, early intervention and self-care**
   Help people to live well and prevent illness. By empowering them to take better care of

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themselves and people they know.

4. **Increases/improves choice and control**
   Put people at the centre of how services are delivered by making sure health and social care services can be accessed easily, in a timely way, and see that they are fair.

Our aims and ambitions for BCF are shared by Blackpool Council who have embraced their new statutory responsibilities to improve health and wellbeing. The Council's Business plan runs in parallel with the current Joint Health and Wellbeing Strategy and features three key themes:

- **Raising Aspirations**
- **Prosperous Town**
- **Healthy Communities**

These themes have been carefully chosen to ensure the people of Blackpool live fulfilled, happy and safe lives. Each theme is underpinned by a series of objectives and those under raising aspiration and healthy communities have a direct relationship to the delivery of the Joint Health and Well-being Strategy and our BCF plan. Objectives include the s**afeguarding and protection of the most vulnerable** and **improving the health and wellbeing especially for the most disadvantaged**. This means the Council has made a clear commitment to:

- Improve the quality of care and range of services to people with dementia and their informal carers
- Maximise choice and control for people with long term conditions
- Continue to support informal carers to ensure appropriate services and support are available to enable them to continue in their caring role
- Address the root causes of preventable emergency admissions to hospital amongst those in our care
- Provide better support, advice and information to help people manage their own support and care
- Give more people control over the care they receive
- Minimise the likelihood of preventable re-admission to hospital through better support and liaison during the discharge process
- Review mental health service provision
- Enable people to retain their independence for longer in their own home
- Ensure people receive good quality care both in their own home and in residential care

Working through the council, CCG and Health and Wellbeing Board we are committed to improving services so that our patients, carers, service users and communities not only enjoy but maintain good health and wellbeing, which will ultimately reduce demands on services over time. We have a rich history of partnership working in Blackpool and we will use these connections to drive forward our shared ambition to provide high quality, sustainable health and social care in order to realise the national vision of a fully integrated system by 2019.

Story of Place

Population and Demography
Blackpool has a resident population of 141,400 (ONS, 2013) and a much larger registered GP population of 172,217 (GP Registers 2013). The population is forecast to rise by 9.8% between 2012 and 2035. Between 2012 and 2035 the number of people aged 65+ is expected to rise by 26%. The growth in older age groups will undoubtedly have implications for health and social care;

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older people may be frail or have dementia and are more likely to have long term conditions such as high blood pressure, heart disease, respiratory disease, diabetes and arthritis. Initial risk stratification shows that 3% of the population account for 48% of the total secondary care expenditure. **(See section 3)**

Deprivation and Transience

Blackpool experiences considerable levels of social need and disadvantage. In 2010, the Town was ranked the 6th most deprived authority out of 354 local authorities in England. Blackpool has extremely high levels of population inflow and outflow (transience). One area, South Beach, has an inflow rate of 193 per 1,000 population, which is the 65th highest inflow rate in England including London. Transience places significant demand on services as many individuals and families moving into the borough have high social needs, particularly those moving into town centre properties in the private rented sector.

Health and Life Expectancy

The health of people is generally worse than the England average and there are marked inequalities both between Blackpool and the national average, and within the town itself. Life expectancy for men is the lowest in the country at 73.8 years and third lowest in the country for females at 80.0 years (England averages of 78.8 for men and 82.8 for women). Men in the least deprived areas of the town can expect to live nearly 10 years longer than men in the most deprived areas. Similarly, for women this difference is eight and a half years. Although the overall trend shows life expectancy to be improving, it is not improving as fast in Blackpool as it is elsewhere and the gap is widening. Not only do people in Blackpool live shorter lives, but they also spend a smaller proportion of their lifespan in good health and without disability. In the most deprived areas of the town disability-free life expectancy is around 50 years. To illustrate this internal inequality, the figure below shows bus routes in Blackpool and how life expectancy increases the further a person lives along the bus route away from the town centre (where the various bus routes intersect).

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Social Isolation

Blackpool shows a high level of risk of social isolation for residents aged 50+ compared to the national average. All areas show a level of risk at least 1.2 times the national average, with concentrations of significantly higher risk levels again in parts of the authority. In 2012/13 Adult Social Care Carers survey identified 47 carers who were socially isolated; 38 were aged 50+ (84.5%). A further 105 carers stated they did not have enough social contact' 84.5% were aged 50 years or older. The modelled social isolation estimates show a complex picture, with social isolation in older people being spread amongst different groups and in pockets within different areas. There is a slight preponderance in northern and southern areas due partly to the age profile within these areas, including some high concentrations of less-deprived elderly; however, there are estimated to be significant numbers of socially isolated older people within most Blackpool wards, with those more-deprived elderly being more evenly spread.

How will The BCF help?'

This landscape of poor health has resulted in greater demands on our health and social care services at an earlier stage in people's lives and there is consensus between partners across the NHS, Council and Voluntary Community and Faith Sector (VCFS) that we need to redefine the way we provide services, ensuring they are provided at the right time, in the right way; better connected, co-ordinated and patient centred. We need to make greater efforts to prevent problems arising, identifying them earlier and responding more quickly to avoid crises. The BCF affords us the opportunity to tighten and accelerate our plans for integrated care across Blackpool.

Through BCF we will provide large scale transformation which is built on good evidenced based practice and existing joint initiatives which are underpinned by a focus on maintaining independence and control through personalisation of care. Our aspiration is that in five years' time, we will have:

- Co-ordinated health and social care focused on the needs of the individual so that people get appropriate help and support when they need it, where they need it
- Developed co-located integrated teams, with multi-professional leadership, based around clusters of GP practices co-ordinating primary, community, and social care
- Enabled integrated teams to have rapid access and direct referral to appropriate specialist services (e.g. tissue viability or stroke rehabilitation)
- Made better use of technology , including Telecare / Telehealth / Telemedicine
- Shared data and relevant patient records, using the NHS number as primary identifier across health and social care as the norm

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- An accountable lead professional
- A single assessment process and co-ordinated care and support plan
- A robust risk stratification tool to identify patients at greatest risk of admission, and intensively case managing these patients
- An efficient and co-ordinated partnership working with the Voluntary, Community and Faith Sector (VCFS) maximising volunteering, befriending schemes and supporting social network interventions.
- Developed and extended the Making Every Contact Count Framework

Public and partner engagement

In shaping our BCF plan, we have sought the views of acute and primary care providers, the third sector, local residents, patients, carers and service users via engagement forums and consultation activities and these are ongoing - a list of activity is detailed on page 54 and evidence in section 1 and section 8

Patients and service users are at the heart of and involved in every aspect of their care and the services which they use. We have listened to what they have told us is most important to them and used this information to shape our plan. Harnessing the narrative developed through National Voices and embedding this within BCF, our vision from the perspective of patients and service users in summary will mean:

1. *There is a single point of access to help and support when I need it*
2. *Information is shared to improve my health and care outcomes and reduce duplication*
3. *I will know the care professional who coordinates my care*
4. *I can stay at home and live independently for as long as possible*
5. *I have been diagnosed and fully understand my condition*
6. *I can manage my own condition using technology appropriately*

We will continue applying the Narrative developed through National Voices. Improving patient and service user engagement is critical for the success of integrated care and in our proposed interventions for the system going forward.

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

Imagine…

Jean is a 74-year-old widow. She moved to Blackpool 10 years ago to enjoy her retirement after happy memories from childhood holidays here. She has lived alone since her husband passed away last year. She gave up smoking 10 years ago but still suffers with emphysema. She also has type-2 diabetes and arthritis. She is lonely and becoming increasingly forgetful and is reluctant to leave the house.

Jean frequently visits her GP but finds it difficult to remember to discuss all her medical needs in a brief consultation, often forgetting the important things. When Jean can't get to see her GP she calls 999. This often results in her being taken to hospital and admitted to a ward. She has to speak to lots of different healthcare professionals, having to explain her conditions repeatedly. She often has to wait for social services before she can go home. The result is that she spends longer than is necessary in hospital. When she is discharged there is often a lack of co-ordination between the hospital, her GP, community and social care services, resulting in Jean not getting the support she needs.

Eventually, after several admissions in just six months, Jean is admitted to a care home…

What if health and social care services were more joined up?

With a professional responsible for co-ordinating Jean's care needs?

This person meets with Jean, her social worker and her GP. Jean decides she wants to manage her care at home with the support of 'Enhanced Primary Care'. A care plan is devised to meet Jean's needs; a copy is given to Jean and the professionals can access this plan online at any time.

Jean now gets regular visits from her care co-ordinator, who supports her to manage her chronic conditions. When Jean's condition deteriorates she knows who to contact and rarely requires an ambulance. On the rare occasion she's admitted to hospital, the discharge process is much quicker, involving a review of her existing care plan.

Jean's health and social care is funded from a joint budget, so the team and her care co-ordinator can make the right decisions with all the relevant knowledge.

Unfortunately, Jean deteriorates. Her co-ordinator reviews her plan with her GP and they escalate her case to the 'extensivist' – a clinician skilled in dealing with patients like Jean who are at high risk of hospitalisation. After tailoring her care to meet the deterioration in her physical and mental health, the extensivist mobilises some telemedicine support to enable Jean to remain safely at home and de-escalates her care back to her GP and care co-ordinator.

Jean has chats with her care co-ordinator and is also put in touch with a local charity, which offers a befriending service, and she goes out to some community groups; this has made her less lonely and she is no longer scared to go out.

Jean didn't need to be admitted to a care home and now gets the help she needs in her own home

Improved outcomes for patients and service users
The BCF has the potential to significantly impact on how these areas will be considered and managed as a holistic entity or set of entities. The success of these changes will, from 2015/16 onwards, help drive :
- reductions in emergency admissions to hospital
- reduce inappropriate demand for nursing and residential home care
- reduce delayed transfers of care
- effective reablement

The benefits of the BCF and the New Models of Care **(see section 2c)** that underpin it will deliver clear improvements across healthcare and social care, as detailed below:

	Extensivist	Enhanced Primary Care
Clinicians and other staff:	✓ Empowered to impact care and have capacity to do so	✓ Practice to full scope of license/capability while expanding system role ✓ Have greater influence on patient outcomes through accountability
Patients:	✓ Receive highly personal care ✓ Gain increased access ✓ Are engaged in the management of their conditions ✓ Become empowered to make informed decisions ✓ Receive consistent, higher quality care in the GP surgery ✓ Are supported through all phases of life, including end of life	✓ Receive whole person focussed care delivered by current GP ✓ Can regularly access care and have questions fully addressed ✓ Work in conjunction with GP to ensure condition mgmt./wellness
Other caretakers:	✓ Gain comfort that loved ones are receiving superior care	✓ Defined role in managing patient care and coordination across clinical resources

	Extensivist	Enhanced Primary Care
Social Worker and other Staff:	✓ Empowered to promote person centred care and support ✓ Empowered to focus on service user outcomes ✓ Empowered to maintain Professional values ad standards	✓ Integrated Teams ✓ Community based ✓ Empowered to maintain professional values and standards
Service Users:	✓ Empowered to make informed decisions ✓ Increased control over day to day life ✓ Asset focused ✓ Encouraged to engage community and other networks of support ✓ Increased physical, mental and emotional wellbeing ✓ Supported within own environment ✓ Continuity of care and support ✓ Only need to tell their story once	✓ Team around the person ✓ Person centred ✓ Asset based ✓ Develops strong community networks ✓ Comprehensive, multi-disciplinary care and support plan ✓ Continuity of care and support
Carers and Caregivers:	✓ Assured of involvement in care provision ✓ Empowered to provide informed support to the care for ✓ Supported in their role to ensure that their own needs are addressed	✓ Assured of involvement in care provision ✓ Empowered to provide informed support to the care for

Progress to date

Blackpool has already developed some excellent examples of integrated working and created a springboard into radical models of care that the BCF will facilitate. Below are examples of the projects and ways of working that will underpin the roll out of the new models.

Wider Primary Care at Scale

Blackpool CCG has developed a number of strategies in primary care to support the wider delivery of care, these include;

In house pharmacists employed and based in GP practice. The service contributes to Blackpool CCG's priorities of extending life expectancy and having healthier lives, by securing improvements to medicines management and maximizing health benefits for patients. The scheme supports national and local outcomes for example, the Combined Predictive Model Scheme utilising the pharmacist's skills to contribute to the care planning for high risk patients.

Hypertension Scheme. The scheme aims to reduce mortality from CVD and to reduce inequalities in mortality within the population and raise public awareness of the importance of managing blood pressure to prevent ill health. Through our 'All Together Now' campaign the scheme targets the highest risk groups and those hard to engage >40 yrs in the general population at a range of public events and in each GP practice.

COPD scheme. The CCG COPD pathway has been rolled out in collaboration with the 'All Together now' campaign and uses evidenced based interventions to increase prevalence:
- Fully implementing evidence-based treatments for patients with COPD who are currently untreated
- Fully implement evidence-based treatments for patients with COPD who are currently partially treated   Finding and treating people with COPD currently undiagnosed
- Review the evidence to treat CVD risk among COPD patients

Atrial Fibrillation. Part of Blackpool CCG CVD strategy, the aim is to raise the awareness of, and improve the detection and management of Atrial Fibrillation (AF) across primary care in Blackpool and supporting collaborative stroke prevention work across Lancashire.

Pulmonary Rehabilitation. For patients at risk of acute COPD exacerbation especially over the winter months.

Access to high quality Urgent and Emergency care

Urgent Care Centre
1. 24/7 Urgent Care Centre Integrating GP Out Of Hospital (OOH) and GP primary care access utilising NHS Pathways.
2. GP/Primary Care Assessment Unit - Rapid Access to Diagnostics and Assessment to confirm diagnosis where it is likely that the patient would be discharged within a few hours.
3. GP/Primary Care led Deep Vein Thrombosis (DVT) service. Rapid Access to Diagnostics to confirm a suspected DVT.

Modern model of integrated care
The following integrated schemes are in place and will be further enhanced by the development of the BCF.

1. <u>Rapid Response Team</u> - Aimed at admission avoidance for people with a diagnosed health and/ or urgent social care need which can be linked to community care plans. An integrated expert health and social care team to provide rapid assessment (within

2hrs) and mobilisation of appropriate support, refer onwards and signpost to appropriate services to ensure a positive and effective patient journey

2. <u>Mental Health Single Point of Access</u> - The service operates as a single point of access to all adult mental health services in the Blackpool locality.

3. <u>Primary Care Mental Health</u> - A fully integrated health and social care service aimed at early intervention, providing a range of inputs from psychological to social support. An innovative service in that it has woven its way into mainstream services such as perinatal, ADHD, ASD and the police to increase access for hard to reach communities.

4. <u>Richmond Fellowship</u> provide a key element of Blackpool's Mental Health strategy and moving patients from acute in-patient settings back into the community with support and to ultimately live independently where appropriate. This is provided from a range of settings, a 24/7 staffed nursing home, supported housing and flats with floating support as patients recover.

5. <u>Community IV therapy service</u>

6. <u>Acute Visiting Service</u> - A paramedic or ambulance worker can ring the out of hours service and get clinical support from a GP out of hours, thus helping to deflect unnecessary conveyances to hospital. Also access to care plans is available to enable clinical staff to use contingencies for people with long term conditions and reduce conveyances to hospital.

7. <u>Frequent Caller Project and Paramedic Pathfinder</u> - Reducing frequent 999 callers and NEL admissions – link with care planning scheme

8. <u>Care Planning Scheme</u> - SpoA for care plans and co-ordination for HCP HCEMISweb, the clinical system, supports the above and sharing of key clinical information

9. <u>Established NHS111 provider</u> with close collaboration with out of hours& Unscheduled Urgent care providers supported by robust Directory of Services (DOS)

10. <u>Better self-management programme for COPD patients</u>, with the 'my breathing book' and care planning to implement prophylactic interventions when exacerbation of the condition is taking place.

11. <u>A full care home management team</u>, working into care homes starting with highest non elective admission rates. The team are completing care plans, offering tissue viability, falls, end of life care and nutritional advice for patients.

12. <u>Dedicated health staff, nurses and AHPs</u> working 7 days a week, to work into a social care intermediate care facility. The health staff are part of the fully integrated team and proactively rehabilitate and educate patients in their recovery, so that most patients go back to their own homes.

13. <u>Community equipment</u> - This is a virtual service which enables rapid access to equipment in a patient's home.

14. <u>Increase use of Telehealth</u> in care homes and patients own homes to ensure that mobile devices improve the monitoring of patients conditions, improving their own confidence and self-management.

15. <u>Empowerment</u> are an organisation which provide dementia advisors and peer support for Blackpool patients and their families. This means wrap around support from the time of diagnosis and then opportunities for social and emotional support for sufferers and their Carers in Blackpool. They offer regular group sessions and outings to provide respite for Carers and opportunities for staff to gently see how Carers are managing and are able to offer timely support when required.

16. <u>North West Ambulance Service</u> schemes to reduce the number of conveyances to A&E departments.

CITIZENS ARE FULLY INCLUDED PATIENTS ARE FULLY EMPOWERED	**WIDER PRIMARY CARE PROVIDED AT SCALE**	**MODERN MODEL OF INTEGRATED CARE**	**HIGHEST QUALITY URGENT AND EMERGENCY CARE**	**PRODUCTIVITY OF ELECTIVE CARE**	**SPECIALISED SERVICES CONCENTRATED IN CENTRES OF EXCELLENCE**
• Working closely with HealthWatch, using focus groups to commission services that patients need in a way they want • Personal helath care budgets • patinet choice	• In house pharmacists, employed and based in GP practice. • Hypertension Scheme • COPD scheme • Atrial Fibrillation • Pulmonary Rehabilitation • Access to high quality Urgent and Emergency care	• Primary/Community based services • Rapid Response team • Mental Health Single point of access • Community IV therapy service • Care planning scheme • EMISweb clinical system supports the aboveuse of telehealth in care homes and patients own homes	• 24/7 Urgent Care Centre • GP/Primary care led Primary Care Assessment Unit • GP/Primary care led DVT service. • Established NHS111 provider with close collaboration with OOH & Unscheduled Urgent care providers supported by robust Directory of Services (DOS) • Frequent caller project	• working collaboratively across Lancashire on the Clinnical Strategy • using support from Oliver Wyman to bring together national evidence to redesign elective provision	• ensuring Specialist Commisisoned services are provieded in a way that delivers world class care for Blackpool patinets

Through the described schemes and other initiatives Blackpool CCG can demonstrate how it has developed the six characteristics of a transformational organisation (as shown in the diagram above). These innovations are also the beginning of a step-change towards the new models of care, supporting their implementation.

Delivering appropriate 7-day services in health and social care with less reliance on secondary care, and more investment in primary care, community care, social care, and voluntary services

1. Mobilising the third sector to deliver a range of services
2. Supporting people to stay out of hospital where their needs can be met in the community
3. Reducing social isolation by developing early intervention and preventative support programmes

Helping people to better understand illness prevention in order that they can take greater responsibility for their own health through more informed choice and control.

Educating and enabling people to recognise the signs and symptoms of ill-health and use more self-care options

1. Recognise, build and use the assets within our communities (skills, capacity, passion,

interests and knowledge) in Blackpool using an Asset Based Community Development approach

1. Developing a volunteer programme across Blackpool
2. Undertaking asset mapping in order to understand what assets we have in our communities and how they can be connected/best used
3. Develop befriending schemes to help reduce social isolation
4. Support social network interventions which help engage all sectors of the community

Creating a culture where our workforce takes a care-co-ordinator role for patient/service user, ensuring that the persons holistic physical and mental health needs are equally valued and supported

Vision for mental health services section - We are working across Lancashire with the specialist mental health trust to develop a state of the art psychiatric unit with adult and specialist dementia beds for the most complex patients who require an inpatient assessment and stabilisation. Together with this there is an expansion of community dementia services to offer assertive outreach 7 days a week, care home liaison and expanded memory assessment services. We are looking to reduce the number of adult specialist teams to avoid silo working and overlay these services in the community across neighbourhood teams. Access to psychiatry will be enhanced in terms of availability across primary and secondary care for frontline generic staff

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

By 2019…
Services across Blackpool will be radically different. Health and social care services will be co-ordinated around the needs of the patient/ service user to maximise efficiency and avoid duplication, with increased emphasis on prevention and proactive intervention; increased provision by the third sector and better engagement and support from communities. The services; tailored to individual needs will be co-ordinated by Primary Care, delivered close to/in people's homes, avoiding unnecessary journeys to hospital. To deliver more focused care to people, resource in primary care will be released by use of Extensivist clinics (concentrating on the sickest of the sick, caring for them in the community without tying up GPs – see diagram below). Fundamentally we want to ensure that as people grow older and their care demands increase they are able to maintain their independence and continue to live at home in a familiar, non-institutional environment for as long as possible.

New models of care in Blackpool
Blackpool CCG (with support from NHS England) has commenced working with external support on developing new models of care. This work is based on international best practice to build on our existing progress in transforming and integrating local care delivery. The new system will be fundamentally different, with clusters of GP practices working together, supported by appropriate services co-ordinating care in their

locality/'neighbourhood', closer to patients' homes.
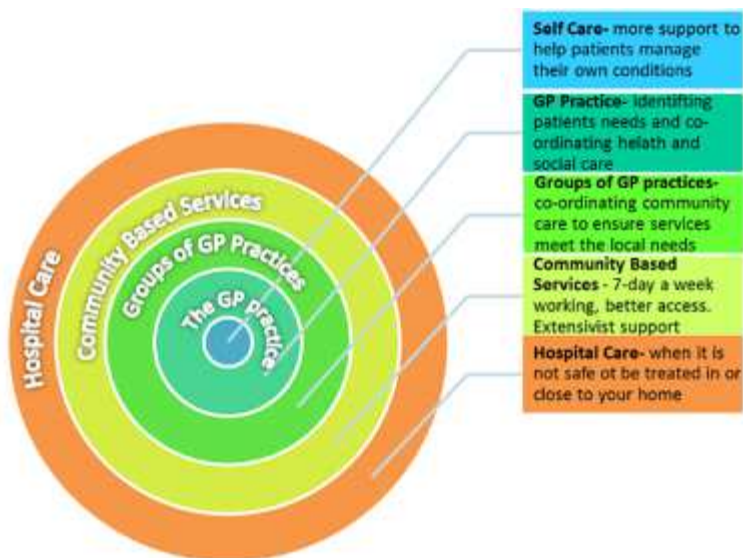
The Extensivist model, which focuses care on patients with the most complex needs. We anticipate from experiences of this model in other health economies that this model will facilitate better management of patients who may not only have multiple physical health needs but whose care becomes more complex due to mental health and social issues. This will also release resource for GP's to have more time to deliver Enhanced Primary Care.

Enhanced Primary Care, which, alongside community and social care, is centred in neighbourhoods. This will enable holistic care to be wrapped around less complex patients who have a single long-term condition that needs to be managed and prevented from escalating.

Both models are founded on identifying a distinct cohort of patients, who are then supported by a specific clinical/social/therapy-led care model. The key component of the care model is clear patient accountability. All care decisions are taken by the patient/their carers, supported by the lead clinician and their care team. This care team has holistic responsibility for an individual's care, acting as the co-ordinating point across the local health and social care system, holding other individuals/organisations to account with respect to their patients. This approach is cohesive with the public health approach of community-oriented primary care, basing interventions on community need.

The neighbourhoods will be based on groups of GP practices covering populations of 20,000 to 40,000, and will take account of health, social care and voluntary resource and estate available to deliver seamless and comprehensive care.

Neighbourhoods
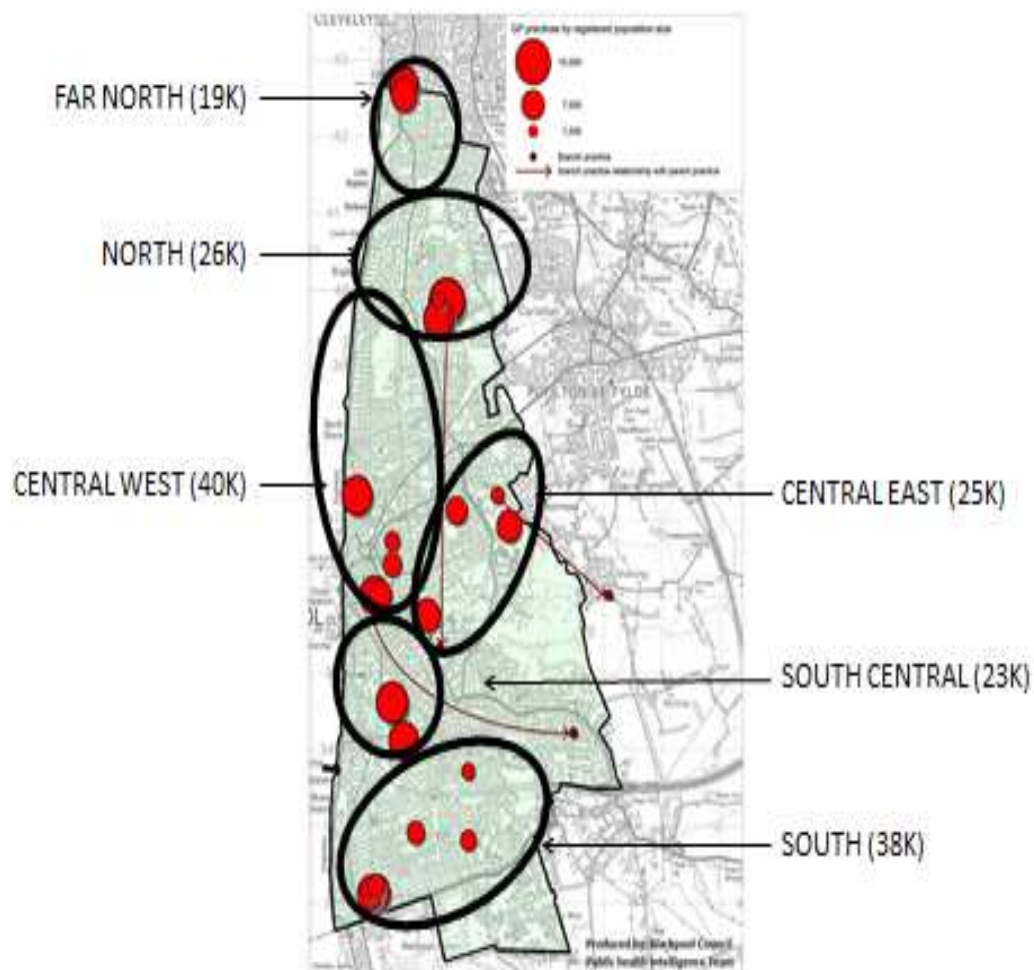
Delivering care closer to home requires organisation of out- of-hospital care at a greater scale. But GP practices will remain at the centre of patient care, providing routine care near to where patients live, continuing to promote health and assist patients in making complex care choices. They will retain overall accountability for a patient's health and co-ordinate care for people with long-term conditions.

Extensivist: care model design
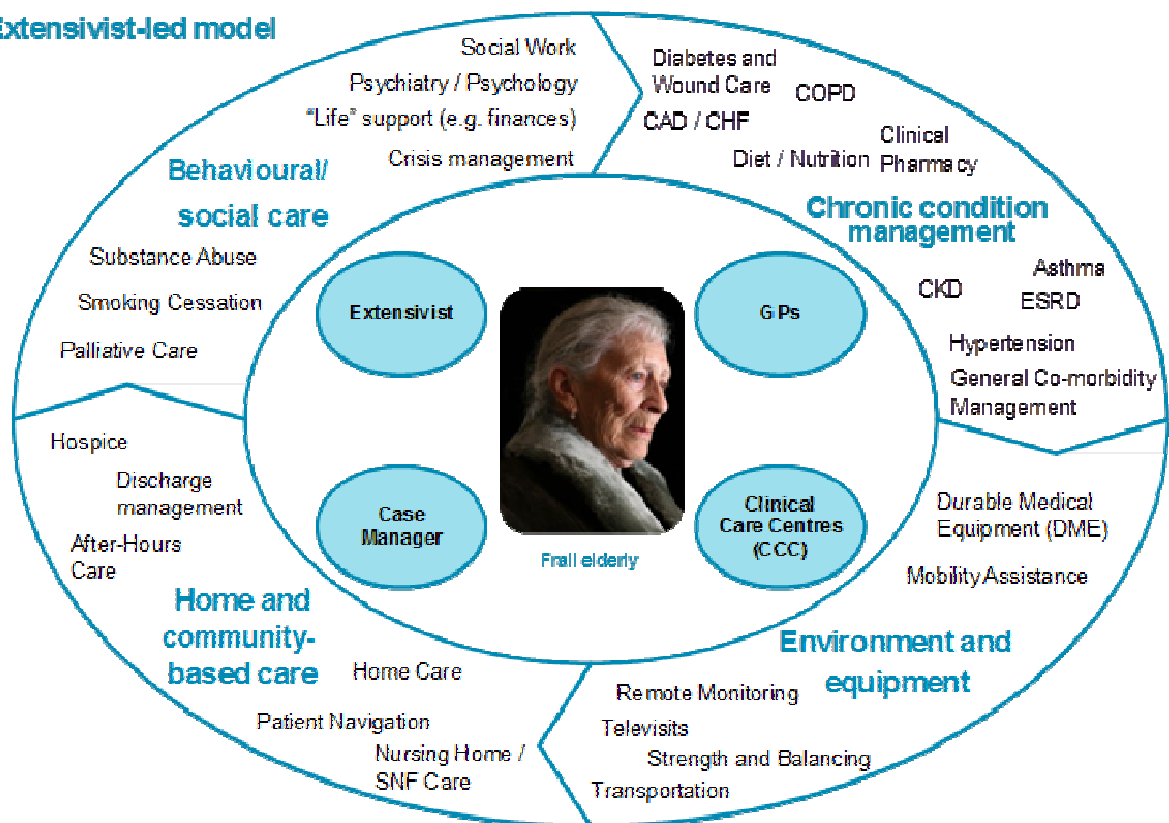
This model is focused on patients with complex needs - the 3% of our population who account for 48% of our secondary care spend. The model has several nuanced orientations; some are medically-led (e.g. for the elderly/frail population), whereas others are socially and behaviourally led.

The Extensivist model is a profoundly different way of delivering care. Care is reoriented around the needs of the patient, cutting across all aspects of health and social need: medical, social, psychological, functional and pharmaceutical. The holistic care system is designed to ensure early intervention and, over time, proactive prevention, breaking the current cycle of slow, reactive care provision.

Each patient's care is led by a doctor called an 'extensivist', who is responsible for managing a specific group of about 2,000 patients. They co-ordinate and deliver disease-specific care programmes and general intervention programmes (e.g. end of life care), which are supplemented by specific specialist services, either long-term condition (LTC) related or episodic. Care takes place at convenient locations for the patient and in settings designed with their needs in mind, with significant home care. In this way, higher levels of compliance with treatment programmes are typically delivered, which in turn supports better outcomes and patient experience.

There will be an initial delivery challenge around identifying individuals with the interest and appropriate experience to be successful in the extensivist role. Additional to this will be: identification and recruitment of the care team; training and development support; integration with current, local, disease-specific pathways and activities; and sufficient change management support to establish these radically new ways of working over a short time period.

Enhanced Primary Care (EPC): care model design
EPC is a new model of primary care for the larger group of patients at the level below those of the Extensivist model in terms of complexity and need. The target patients are those with a single long-term condition, recognising the acuity and support required varies considerably, e.g. well-managed diabetes versus severe liver disease.

The GP is the accountable professional, supported by their team, as the responsible professional for supporting the patient in maintaining/improving their health condition/status. The effective co-ordination of the multi-disciplinary team surrounding the patient, and their authority to access efficiently broader health and social care services, substantially improves proactivity of care, consistency and access. This model often requires a networked GP model, or alternatives, to ensure timely access for patients on a 24/7 basis.

The initial challenge of the EPC model is 'knitting' together the key elements of support services required. Effective delivery of this model is heavily reliant on nurse care manager accountability and acceptance from other parts of the system to ensure that access and management of their patients in other settings reflects the patients' needs and acuity. Given the critical nature of this change, we will introduce strong EPC governance, potentially including service level agreements, to ensure compliance across the system.

Community Orientated Primary Care (COPC)
The EPC model will also be able to provide the infrastructure for COPC, which is an evidence-based public health approach to tackling the health problems of a defined community or neighbourhood, and incorporates population-based and epidemiological input/data. It 'marries' the best of primary care with the best of public health, with the primary care practitioner taking responsibility for the care of an identified community.

In Blackpool, this model of working will be adopted and members of the community and the wider voluntary, community and faith sectors will be involved in the design and implementation of each GP neighbourhood model. The ethic of service is to drive community health improvement, and within each GP neighbourhood develop and implement prevention and treatment plans for their priority areas. The aim is to not only treat diseases but also to develop programmes for health promotion, protection and maintenance.

Each GP neighbourhood will need to take a different approach in reaction to the community's health needs, strengths and resources; including whether relationships have been established between the health service and the surrounding communities.

How the BCF will support delivery of the new models

The Extensivist, EPC and COPC models are key components in pivoting our primary care services to become more proactive and will either be introduced simultaneously or in quick succession. We expect the Extensivist model to stabilise the sickest of the sick with multiple long-term conditions, and the EPC model to enhance single-condition management, reducing the rate of condition progression. Effective delivery of these models will impact on activity in secondary care, helping to reduce the current pressure points, and is likely to lead to subsequent further redesign in these areas. The new models will make more efficient use of social care and have social care input as key members of the teams. ***The bottom line impact will be fewer non-elective admissions.***

Making better use of current resources and moving care closer to people's homes will drive the required reductions in non-elective activity. By integrating services under the umbrella of and funded by the BCF the HWBB will achieve the 3.5% reduction in non-elective admissions and realise the performance element of the BCF to fund these services identified in section 4d.

Without the BCF…

If the BCF was not in place the momentum to develop new models would be lost. Blackpool HWBB see the BCF as a catalyst to drive integration and efficient working, focusing on the patients' needs to deliver the required change to meet the increasing demand within a limited cost envelope. Without the ambitious target of substantially reducing non-elective admissions the current system may not develop at the same pace and there would be a risk that demand would outstrip supply. The BCF helps focus commissioners, providers and people to work together to deliver the national vision of an integrated health and care system.

3) CASE FOR CHANGE

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

In depth analysis of the Blackpool population is still ongoing so that we better understand the potential impacts of new models of care which will continue to inform our longer term strategic plan. It is clear from international evidence that the proposed models of care fit well with our existing plans around developing out of hospital care and the work Blackpool CCG and the Council has been undertaking on developing primary care and community services. Evidence already shows that a small percentage of the population are consuming a disproportionate amount of health and social care spend. These patients tend to end up admitted as an emergency to hospital due to services not meeting their needs. Gaps or lack of co-ordination of out of hospital services lead to a higher number of unnecessary admissions.

How is resource currently spent
An initial stratification of the Blackpool CCG population on secondary care spend (see diagram below) shows that 3% of the population account for 48% of the total expenditure. This demonstrates that there is an opportunity in Blackpool to do things differently that will benefit patients whilst reducing unnecessary spend.
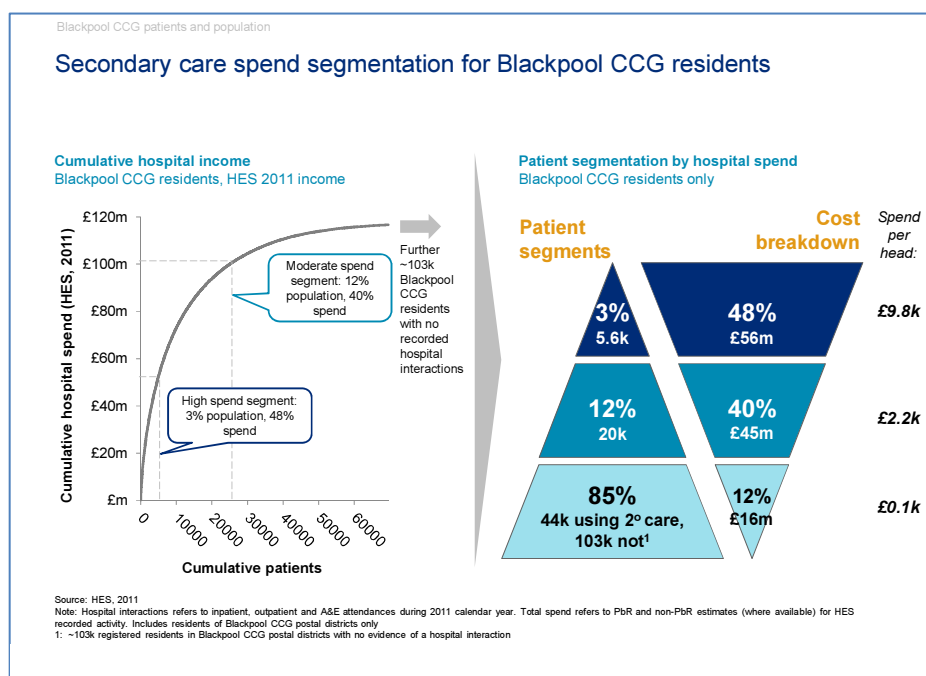
Risk Stratification

The Combined Predictive Model (CPM) has been used by Blackpool GPs for some years and is a risk stratification tool, developed by the Kings Fund and BUPA Health Dialog (formerly Health Dialog UK) and published in 2006. It improves on previous predictive models such as PARR by increasing predictive accuracy across the risk continuum, allowing for tailored interventions and the modelling of expected "returns". The CPM utilizes four datasets: Inpatient, Outpatient, Accident and Emergency and General Practice medical records. The system was created by NHS Blackpool and has been maintained and developed by Lancashire CSU.

It is used both as a commissioning tool and in primary care to identify patients most at risk of hospitalisation. The clinicians ensure care plans are in place for these patients to maximise interventions and reduce the need for unplanned admissions.

Below is an example of the commissioner's view of the tool.

The CCG Summary report is designed to show the high level impact of targeting a specific cohort on expected admissions and costs. It answers the question "If I spend £X amount of money on an intervention with Y% impact, on patients in a specified cohort, what will be the effect on expected emergency admissions and their costs over the next 12 months, on both the specified cohort and the CCG / GP Practice as a whole"

In addition to answering these questions for the specified cohort, the report provides two standard cohorts to compare with, for given values of X and Y:

➢ Maximise Reinvestment - The maximum number of patients, in rank order, that could be targeted for intervention in the CCG or selected GP Practice (no other filters are applied), whilst imposing a revenue neutral condition.

➢ Maximise Cost Reductions – The number of patients, in rank order, that could be targeted for intervention in the CCG or selected GP Practice (no other filters are applied), in order to maximise cost reductions.

These two scenarios are illustrated graphically on the chart at the bottom of the report. The Change in Number of Admissions will always decrease as more patients are targeted. Changes in costs, however, offer diminishing returns as more patients are targeted, beyond a certain point, marked "Max Reductions". Further along the curve, at the point marked "Full Reinvestment", the costs begin to increase (above the zero line). Targeting patients beyond this point will still reduce emergency admissions, but will result in net increased costs. In this example the top 10% high risk patients have been selected.

Aristotle Business Intelligence

Combined Predictive Model - Commissioning Tool
Customised Report

NHS
Midlands and Lancashire
Commissioning Support Unit

CCG Selected: Blackpool CCG
Assessment Period: Jun-12 – Jun-14
Community Matron Status: No Record
Chronic Conditions: ASTH, CAD, CHF, CNCR, COPD, DEPR, DIAB, HTEN, AF, CKD, DMNT, EPI, HTHY, MH, STRK, NO_LTC

Intervention Cost Per Patient: £500
Intervention Impact: 20%
Age Range: 0-120
Gender: All Persons

	Selected Cohort Only	GP Practice Level Summary		
		Selected Cohort	Maximise Reinvestment	Maximise Cost Reductions
Total Number of Patients	-	170,925	170,925	170,925
Number of Patients Targeted For Intervention	18,954	18,954	3,916	1,246
Percentage of Patients Targeted For Intervention	-	11.09%	2.29%	0.73%
Emergency Admissions in Last 12 Months	15,435	19,577	19,577	19,577
Average Emergency Admissions per Person in Last 12 Months	0.81	0.11	0.11	0.11
Emergency Admissions Without Intervention in Next 12 Months	9,593	13,217	13,217	13,217
Reduction in Emergency Admissions Over Next 12 Months [1]	1,919	1,919	924	499
Emergency Admissions in Next 12 Months	7,674	11,298	12,293	12,718
Percentage Reduction in Total Emergency Admissions	20.00%	14.52%	6.99%	3.78%
Cost of Emergency Admissions over Last 12 Months [2]	£28,877,069	£33,518,489	£33,518,489	£33,518,489
Average Cost per Emergency Admission over Last 12 Months [2]	£1,871	£1,712	£1,712	£1,712
Cost of Emergency Admissions Without Intervention over Next 12 Months	£18,391,123	£22,150,974	£22,150,974	£22,150,974
Cost of Intervention (Number of Patients Targeted * Intervention Cost Per Patient)	£9,477,000	£9,477,000	£1,958,000	£623,000
Intervention Reduction / (Increase) [3]	£3,678,225	£3,678,225	£1,972,939	£1,060,680
Change in Costs over Next 12 Months	£5,798,775	£5,798,775	(£14,939)	(£437,680)
Cost of Emergency Admissions over Next 12 Months	£24,189,898	£27,949,749	£22,136,035	£21,713,294

Risk Segment (Assigned at CCG level)	Patients	Percentage
Case Management: Very High Relative Risk 0.5%	865	0.51%
Disease Management: High Relative Risk 0.5 - 5%	7,693	4.50%
Supported Self-Care: Moderate Relative Risk 6 - 20%	25,674	15.02%
Prevention and Wellness Promotion: Low Relative Risk 21 - 100%	136,693	79.97%
	170,925	

Impact of Intervention by Number of Patients Targeted
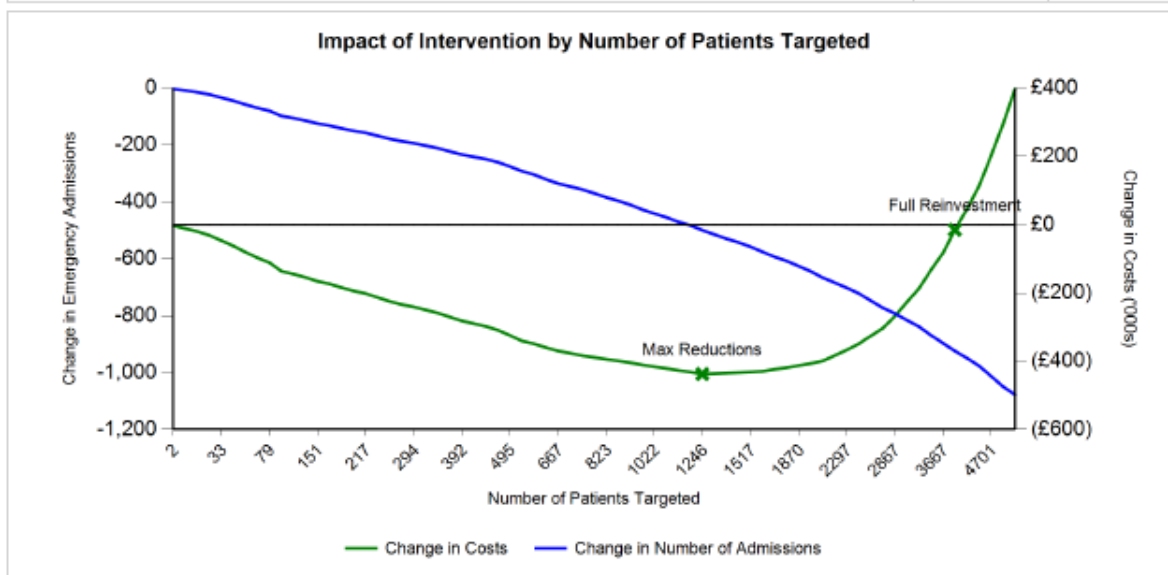
[1] The expected number of emergency admissions multiplied by the intervention impact, for targeted patients
[2] These figures exclude block contract costs, and any spells where cost information is not yet available
[3] The expected reduction in emergency admissions multiplied by the expected cost per admission

Patient List View

Allows commissioners to review pseudo-anatomised data to understand the number of long term conditions and type of condition and associated admission risk and resultant cost. Further development is underway with the CSU to look at population segmentation at Blackpool and neighbourhood levels to understand how the data used in the CMP tool can be utilised to influence commissioning and clinical redesign decisions.

In General Practice

The CPM allows GP teams to review their patients at highest risk of admission and at a glance lets them see the level of support already in place. This will empower clinicians to make the right decisions and record this in the patient's care plan and so reduce the risk of further unplanned admissions. It can later be reviewed to see what interventions were successful.
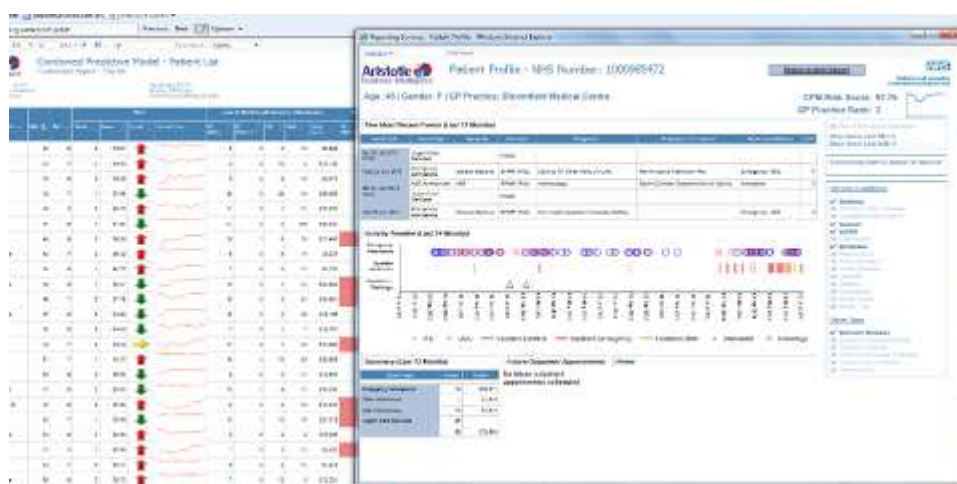
What about the BCF?

The BCF will need to be targeted at the patients with the most need. The CPM tool allows commissioning decisions to be made whilst directing clinical and social care resource to those patients who require community interventions to prevent hospitilisation. It also suggests which patients may benefit from a proactive care plan should they deteriorate rather than a reactive response from the emergency services.

Tools such as the CPM will also allow us to monitor the success of commisisoned services and interventions.

4) PLAN OF ACTION

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

See also BCF Project Initiation Document in section 1
The Project must be completed by April 2015. The key milestones are:

Task	Lead	Completion Date
Formalise BCF governance arrangements	Strategic Commissioning Group to be taken forward by BCF Programme Board	Dec 13
Agree reporting/consultation schedule to Health and Wellbeing Board, CCG Governing Body, Health Scrutiny and Fylde Coast partners	Strategic Commissioning Group to be taken forward by BCF Programme Board	Dec 13
Develop PID and project milestone plan	Strategic Commissioning Group to be taken forward by BCF Programme Board	Nov 13
Identify Planned schemes	Strategic Commissioning Group to be taken forward by BCF Programme Board	Dec 13
Ensure BCF planning is articulated in Five Year Strategic Plan	Blackpool CCG	Jan 14
Deliver visioning session to secure partner and provider buy-in, to propose blueprint for the model and consider impact and implications local	Strategic Commissioning group with follow on activity taken forward by BCF Programme Board	Feb 14
Hold regular progress meetings with BCF workstream leads and key partners reporting to Strategic Commissioning Group on outcomes and issues	BCF Programme Board	Ongoing
Formally establish BCF workstreams to lead on development of the model to include pooled fund arrangements between Blackpool CCG and Blackpool Council under Section 75 agreement, transfer of staff, sites/accommodation and contracts.	BCF Programme Board	Feb 14
Finalise principles and understanding of pooled budget arrangements	Blackpool CCG/Blackpool Council	Feb 14
Finalise BCF metrics and undertake initial impact assessment	BCF Programme Board/Blackpool CCG/Council	Feb 14

Strengthen links with Fylde Coast Out of Hospital Strategy Steering Group and nominate representative to attend meetings and feedback	BCF Programme Board	Feb 14
Review commissioning processes	BCF Programme Board	Mar 14
Identify and align BCF schemes to JHWS priorities and establish mechanism to track performance/delivery of planned schemes	BCF Programme Board	Jun 14
Align BCF project with Out of Hospital Strategy workstreams and refresh governance arrangements	BCF Programme Board	Jun 14
Oversee ICT arrangements and requirements and develop IT and data sharing policy	BCF Programme Board HR/ICT & Shared Information workstream Workforce workstream	Jun 14
Appoint Care Bill and BCF project Lead to ensure appropriate links to Care Act	Blackpool Council	Jul 14
Develop and implement communication plan to continue to raise awareness of and involve partners, providers and public in development and implementation of the model	Blackpool HWB and Comms workstream	Aug 14 and ongoing
Oversee financial arrangements related to the model and develop finance strategy/plan includes pooled budget and risk share arrangements	BCF Programme Board and Finance workstream	Sep 14
Care Act regulations and guidance published and reviewed to ensure key elements are embedded in BCF	Care Bill and BCF project Lead/Care Act Project Board and BCF Programme Board	Oct 14
Development and Implementation of Planned Schemes (see planned schemes rollout plan on page 36)		Oct 14 – Dec 15
Deliver a series of engagement activities across GP Practises on new models of care reporting the outcome to BCF Programme Board to inform development of the BCF model	Blackpool CCG	Dec 14
Develop Transition HR Policy to new model – determine requirements, structure and learning and skill needs and undertake workforce training	BCF Programme Board HR & Workforce workstream	Jan 15
Implement Care Act Care and support reforms	Care Bill and BCF project Lead and BCF Programme	Apr 2015

	Board	
Relocate staff to new sites	BCF Programme Board/ Fylde Coast Out of Hospital Strategy Steering Group	End Mar 15
Implementation of BCF Model & new Models of Care	BCF Programme Board/Blackpool CCG	Apr 15
Monitoring and Evaluation of Planned Schemes (incl. new models of care)	BCF Programme Board/ Blackpool CCG	Apr 15 and Ongoing

The Project will operate alongside the following related projects:

Project	Timespan
Joint Health and Wellbeing Strategy	May 2013-2015 refresh in early 2015
Blackpool CCG 2 year Operational Plan	June 2014-2016
Fylde Coast 5 year strategic plan	June 2014-2019
Care Act Implementation Project	June 2014 –2015
Acute Trust Strategic Plan	2014-2020
Big Lottery Fulfilling Lives Programmes:	
• Better Start	2014 - 2024
• Headstart	Sept 2014 - 2021
• Fulfilling Lives	Sept 2014 - 2021

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

Blackpool CCG led the jointly agreed Fylde Coast Unscheduled Care Strategy (2012) and the Fylde Coast Intermediate Care Review (2013). These included key partners on the commissioning and provider sides with input from external partners. Both identified the need to have better integration of health and social care. From these projects, work is already being delivered in a more co-ordinated and joined up way, providing better care for the citizens of Blackpool.

All key partners continue to be fully engaged in refining and delivering these strategies via the long standing Urgent Care Working Group/ Board and the Fylde Coast Commissioning Advisory Board. Blackpool CCG, Fylde & Wyre CCG, Blackpool Council , Lancashire County Council, Lancashire Care Trust and Blackpool Teaching Hospitals Trust are working together to ensure transformational change is delivered.

The Health and Wellbeing Board is central to the development and implementation of joined-up health and social care strategies, in particular the Better Care Fund.

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

The BCF program will be overseen by the BCF Programme Board. The detailed Project Initiation Document that describes delivery of the new models of care is attached on page2. The Programme Board will be supported by key groups as outlined below:

Blackpool Council and Blackpool CCG will work through Blackpool HWBB and its subgroup the Strategic Commissioning Group (SCG) to develop the locality plan and deliver the BCF 'project'.

Blackpool HWBB is responsible for overseeing the integration process and is the platform for cross-organisational discussions. The HWBB is responsible for sign off of the locality plan and will monitor the agreed spend set out within it and is accountable for delivery.

Strategic Commissioning Group (SCG) is the advisory group to the HWBB. The SCG is responsible for working with commissioners across health, social care and health related services to promote and encourage joint/integrated working and where appropriate develop arrangements for pooled budgets. The group orchestrated sign up from partner organisations to the principles of the locality plan and established the BCF Programme Board.

BCF Programme Board is an executive level cross-organisational group charged with the co-ordination and development of the locality plan for Blackpool. It is the lead for the BCF 'project'. The group will report regularly to the SCG on progress.

BCF Workstreams to deliver the 'project' the BCF Programme Board created five principal workstreams: **Design, Delivery & Estates, HR & Workforce, ICT/Shared Information, Finance** and **Communications**. Due to the cross-over in functions and to maximise opportunities for joint working, the BCF workstreams have been integrated into the Task and Finish groups of the Fylde Coast Out of Hospital Strategy Steering Group, this will reduce duplication in the system and ensure the delivery of agreed activities. Project plans will be merged to create an overarching PID reflective of the vision and ambitions for high quality, responsive integrated care across Blackpool and the Fylde Coast. The PID and group activity will be monitored by a dedicated Project Manager (PMO).

Fylde Coast Out of Hospital Strategy Steering Group is an executive level group charged with co-ordinating Out of Hospital and Unscheduled Care for the Fylde coast population. The Steering group will work collaboratively with the BCF Programme Board to ensure consistency in developing systems across the Fylde Coast and to reduce duplication of effort.

Healthwatch Blackpool will take a joint lead in all public and patient consultation activities throughout the lifetime of the BCF 'project', feeding back results to the BCF Programme Board.

Fylde Coast Commissioning Advisory Board will receive updates on the project to ensure alignment with services which cover the Fylde coast.

The Project will maintain a dialogue with Fylde and Wyre CCG about those aspects of the system which span local authority/CCG boundaries

Programme structure
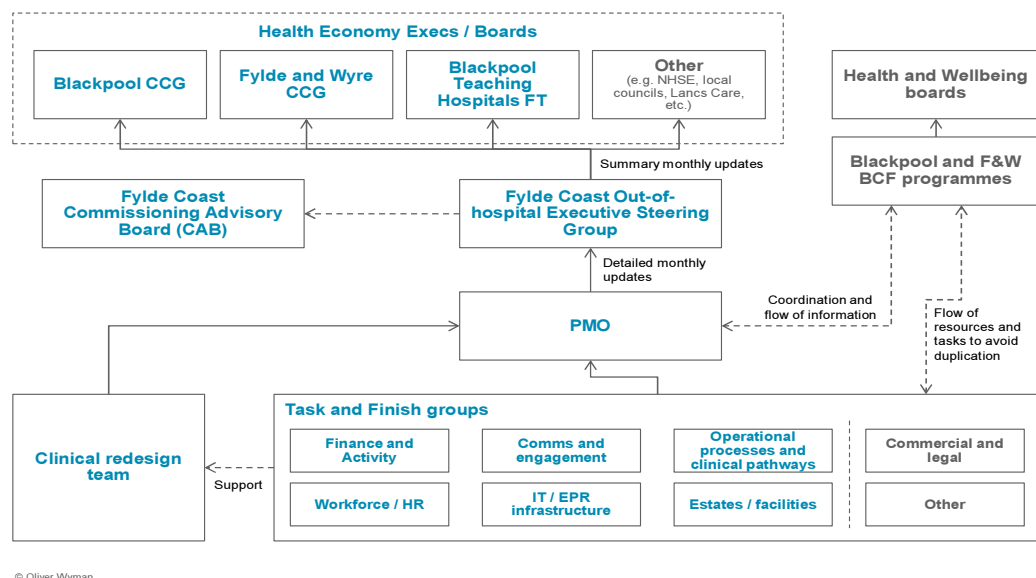
o List of planned BCF schemes

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

Scheme Ref	Planned Schemes	Expected benefits
A	Extensivist Model	- Fewer Hospital admissions - Improved self-care - Better integration of health, social care and voluntary organisations
B	Enhanced Primary Care	- Fewer Hospital admissions - Improved self-care - Better integration of health, social care and voluntary organisations
C	Implementation of Electronic Palliative Care Co-ordination System (EPaCCS)	- Reduce the number of inappropriate admissions to an Acute Setting. - All stakeholders involved in the care of the patient will have access to the patients Care Plan which will include

		details of medication, Preferred place of Care.
D	Care plans for all patients who are identified as End of Life	**Appendix A.** Reduce the number of inappropriate admissions to an Acute Setting **Appendix B.** Patient Care will be better managed within the Community.
E	Roll-out of Care Homes Support scheme	• Enhance the quality of care in care homes. • Reduce non-elective admissions from care homes. • Reducing the episodes of end of life care in Acute settings.
F	Review Falls Lifting Service linked to the Vitaline Pendant Scheme	a) Reduce the number of Ambulance call-outs and conveyances to hospital due to falls b) Reduce the number of A&E attendances and non-elective admissions due to falls. c) Increase referrals into the Falls Advice and Assessment Service. d) Reduce the risk of repeat falls e) Reduce the admissions to long term care. f) Improve the long term outcomes for older people. g) Support people to stay in their own home
G	Implement recommendations of hospital discharge review	• Reduce delayed transfers of care. • Improve patient experience.
H	Review all urgent and emergency services to assess 7 day availability and draw up plans for future commissioning arrangements in line with recent guidance	• Reduce A/E attendance and Ambulance Calls. • Reduce non-elective admissions • Increase numbers of people assisted to manage own long term condition.
I	Review services for carers and develop programme for improvement	• Improved support for carers • Reduced non-elective admissions • Reduced admissions to long term care.
J	Using existing risk stratification tools build on the current Care Co-ordination pilot, broadening scope to include social care risk factors and increase	• Reduced non-elective admissions. • Improved self-management of conditions. • Provide information to support development of the models to support full implementation of Health and Care Strategy

	the number of people with an Anticipatory Care Plan	
K	To broaden the scope of existing 999 frequent callers pilot in order to identify more individuals who could benefit from a proactive, person centred anticipatory approach	• Reduction in calls to 999 • Reduction in ambulance conveyances • Reduced non-elective admissions. • Improved self-management of conditions. • Provide information to support development of the models to support full implementation of Health and Care Strategy
L	Increasing re-ablement capacity to ensure that it is the primary offer for the majority of people prior to receiving a long term care service	• Reduced non-elective admissions • Reduced admissions to long term care. • Reducing demand for long term community based care packages • Increased independence and positive outcomes for individuals
M	Implement the recommendations from benchmark intermediate care review to ensure sufficient capacity within • Residential Rehabilitation (Nurse and non-nurse led) • Residential recuperation • Community therapy	• Reduced non-elective admissions • Reduced length of stay and delayed transfers of care • Reduced admissions to long term care. • Reducing demand for long term community based care packages • Increased independence and positive outcomes for individuals
N	Scope the increased use of telecare / telemedicine and telehealth	• Using the existing infrastructure pilot virtual GP support to Nursing homes • Review options to invite providers to the market to have better support to keep people in their own homes through technology

Impact of Schemes on different segments of population

Planned Schemes Rollout	OCT 14	NOV 14	DEC 14	JAN 15	FEB 15	MAR 15	APR 15	MAY 15	JUN 15	JUL 15	AUG 15	SEP 15	OCT 15	NOV 15	DEC 15
Under development /planning (blue) / **Implementation** (green)															
EPaCCS	Dev	Dev	Dev	Impl	Impl	Impl	Impl	Impl	Impl	Impl	Impl	Impl	Impl	Impl	Impl
End of Life Care plans	Dev	Dev	Dev	Impl	Impl	Impl	Impl	Impl	Impl	Impl	Impl	Impl	Impl	Impl	Impl
Care Homes Support scheme	Impl	Impl	Impl	Impl	Impl	Impl	Impl								
Implement hospital discharge	Impl	Impl	Impl	Impl	Impl	Impl	Impl								
Review urgent and emergency 7 day working	Impl	Impl	Impl	Impl	Impl	Impl	Impl	Impl	Impl	Impl	Impl	Impl	Impl	Impl	Impl
Improvement carers services	Impl	Impl	Impl	Impl	Impl	Impl	Impl								
Risk stratification care co-ordination	Dev	Dev	Dev	Impl	Impl	Impl	Impl	Impl	Impl	Impl	Impl	Impl	Impl	Impl	Impl
999 frequent	Impl	Impl	Impl	Impl	Impl	Impl	Impl								
Increasing re-ablement	Impl	Impl	Impl	Impl	Impl	Impl	Impl								
Implement intermediate care review	Dev	Dev	Dev	Dev	Dev	Dev	Impl	Impl	Impl	Impl	Impl	Impl	Impl	Impl	Impl
Increased use of telehealth	Impl	Impl	Impl	Impl	Impl	Impl									
New Models of Care	Dev	Dev	Dev	Impl	Impl	Impl	Impl	Impl	Impl	Impl	Impl	Impl	Impl	Impl	Impl

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

No.	Description of Risk	Gross Risk Score			Controls and Mitigation	Net Risk Score		
		I[1]	L[2]	GS		I	L	NS
1	Pressure on Council budgets reduces the effectiveness of BCF	4	4	16	The section 75 agreement will require the CCG to approve expenditure	4	3	12
2	Operational pressures may restrict community health and social care workforce to deliver transformation	4	4	16	Workforce planning will be part of BCF project management	4	3	12
3	Recruitment and retention of specialised health professionals	5	3	15	We are working with partners and external agencies to attract potential employees with the appropriate skills to deliver BCF	4	3	12
4	Successful diversion of activity away from the acute trust will reduce their income faster than they can shed their costs	5	4	20	Contingency will need to be made available by the CCG for double running costs etc.	5	2	10
5	The BCF schemes fail to divert adequate activity away from the acute trust	5	4	20	Discussions on-going with our main provider as to how this risk will be mitigated within the contract negotiation	5	3	15
6	Introduction of the Care and Support Bill will bring additional cost pressures to the system which are not fully understood at this time	4	4	16	We will undertake an initial impact assessment of the effect of projected costs of the Care Bill and continue to refine our assumptions as we develop integrated services.	4	3	12
7	Operational capacity to maintain day to day integrity of the business, safely, whilst delivering change and new models of working	5	3	15	Both organisations will utilise their existing capacity to support the proposed transformation and where possible will identify dedicated resources to oversee manage and deliver.	5	2	10
8	Inadequate level of commissioning support to deliver the agenda	4	3	12	The CCG is working closely to understand the change in resource requirements to deliver the BCF agenda	4	2	8

[1] I = Impact   (5=Catastrophic, 4=Major, 3=moderate, 2=Minor, 1=Insignificant)

[2] L=Likelihood   (5=Almost Certain, 4=Likely, 3=More Than Even, 2=Less Than Even, 1=Improbable)

b) Contingency plan and risk sharing

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

The expected outcomes and benefits as a result of the BCF investment will be measured and performance monitored by the HWBB's Strategic Commissioning Group. An example of how this might be reported is:

Metric	Baseline 13/14				Progress 15/16				
	13-14 Q4	14-15 Q1	14-15 Q2	14-15 Q3	14-15 Q4	15-16 Q1	15-16 Q2	15-16 Q3	15-16 Q4
Total non-elective admissions (general & acute), all-age	4,851	4,983	4,646	4,916	4,887	4,899	4,911	4,923	4,935

Metric		2014-15				2015-16			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	*825.3*	*850.1*	*874.8*	*899.8*	*924.5*	*949.3*	*974.0*	*999.9*

The HWBB has adopted a local performance framework. This will be supplemented with the new BCF metrics and will be quality assured by the HWBB Strategic Commissioning Group.

In addition to the national metrics outlined in the table above the Strategic Commissioning Group will monitor progress against the local performance framework (as embedded in table 2, document 3).Reporting on progress is routinely reported to the HWBB who have been consulted with on this plan and understand the spend attributed to it.

6) ALIGNMENT

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

The BCF vision and schemes are allied to the core of the CCG 5 year strategic plan (table 2, document 9.) and complement the current HWBB vision and strategy which were informed by the JSNA, CCG Commissioning Plan and Local Authority Commissioning Plan thus ensuring alignment. The BCF also acts as a catalyst; accelerating alignment and integration with nationally directed and other locally driven initiatives, such as personal health budgets (PHB). Blackpool CCG is on the Accelerated development programme for PHB and has developed a policy and guidance for implementation which will have a direct link into our BCF plan. A pilot has now commenced with 6 cases already in receipt of a PNB. Housing is a key strategic priority for both the Council and Health and Wellbeing Board and a new housing strategy is currently under development. The provision of suitable housing options will be vitally important to the successful delivery of our BCF plan as this will enable people to live more independently and avoid the need for more costly interventions later on. A key objective is to ensure that we create an integrated strategic commissioning approach to housing provision which will include:

- Suitable housing options: the development of a housing supply that meets the needs of the community
- housing adaptations for those most in need
- provision of housing related support: warmer Homes Programmes, safety in the home initiatives

Examples of other related activity alignment can be demonstrated by the examples below.

Whilst the BCF focuses on adult social care we would like to eventually extend the scope to include the family unit, including children, providing integrated services to improve our services. Some of the drive for this wider integration will be provided using the catalyst of the following projects:

A Better Start: to improve the life chances of babies and young children
"This welcome investment from the Big Lottery Fund means that we shall be able to help the most vulnerable babies get a better start – it is an important investment for the future of our society." Lord Robert Winston, Imperial College London

A Better Start, a partnership of Blackpool Council, Blackpool Teaching Hospitals, Blackpool CCG, Lancashire Police, and local parents led by the NSPCC, aims to improve life chances of babies and children through improved social and emotional development, nutrition, language and communication development and system change. The partnership has been awarded £45m to implement innovative but proven initiatives for pregnant mothers, babies and young children, using evidence and science-based approaches and a systems leadership approach to transform the way in which we deliver initiatives around some of the most vulnerable in society. Early initiatives being delivered under this agenda will include:

- Expanding the Family Nurse Partnership so it can cover all parents under 20 in Blackpool
- The commissioning of Groundwork to work with communities around the development of green spaces for physical exercise and growing food, in collaboration with the Council's Parks, Sports and Leisure teams
- Further roll out of the Star Buddies volunteer breastfeeding champions programme
- Establishing a Parents Under Pressure programme, which offers an intensive 20 week course for parents in receipt of drug or alcohol treatment
- Food Dudes, a programme encouraging parents to give children a healthy diet
- The development of a Centre for Early Childhood Development, which will link into and undertake research on this topic, sharing emerging best practice on child development nationally and internationally

Although the funding has been awarded to 7 of Blackpool's 21 wards, our compact urban form means that the general approach it takes is being extended to cover the whole borough, in line with the Council's focus on delivering upstream solutions around early intervention. As with the BCF, part of the delivery mechanism involves partners pooling budgets or aligning commissioning. Blackpool Council has recently established a Children's Partnership which includes representation from BCF partners who will have oversight of the Better Start programme; this will give the potential to exploit synergies between the initiatives in the medium term.

The Children's Partnership will also work with the National College on their systems change programme using Better Start as our 'challenge'. The team is led by Blackpool Council's Director of Children's Services and Head of Commissioning at Blackpool CCG along with colleagues from the from NSPCC. As part of the challenge, Local Vision will be brought in to provide additional support to work around systems development.

Head Start
Lancashire Mind are leading the Fulfilling Lives: HeadStart investment in Blackpool. This pilot initiative, which is a precursor to a larger bid for Big Lottery Funding under the same programme, will equip young people to cope better with difficult circumstances in their lives, so as to prevent them experiencing common mental health problems before they become serious issues. This investment has been designed with the help of young people in direct response to the mental health needs of adolescent young people. We know adolescence is a difficult time for many young people: their experiences in school, family lives, and the modern pressures of growing up can trigger problems that could be avoided or reduced through earlier support. The funding will enable work in schools, youth clubs and with families, community groups, and charities to make sure that young people have a chance to benefit from this all-round support.

Fulfilling Lives
A third Big Lottery Funded initiative, Fulfilling Lives has been awarded £10m to employ and develop 24 specially trained workers. Led by Addaction, the project will, identify those in the resort worst affected by drug and alcohol problems, mental illness and homelessness, Given the scale of the problems, and the frequency with which those worst affected use services,

the scheme provides support at all hours, all through the year, with the help offered to service users having a consequential benefit to emergency services which they would have otherwise accessed.. The aim of the scheme is to improve the lives of the most vulnerable people in the town through a full rehabilitation which leads to them entering employment via a phased programme.

The project is about to launch, and there are clear opportunities from linking to the initiative, particularly as the programme becomes embedded and the first findings of the accompanying evaluation programme become available.

Blackpool CCG has worked with the Business support Unit at the CSU to accelerate the IT strategy to ensure the foundations are in place to support best use of technology as the models of care are rolled out, this is detailed in the table below:

Priority Areas	Impact
GP Clinical Systems	➢ Using a standardised clinical system enabling connectivity between healthcare systems, allowing clinicians to securely share and access real time patient information and link into secondary care and out of hour's services ➢ simplified distribution of templates ➢ search and report tools
Document management	➢ DocMan system simplifies workflow processes and GPs will spend less time on administrative tasks ➢ The EDT Hub will provide a secure, reliable and flexible platform for the electronic communication of documentation between Secondary, Primary and Social Care providers
PC Infrastructure	➢ During 2013-14 Blackpool introduced the all in one desktop to each and every GP's desk. This provided a richer experience when using unified communication tools ➢ It provides a platform for the use of voice, video and presence, enabling the future vision of virtual GP consultations
Mobility	➢ Clinicians can access the core elements of EMIS Web on a tablet device anytime, anywhere, making it easier to deliver care closer to home ➢ Potential mobile communications solution while out of the practice (used in the care homes setting for example, enabling a tablet device to be present with the patient while the GP remains in the practice)

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

The BCF provides the main substance of the CCG 2 year Operating Plan and the 5 year Strategic Plan. The three plans were not developed in isolation but in conjunction, ensuring that they were all based on the same evidence and information and a common decision making process with partners. As such the implementation of these plans and the plan of action are mirrored across all the plans where there are correlating projects. This revised BCF has a different nationally enforced performance element which is not aligned with the 2 year operational plan submitted. The difference is that the national requirement is a 3.5% reduction in NEL activity. This will supersede the previously submitted operating plan assumptions.

c) Please describe how your BCF plans align with your plans for primary co-commissioning
- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

Co commissioning of Primary Care
In May 2014 NHSE announced a new option for CCG's to co-commission primary care in partnership with NHSE England giving CCG's new powers to drive up quality of care, reduce health inequalities in primary care helping to sustain local NHS over the next 5 years.

Blackpool CCG believes the co-commissioning of Primary Care Services will underpin its established Primary Care development work embedded within its existing structure.

Engagement with its constituent practices to support improvements to the health of people in Blackpool has been integral to the development of a number of unscheduled care schemes delivered in wider primary. Approval to co-commission services will;

- Achieve greater integration of health and care services and support achievement of the BCF vision, in particular more cohesive systems of out-of-hospital care that bring together general practice, community health services, mental health services and social care to provide more joined-up services and improve outcomes;
- Raise standards of quality (clinical effectiveness, patient experience and patient safety) within general practice services, reduce unwarranted variations in quality, and, where appropriate, provide targeted improvement support for practices;
- Enhance patient and public involvement in developing services, for instance through asset-based community development;
- Tackle health inequalities, in particular by improving quality of primary care in more deprived areas and for groups such as people with mental health problems or learning disabilities.

The role of primary care is critical to the success of the BCF. Primary care representation has been nominated for each neighbourhood to meet monthly with Blackpool CCG and Council colleagues to deliver the transformation of primary care required to support the BCF.In summary, Blackpool CCG believes that developing robust co-commissioning arrangements with NHSE (and other commissioners) is an essential step to deliver truly integrated services in line with the BCF, at the scale and pace required, to meet the local and national challenges.

7) NATIONAL CONDITIONS

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

- Protecting social care services

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

Blackpool Council will maintain eligibility at Critical and Substantial pending the implementation of the requirements of the Care Act and the introduction of minimum national eligibility criteria. It has been agreed that those social care services that are evidenced based, that meet the BCF vision and deliver the improved outcomes will be protected, these are restricted to and listed as expenditure schemes in part 2 of the template. The schemes and details of finances within this plan are built on the principles of integration and joint working. While Blackpool Council faces an unprecedented reduction in its funding, there will also need to be savings to CCG budgets to facilitate the necessary investment. The BCF offers the opportunity to develop existing programmes of joint working, and to foster integration between health, adult social care and other partners including housing and transport. The joint commissioners recognise that there are risks and challenges attached to implementation within the timescales. This plan recognises that the risks are shared and that a joint contingency plan needs to be in place to mitigate against them

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

Blackpool Council currently provides adult social care and support to individuals who meet the substantial or critical level of need outlined in Fair Access to Care Services (FACS). This includes an individual whose independence and wellbeing is, or is likely to be, undermined by an inability to undertake the majority of personal care and daily living routines. It would also include those who have been, or are likely to be, exposed to abuse and/or neglect, and those whose alternative care and support networks are not sustainable. There are similar criteria for those providing informal care and support to ensure that their own health and wellbeing is not compromised as a result of their caring role. Whilst there will be changes to eligibility criteria in April 2015 with the implementation of the Care Act, it is anticipated that the national minimum will be set at a similar level. The Care Act will, however, mean significant changes in terms of the number of carers likely to request support, and a duty on Blackpool Council to assess people who are likely to meet the eligibility criteria, but fund their own care and support. There is also a focus on the principles of wellbeing, personalisation and prevention throughout the Care Act, and whilst these are inherent within FACS, they will need to be explicitly considered during the support planning process. The Council will also have a duty to ensure that all sectors of the population have access to universal information and advice service which is aimed at all sectors of the population.

Blackpool Council and Blackpool CCG have several existing integrated care pathways, aligned to a focus on promoting independence and supporting people in the community rather than in hospital or residential care settings. Our multi-disciplinary Rapid Response Teams will continue to provide 7 day services to prevent admission where possible, and to facilitate timely discharge where this has been unavoidable. Similarly the Hospital Discharge Teams ensure that discharges are effectively planned to promote a successful return to the community.   These schemes will be further developed under the BCF, alongside the introduction of the Extensivist and Enhanced Primary Care Models, which will place adult social care within multi-disciplinary neighbourhood teams delivering personalised, preventative care and support to those people most at risk of losing their independence

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

£4.989m has been allocated for the protection of adult social care services which includes the local proportion of the £135m towards the costs of the Care Act.

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

The Care Act 2014 requires local authorities to promote wellbeing and independence when carrying out any of their care and support functions, and to ensure that any process, activity or broader responsibility focuses on the needs and goals of the person concerned. Services, facilities and resources will also be required which promote self-determination, maximise independence and prevent, reduce and delay need where possible. Market shaping and commissioning activity which focuses on outcomes and wellbeing, promotes quality services and encourages co-production with partners will be required to ensure that local needs are met and to assure quality and sustainability. Service delivery will need to be diverse and vibrant to respond to the needs of all the people in the area who have care and support needs, including carers and those who pay their own care costs. The Care Act also requires that accessible and appropriate information is available to ensure that people are able to make informed choices to address their care and support needs, now and in the future
Blackpool Council's Care Act Project Board has been established to oversee the changes required, with five workstreams and dedicated project support to provide oversight and governance to the ongoing activity. The Care Act Project Lead also acts as in advisory capacity to the BCF Programme Board:

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                    ┌──────────────────┐
                    │   Care Act       │
                    │  Project Board   │
                    └────────┬─────────┘
                             │
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│           ││and     ││            ││           ││          │
│           ││Market  ││            ││           ││          │
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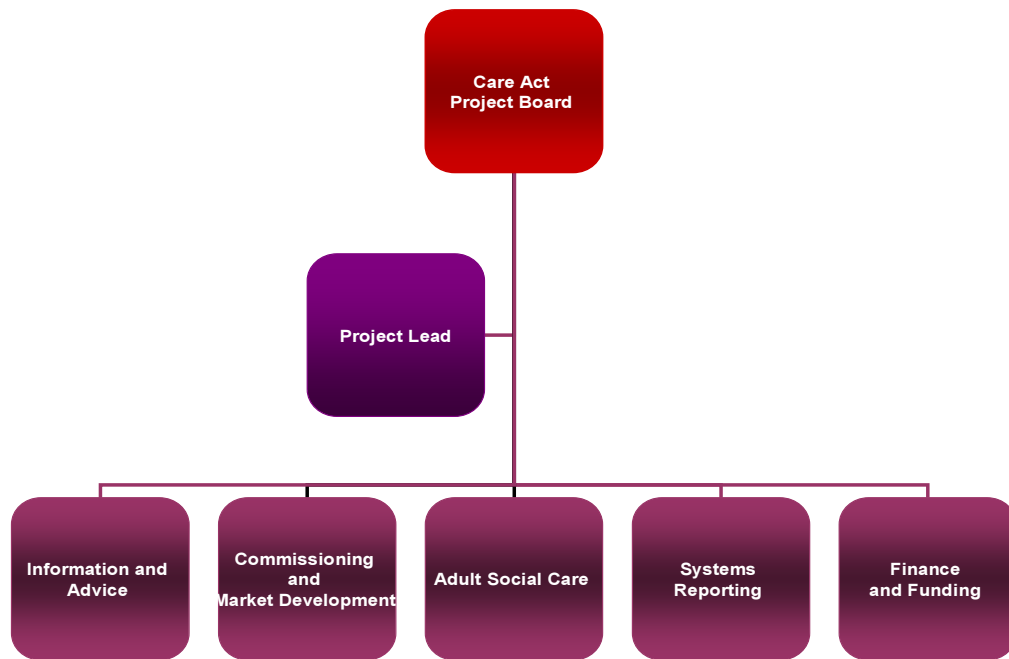
Activity is now underway to map current services and to consult with service users, carers, the wider public, social care staff and partner organisations to ensure that service delivery is outcome focused, and can meet the goals of Blackpool's diverse population, while at the same time being sustainable on a long-term basis. Work has also started on developing our existing partnerships with third sector organisations to promote community involvement and to ensure resilience in the future.

The BCF models of care will contribute to the Care Act requirements to deliver personalised, preventative services which are outcome based and focus on wellbeing and self-determination, and will inform commissioning. Workforce development in all organisations needs to include knowledge and skills to deliver Care Act requirements and BCF models of care. IT developments for Care Act will need to enable interface for future integrated working. Delivery of the Care Act and the BCF models both rely on a significant amount of community development – would benefit from this being done as a joint piece of work to avoid duplication/multi-tiered services. Information sharing pathways also need to be developed to take account of the requirements of both projects – this also includes use of NHS number as identifier.

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

We currently fund £300,000 to day care for dementia sufferers to provide respite for carers.

Additional funding of £125,000 covers:
- Carers Relief and Breaks Grant to carers
- Flexible breaks for carers e.g. taking up a hobby or training course, going on a day trip, holiday, joining a gym, pamper sessions or visiting friends.
- Support for carers in their caring role and prevent a break down in the caring role.
- Help for carers look after their own health and wellbeing.

Supporting carers will contribute to reducing non elective admissions and admissions to long term care as patient care in their own home is less likely to break down. The service specification is included **(see table 2, document 16)**

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

Blackpool Council's budget for the forthcoming financial year is set to be the most challenging to date with an estimated savings target of at least £20m on the back of successfully delivering £68m over the previous 4 years. The medium term is equally bleak with current forecast savings requirements at £14.4m and £11.4m in 2016-17 and 2017-18 respectively. Given Blackpool Council's General Fund Net Requirement is £141m for 2014-15 it can be seen these figures represent a huge proportion of total council expenditure.

Whilst the BCF will protect the existing levels of social care expenditure through the section 256 and locally agreed Community Contract, Adult services will need to make savings in the region of £5.8m, £4m and c£3m over the next three years so the council will probably not be able to protect those current services that meet the BCF vision and deliver the improved outcomes.

- 7 day services to support discharge

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

A number of services have already been established to support this commitment such as the Rapid Response Nursing Service and rapid response plus, both of which have direct access to Council funded Short Term Intensive Domiciliary Support 7 days per week .Other services such as 'Blue Light' and our residential intermediate care facilities are already 7-day services. Partners are committed to developing integrated 7-day services which support people to be discharged and prevent unnecessary admissions to hospital at weekends. The intention is to establish integrated working practices across health and social care by further widening direct access by health professionals, as part of the integrated model of case management, to the full range of social care services which prevent admissions and support discharge. This will improve patient experience by reducing the number of hand-offs and will create efficiencies by eliminating duplication of assessments. There will also be work with providers of services such as reablement, rehabilitation beds and recuperation beds, to ensure their readiness to accept referrals 7 days per week.

We will use learning form the new resilience plan **(see table 2, document 10)** to create a template to deliver improved 7 day working in Blackpool, this will mean:
- Resource has been allocated to provide domiciliary hours and bed capacity to support Early Supported Discharge
- Blackpool Council funding will be used to provide 7 day social work cover for the HDT (between the months of October-March)
- Overnight continuous care will be provided, with expansion of the existing ARC model of care and increased access to domiciliary packages of care.

We already have 7 day access to key elements of the urgent care pathway (Rapid response nursing, crisis social care).

Services will be improved to provide more responsive and patient-centred delivery seven days a week. We are collecting data about the potential to increase in deflections to primary care and increase deflections to 20% during the hours that an additional nurse is on duty. Patients will be diverted away from the emergency floor by offering clinical triage and treatment alternatives, providing better patient experience and care closer to home

Safe Mobile Care (SMC) is a simple aid to self-management of Long Term Conditions, along with reducing hospital admissions and re-admissions; using proactive real-time alerting and monitoring whilst enhancing service provider productivity.

Utilising simply enabled monitoring devices and peripherals, the solution can be used on

discharge from the hospital, in a care home setting or in the patient's own home. It allows remote monitoring of patients by our clinical services and to effectively support patients so as to enhance their quality of life and improve health outcome whilst facilitating 7 day working.

The solution is capable of supporting a wide range of Long term conditions using personalised care plans to best meet an individual residents care needs. LTC's include: COPD, Chronic Heart Failure; Diabetes, Urinary Tract Infections, Asthma, Hypertension using a combination of clinically validated questionnaire sets, vital sign monitoring, medication reminders and coaching content.

The target outcomes are to:
- Sustain independent living: through the use of relevant and integrated familiar everyday technology that empowers patients to better understand and manage their condition.
- Improve quality of life; reduce patient anxiety and increases confidence in an individual's ability to self-manage their condition.
- Support early patient discharge from hospital.
- Prevent re-admission.
- Reduce length of stay within hospital

- Data sharing

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

Blackpool Council's social care system already allows the recording of NHS numbers. The Council is working with health partner organisations to consider the option of a number tracing service. In parallel, the Council has submitted the NHS Information Governance Toolkit and achieved N3 connectivity in July 2014, to enable the Council to carry out its own number tracing function. Some integrated services already use the NHS number as the primary identifier. We have a plan to implement this across all health and social care services by April 2015.

Blackpool Council social care system Core Logic Frameworki already allows the recording of NHS Numbers . A joint project has been established with the Council and the NHS with the purpose of securely sharing data with frontline workers in both Primary Care, Social Work and with other integrated services.The key phases of the project are
- Establishing a shared record platform which will use the NHS Number as the primary identifier
- Integrate Clinical, Social Care and partner data systems to the shared record platform
- Agree which shared data sets will enable Frontline workers to make better, faster decisions and expose these data sets as read only to Frontline workers whilst managing IG risks through the Governance board

- A risk log is in the process of being established with particular attention being to the integrity, security and safe handling of patient data. A strong governance model will be established which enable each organisation to maintain complete control of their data sets ensuring only data they have sanctioned will be exposed via the shared record platform.
- The shared recorded platform itself will not store any data but will facilitate the transmission of data in real-time from the disparate systems to the frontline workers.

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

Blackpool is committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK).The project team is working very closely with NHS North West Shared Infrastructure Service who are instrumental in establishing the Shared Record Platform. The Shared Record Platform is based on Open API and Open standards. Dialogue and engagement with suppliers of the feeder systems is on-going to ensure there is a commitment to develop and support these standards. The shared record platform will use tried and tested middleware which fully complies with the latest version of the Interoperability Tool Kit (ITK). All systems and infrastructure interconnecting via the platform will be required to comply with ITK. Where this not the case plans will be put in place to develop the systems towards this standard and all new system procurement will be required to meet this standard.
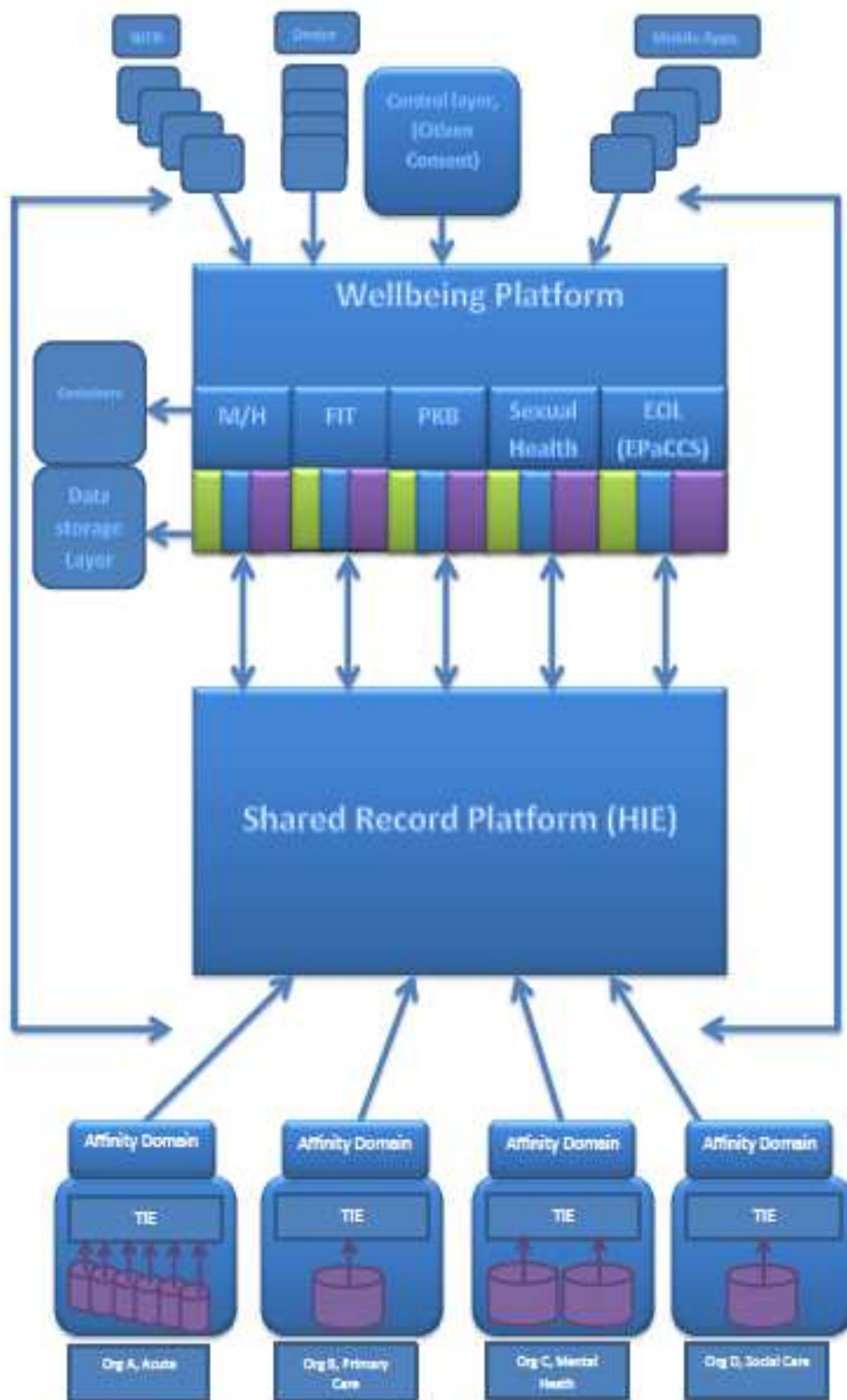
Proposed NWSIS/LPRES Digital Health platform overview
Andrew Thompson –Head, Northwest SIS.

July 23rd 2014

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

Blackpool Council achieved NHS IG Toolkit Level 2 compliance in Spring 2014. Refer to section C (i)

- **Joint assessment and accountable lead professional for high risk populations**

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

When we reviewed the CCG's secondary care spends by age and co-morbidity, not surprisingly the elderly (greater than 60 yrs. old) are the largest users of secondary care but interestingly the 55% that are comparatively well in this group account for only 32% of this spend. Therefore in the design phase consideration will be given to orientating the elderly/frail Extensivist to provide better more proactive care to those individuals with comorbidities rather than the total over 60s population. An initial stratification of the Blackpool CCG population on secondary care spend (see graph in question 3) shows that 3% of the population account for 48% of the total expenditure. This demonstrates that the proposed models of care would work well in the Blackpool area and further more detailed analysis is being undertaken to understand the potential impact and detailed operational plans required to implement the transformational changes.

Risk stratification (Combined Predictive Model tool) (SEE SECTION 2)

In addition to the population view, Primary Care have been identifying patients at risk of admission using the Combined Predictive model Risk Stratification tool for their practice population and ensuring appropriate care plans are in place for patients at risk of hospital admission.

In 2011 Blackpool CCG developed a bespoke version of the King's Fund Combined Predictive Model (CPM) tool that identifies patients at risk of unplanned hospital admission and scores this risk in terms of a percentage. From the evidence, the following factors have been identified in the achievement of successful outcomes:
- Accurate case-finding to ensure interventions target patients with defined care needs
- Appropriate caseloads to ensure that patients are receiving optimum care
- A single point of access for assessment and a joint care plan
- Continuity of care to reduce the risk of an unplanned admission to hospital
- Self-care to empower patients to manage their own condition
- Joined-up health and social care services, with professionals working to aligned

financial incentives and in multi-disciplinary teams
- Information systems that support communication and data that is used proactively to drive quality improvements.

The aim of the scheme was to target a number of disease-specific areas and provide enhanced care over and above the core contract. The scheme enhanced the management of long-term conditions, leading to improved outcomes, avoided hospital admissions and better quality care provided and delivered in the primary care setting.

Each practice now better understands their at-risk population and has created care plans, selecting from the evidence above to better manage these patients in the community setting and support patients and their carers to remain in their usual place of residence.

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

Blackpool already uses a locally developed and tested risk stratification tool based on the accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. This cohort are then reviewed with their lead clinician and a care plan is completed which can be referred to at any time in or out of hours. The care plans are available to the out of hours triage service and the acute trust. The responsible GP will identify a lead accountable professional in each case.

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

There is a risk stratification tool (Combined predictive model) available to all NHSB practices to identify all patients at high risk of admission (Vulnerable elderly and those with complex needs)

At CCG level (Sept 14) there are 8,500 individuals identified as very high 0 – 0.5% and 0.5% - 5% risk of admission.
Very high risk 0 - 0.5%. 863
High Risk 0.55 – 5%.   7,699

Fylde Coast Medical services provide the care co-ordination (single point of access) for patients identified in the top 2% with a care plan. 1505 (17.5%) are in place.

There is a national enhanced service in place to support GP's in risk stratification and proactive care designed to improve quality of care for frail elderly and other patients with complex needs (includes dementia and Mental health). 2% of the registered list will be enrolled onto proactive care plans' addition there is a local GP+ scheme with focussed outcomes for individuals with COPD, end of life and risk of admission between 2 – 5%. Practices are also supported with tools to identify individuals with risk factors who may require management review to optimise treatment. The GP plus scheme also provides indicative outcomes to increase care plans for COPD patients.

An example of 'the perfect care plan' which is available to practices via the GP+ scheme is included in **(table 2, document 14)**

The national enhanced service also includes people with mental health problems.

The National Dementia Strategy sets an ambitious programme to deliver improvements in dementia care by 2015. The new nationally driven Of target is for 66% of people thought to be living with dementia to be listed on surgery held dementia registers by March 2015.

In response CCGs across Lancashire have jointly commissioned Lancashire Care NHS Foundation Trust to provide a dedicated 'dementia gap team' to begin to address this diagnostic gap. The team will in-reach into primary care using GP clinical systems to gather information and record findings.

8) ENGAGEMENT

a) Patient, service user and public engagement

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

Healthwatch Blackpool, as a statutory partner of the HWBB, have committed to leading on the engagement of patients, service users and the public to inform the development of this plan. The first event at the end of January was well received. The event was an interactive session with members of the public and service users. We captured live feedback on an electronic voting system **(table 2, document 6).**

Forum	Date
Healthwatch Blackpool, 'Listening Event'	October 2014
Health and Wellbeing Board	3 September 2014
Learning Disability Partnership Board	21 February 2014
Health and well Being Board	15 February 2014
Residential Provider Forum	7 February 2014
Generic Provider Forum	6 February 2014
Healthwatch Blackpool, 'Listening Event'	31 January 2014
Blackpool Disability Partnership Board	21 January 2014
Learning Disability Care At Home Forum	15 January 2014
Carers Partnership Board	15 January 2014
Health and well Being Board	15 January 2014
CCG Governing Body (public)	14 January 2014
Mental Health Partnership Board	10 January 2014
Health and Wellbeing Board	18 December 2013
Health and Wellbeing Board	20 November 2013

Age UK Blackpool & District has also agreed to jointly deliver a programme of engagement and consultation events with its members to support the further development of plans.

We will continue to engage with our existing patient and service user forums and provider forums and listening events, throughout the development and implementation of plans, to ensure local outcomes are achieved. We will also continue our engagement with representatives from public and patient groups in the CCG Patient and Public Involvement (PPI) Forum. Another example of how we have engaged with the public is during our public consultation on community hospital rehabilitation. Having completed extensive engagement activities, we published and shared the findings to show the themes from the consultation ('You Said') and how we had or would be including those comments in the plan ('We Did'). We will continue to use social media, in particular Twitter (@BlackpoolCCG), to communicate and engage, as well as our website.

Difficult to reach groups

We have also executed several communication campaigns to improve the health of the local population. These include 'Altogether Now – a Legacy for Blackpool' http://altogethernowblackpool.com/ As part of this partnership programme, a health film highlighting the health challenges that are faced in Blackpool, and encouraging action from the public to respond to these challenges, has been developed.

From these events we agreed to co-design and implement a range of patient-centric models, based on solid evidence from other health economies, national and international, that will drive improved outcomes and quality through far more proactive care.

b) Service provider engagement

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

i) NHS Foundation Trusts and NHS Trusts

Blackpool HWBB, in its development of this plan, have engaged with the full membership (below) including our main providers of health and social care services.

Blackpool CCG led the jointly agreed Fylde Coast Unscheduled Care Strategy (2012) and the Fylde Coast Intermediate Care Review (2013). These included key partners on the commissioning and provider sides with input from external partners. Both identified the need to have better integration of health and social care. From these projects, work is already being delivered in a more co-ordinated and joined up way, providing better care for the citizens of Blackpool.

All key partners continue to be fully engaged in refining and delivering these strategies via the long standing Urgent Care Working Group/ Board and the Fylde Coast Commissioning Advisory Board. Blackpool CCG, Fylde & Wyre CCG, Blackpool Council , Lancashire County Council, Lancashire Care Trust and Blackpool Teaching Hospitals Trust are working together to ensure transformational change is delivered.

The NHS Operating Plan financial and metrics templates and projected trajectories include the expected changes associated with implementation of the BCF.
   https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/33773
   9/BLACKPOOL_Operational_Plan_14-16_-_TRUNCATED_1_.pdf

Blackpool CCG has worked closely with its main provider of Acute Hospital Care, Blackpool Teaching hospitals NHS Foundation Trust (BTH). They are integral stakeholders in the delivery of the new models of care. They understand the need to shift delivery of acute services towards more community orientated working and their plans reflect see plan on a

page **(table 2, document 13)**

Patients will only be admitted to hospital when they require acute treatment that cannot be safely or efficiently provided in a community setting. The following sections summarises BTH plan:

General acute based services
- Medical and surgical high dependency patients will be supported by intensive therapy unit and high dependency unit beds.
- BTH will establish a centralised rehabilitation service, to which patients can be transferred following acute medical/ surgical treatment at Blackpool Victoria Hospital, or can be repatriated to following surgery/treatment elsewhere in Lancashire.
- BTH will continue to provide elective cardiothoracic, cardiology and haematology services for Lancashire and South Cumbria.
- BTH will continue to provide national artificial eye services to England.
- BTH will continue to provide level 2 neonatal services.

Unplanned care provision
- The acute trust will provide core un-planned (non-elective) services, including:
- A&E
- Diagnostics
- Clinical decision unit
- Trauma and emergency surgery (orthopaedics, general surgery, urology, gynaecology, maternity)
- Paediatric services
- The acute trust will support the continued provision of major trauma services at specialist centres (Lancashire Teaching Hospitals NHS Foundation Trust).
- A&E will treat 'true accidents and emergencies'. Patients with minor injuries, or who require a period of longer assessment, will be treated in a more appropriate environment.
- A multi-disciplinary clinical decision unit will be established, to allow a holistic, rapid assessment by experienced clinicians.
- Elderly patients will be managed in a dedicated frail elderly unit, with a named clinician responsible for their care.

Planned care provision
- Core planned (elective) services will be provided on the acute hospital site, or in an ambulatory care setting if appropriate.
- Ambulatory care centres will be established that provide diagnostics, outpatient services, treatment regimens and minor surgical procedures in a non-acute setting.
- Outpatient services will become 'one stop', with access to diagnostics, specialist opinion and pre-operative assessment.
- BTH will continue to work in partnership across Lancashire to develop federated service models wherever this will increase quality of care, service sustainability or improve cost effectiveness.

> • Local support for cancer treatment pathways will be provided, even if the surgical intervention is undertaken elsewhere in the region.

ii) primary care providers

> We have undertaken a series of engagement events with wider primary care. An event on 12th February 2014 had representation from all GP practices; to debate the new model of community based integrated Health and Social Care and the practicalities of how this could be implemented. Further events have taken place and have been positively received. We have regular CCG GP member meetings and hold monthly sessions with all our GP practices. This encourages and captures feedback on our planning and prioritisation. We have also developed a newsletter that the CCG shares with GP member practices to aid dissemination across practice staff. We are committed to involving clinicians in the development of the plan and will continue to do this through workshops and clinical engagement events.

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

> As a first step, a visioning session was held on 5th February 2014 for health and social care commissioners and providers across the Council, NHS and Voluntary, Community and Faith Sector (VCFS). The session served to:
>   a) Build on the HWBB's introductory work to develop the BCF vision
>   b) Seek contributions in the ongoing planning of the BCF 'project'
>   c) Provide insight into neighbourhood/population mapping in developing new models of care
>   d) Provide insight and understanding of voluntary and community sector structures and capacity and how this could be built into the BCF plan
>
> The VCFS recognises the implications and opportunities afforded by the BCF and as the capacity, skills and strength of the sector builds, VCFS providers will ensure that all operational and delivery plans are shaped to meet local BCF requirements. In order for this to happen, ongoing engagement and involvement of providers will be maintained via planning workshops and events which will be facilitated by Blackpool Wyre and Fylde Council for Voluntary Services who are the infrastructure body for the sector and will act as the conduit between the BCF and VCFS providers.

c) Implications for acute providers

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

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

Blackpool CCG meets fortnightly with Blackpool Teaching Hospitals NHS Foundation Trust (BTH) to progress the transformation of the health care system. The discussions focus on the implications of the BCF and the potential impact on BTH activity shifting from the Acute Sector to the Community and Social Care sectors.

The CCG is currently spending around £1.398m on services that are deemed to be part of the BCF. The BCF submission will show that this sum should be £1.6m (based on historic Department of Health figures rather than what was actually agreed in Blackpool) and the difference will be resolved as the detailed plans are agreed, but they are not substantial. In addition, in 2015/16 the CCG will receive from NHS England £4.142m to transfer into the BCF. Finally, the CCG will have to transfer £6.892m from existing budgets (in addition to the £1.398M mentioned above) into the BCF bringing the total to £12.432m.

It is expected that the whole of the sum will be utilized to ensure that integrated out of hospital health and social care services are provided as an alternative to hospital admission and therefore the BCF will be used to substantially reduce the amount that is spent on acute and mental health inpatient services by approximately £7m. This sum will be deducted from those providers as patients are treated and cared for within community and primary care services and demand for hospital services is substantially reduced.

The table below shows the links between the 2014/15 budget and the approach that is being taken with regards to the BCF

	15/16	16/17	17/18	18/19
	£m	£m	£m	£m
Expected recurrent reduction to NEL costs				
Savings in 15/16	-2.0	-2.0	-2.0	-2.0
savings in 16/17		-2.5	-2.5	-2.5
Savings in 17/18			-2.5	-2.5
Total recurrent savings	-2.0	-4.5	-7.0	-7.0
Provision of non-recurrent support	2.0	2.5	2.5	0.0
In year impact of savings	0.0	-2.0	-4.5	-7.0

We are looking to enhance the skills of the generic community workforce, nurses, AHPs and

voluntary sector so that they can assess the mental and physical health needs of the Blackpool community. Training in low level screening tools will be developed including the use of technology based software to rate anxiety, depression and memory problems.

Workforce Planning is a significant workstream within the development of the new models of care and the workforce plan was jointly agreed and signed off by the CCG in June 2014

Also coaching and the management of symptoms and low level interventions would be part of the offer to patients so that they do not have to see multiple practitioners where possible. This will be overlaid by access to mental health professionals working within and across neighbourhood teams to offer more specialist input and intervention when required.

Local provider plans are different in terms of actual activity figures as are the CCGs 2 year operational plans, as the base line period and planning periods are different. The BCF aims to deliver a 3.5% reduction in NEL admissions against a baseline of 2014 (January to December) whereas plans are developed on the basis of financial years (April to March).
The CCG has reviewed its level of ambition in light of local and national pressures on NEL admissions, in Q1 of 2014 from a planned 5.5% in 2015/16 to 3.5% reduction in line with the BCF ambition, representing a more realistic target in a time when radically new models of care are being embedded. A Fylde Coast resilience plan has been developed in conjunction with key partners and this aims to manage surges in activity. **(See table 2, document 10)**

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

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
A & B
Scheme name
New Models of Care: Extensivist and Enhanced Primary Care
What is the strategic objective of this scheme?

Both the Extensivist and EPC models are key components in pivoting our primary care services to become more proactive and will either be introduced simultaneously or within a couple of months of each other. We expect the Extensivist models to stabilize the sickest of the sick with multiple LTCs and the EPC models to enhance single condition management reducing the rate of condition progression. Effective delivery of these models will impact activity in secondary care, helping to reduce the current pressure points, and is likely to lead to subsequent further redesign in these areas supported by additional new models of care such as hospitalists for unplanned admissions and ambulatory surgery centres for a proportion of elective procedures.

- Integrating re-ablement and intermediate care
- Building capacity in the community via the voluntary sector
- Shifting from a model of dependency and direct provision to supported self-management and care

Overview of the scheme
Please provide a brief description of what you are proposing to do including:
o   What is the model of care and support?
o   Which patient cohorts are being targeted?

Proposed Care Models

Introduction

This project consists of two sub projects

Extensivist

- This model of care will provide proactive, personalised care 'wrapped around' those with multiple complex conditions, i.e. 'the sickest of the sick'. Some are medically-led (e.g. for the elderly/frail population), whereas others are social and behaviourally led.

- The care model is underpinned by clear holistic accountability and empowerment of

the Extensivist and their team. Care is reoriented around the needs of the patient cutting across all aspects of health and social need: medical, social, psychological, functional and pharmaceutical. The holistic care system is designed to ensure early intervention and over time proactive prevention, breaking the current cycle of slow reactive care provision.

- Separate full-service clinics are set up to serve targeted patients exclusively, and extensivist physicians – who also follow the patients to other care settings as needed – have very small numbers of patients, (typically 300 to 500), to allow deep focus.

- This model has been shown in other parts of the world to:

  - support more effective condition management – keeping patients well for longer and giving them more control of their condition;

  - improve patient satisfaction, e.g. 80% of patients would recommend the service to a friend;

  - reduce hospital admissions by around 25% and A&E attendances by around 20%;

  - when hospital admission is necessary, the length of stay can be reduced by the availability of rehabilitation care managed by the patient's specialist community-based doctor.

Currently the Extensivist model is being developed for two pilot sites at Lytham and Moor Park but this project will plan for the introduction of the Extensivist model to the entire Fylde Coast population subject to further analysis on the cohort of patients and also subject to the pilot sites delivering the outcomes that will be set out in the business case.

Enhanced Primary Care (EPC)

- This is a new model of primary care for the larger group of patients at the level below those of the Extensivist model in terms of complexity and need. The target patients are typically those with single long term conditions, recognising the acuity and support required varies considerably, e.g. well managed diabetes vs. severe liver disease.

- The EPC model is clear with respect to accountabilities and responsibilities placing the Accountable General Practitioner (GP), supported by their team, as the responsible professional for supporting the patient in maintaining and improving their health condition. The effective co-ordination of the multi-disciplinary team surrounding the patient and their authority to access efficiently broader health and social care services substantially improves proactivity of care, consistency and access.

- This model often requires a networked GP model, or alternatives, to ensure timely access for patients on a 24/7 basis.

- Currently this element of the project needs to be developed and a preliminary piece of work needs to be done to identify current services and how they might fit into the EPC model.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

- Public and Patients
- Blackpool Council
- Blackpool CCG
- Blackpool Health and Wellbeing Board
- NHS England (Lancashire)
- Public Health England (Lancashire and Cumbria)
- Fylde Council
- Fylde and Wyre CCG
- Fylde Coast Commissioning Advisory Board
- Blackpool Teaching Hospitals NHS Foundation Trust
- Lancashire Care NHS Foundation Trust
- GPs
- Health Watch Blackpool
- Providers of public health services.
- Children's Partnership and associated partners.
- Local voluntary sector
- Local Government Association
- ADASS
- LMC
- Trade Union
- JNCC
- Staff Side

The evidence base
Please reference the evidence base which you have drawn on
o to support the selection and design of this scheme
o to drive assumptions about impact and outcomes

- The population of both CCGs is growing and will have a greater proportion of people in the over 65 age group in the next 10 years. With the changing profile of the population and people living longer there will be an increasing need for support to those with long term conditions, e.g. diabetes, heart disease, breathing, difficulties and dementia.

- The financial envelope in which the CCGs operate cannot sustain the health system in its current configuration and to provide services that address the challenges that the CCGs face, transformational changes will need to occur.

- The CCGs have reviewed different healthcare systems across the world to assess which new models of care could be successfully implemented in the Fylde Coast to improve quality and patient experience and address the challenges faced. This work have been informed by a detailed analysis of current populations, comorbidities, age, the associated spend on healthcare and what patients and the public think.

- This project focuses on the Fylde Coast area which consists of patients within both CCG areas. The cohort of patients are those that have long-term conditions and the aim is to develop and implement an integrated and coordinated health system for patients with the highest needs, successfully improving quality, outcomes and patient experience with the use of fewer resources.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Blackpool Council	Y	5,790,000	1,649,000	1,649,000
Blackpool CCG	N	1710000	12,432,000	12,432,000
BCF Total		7500000	14081000	14081000

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

1.	Extensivist
1.1	Effective condition management.
1.2	Enhanced patient experience.
1.3	Improved clinical outcomes.
1.4	Patient satisfaction improves considerably, e.g. 80% of members in other LHEs would recommend a friend.
1.5	Hospital admissions are reduced by approximately 25%.
1.6	Outpatient and Accident and Emergency attendances decline by approximately 20%.
1.7	Hospital admission length of stay can be reduced by the availability of rehabilitation care outside hospital managed by the Extensivist.
1.8	Reduction in secondary care spend of £3 - 4 million for Blackpool CCG.
1.9	Reduction in secondary care spend of £2 - 3 million for Fylde & Wyre CCG.
2.	Enhanced Primary Care
2.1	Enhanced patient experience.
2.2	Improved clinical outcomes.
2.3	In slowing the rate of disease progression and reducing the rate of flare ups it drives significant decreases in the rate of admission by approximately 45.%
2.4	Unscheduled A&E and MIU attendances reduced by approximately 30% when delivered to the expected standards. This substantially offsets the investment in increased outpatient appointments (up by approximately 8%) needed to manage the patient's LTC.
2.5	Reduction in secondary care spend of £10 - 12 million for Blackpool CCG.
2.6	Reduction in secondary care spend of £8 - 10 million for Fylde & Wyre CCG.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand

Better Care Fund Programme Board Governance

Accountability

Sharing
information

Direct reporting

Health and Wellbeing Board

Strategic Commissioning Group

Better Care Fund Programme Board

Fylde Coast
Commissioning
Advisory Group

Healthwatch
Blackpool

Project Workstreams

Design, Delivery and Estates	HR and Workforce	ICT and Shared Information	Finance	Comms and Engagement
Task and Finish Group	Task and Finish Group	Task and Finish Group	Task and Finish Group	Task and Finish Group
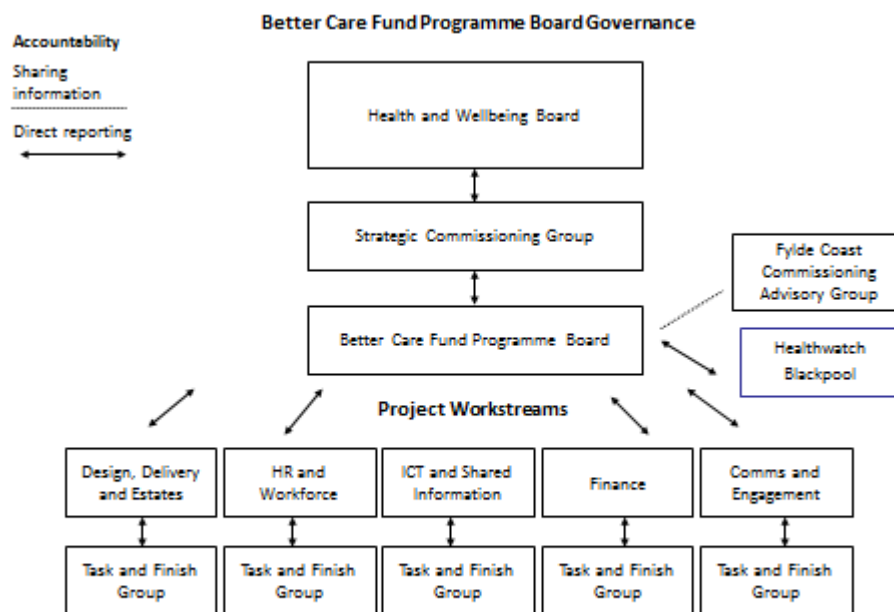
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population

Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

Delayed transfers of care from hospital per 100,000 population (average per month)

Avoidable emergency admissions (composite measure)

Patient / service user experience TBC

Local Measure TBC

What are the key success factors for implementation of this scheme?	
Close working of Health and Social Care. Creating sufficient capacity and skill sets The Project will operate alongside the following related projects: - Blackpool Joint Health and Wellbeing Strategy - Blackpool CCG 2 year Operational Plan - Fylde Coast 5 year strategic plan - Acute Trust Strategic Plan - Better Start (Big Lottery Fund Programme) - Headstart (Big Lottery Fund Programme) Fulfilling Lives - Complex Needs (Big Lottery Fund Programme)	

Scheme ref no.
C

Scheme name
Implementation of Electronic Palliative Care Co-ordination System (EPaCCS)

What is the strategic objective of this scheme?

EPaCCS is a national initiative to support the co-ordination of care so that people's choices about where they die, and the nature of the care and support they receive, will be respected and achieved wherever possible. It is a network to facilitate the sharing of information and guidance on locality registers for end of life care.

The End of Life Care Strategy (2008) identified the need to improve co-ordination of care, recognising that people at the end of life frequently received care from a wide variety of teams and organisations. The development of Locality Registers (now Electronic Palliative Care Co-ordination Systems known as EPaCCS) were identified as a mechanism for enabling co-ordination. By supporting the elicitation, recording and sharing of people's care preferences, and key details about their care, it is anticipated that EPaCCS will improve the quality of care, with provision meeting people's expressed wishes and preferences.

Early findings from the South West SHA Locality Register pilot showed that the vast majority of people on the register were able to die outside of hospital, and in their preferred place of care. **Why EPaCCS?** EPaCCs will contribute to increases in the quality of end of life care individuals receive by improving co-ordination and communication across sectors, ensuring that all those involved in care will be aware of the individuals wishes and preferences as recorded in Advance Care Plans (ACPs) as well as treatment care plans. They contribute to the patient Choice agenda as well as the Quality, Improvement, Productivity and Prevention (QIPP) agenda and improve patient safety by reducing harm through coordinated communication in standardised format to reduce the risk of inappropriate interventions.

In addition to communicating key medical information to healthcare professionals involved inpatient care, EPaCCS supports conversations about end of life care wishes. Typical implementation has initially focussed on the technical requirements of the system and then on transferring people already known to services onto EPaCCS. The original objective was to identify 1% of the GP practice population and PCTs were responsible for liaising with primary care to complete this work.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:
  o What is the model of care and support?
  o Which patient cohorts are being targeted?

The model of care is to provide GPs with an EMIS template which can then be populated with information for end of life patients i.e. DNACPR, PPC etc. This template can then be shared electronically with other providers.

Initially 1% of the practice population will be identified. The EPaCCS scheme is closely linked to the out of hours care coordination scheme and therefore care plans will also be developed and coordinated for patients seen out of hours, as part of the Blackpool Care Home scheme and the Hospice at Home pilot.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

As part of the Fylde Coast Strategic EolC group, an EPaCCS group was established that meets bi-monthly. The group is led by the Clinical EoLC Project Lead for the Fylde Coast and its membership includes representation from Blackpool CCG and Fylde and Wyre CCG, Blackpool CCG Lead GP for end of life care, Blackpool Teaching Hospital representation including Consultant in Acute Palliative Care, IT project managers, Social Care, out of hours provider, ambulance service, local Hospice, and NHS England. The group is responsible for maintaining an action plan with agreed timescales and targets and for feeding back to the main group.

Support has been provided at national and regional level to integrate IT systems across providers.

The evidence base

Please reference the evidence base which you have drawn on
- o to support the selection and design of this scheme
- o to drive assumptions about impact and outcomes

The evidence base was identified by the Department of Health and showed that 1% of a practice population could be identified as end of life patients. The focus was to identify this group of patients and coordinate their care via electronic end of life care plans. This information could then be shared across all service provision so patients could be cared for in their preferred place of care.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Funding has mainly been identified as part of the MIG rollout and EMIS development for the Fylde Coast. Commissioners are hoping to use End of Life Care MPET (multi professional education and training) funding to employ a temporary Fylde Coast EPaCCS Project Manager to coordinate the introduction of the scheme across the providers especially primary care.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The anticipated outcomes are to identify end of life patients, ensure an electronic care plan and relevant documentation has been completed, and to ensure this is shared with all the relevant providers. The overall outcome is to improve end of life care for patients on the Fylde Coast. This should also include reducing admissions and length of stay in hospital as patient care will be better planned.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
The EPaCCS Project manager will be responsible for closely monitoring the agreed outcomes via the EPaCCS group and Fylde Coast Strategic End of Life Care group. The scheme will aim to audit the number of care plans completed and identify issues so they can be discussed and resolved at the EPaCCS group. A care coordination report is submitted to commissioners and this will also show the number of end of life care plans developed.
What are the key success factors for implementation of this scheme?
The implementation of the scheme is dependent on the roll out of EMIS community, the MIG (Medical Interoperability Gateway) across the Fylde Coast, and other providers such as the Hospice and Social Care having access to these new IT systems. So far the scheme has been successful due to the communication and commitment of those involved and the understanding that the scheme will make a difference to the coordination of care for end of life patients.

Scheme ref no.

D
Scheme name
Care Plans for EoL patients, including Hospice at Home
What is the strategic objective of this scheme?
Appendix C. Reduce the number of inappropriate admissions to an Acute Setting **Appendix D.** Patient Care will be better managed within the Community.

Overview of the scheme
Please provide a brief description of what you are proposing to do including:
     o   What is the model of care and support?
     o   Which patient cohorts are being targeted?

The aim of the service is to provide practical care and emotional support in the last months of life, to the population of patients registered with a GP practice within Blackpool Clinical Commissioning Group (CCG) and Fylde and Wyre CCG.

The overall aim of the service is the enablement of patients at the end of life to achieve their preferred place of care and death in a context of dignity and comfort.

The service provider will work in collaboration with existing NHS services and End of Life Care providers (e.g. District Nursing, Community Matrons, Rapid Response, Early Discharge Team and Fylde Coast Medical Services (FCMS) and Marie Curie).   The aim of this collaborative service is:

1. To provide an increase in accessible quality end of life care to cover 7 days per week overnight between the hours of 10pm and 8am in the community.

2. To improve the quality of services for patients at the end of life, enabling them to be cared for and die in the place of their choice and avoiding inappropriate hospital admissions.

3. To work closely with the Trinity Clinical Specialist Team to respond to patients and family's needs at the end of life by anticipation and forward planning.

4. To reduce the number of inappropriate hospital admissions for end of life care.

5. To increase the number of patients dying in their preferred place of death.

6. To support the facilitation of an early discharge from hospital or hospice in accordance with a patients and families wishes for end of life care.

7. To provide additional care to patients on an End of Life community care plan which will include management of medication issues including setting up syringe pumps, complex discussions around end of life and assessment of symptoms overnight. Patients will be handed back to the usual caring team in the morning, where complex specialist palliative care needs are apparent the patient will be referred to the Trinity Clinical Nurse Specialist team for prompt assessment and medical review as appropriate; including specialist medical review as needed.

8. Follow up for symptom management and review

9. Family / carer support.

General Overview

End of Life care can be defined as the health and social care received in the period preceding and after death - provided to both patients and their carers. It is not disease specific and covers patients with increasing general frailty usually complicated by a number of co-morbidities such as chest or heart disease at the end of their life; those suffering from dementia, as well as people with those conditions that traditionally carry a life limiting diagnosis.

This service is provided by Trinity Hospice who will work in partnership with other organisations and health care professions to enable patients to die in their preferred place of care acknowledging the need to identify patient choice. All patients nearing the end of life should be identified, have their needs assessed, care planned and provided for, enabling them to live well and die well in the place and in a manner of their choosing.

The aim of the service is to provide end of life care via agreed care plans which are developed in partnership with the patient, family/carer and health and social care professionals. This approach will reduce gaps in service provision and increase choice

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

For the services to be effective, it is vital that it is integrated with all providers of palliative and end of life care. This includes, but is not limited to:

- ✓ Blackpool CCG

- ✓ Fylde and Wyre CCG

- ✓ Blackpool Teaching Hospital

- ✓ The patient's key worker

- ✓ GP's

- ✓ District Nurses / Rapid Response/ Rapid Response + / Night Nursing service

- ✓ Community Matrons

- ✓ Out of Hours GP provision (FCMS)

- ✓ Specialist palliative care services

- ✓ Nursing and care homes

- ✓ Marie Curie

- ✓ Ambulance Service

- ✓ Acute Services including hospital discharge

- ✓ Social Services

- ✓ Continuing care team

- ✓ Other agencies involved in the patient care

- ✓ Commissioners of services

- ✓ Family members/ carers

The evidence base
Please reference the evidence base which you have drawn on
- o to support the selection and design of this scheme
- o to drive assumptions about impact and outcomes

- ✓ Department of Health : National End of Life Care Strategy (2008)

- ✓ NICE Guidance in Supportive and Palliative Care (2004)

- ✓ Blackpool, Fylde and Wyre, Baseline Review of End of Life Services (2012)

- ✓ Department of Health "Our NHS Our Future"

- ✓ "Building on the Best' document recognising the importance of choices at the end of life, December (2004)
- ✓ NHS Confederation recommendation on End of Life care planning Oct 2005 and White Paper , all party parliamentary group , Dying Well.
- ✓ White Paper – "Our health, our care, our say", focusing on the development of patient pathways in the community.
- ✓ Darzi Next Stage Review , 2008

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
£100,000

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- • Increase the number of patients dying in their preferred place of care

- • Increase provision of quality end of life care at home particularly overnight.

- • Increase the quality of life for patients through the reduction of distressing symptoms

- Reduce strain and anxiety experienced by carers and families

- Reduction in the number of inappropriate out of hour's admissions to hospital for patients who are coming to the end of their life.

- Increased provision of, and improving access to, out of hours nursing services.

- Increased patient and carers satisfaction

- To demonstrate a link to Specialist palliative care services and services provided by Trinity Hospice

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Quality Performance Indicator	Threshold	Method of measurement	Consequence of breach	Report due
Infection Control	Baseline Audit	Clinical Audit		Annually
SUI	Learn from significant events of excellence and where patient experience was less than aspired for	Case Studies and significant incident reporting All SUIs to be reported by numbers, type and lessons learnt	Review, development of action plan to remedy, strict monitoring of compliance	Quarterly
Service User Experience	70% very satisfied	Patient and carer satisfaction surveys to include satisfaction with support, compassionate care and maintenance of dignity. Minimum response 20% of caseload	Review, development of action plan to remedy, strict monitoring of compliance	Annually
Improving Service Users & Carers experience: Complaints, Compliments, Concerns & comments: Numbers reported	Clear and timed action plan to implement results of surveys and	Audit of patient surveys Evidence of learning from compliments & complaints etc.	Review, development of action plan to remedy, strict monitoring of	Bi-annually

themes, actions and lessons learnt. All written/serious complaints to be deal with in line with policy.	complaints		compliance	
Inappropriate admissions to hospital			Review, development of action plan to remedy, strict monitoring of compliance	Quarterly
Reducing inequalities. The service is able to demonstrate equitable access	If inequalities are identified then to be discussed with relevant CCG	Report demonstrating number of referrals, referrer and ethnicity will be provided	Review, development of action plan to remedy, strict monitoring of compliance	Quarterly
Care Management		5 PPC 6 ACP 7 Rapid Response 8 Fast track 9 EOLC 10 Number of OOH visits 11 Calls to advice line		Quarterly
Outcomes ✓ Response time ✓ Number of episodes of care ✓ Unmet need ✓ Number of inappropriate referrals A. No of deaths at home B. Reduced		Activity report		Quarterly

inappropriate hospital admissions				
All staff should receive appropriate level training in the Safeguarding of Vulnerable Adults (and Children where appropriate)	All existing staff and new staff	Training record showing the numbers who have trained as a % of the whole workforce. Report to indicate any issues with safeguarding. Annual report		Annual
Mental Capacity Act & Deprivation of Liberty All staff should receive appropriate level of training in relation to the Mental Capacity Act and Deprivation of Liberty	All existing staff and new staff	Training record showing the numbers who have trained as a % of the whole workforce. Report to indicate any issues with Mental Capacity Act & DoL Annual report		Annual
All staff to have an appropriate level of DSB/ CRB check	All existing staff and new staff	Management report		Annual
NICE Guidance- A robust process should be in place for the dissemination of NICE Guidance	No threshold	Report progress/activity on all relevant guidance published during the year		Annual
Specialist training in end of life and palliative care for Registered General Nurses and Health Care Assistants	All staff	Training record		Annual

What are the key success factors for implementation of this scheme?

The success of the service will be reliant on excellent working relations with health and social care professional across the locality and it is expected that good working relationships will be developed with all providers of end of life care across the locality.

In addition to the patient and their carer, key relationships will include care providers in primary and secondary care, social care and the voluntary sector.

The service will be well co-ordinated and flexible to ensure that service users and carers receive efficient and effective delivery of services.

Scheme ref no.
E

Scheme name
Care Homes Support Scheme

What is the strategic objective of this scheme?
- Enhance the quality of care in care homes.   - Reduce non-elective admissions from care homes.   - Reducing the episodes of end of life care in Acute settings.

Overview of the scheme
Please provide a brief description of what you are proposing to do including: - What is the model of care and support?   - Which patient cohorts are being targeted?

Blackpool and Fylde & Wyre CCG's have agreed an Unscheduled Care Strategy for the Fylde Coast. The strategy sets out nine key work streams to deliver an improved quality of care to patients, and reduce the cost of delivering healthcare. The work streams that make up the strategy are interdependent and the schemes within them are designed to deliver a number of common goal:-

The scheme was established to fulfil the requirements of work stream seven to:-

- Develop advanced care planning in care homes
- Benchmark care homes and identify high utilisation of unscheduled care services
- Engage with care home providers
- Identify cause and effect of high utilisation
- Identify 'best practice'
- Develop best practice guidelines
- Implement best practice in care homes, providing support where appropriate
- Link both care home development and end of life strategy to work stream multi-agency care plans and risk stratification tool and develop advanced care plans for frequent attenders
- Link to work streams encompassing single point of access, advanced care plans and primary care to ensure ACP and special notes support care homes and end of life care.

  o **Objectives**

The key objectives are:-

- To reduce the inappropriate prescribing of nutritional sip feeds.
- To follow the agreed safeguarding procedures, and have had training in safeguarding adults included MCA and DOLS and be able to identify adults 'at risk' and know what to do if they identify safeguarding adult concerns.

- To work with existing services to establish a rolling education and training plan for

care home staff which includes dietetics, end of life care, COPD, heart failure, dementia.

- To reduce A & E attendances.
- To reduce NWAS conveyances.
- To reduce non-elective admissions.
- To maintain the lower level of conveyances and hence A & E and non-elective admissions from the 2013/14 cohort of care homes.
- To ensure 100% of residents in the targeted care homes will have a community care plan logged with the FCMS Care coordination scheme and the GP.
- To ensure 100% of residents in previously targeted care homes have their community care plans reviewed every three months and updates provided to FCMS and the GP.
- To ensure all patients prescribed sip feeds are reviewed regularly as per Blackpool Sip Feeds Prescribing Guidance, the review to be recorded in the care plan.
- To ensure 100% patients have a falls checklist completed.
- Dementia objectives / dementia targets

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

- Blackpool CCG commissioners
- GP Practice and the wider primary care team.
- Out of hours services
- North West Ambulance service
- NWAS commissioners
- BTH - A&E
- BTH Community services i.e. Community Matrons, District nursing, physiotherapy, occupational therapy, speech and language therapy, End of Life team, Rapid Plus
- Blackpool Council including Public Health, Community Equipment service, Intermediate Care, Social services, safeguarding.
- LCFT
- Trinity Hospice
- Age UK
- Healthwatch

The evidence base
Please reference the evidence base which you have drawn on
o to support the selection and design of this scheme
o to drive assumptions about impact and outcomes

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
£223,000

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in

For 2014/15 the team will work with a different cohort of around 25 homes.

The impact of the service working with the new cohort of care homes and incorporating some new aspects of services is as follows:

- Reduction in A & E attendances of 189 with a cost saving of £22k
- Reduction in NWAS conveyances of 100 but no associated savings that can be realised
- Reduction in non-elective admissions of 100 and savings of £170k
- Maintenance of the lower level of conveyances and hence A & E and non-elective admissions from the 2013/14 cohort of care homes
-

Breakdown of savings required:-

Continuation of year 1 (17 care homes)   £192,000

Year 2 (25 care homes)   £192,000

Cost of scheme   -£223,000

Net savings   £161,000

The net savings in a full year, taking into account the cost of the development is £161k.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The targets below are expected as a minimum. Performance under target must be investigated and reported to the commissioner within 30 days.

The provider will provide a monthly information report which includes the below:-

Performance Indicator	Indicator	Threshold	Method of Measurement	Frequency of Monitoring
Service User Experience	Care homes feedback	100%	Report	Quarterly
	Patient / carer feedback		Report	Quarterly
	GP feedback		Report	Yearly
Complaints / compliments			Month total and year to date	Quarterly
SUI / safeguarding alerts	Commissioners to be notified the same day.		Month total and year to date	Quarterly
Dietetics – group education			Audit / report	6 monthly
Dietetics – Food fortification	Reduction of inappropriate prescribing of sip feeds		Audit / Epact data if available	Quarterly

Care Plans				
Total number of care plans completed broken down by care home and GP practice		100% recorded	Month total and year to date	Monthly
Number of care plans completed in 2013/14 and 2014/15 reviewed every three months		100% recorded	Month total and year to date	Monthly
Number of care homes		100% recorded	Month total and year to date	Monthly
Number of patients seen		100% recorded	Month total and year to date	Monthly
Urgent Care management data				
Maintenance of lower level of conveyances, A & E and non-elective admissions.		To be agreed with the BI team	Submission to CSU BI	Monthly
Reduction in NWAS conveyances		100	Submission to CSU BI team.	Monthly
Actual A & E attendance deflections	Patient has not subsequently been seen & treated in A & E within 30 days	189	Submission to CSU BI team.	Monthly
Admissions avoidance	Patient has not subsequently been seen & treated in A & E within 30 days	100	Submission to CSU BI team.	Monthly
Dietician				Monthly
Number of patients seen after dietetics referrals from GP / community service				Monthly
Number of patients with food management plan				Monthly
Number of inappropriate referrals				Monthly
Number of patients seen in targeted care homes				Monthly
End of Life Care / Falls				Monthly
Number of end of life patients				Monthly
Number of end of life patients with ACP completed				Monthly
Number of patients with falls checklist completed				Monthly

Physiotherapist				
Number of contacts				Monthly

All targets are being met. In addition to the targets that help to deliver financial benefits to the organisation data has been collected on quality markers as defined by the safety thermometer project from the department of health.

Scheme ref no.
G
Scheme name
Hospital (Supported) Discharge Review
What is the strategic objective of this scheme?

- Improve patient experience.
- Increased use of Intermediate Care/Transitional services

- Reduced number of re-admissions due to poor discharge planning

- Reduced length of stay in hospital

- Reduced delayed transfers of care

- Reduction in placements into long-term residential care from the acute hospital setting.

Overview of the scheme
Please provide a brief description of what you are proposing to do including:
o   What is the model of care and support?
o   Which patient cohorts are being targeted?

The summary below highlights those actions which will have the highest impact, and summarises the improvements which could occur:

- Re-design of the Supported Discharge pathway will deliver immediate improvements to patient/service user and carer experience and an enhanced multi-disciplinary response to individual needs.

- Implementation of the agreed key tasks and responsibilities to facilitate the Supported Discharge pathway and implementation of new working practices will lead to regular and formalised MDT input to the supported discharge process, which will create better understanding and ownership.

- Development of the workforce through implementation of roles and responsibilities and training and development will lead to improved clarity and fewer hand-offs.

- The change in culture to achieve integrated service delivery across health and all social care partners will optimise the use of existing resources and embed a culture of mutual support.

- Development and implementation of clear access/inclusion criteria, standardised, proportionate assessment processes and standardised onward referrals will help to streamline the discharge process leading to more effective communication with

patients and carers and improved use of existing resources.

- Rebalancing existing HDT resources will enable the more effective use of existing resources.

- Formalising 7 day support from the SDT will ensure that there is continuity of discharge support throughout the week

- Appointment of an over-arching management post to implement the recommendations will ensure that actions are undertaken and momentum is maintained.

- Development and ongoing review of the performance management framework will lead to a better understanding of how the pathway is operating and inform further improvements and the matching of capacity and demand

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Blackpool CCG
Fylde and Wyre CCG
Blackpool Teaching Hospitals NHS FT
Social Care
Voluntary Sector
Patients
Carers

The evidence base
Please reference the evidence base which you have drawn on
  o to support the selection and design of this scheme
  o to drive assumptions about impact and outcomes

Although Blackpool Teaching Hospitals NHS Foundation Trust has been a consistently strong performer against the national 4 hour standard for A&E, over the past 12 – 18 months, achieving this target has become increasingly difficult. The 4 hour target is an important proxy indicator for emergency flows through the urgent care system. The Trust and its partners, however, feel it is important to seek further improvement, particularly with in relation to meeting challenging local QIPP targets, rising emergency demand and other financial pressures.

As a result, Blackpool Teaching Hospitals NHS Foundation Trust and local CCGs commissioned ECIST (Emergency Care Intensive Support Team) from NHS IMAS, to undertake a length of stay review during the summer of 2012. This team has worked with a number of health economies nationally. The findings demonstrated a number of internal and external delays impeding discharge, some of which, an effective Hospital Discharge Team could assist in reducing. The review highlighted a number of recommendations/areas for further action for the local health and social care economy. In particular, it indicated

that a new approach to discharge was required, both internally within the hospital, but also community-facing systems and processes

<table>
<tr><td>Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan</td></tr>
</table>

<table>
<tr><td>Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below</td></tr>
</table>

Under development but monthly performance reports to include

Number of patients managed by each Discharge Co-ordinator
Number and type of assessment completed by Discharge Co-ordinators
Outcome of assessments including number of re-instatements
Number of complex referrals to the Specialists in the SDT
Outcome of complex referrals to the Specialists in the SDT
Actual discharge destination for all patients worked with
Average length of stay for SDT supported patients
Average number of days from hospital fit to discharge for patients worked with
Reasons for delays where hospital fit to discharge is more than one day
Broader Impact of improved discharge processes (also included in the Intermediate Care Strategic System KPIs)
Reduction in the number of Excess bed days
Reduction in the % of patients over 65 going directly to long term care
Reduction in number and length of stay of long staying patients (those with length of stay over, 14 days, 21 days, 28 days etc.)
Increase in the number of referrals to intermediate care/transitional service
Reduction in the number of re-admissions within 28 days

<table>
<tr><td>Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?</td></tr>
</table>

The Standard Assessment proforma should be electronic allowing data to be routinely collected as a by-product of the patient management process and not as a separate

administrative process. Reports would be electronically generated and reviewed on a monthly basis.
What are the key success factors for implementation of this scheme?

Scheme ref no.
H

Scheme name
Urgent and Emergency Care – 7 day availability

What is the strategic objective of this scheme?

- Reduce A/E attendance and Ambulance Calls.
- Reduce non-elective admissions
- Increase numbers of people assisted to manage own long term condition.

Overview of the scheme
Please provide a brief description of what you are proposing to do including:
o What is the model of care and support?
o Which patient cohorts are being targeted?

- Currently have 7 day access to key elements of the urgent care pathway (Rapid response nursing, crisis social care). Resource allocated to provide domiciliary hours and bed capacity to support. Blackpool Council funding will be used to provide 7 day social work cover for the HDT (between the months of October-March), Provide overnight continuous care, expand the existing ARC model of care, Increase access to domiciliary packages of care
- Resource to support ECIST recommendation of using a pilot clinical triage at UCC front door
- Funds identified to meet spikes of unpredictable high demand, and associated back logs
- Increase A&E mental health liaison for the Fylde coast to enable timely assessment and discharge, and to introduce a follow up in liaison services where necessary to prevent re-attendance/ admission. Mental health liaison service also to support management of patients awaiting allocation of an inpatient bed. Crisis intervention and mental health liaison services to work collaboratively with BTH services to prevent breakdown in communication. Blackpool has particularly high levels of people presenting in crisis due to long waiting times for assessment in primary care and intervention, so waiting list initiative to be put in place to reduce escalation of issues and presentation at A&E.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Blackpool CCG
Fylde and Wyre CCG
Blackpool Council
Lancashire County Council
Blackpool Teaching Hospitals NHSFT

The evidence base
Please reference the evidence base which you have drawn on

o to support the selection and design of this scheme
o to drive assumptions about impact and outcomes

High quality care for all, now and for future generations: Transforming urgent and emergency care services in England. The Evidence Base from the Urgent and Emergency Care Review
http://www.england.nhs.uk/wp-content/uploads/2013/06/urg-emerg-care-ev-bse.pdf

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
• £225,000
• £25,000
• £149,670
• £239,545

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

- Reduction in Dtoc / Bed days, Reduction in number of permanent residential placements. Increase in patients remaining in own home 91 days after admission. Reduction in re-admissions after 30 days. Quality patient experience. Opportunity for individual independence optimised
- To collect data about the potential to increase in deflections to primary care
- To increase deflections to 20% during the hours that the additional nurse is on duty. Divert patients away from the emergency floor by offering clinical triage and treatment alternatives. Better patient experience and care closer to home.
- Set number of patients to be managed and maintain the A&E standard. Lcft cquin scheme for liaison services. Reduction in waiting times for primary mental health services. Prevent inappropriate emergency hospital admissions and reduce length of stay for people with suspected or known mental health problems. This includes all ages including adolescents and the elderly.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

KPIs and reporting will developed within PID, Service specifications or contract

What are the key success factors for implementation of this scheme?

Scheme ref no.
I
Scheme name
Improved services for Carers
What is the strategic objective of this scheme?
- Improved support for carers   - Reduced non-elective admissions   - Reduced admissions to long term care.

Overview of the scheme
Please provide a brief description of what you are proposing to do including:
    o What is the model of care and support?
    o Which patient cohorts are being targeted?

Aims and Objectives of the Carers' Breaks Grant Project The aim of the Carers Relief and Breaks Fund is to reduce the risk of carer breakdown and to enable carers to continue in their caring role through the provision of a grant of a one off grant up to £250. Objectives I. To provide a Carers Relief and Breaks Grant to carers II. To enable carers to have a flexible break e.g. taking up a hobby or training course, going on a day trip, holiday, joining a gym, pamper sessions or visiting friends. III. To support carers in their caring role and prevent a break down in the caring role. IV. To help carers look after their own health and wellbeing. Eligibility
The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
•Blackpool CCG Blackpool Carers Centre • Dementia Advisor Service • Dementia Peer Support Service • Stroke Association Family Support Service • Age UK Carers' Breaks Service • Blackpool Social Services • Blackpool Community Mental Health Team

The evidence base
Please reference the evidence base which you have drawn on
    o to support the selection and design of this scheme
    o to drive assumptions about impact and outcomes

National/local context and evidence base Strategy Links: ➢ National Carers Strategy 'Carers At The Heart Of 21st Century Families And Communities',

➤ the 'Blackpool Council and NHS Blackpool Joint Commissioning Strategy for Adult Carers 2010 – 2015'
➤ Blackpool Council and NHS Blackpool Older Adults Mental Health Commissioning Strategy 2009 – 2019.
➤ 'Carers at the Heart Of 21st Century Families And Communities' states that there should be greater emphasis on the provision of planned, high quality, flexible breaks for carers.

The actions proposed in the 'Blackpool Council and NHS Blackpool Joint Commissioning Strategy for Adult Carers 2010 – 2015' contribute to the delivery of the commitments identified in the National Carers Strategy. |

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
£125,000

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

1 carers will have improved health and well-being
2 carers will have improved quality of life
3 carers will be able to make a positive contribution
4 carers will have improved choice and control
5 carers will have freedom from discrimination
6 carers will have economic well being
7 carers will have personal dignity and respect

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Quarterly KPI reporting and Strategy Implementation Group

What are the key success factors for implementation of this scheme?

Full implementation of strategy and carer experience

Scheme ref no.
J
Scheme name
Care Co-ordination
What is the strategic objective of this scheme?
Using existing risk stratification tools build on the current Care Co-ordination pilot, broadening scope to include social care risk factors and increase the number of people with an Anticipatory Care Plan   • Reduced non-elective admissions.   • Improved self-management of conditions.   • Provide information to support development of the models to support full implementation of Health and Care Strategy

Overview of the scheme
 Please provide a brief description of what you are proposing to do including:
       o   What is the model of care and support?
       o   Which patient cohorts are being targeted?

Blackpool and Fylde & Wyre CCG's have agreed an Unscheduled Care Strategy for the Fylde Coast. The strategy sets out nine key work streams to deliver an improved quality of care to patients, and reduce the cost of delivering healthcare.   The work streams that make up the strategy are interdependent and the schemes within them are designed to deliver a number of common goals including: • Identifying those at greatest risk of emergency admission   • Proactively managing their care   • Encouraging patients to be responsible for their health and well-being, and better manage their long term conditions leading to improved control and better health outcomes   • Having robust community health and social care resources to manage these patients   • Health and social care working together I better team working within neighbourhoods led by GP Medical Practices   • A service to coordinate the care patients need and signpost to appropriate services when at risk of admission through some destabilisation of their condition   • Improved communication between all those involved in the care of a patient 24/7   The Single point of access is a key element of work stream 1- single point of access and coordination of care. It is designed to support the unscheduled care strategy by coordinating care plans for people deemed to be at high risk of accessing unscheduled care services, including those at the end of life by providing a single ' number 24 hours a day, 365 days, a year for those people to access services (other than GP led care)
The delivery chain   Please provide evidence of a coherent delivery chain, naming the commissioners and

providers involved

- Blackpool CCG
- Fylde and Wyre CCG
- North West Ambulance Service
- NWAS Commissioners
- Out of Hours Service
- GP Practice and the wider primary care team (including the GP Out of Hours Service)
- Rapid Response Team
- District Nursing Services/Community Matrons
- Specialist Nursing Services
- Social Services
- Intermediate Care
- Specialist community palliative care service
- Third sector organisations such as Vitaline, Age Concern etc.
- Community Pharmacists
- Medicines Management Teams
- Primary Care Assessment Unit and Urgent Care Centre Team
- A&E/AMU Consultants, Managers and the Team
- Secondary Care Consultants and Teams to ensure continuity of service
- Acute Trust Management Colleague

The evidence base
Please reference the evidence base which you have drawn on
   o   to support the selection and design of this scheme
   o   to drive assumptions about impact and outcomes

The principle of care planning for patients is well documented. Schemes have been running on the Fylde Coast for some time involving the use of the Combined Predictive Risk Model to identify those sections of   the population most at risk of accessing unscheduled care services and to have care plans developed for them at practice level. The extension of this service follows the review of a 12month pilot in 13/14. Analysis of this pilot (data period early September to the end January), indicated that 86% of cases managed by the service were deflected from A&E. It is anticipated the continuation of this service will contribute towards the Health Economies aim to reduce demand on emergency care services, this includes 999 PES, A&E and non-elective admissions

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
£100,000

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

It is anticipated from the 13/14 pilot data (period early September to the end January), the service will manage a total 1,188 contacts/care plan interventions per year.85% of those cases are expected to result in an avoided A&E attendance a total of 1010 cases. Of those

1010 cases, a further 30% would have resulted in a non-elective admission. Taking a 50/50 split between Blackpool and Fylde and Wyre the resultant activity outcomes are expected as follows for Blackpool;

- o 505 A&E deflections per year
- o 152 Avoided Admissions

The above equates to savings
follows
505 X £118 = £59,590
152 X £1,700 = £2
58,400

Total Gross Savings
=£317,990
Total Net Saving
 =£217,990

The Provider is expected to deliver the above activity and savings.

Performance Indicators	Indicator	Target	Method of Measurement	Frequency of Monitoring
CARE PLANS & URGENT CARE MANAGEMENT DATA				
Total Care Plans received and broken down by practice	Must indicate number and percentage by practice population	100% recorded	Month total & year to date	Monthly report (data will be 1 month later i.e. January submitted in February)
Total COPD Care Plans received and broken down by practice	Must indicate number and percentage by practice population	100% recorded	Month total & year to date	As above
Total number care plans from Care Homes		100% recorded	Month total & year to date	As above
Total number of End of Life care plans	To be developed in 14/15	100% recorded		As above
Total Care Plans Interventions enacted		100% recorded	Submission to CSU BI Team. CSU BI Team to return figures to FCMS for inclusion in the monthly report	Monthly (data will be 2 months behind FCMS report due to SUS i.e. January data will be submitted in March report)
Actual A&E Attendance Deflections	*patient has not subsequently been seen and treated in A&E within 30 days*	85% Of the total interventions enacted Circa 505 cases per year	Submission to CSU BI Team. CSU BI Team to return figures to FCMS for inclusion in the monthly report	Monthly (data will be 2 months behind FCMS report due to SUS i.e. January data will be submitted in March report)
Admissions avoidance (based on 30% of actual A&E deflections)	*patient has not subsequently been seen and treated in A&E within 30 days*	30% Of the total A&E attendances Circa 152 cases per year	Submission to CSU BI Team. CSU BI Team to return figures to FCMS for inclusion in the monthly report	Monthly (data will be 2 months behind FCMS report due to SUS i.e. January data will be submitted in March report)
Urgent Care Outcomes	Admission avoided Admission to hospital	100% recorded	Month total & year to date	Monthly report (data will be 1 month later i.e. January submitted in February)
Urgent Care Outcomes – admission avoidance cases	Breakdown of services i.e. GP, OoH,Rapid, Matrons,	100% recorded	Month total & year to date	Monthly report (data will be 1 month later i.e. January submitted

referred to alternative service	Social care etc.			in February)
Total number patients presented to A&E or UCC with Care Plan	Indicate number and narrative of remedial follow up actions taken	100% recorded	Month total & year to date	Monthly report (data will be 1 month later i.e. January submitted in February)
CALL HANDLING				
Total number of calls to 01253 955750			Month total & year to date	Monthly report (data will be 1 month later i.e. January submitted in February)
No more than 5% of all calls are abandoned	Number of abandoned calls as a % of all calls		Number of abandoned calls as a % of all calls	As above
Where an introductory message is used it should be no more than 30 seconds long and calls should be answered within 60 seconds of the being completed	Full compliance 95% or greater Partial compliance 90-94.9% Non-compliance 89.9% or less		Time taken to answer calls, as recorded by telephony system	As above
A robust system is in place for the identification of Life Threatening Emergencies				As above
All details of contacts should be sent to the GP practice before 8am the following day	Full compliance 95% or greater Partial compliance 90-94.9% Non-compliance 89.9% or less			As above
Flags for all care plans should be inputted onto Adastra within 6 hours of the validation of the Care Plan			Number of flags in Adastra compared with number of care plans received	As above
Regularly audit samples of patient contacts and journeys			Data extract from Adastra system	As above
PATIENT SATISFACTION				
Patient Satisfaction Survey	Patient Survey to provide evidence for Objectives 1,2 and 3			Monthly/quarterly TBD

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
This will be measured via the KPISs and within the Fylde Coast Urgent Care Health Economy Dashboard
What are the key success factors for implementation of this scheme?
The Single point of access is a key element of work stream 1- single point of access and coordination of care. It is designed to support the unscheduled care strategy by coordinating care plans for people deemed to be at high risk of accessing unscheduled care services, including those at the end of life by providing a single number 24 hours a day, 365 days, a year for those people to access services (other than GP led care).

Scheme ref no.
K
Scheme name
999 Frequent Caller Scheme
What is the strategic objective of this scheme?

The Project will manage the top 100, 99 frequent callers across the Fylde Coast. This should result in for BCCG the following reductions in activity;

Maintenance of cohort 1 equates to circa 1,089 A&E attendances and 327 NEL admissions). Cohort 3 equates to circa 703 A&E attendances and 211 NEL admissions.

Effectively manage frequent callers of North West Ambulance Service within the Fylde Coast footprint.

Establish and utilise multi-agency and existing professional services to negotiate an adequate reduction in 999 calls.

Work in partnership with the Hospital Link Worker based at Blackpool Victoria Hospital to identify and mange homeless patients and those at risk of homelessness in reducing 999 calls and bed days.

Demonstrate a reduced workload on unscheduled care services and the wider health economy resulting from reduced 999 calls, which otherwise would have attended the Emergency Department or result in a ward admission.

Design and test a robust and sustainable approach to safely manage the chaotic and demanding nature of the patient group.

Provide fertile commissioning intelligence and in doing so, lower the stigma associated with frequent callers.

Develop a replicable service which can be integrated and managed over the longer term.

Overview of the scheme
Please provide a brief description of what you are proposing to do including:

- o What is the model of care and support?
- o Which patient cohorts are being targeted?

General Overview

The service will be led by an Advanced Paramedic from North West Ambulance Service and the Top 100 most frequent callers of 999 will be managed until March 2015. Frequent caller establishments i.e. prisons, popular holiday attractions and hotels will also be addressed and their call to 999 managed.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The project will interconnect Health and Social Care through establishing robust working relationships with:

- Hospital Link Worker
- Blackpool and Fylde & Wyre CCGs
- Emergency Departments
- GP Practice and the wider primary care team Mental Health Services
- Drug and Alcohol Services
- Police
- Help Direct (F&W)
- Integrated Care Coordinator (F&W)
- Social Services
- Mental Health Helpline
- Community Therapy Team (F&W)
- Blackpool Fulfilling Lives Programme, sponsored by Big Lottery (Blackpool only)
- Community Services (community matrons, respiratory teams, falls teams etc.)
- North West Ambulance Service

The evidence base
Please reference the evidence base which you have drawn on
o   to support the selection and design of this scheme
o   to drive assumptions about impact and outcomes

Evidence Base

One of the areas of increasing activity and cost in relation to unscheduled care services is emergency ambulance call outs, with activity growing at approximately 6% per year. Using data from North West Ambulance Service (NWAS), frequent callers of 999 will be identified through a range of routes. From previous work undertaken it is clear that some individuals have little clinical reason for doing so; others have genuine reason for calling or may be highlighted as vulnerable. From August to 2013 to January 2014, the project managed the top 50 most frequent, chaotic and vulnerable callers of 999 across the Fylde Coast. The number of 999 calls generated by this group reduced by 88% and sustained over a six month period including the difficult Christmas period.

Prior to the pilot taking place it was felt that the group being focussed on would be unresponsive to any intervention and that there would be poor compliance with any actions agreed. This perception was proved to be incorrect with people responding well to having someone to talk to about their wider social needs and helping them to address these.

There is currently no service operating within the Fylde Coast providing this support.
It is acknowledged that CQUIN funding is in place for North West Ambulance Service to

address frequent callers across the North West region with one lead individual managing all patients across Cumbria and Lancashire area.

However the Blackpool, Fylde and Wyre Pilot will undertake more in-depth work with frequent callers and providers than the above CQUIN scheme. This gives depth if understanding to the drivers of 'frequent callers behaviours' and more support to the individuals in a supportive/rehabilitation type model of care.

There has been an 88% reduction in 999 calls over the past six months. If the Top 50 continued to call 999 with the same frequency over the next 6 months as demonstrated in their pre-intervention three months, it is predicted they would call 1406 times. The actual number of times they called was 150; potentially avoiding 924 ambulance journeys. This work is to be continued and grown to capture the Top 100 frequent callers across the Fylde Coast.

Evidence from the pilot suggests that where it is implemented effectively, it has improved the quality of life for patients, families and serving healthcare professionals. It also supported better care outcomes, safely reduced the utilisation of ambulance resources, Emergency Department attendances and hospital admissions, enabling a more cost effective approach to unscheduled care activity.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan £65,000 total

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Objectives

The objectives of the pilot are to provide a robust evidence base from which the service can be commissioned on a substantive long term basis via the delivery of the below;

- Identifying those at greatest risk of 999 calls and Emergency Department attendance.

- Proactively managing their care using a truly personalised approach.

- Empowering patients to take ownership of their health and well-being whilst decreasing their dependency upon unscheduled care services.

- Forming robust community health, social care and mental health contacts to manage patients, creating true integrated working.

- Providing a service driven by quality with positive human outcomes observed.

- By acting as a conduit to negotiate and de-escalate issues before a crisis occurs; a situation which has historically led to a destabilisation of their condition and resulting in

a 999 call.

- Improving communication and partnership working between those involved in patient care 24/7.

- Identify patterns and 'causal factors' which trigger relapse behaviours in former Frequent Callers in order to shape future commissioning of service and/or demand/capacity planning

- Reducing 999 calls and conveyances

- Reducing A&E attendances and avoidable NEL admissions

- Identifying the core skills, knowledge and experience required to support Frequent Callers within the new emergent neighbourhood models of care

- Developing a Job Description and Specification from the above in order to support the neighbourhood models in the future

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The Provider/Project Lead will maintain the original top 50 frequent callers (cohort 1) and manage the subsequent next top 50 frequent callers (cohort 2), making that the Top 100 frequent caller patients across the Fylde Coast, including selected establishments who call more frequently than others.

Year-end evaluation of the project will also need to identify the actual split of activity between Blackpool and Fylde and Wyre CCGs in both cohorts.

The Project Lead will be expected to provide three monthly reports to monitor progress against targets and objectives

Performance Indicator	Evidence/Target	Timescale	Method of Measurement	Frequency of Monitoring
Identify the core skills, knowledge and experience required to support Frequent Callers within the new emergent neighbourhood models of care	Job Description and Job Specification	August 14	See below	See below
Develop a Job Description and Specification from the above in order to support the neighbourhood models in the future	Job Description and Job Specification	Sept 14	Submission of JD & Job Specification to Commissioners	3 month report – status position
Cohort 1 – Maintenance of A&E attendances & NEL admissions in 14/15 (Top 50 callers)	1,089 A&E attendances 327 NEL admissions	3 monthly & year-end	3 month report & year-end evaluation	3 month report – status position Year End Evaluation
Cohort 2 – Reduction in A&E/NEL	**703 A&E attendances 211 NEL Admissions**	3 monthly & year-end	3 month report & year-end evaluation	3 month report – status

admissions activity (subsequent next top 50 callers				position Year End Evaluation
Cohort 1 and 2 split by CCG	**Above A&E attendances and NEL admissions split by CCG %**	3 monthly & year-end	3 month report & year-end evaluation	
Savings demonstrated	**Minimum savings across the 2 cohorts to be no less than £764k combined**	3 monthly & year-end	3 month report & year-end evaluation	

What are the key success factors for implementation of this scheme?

This in essence has been an evolving project to collate commissioning information to shape future services responses and ascertain the support required for 'Frequent Callers' or high intensity users of unscheduled care services. The maintenance target for cohort 1 and the reduction target for cohort 2 are estimates based on 13/14 findings and a number of assumptions. It may be that the overall reduction at year end between the two cohorts is higher or lower than predicted but early indications show the estimates to be achievable.

It also needs to be considered that reductions take place over a period of time, on a sliding scale therefore total reductions may not achievable in year.

Success depends on this service being embedded into permanent practice. Additional members of staff within a dedicated projected team would provide the resilience required if the current project lead steps out.

Multi agency working is essential, in particular with the police, so if opportunity arose to work collaboratively and share resources (and therefore cost), this would be a favourable option to increase capacity for the current project.

Scheme ref no.	
L	
Scheme name	
Increased Reablement capacity	

What is the strategic objective of this scheme?
Increasing re-ablement capacity to ensure that it is the primary offer for the majority of people prior to receiving a long term care service. Elements of two schemes contribute to this, Early Supported Discharge to ensure the speedy discharge of frail elderly patients, once medically fit and provide intense therapy and domiciliary support and 7 day working to improve services to provide more responsive and patient-centred delivery seven days a week.

Overview of the scheme
Please provide a brief description of what you are proposing to do including:
  o What is the model of care and support?
  o Which patient cohorts are being targeted?

- Reduced non-elective admissions   - Reduced admissions to long term care.   - Reducing demand for long term community based care packages   - Increased independence and positive outcomes for individuals   Resource allocated to provide domiciliary hours and bed capacity to support ESD Blackpool Council funding will be used to provide 7 day social work cover for the HDT (between the months of October-March), Provide overnight continuous care, expand the existing ARC model of care, Increase access to domiciliary packages of care. An integrated team will ensure the speedy discharge of frail elderly patients, once medically fit and provide intense therapy and domiciliary support (default position being to the individuals home setting) in order to prevent delayed discharges, maximise the individuals independence, decrease the number of permanent residential placements, ensure a high quality patient journey. Additional community nurses for weekend cover and also 7 day hospital discharge team working. Additional Social Work Capacity in the Hospital Discharge Team to support changes in bed configuration, 1 additional social worker would be required for every 20 additional beds.

The delivery chain Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved
Blackpool CCG Fylde and Wyre CCG Blackpool Teaching Hospitals NHS FT (Acute and Community Services) Lancashire Council

Blackpool Council

The evidence base
Please reference the evidence base which you have drawn on
     o   to support the selection and design of this scheme
     o   to drive assumptions about impact and outcomes

To be added from PID 1. Department of Health (2010) A Vision for Adult Social Care: Capable Communities and Active Citizens 2. Department of Health (October 2010) Press Release. £70 million support to help people in their homes after illness or injury. Accessed via http://www.dh.gov.uk/en/MediaCentre/Pressreleases/DH_120118 3. Department of Health (2010) The Operating Framework for the NHS in England 2011/12 4. Glendinning, C., Jones, K., Baxter, K., Rabiee, P., Curtis, L., Wilde, A., Arksey, H. and Forder, J. (2011) 5. Home care re-ablement services: investigating the longer-terms impacts, *Research Works*, 2011-01, Social Policy Research Unit, University of York, York.
Investment requirements Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan 7 day working £225,000 also includes elements from other social care schemes such as domiciliary care ESD £175,000
Impact of scheme Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan Please provide any further information about anticipated outcomes that is not captured in headline metrics below
• Prevent delayed discharges • Maximise the individuals independence • Decrease the number of permanent residential placements • Ensure a high quality patient journey. • Reduced non-elective admissions • Reduced admissions to long term care. • Reducing demand for long term community based care packages • Increased independence and positive outcomes for individuals
Feedback loop What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?
Monitored by Blackpool Council
What are the key success factors for implementation of this scheme?
TBC in PID

Scheme ref no.
M
Scheme name
Implementation of Intermediate Care Recommendations
What is the strategic objective of this scheme?

- Reduced non-elective admissions
- Reduced length of stay and delayed transfers of care
- Reduced admissions to long term care.
- Reducing demand for long term community based care packages
- Increased independence and positive outcomes for individuals

The recommendations are still under development

Overview of the scheme

Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

- Implement a simplified and improved intermediate care pathway.

- Review and identify opportunities to re-balance intermediate care capacity over time.

- Refine the existing plans for a single point of access for intermediate care.

- Develop an intermediate care at home team.

- Develop a single standardised assessment process for intermediate care.

- Consider overall management of the system.

- Review medical cover.

- Link in with the Blackpool Hospitals Supported Discharge new pathway in relation to access to intermediate care.

- Expand Telehealth and Telecare opportunities.

- Review intermediate care service specifications.

- Develop a performance management framework.

Develop and implement a Communications Strategy.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Blackpool CCG
Fylde and Wyre CCG
Blackpool Teaching Hospitals NHS FT
Lancashire County Council

The evidence base
Please reference the evidence base which you have drawn on
      o   to support the selection and design of this scheme
      o   to drive assumptions about impact and outcomes

The definition of intermediate care is as follows:-

"a range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission and premature admissions to long-term residential care, support timely discharge from hospital and maximise independent living".

"Halfway Home" makes it clear that intermediate care must involve multi-disciplinary team working, often offering a spectrum of care including both health and social care professionals. Blackpool health and social care economy tend to use the terms "intermediate care" or "rehabilitation" in health teams and re-ablement as provided by social care teams. The Fylde & Wyre health and social care economy tends to refer to intermediate care as "transitional care", "residential rehabilitation", and "domiciliary rehabilitation" but all are differing aspects of care provided as part of the intermediate care spectrum. It should be noted here that intermediate care services are provided free at the point of delivery for a period of 6 weeks (sometimes up to 8 weeks).

The Unscheduled Care Strategy on the Fylde Coast has highlighted the complexity of current provision of intermediate care services commissioned with some potential duplication and apparent fragmentation of services. Initial investigations confirmed that there is no single coherent intermediate care pathway and many referral routes into the system. There is good use of the third sector in the provision of intermediate care services, complementing the role of the statutory agencies, and both Age Concern and the British Red Cross provide valuable services all supporting intermediate care services. Public Health services on the Fylde Coast also appear to be proactive in commissioning complementary schemes. This review wishes to build upon the good practice identified as part of the review.

Further impetus for a timely review of intermediate care services has stemmed from the development of the Blackpool Hospitals Supported Discharge Team Project which is also underway, and reporting to the Unscheduled Care Board within the same timescales as this intermediate care review. Rapid access to effective intermediate care services by the hospital discharge team is crucial to supporting timely discharge from hospital for patients required a supported discharge package and through the delivery of rehabilitative care, helping to reduce the numbers of older people going into residential care or being admitted to hospital. The intermediate care provision locally also has a key role as a step-up resource from the community contributing to a reduction in unscheduled admissions to hospital and therefore forms a key strand of development

work within the Fylde Coast unscheduled care strategy.

A review of the Fylde Coast Intermediate Care Services was commissioned on behalf of the Fylde and Wyre Health & Social Care Economy Unscheduled Care Board in May 2013. The methodology, scope, interfaces and anticipated outcomes for the review are documented in a Project Initiation Document (PID) which was signed off by the Unscheduled Care Board on 10th May 2013. Project Management support from Benchmark Management Consultancy Ltd was identified to manage the review, which reported at the beginning of July 2013.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
tbc

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

1. **Patient Experience & Quality** – The implementation of this recommendation will lead to improved patient and carer experience through more effective engagement and communication, improved patient expectations and relationships.

2. **Cash Releasing Savings** – The implementation of this recommendation will reduce the costs of the existing service and over time will lead to release of funding.

3. **Operational Efficiencies** – The implementation of this recommendation will lead to a better use of existing resources which will lead to the creation of additional capacity to support the intermediate care services and other processes.

4. **Avoided Costs** – The implementation of this recommendation will lead to the avoidance of costs for the Health and Social Care System, e.g. admission avoidance, more use of re-ablement/transitional services to support home-based care.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

TBC

What are the key success factors for implementation of this scheme?

TBC

Scheme ref no.
N
Scheme name
Telehealth / Safe Mobile Care
What is the strategic objective of this scheme?
To provide support to keep people in their own homes through technology and avoid unnecessary admissions

Overview of the scheme
Please provide a brief description of what you are proposing to do including:
    o   What is the model of care and support?
    o   Which patient cohorts are being targeted?

1.Safe Mobile Care (SMC)

Safe Mobile Care is a simple aid to self-management of Long Term Conditions, along with reducing hospital admissions and re-admissions; using proactive real-time alerting and monitoring whilst enhancing service provider productivity. Utilising simply enabled monitoring devices and peripherals, the solution could be used on discharge from the hospital, in a care home setting or in the patient's own home. It allows remote monitoring of patients by our clinical services and to effectively support patients so as to enhance their quality of life and improve health outcome. The solution is capable of supporting a wide range of Long term conditions using personalised care plans to best meet an individual residents care needs. LTC's include: COPD, Chronic Heart Failure; Diabetes, Urinary Tract Infections, Asthma, Hypertension using a combination of clinically validated questionnaire sets, vital sign monitoring, medication reminders and coaching content.

Aims to sustain independent living through the use of relevant and integrated familiar everyday technology that empowers patients to better understand and manage their condition.

• Patient Outcomes:

1. Improves quality of life, reduces patient anxiety and increases confidence in an individual's ability to self-manage their condition.
2. Support early patient discharge from hospital.
3. Prevent re-admission.
4. Reduce length of stay within hospital

2. Telehealth with NWAS to safely extend the scope of Advanced Visiting Service (AVS)/pathfinder linking into AVS GP for monitoring and feedback. Aim to divert patients away from the emergency floor by offering clinical triage and treatment alternatives. Better patient experience and care closer to home.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Blackpool CCG
Fylde and Wyre CCG
Blackpool Teaching Hospitals
NWAS
Blackpool Council
Primary Care
Any other agencies involved in an individual patient's care

The evidence base
Please reference the evidence base which you have drawn on
o   to support the selection and design of this scheme
o   to drive assumptions about impact and outcomes

TBC from PID when complete

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan
NWAS £35,000
SMC £35,000

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

NWAS scheme:

- To maintain and increase the deflection rate of 90% and the 30 day re-presentation rate to 70% of that 90%
- To safely extend the scope of the clinical conditions supported within their own home via the paramedic/GP interface

SMC

1. Facilitate safe return home from hospital
2. Support early patient discharge from hospital, prevent re-admission, thereby reducing patients need to inappropriately access our services, driving improved service outcomes at a reduced cost.
3. Improve prevention and early intervention: to reduce burden on acute and primary care resources. Prevent avoidable emergency admissions / Reduce length of stay within hospital / Reduce admissions.
4. Improve service value and efficiency of service provider: Support the Community Service productivity gains for frontline staff; reduction in travel times and frequency, assessing patient contacts (face to face: telephone)

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

KPIs will be developed from above intended impacts and reporting process developed from providers to commissioners.

What are the key success factors for implementation of this scheme?
Communication between providers of services and other key partners involved in the care of the patients

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Blackpool Health & Wellbeing Board
Name of Provider organisation	Blackpool Teaching Hospitals NHS Foundation Trust
Name of Provider CEO	Gary Doherty
Signature (electronic or typed)	Gary Doherty

For HWB to populate:

Total number of non-elective FFCEs in general & acute	2013/14 Outturn	20477
	2014/15 Plan	20477
	2015/16 Plan	19352
	14/15 Change compared to 13/14 outturn	0
	15/16 Change compared to planned 14/15 outturn	1125 (5.5%)
	How many non-elective admissions is the BCF planned to prevent in 14-15?	0
	How many non-elective admissions is the BCF planned to prevent in 15-16?	700 (3.5%)*

*this is an adjusted figure to calculate the number of Blackpool residents who should no longer be admitted to BTH when the BCF is implemented (the majority of patients are registered with a Blackpool CCG practice but some will be registered with Non-BCCG practices)

For Provider to populate:

	Question	Response
1.	Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?	BTH agree with the planned percentage reduction but have no process to endorse the figure of Blackpool Council residents who will avoid a NEL admission as the data is collected at CCG level. There is also an added concern that the 2014/15 plan will be an underestimate of the actual activity. However we are engaged in the BCF agenda and are planning to achieve a 3.5% reduction in NEL admissions when compared with the baseline of the 2014 calendar year.
2.	If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?	
3.	Can you confirm that you have considered the resultant implications on services provided by your	Yes. BTH have members on Blackpool HWBB, the

	organisation?	Strategic Commissioning Group and the BCF Programme Board and are fully engaged with the vision and aims of the BCF. The CEO of BTH is the Responsible Officer for the 'Out of Hospital Strategy' and the New Models of Care across the Fylde Coast. As such BTH are closely linked with the work done in planning and the delivery of the core part of the BCF. BTH form part of the program management office that will deliver the new models of care and the BCF plan. BTH are key partners in defining the critical path to successful delivery. Risks are outlined in section 4.
	Additional Commentary from North West Ambulance Service	NWAS worked with Commissioners in the North West (NW) during 2013/14, to produce detailed Commissioning Intentions for 2014/15, and higher level intentions for 2014 to 2019. The strategic direction which underpins these intentions is informed by the national guidance published in 2013 on urgent and emergency care; the most recent being Keogh (November 2013). The strategic headline within the document is how the Paramedic Emergency Service moves to "mobile urgent treatment centres" and how the majority of patients will be treated closer to home; with specialist services being further centralised. Within the Commissioning Intentions, is an intention for the Lead commissioner and NWAS to work with CCGs and Health & Well-Being Boards in support of the Better Care Fund (BCF). The Lead Commissioner, through the NW Ambulance Strategic Partnership Board (SPB) and in conjunction with the five counties, and thirty three CCGs, produced ambulance narrative for inclusion in the Five Year Strategic Plans.

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...derstanding the NCAR process and implementing the Better Care Fun...

The letter this report accompanies sets out the result for the NCAR (Nationally Consistent Assurance Review) for your area's BCF plan. Your plan has been placed in one of four categories, which are:
- Approved
- Approved with support
- Approved subject to conditions
- Not approved

How was the NCAR approval category reached?

The approval categories recognise the challenging task required of local areas as part of an ongoing process to transform local services and improve the lives of people in your community. The aim is t... to be ready to implement their BCF schemes from next April, so the assurance categories reflect local areas' state of readiness.

The NCAR review provides an assurance rating for each plan based on both its quality as an approach and its deliverability in the local context. There were four key elements to the review:
1. A standardised review of the quality of the plan, by external review experts and a conversation with HWB Boards
2. An assessment of the local context or delivery risks in which plans will be implemented, by NHS England area teams with HWBs and local government regional colleagues
3. Moderation by a reviewer team informed by NHS area team and regional colleagues
4. National calibration overseen by the BCF Task Force

The principles behind the design of the review include:
1. Maximising the time available to develop the plans and minimising the time for assurance
2. Using independent external experts to conduct the reviews
3. Using a consistent set of checks for each plan
4. Giving each health and wellbeing board the opportunity to discuss key risks or issues
5. Keeping the focus on actions and risks
6. Involving area team and regional colleagues from NHS England and the Local Government Association to provide a context for the local system

What does the approval category mean?

Approved	No significant actions required and the plan can move forward to implementation
Approved with support	There are some required actions but these do not represent a fundamental flaw in the plan's approach or a material concern and can be resolved by a clarification or additional inform...
Approved subject to conditions	While the fundamental approach is suitable, there are specific challenges that need to be addressed before proceeding to implementation, such as: - A material concern about the ability to deliver the national conditions - A material concern about the credibility of the non-elective target, given either current performance or the provider engagement in the plan - The volume of corrective actions or unmitigated risks in the plan being such that a significant level of further work is required before they can be assured
Not approved	The plan falls short of key criteria either because it is not signed-up to by all parties or the fundamental approach is flawed

What happens next?

The letter attached to this report also sets out the next steps arising from your approval category. This will vary according to the nature and degree of actions required. The NCAR Report tabs in this r... in detail all the actions identified by the NCAR review. These will range from minor clarifications to more substantial concerns, and each local area will be assisted to prioritise and address the identifi...
The next steps for local areas in each approval category are:

Approved	The local area is given full responsibility for its BCF budget, and any ongoing support or oversight will now be handled by NHS England regional and area teams
Approved with support	The local area is given full responsibility for its BCF budget but will be required to submit further information or evidence in line with the outcome of its NCAR report. Ongoing support... oversight will be handled by NHS England regional and area teams, who will appoint a relationship manager to agree a timetable with the local area to complete the agreed actions. Th... will coordinate and track the agreed actions, assessing additional evidence supplied and moving plans to a fully approved status; it is expected this will happen quickly, by the end of N...
Approved subject to conditions	The local area will be approved to continue improving its plan but will not receive full responsibility for its BCF budget until it meets the conditions set. It will be assigned a named Bett... Advisor who will get in touch shortly to arrange a meeting with the area to understand how they can help to develop an action plan within two weeks to address the NCAR conditions,... what support is needed to gear up toward implementation. The local area may need to resubmit its plan in full or part, depending on the nature of the conditions. Once the plans have... reassessed, it is expected that the plan will move to the approved or approved with support category, which is intended to be by the end of December 2014
Not approved	The local area is not given responsibility for its BCF budget at this stage, and by implication will be limited in terms of proceeding implementation activities that commit BCF expenditur... assigned an Better Care Advisor who will get in touch shortly to arrange a meeting with the area to understand how they can help to develop an action plan and agree appropriate sup... enable the area to develop a cohesive and credible plan. It is intended that this is resubmitted by early January 2015, when it will be reassessed, with the intention that the plan will m...

If you are placed in any approval category other than 'approved', you will need to complete an Action Plan in coordination with your Better Care Advisor or NHS England relationship manager (as app... Details of this is included in the letter but the Action Plan template is included in this report.

What are the conditions?

As set out in the NCAR methodology published in August 2014, areas whose plans fall into the 'Approved Subject to Conditions' category will need to fulfil specified conditions before their plan is fully... If required, you will receive additional support to assist you in meeting these conditions and further details will be included in the accompanying letter.

Theme	Conditions
1. National conditions	Condition 1a: The plan must further demonstrate how it will meet the national condition of protecting social care to ensure that people can still access the services they need
	Condition 1b: The plan must further demonstrate how it will meet the national condition of having an agreed impact on acute care sector to prevent people reaching crisis point and r...
	Condition 1c: The plan must further demonstrate how it will meet the national condition of Seven day health and care services: to ensure that people can access the care they need wh...
	Condition 1d: The plan must further demonstrate how it will meet the national condition of Data sharing, including the use of digital care plans and NHS number so people don't endle... their story and professionals spend less time filling out paperwork
	Condition 1e: The plan must further demonstrate how it will meet the national condition of Joint assessments so that services can work together to assess and meet people's holistic...
	Condition 1f: The plan must further demonstrate how it will meet the national condition of having an accountable professional who can join up services around individuals and preven...
2. NHS funding	Condition 2: The plan must further demonstrate how it are meeting the minimum funding requirement for NHS out of hospital services
3. NEL ambition	Condition 3: The plan must further demonstrate how they will deliver the planned NEL reduction
4. Plan quality	Condition 4a: The plan must address the outstanding narrative risks identified in the NCAR report
	Condition 4b: The plan must address the outstanding financial risks identified in the NCAR report
	Condition 4c: The plan must address the outstanding analytical risks identified in the NCAR report

Will there be support around implementation?

The BCF Task Force is developing a range of materials and support to further assist local areas as they move towards implementation. This will take the form of a programme of guidance and coaching... developing system enablers at a local level, including information systems, operational management processes and governance arrangements, as well as developing robust and effective delivery and... management arrangements.

Keep in touch

For further information:
- Visit the NHS England BCF web pages, http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/
- Subscribe to the Task Force's weekly bulletin at bettercarefund@dh.gsi.gov.uk

Reviewer Body:
South West CSU

Blackpool

Please select 'preliminary' Quality of written plan (y-axis):
Medium-High Quality

Priority order for HWB Discussion	Review Area	Risk Category	Risk Applicable \ Line of Enquiry (please select from dropdown list)	Reviewer's Reasoning \Notes	Notes of discussion with HWB and Area Teams	Outcome Staus \ Pending HWB Action (please select staus from dropdown list in the first box)
Example	Analytics	Showstopper	A1-P4P: validity issue with values submitted - errors in plan values entered are causing incorrect results	DTOCs (in 6. HWB Supporting Metrics tab, template 1) shows increase in rate quarter on quarter for two quarters, but no rationale is given in the box provided (cell R29), as required by the guidance. Increase is fairly marginal on each so may be due to local factors	HWB understood the issue during the call and agreed to look into before the final assessment day	No longer a risk - if the following action is put in place (enter action in box below) / A rationale is added to the required box for the red ratings in 6. HWB Supporting Metrics tab, template 1, that explains the increased DTOCs in the two quarters.
1	Narrative	Showstopper	N1-The National Conditions have not been met	Question 9a ii)Plans for 7 day services not clear; no assurance to protect those current services that meet the BCF vision and deliver the improved services; iii) data sharing plans not clear, iv) Joint assessment and accountable lead professional for high-risk populations could be clearer.	This was discussed in the teleconference to clarify that 7 day services were already in place and this is relfeccted in the contracts therefor not included in the BCF plan because we are already contracting for appropriate 7 day services. This can be evidenced in the SDIP with BTH. New services delivered as part of BCF, e.g. Extensivist will be commissioned on a 7 day basis as outlined in the Project Brief	No longer a risk - no further action required
2	Narrative	Showstopper	N2-The CCG(s), Local Authority/ies and Health and Wellbeing Board have not authorised and signed off the plan: the BCF plan must be agreed and signed off locally.	Blackpool Council signature missing from Section 1.	Signature to be obtained. Email sent 23/9/2014 to AW	No longer a risk - no further action required / Signature obtained
3	Analytics	Showstopper	A1-P4P: validity issue with values submitted - errors in plan values entered are causing incorrect results	Query CCG baseline quarterly activity for Q1 14-15: Q1 14-15 on Tab 5 = 5,551 does not match trends baseline = 4,983.	Q1 14-15 Baseline figure on 'Tab 5. HWB P4P metric' is confirmed as being the correct figure. There is variance from the baseline Q1 figure on 'tab 7. Metric Trends' as this is based on submitted 14-15 plans, whereas the baseline for the BCF plan uses Q1 14-15 actual reported figures, which reflect reported over performance against plan in this quarter. There is an assumption that actuals will come down closer to plan for the remainder of the baseline period due to utilisation of available resilience funding, therefore the plan figures are still used for quarters 2 and 3 14-15.	No longer a risk - no further action required
4						<Please select Risk Status>
5	Finance	Top Risks	F4-BCF financial risks are not fully identified, inadequate contingencies, lack ownership	Question 6c – no contingency plans or risk share arrangements described.	The main risk is that NEL admissions will not be reduced. This has been adressed in a number of ways, both inside and outside the BCF. First, the BCF has been re-assessed in the light of the experience on NEL admission in the first 4 months of 2014/15 and a new baseline calculated. Second, the planned reduction in NEL admissions in the local hospital (£2m) is neutralised in 2015/16 by the application of £2m NR money to enable the Trust sufficient time to extract the savings (this is referenced in the narrative on page 57). This mechanism is adopted for two further years of the strategy. Third, should NEL admissions exceed the planning assumptions for the	No longer a risk - no further action required
6	Narrative	Top Risks	N3-The plan does not describe a clear overarching vision for the future of health and social care in the local area	Doesn't adequately describe status quo or how needs will change over next 5 years. In depth needs analysis on-going. Generic findings, not precise or analytically driven	The current status quo has been summarised in the BCF but is outlined in depth in the JSNA including health needs, how neeeds will change, mosiac modelling and population segemntaion. The JSNA is a live document that is updating all the time hence the lanuage in our BCF submission. See JSNA link http://blackpooljsna.org.uk/core-documents/	No longer a risk - if the following action is put in place (enter action in box below) / Suggest cross reference to other plans is added to BCF Part One.
7	Narrative	Top Risks	N4-The plan does not sufficiently explain how the overarching vision will be achieved	The plan lacks certain details required to provide assurance of delivery.	Interdependencies are not recorded in the BCF but in the Unscheulded Care Strategy and the CCG 5 year plan. The 5 year plan and Project Brief document also describe the programme management office which hold and monitor a detailed project plan and report through the FCAB	No longer a risk - if the following action is put in place (enter action in box below) / Suggest cross reference to other plans is added to BCF Part One.
8	Narrative	Top Risks	N5-The plan is not aligned	Interdependencies of other initiatives not clear.	The CCG 5 year plan outlines the interdependencies with other initiatives and cross organisational plans. Also see priority 7	No longer a risk - if the following action is put in place (enter action in box below) / Suggest cross reference to other plans is added to BCF Part One.
9	Narrative	Top Risks	N7-There is unsufficient detail as to how the schemes will be delivered	Insufficient analysis and targeting of the impact of schemes on secondary care reductions.	see unscheduled care strategy, Fylde Coast reselience plan and project brief, new models of care. Between them , these documents describe how schemes imact one another. They describe a coherent vision which is aligned with BTH of moving care from the acute to community setting (see also BTH FT plan on a page)	No longer a risk - if the following action is put in place (enter action in box below) / Suggest cross reference to other plans is added to BCF Part One.
10	Finance	Top Risks	F3-Schemes are not financially evidence-based or financially modelled adequately for full benefits realisation	See question 6a – difficult to cross reference savings in tab 4 to annex 1. Potentially large (favourable) discrepancy regarding schemes A&B possible timing issue as BCF numbers are for 2015/16 only.	The development and implementation of extensivist services is designed to link existing out of hospital services together more effectively than now and overall to have a bigger impact on NEL admission reduction. The schemes in annex 1 refer to those that already exist. The extensivist service is in the process of being designed for implementation from late in 2014/15. The local health and social care economy expects to deliver a higher level of NEL admission savings over the next three years than identified in the BCF. We have pitched our submission on the national expectation pending agreement locally on the actual impact from extensivist services.	No longer a risk - no further action required
11	Analytics	Top Risks	A3-P4P: contextual information indicates that the non-elective plan may be under or over ambitious	Dependant on check of baseline from 2a. – may also affect 2d (A5 Top) Q1 plan is higher than projected trend due to Q1 baseline used for the plan. Cannot cross check with any detail of reduction in activity from the	The CCG has assessed the progress of NEL admissions in 2014/15 and has revised the baseline to reflect higher than planned actual performance as part of a process to ensure that our estimates are realistic. We have used actual outturn figures for Q4 2013/14 and Q1 2014/15 with an estimate for the remaining six months of 2014. We have had to change our original financial estimates to take into account the recent rise in NEL admissions. All schemes apply to NEL admissions, but as indicated in row 10 above, the advent of an extensivist service will join them together better and have a greater overall effect in reducing	No longer a risk - no further action required
12	Analytics	Top Risks	A4-P4P: the overall level of ambition is not consistent with the quantified impact of the schemes contributing to a reduction in non-elective admissions	Detail is not available in tab4 - all schemes are amalgamated and applied as one reduction to NEL admissions.	The narrative in the cells above explains why we have not looked to quantify the imapct of each scheme in the financial tables.	No longer a risk - no further action required
13	Analytics	Top Risks	A4-P4P: the overall level of ambition is not consistent with the quantified impact of the schemes contributing to a reduction in non-elective admissions	Schemes detailed in Part 1, Annexe 1 do not seem to be cross-referenced with Tab 4, HWB Benefits Plan, Part 2.	See above.	No longer a risk - no further action required
14	Finance	Further Risks	F8-Insufficient funding for critical schemes	Question 4b – unable to cross reference expenditure plans (tab 3) to annex 1 costs	as requested in the template we included the costs in the expediture plan but did not duplicate these in annex 1 as it did not request us to do so.	No longer a risk - no further action required
15	Finance	Further Risks	F9- Unrealistic savings	Savings from reducing residential admissions (tab 6) not reflected in the summary of benefits (tab 4) (5c)	See rows 10 and 11 above.	No longer a risk - no further action required
16	Finance	Further Risks	F9- Unrealistic savings	Reduction in delayed discharges (-18%) is ambitious (tab 6) – query on call (5d).	awaiting council information	No longer a risk - if the following action is put in place (enter action in box below) / Info from Council to be obtained and reviewed by review team.
17	Finance	Further Risks	F9- Unrealistic savings	No savings shown for 2015/16 (see 5a and 5b) – almost certainly a data entry error	this is a data entry error. All savings are 2015/16 onwards. We have not planned for 2014/15 savings in the BCF	No longer a risk - if the following action is put in place (enter action in box below) / Amend Part Two to correct error.

#	Area	Category	Risk			Status
18	Narrative	Further Risks	**N8-Insufficient documentation of the risks**	Identified Risks are high level; no identification of scheme level risks. Pooled funding amount has not been quantified. No analytics or modelling presented. No articulation of a plan of action or risk sharing arrangements across the systems.	The individual scheme risks are outlined in the individual business cases which are embeded in the CCG 5 year plan the schemes relating to the Extensivist and Enhanced Primary Care are being managed through the Fylde coast Programme Management office as outlined in the Project Brief, new models of care document and the CCG 5 year plan.	**No longer a risk - if the following action is put in place (enter action in box below)** Cross reference BCF plan to individual business cases.
19	Narrative	Further Risks	**N9-Insufficient evidence of engagement**	Not clear what ongoing forums exist to engage with the range of providers (other than fortnightly meetings with BTH). Not clear if the implication of BCF delivery is reflected in their operational plans.	see TOR SCG and Fylde Coast Commissioning Advisory board/ HWBB has membership from CCG/ Acute and community Trust/ Mental Health Trust and Blackpool Council and they meet monthly. The BCF vision is replicated in the Provider plan, see BTHFT Plan on a Page	**No longer a risk - no further action required**
20	Analytics	Further Risks	**A7-Supporting Metrics: the level of ambition for a given metric is not consistent with the quantified impact of the schemes contributing to it**	Quantified impact of supporting schemes in tab 4 are amalgamated into one for 14-15 only and applied to reduction in NEL admissions. There are no details of schemes relating to the set metrics. There are no schemes applied to 15-16 on tab 4.	see priority 11 and 17	**No longer a risk - no further action required**
21	Analytics	Further Risks	**A8-Supporting Metrics: contextual information indicates that the plan(s) may be under or over ambitious**	Residential admissions – low level of ambition for both years (planned increase for 14-15 and decrease less than statistical improvement for 15-16) considering very low projected change in 65+ population. Reablement – low level of ambition considering very low projected change in 65+ population.	awit BCC response	**No longer a risk - if the following action is put in place (enter action in box below)** Info from Council to be obtained and reviewed by review team.
22	Analytics	Further Risks	**A9-Supporting Metrics: under or over ambitious plans are not explained fully or appropriately**	Planned increase in % residential admissions in 14-15 (rate is RAG rated green). No details provided in tab 4 – HWB Benefits Plan. DToCs – Red rating for Q1 and Q2 14-15 – mitigated by reason given – 'amended to take account of the additional delays due to the addition of nurse led unit data'. Can be seen that the Baseline Q1 and Q2 figures are low and that there was a step change starting Q3 13-14.	Awaiting BCC response	**No longer a risk - if the following action is put in place (enter action in box below)** Info from Council to be obtained and reviewed by review team.
23	Analytics	Further Risks	**A10-Supporting Metrics: information provided on Patient Experience Metric is not valid**	i. There is no patient experience metric described. ii. Local metric is not listed in the technical guidance; the chosen metric does not meet the criteria described – more information is required.	There was no natrional metric at the time of initial submission, in the refresh we choose to stick with the origional metric of the NHS number. This was supported by NHS England at the time.	**No longer a risk - no further action required**
24	Analytics	Further Risks	**A11-Supporting Metrics: information provided on Local Metric is not valid**	i. No metric described. [ii. All criteria for the metric are met]	see priority 23	**No longer a risk - no further action required**
25	Analytics	Further Risks	**A11-Supporting Metrics: information provided on Local Metric is not valid**	i. No metric described. ii. Not obviously linked to a scheme in Part 1 – Annex 1 that I can see.	The local metric is not being funded directly from the BCF, in line with the technical guidance it is therefor not detailed in Annex 1, part 1. the plan can be provided if required.	**No longer a risk - no further action required**
26	Area	Category	**<Please select applicable risk>**			**<Please select Risk Status>**
27	Area	Category	**<Please select applicable risk>**			**<Please select Risk Status>**
28	Area	Category	**<Please select applicable risk>**			**<Please select Risk Status>**
29	Area	Category	**<Please select applicable risk>**			**<Please select Risk Status>**
30	Area	Category	**<Please select applicable risk>**			**<Please select Risk Status>**

Part E: BCF Plans NCAR Review Summary

Blackpool

South West CSU

Overall Assurance Outcome from NCAR

Approved with Support

Quality of written plan (y-axis)

Medium-High Quality

Context and environment risk assessment (x-axis):

Moderate risk

Key facts

Minimum CCG contribution 15/16 (£000s)	£12,432
Additional CCG contribution 15/16 (£000s)	£1,149
Total contribution (including LA) (£000s)	£15,230
Risk raised relating to National Conditions as part of initial NCAR review?	No
Non-elective activity reduction %	- 3.5%
P4P size/value (£000)	£1,332
Did the initial technical review confirm the minimum required investment in NHS Commissioned out of hospital services?	Yes

No of Risks either requiring further action or still outstanding:
1. No longer a risk - if the following action is put in place
2. Risk remains outstanding

Narrative	5
Analytics	3
Finance	2

Lead Reviewer's Narrative

a) Overall findings
The Blackpool plan provided good levels of detail and the call with the HWB was able to agree action plans for all of the risks identified. The volume and complexity of the actions can be resolved within one month and as a result the plan is **Approved with Support**. The 3.5% target is credible and well evidenced interventions are in place to achieve the reduction. The local acute trust supports the BCF plan but has reservations about the likelihood of delivery. Related to this, whilst the plas was comprehensive, the HWB are encouraged to consider whwther the volume of schemes they are seeking to implement is genuinely manageable, and to ensure they are confident that the right governance and oversight mechanisms are in place to ensure the implementation remains focused on achieving the key outcomes.

b) Narrative Plan Template
The majority of the narrative risks were resolved through the clarification answers provided by the HWB. Where actions are outstanding these relate to better cross-referencing of other documentation, and drawing on that documentation for supporting evidence. For example the 5 year plan addresses many of the inter-dependency issues, and these need to be drawn out and made more explicit in the BCF plan to provide assurance that these interdependencies are being managed.

c) Activity & Finance Template
The financial plans were well detailed and provided good evidence. The majority of risks identified through the review were closed through the clarifications provided. Two risks remain outstanding. One of these is surrounding the feasibility of the delayed discharge reductions (18%) and the other relates to a data entry error on the part 2 template.
The action for the first risk is for further evidence to be provided over the feasibility of an 18% reduction in delayed discharges, clearly linking back to the schemes that will achieve this and how.
The data entry error for 15/16 savings should also be addressed and the part 2 plan resubmitted.

d) Pending\Mitigating Actions
- Cross-referencing of the plan to related core documentation to address rtisks N3, N4, N5 and N7
- Correction of data entry error on the savings values for 14/15 and 15/16
- Further evidence and challenge over the 18% delatyed discharge reduction

Top 10 Schemes (in order of highest expenditure first)	Expenditure as at 15/16 (£000s)
Scheme Name1: Extensivist service	£2,000
Scheme Name2: GP Plus NEL	£1,800
Scheme Name3: disabled Facilities and Social Capital Grants	£1,649
Scheme Name4: Maintaining Eligibility Criteria	£1,459
Scheme Name5: Community Schemes aimed at NEL reduction and OOH	£1,000
Scheme Name6: Community Equipment &adaptationsexisting plus (S256)	£935
Scheme Name7: Rapid Response	£800
Scheme Name8: Vitaline	£680
Scheme Name9: Support for Social Care Act	£600
Scheme Name10: Bed Based Intermediate Care Services	£591

Blackpool

Please select 'preliminary' Quality of written plan (y-axis):
Medium-High Quality

Priority order for HWB Discussion	Review Area	Risk Category	Risk Applicable \ Line of Enquiry (please select from dropdown list)	Reviewer's Reasoning \Notes	Notes of discussion with HWB and Area Teams	Outcome Staus \ Pending HWB Action (please select staus from dropdown list in the first box)	How Agreed Action Will be Met You will also need to consider what additional resources and skills sets will be required within your local area to meet these actions	Target Date for Completion
Example	Analytics	Showstopper	A1-P4P: validity issue with values submitted - errors in plan values entered are causing incorrect results	DTOCs (in 6. HWB Supporting Metrics tab, template 1) shows increase in rate quarter on quarter for two quarters, but no rationale is given in the box provided (cell R29), as required by the guidance. Increase is fairly marginal on each so may be due to local factors	HWB understood the issue during the call and agreed to look into it before the final assessment day	No longer a risk - if the following action is put in place (enter action in box below) A rationale is added to the required box for the red ratings in 6. HWB Supporting Metrics tab, template 1, that explains the increased DTOCs in the two quarters.	e.g. review of raw data	10/12/14
1	Narrative	Showstopper	N1-The National Conditions have not been met	Question 9a ii)Plans for 7 day services not clear; no assurance to protect those current services that meet the BCF vision and deliver the improved services; iii) data sharing plans not clear, iv) Joint assessment and accountable lead professional for high-risk populations could be clearer.	This was discussed in the teleconference to clarify that 7 day services were already in place and this is reflected in the contracts therefor not included in the BCF plan because we are already contracting for appropriate 7 day services. This can be evidenced in the SDIP with BTH. New services delivered as part of BCF, e.g. Extensivist will be commissioned on a 7 day basis as outlined in the Project Brief	No longer a risk - no further action required	email was sent 23/9/14 no further action	complete
2	Narrative	Showstopper	N2-The CCG(s), Local Authority/ies and Health and Wellbeing Board have not authorised and signed off the plan: the BCF plan must be agreed and signed off locally.	Blackpool Council signature missing from Section 1.	Signature to be obtained. Email sent 23/9/2014 to AW	No longer a risk - no further action required Signature obtained	no further action required	complete
3	Analytics	Showstopper	A1-P4P: validity issue with values submitted - errors in plan values entered are causing incorrect results	Query CCG baseline quarterly activity for Q1 14-15: Q1 14-15 on Tab 5 = 5,551 does not match trends baseline = 4,983.	Q1 14-15 Baseline figure on 'Tab 5. HWB P4P metric' is confirmed as being the correct figure. There is variance from the baseline Q1 figure on 'tab 7. Metric Trends' as this is based on submitted 14-15 plans, whereas the baseline for the BCF plan uses Q1 14-15 actual reported figures, which reflect reported over performance against plan in this quarter. There is an assumption that actuals will come down closer to plan for the remainder of the baseline period due to utilisation of available resilience funding, therefore the plan figures are still used for quarters 2 and 3 14-15.	No longer a risk - no further action required	no further action required	complete
4						<Please select Risk Status>	no further action required	complete
5	Finance	Top Risks	F4-BCF financial risks are not fully identified, inadequate contingencies, lack ownership	Question 6c – no contingency plans or risk share arrangements described.	The main risk is that NEL admissions will not be reduced. This has been addressed in a number of ways, both inside and outside the BCF. First, the BCF has been re-assessed in the light of the experience on NEL admission in the first 4 months of 2014/15 and a new baseline calculated. Second, the planned reduction in NEL admissions in the local hospital (£2m) is neutralised in 2015/16 by the application of £2m NR money to enable the Trust sufficient time to extract the savings (this is referenced in the narrative on page 57). This mechanism is adopted for two further years of the strategy. Third, should NEL admissions exceed the planning assumptions for the baseline year, there will be a reduction in funding for developments in primary care and community services (extended primary care) but not extensivist services.	No longer a risk - no further action required	Additional information was provided to reviewer and this risk is included on corporate risk register. As per NCAR comments no further action required	complete
6	Narrative	Top Risks	N3-The plan does not describe a clear overarching vision for the future of health and social care in the local area	Doesn't adequately describe status quo or how needs will change over next 5 years. In depth needs analysis on-going. Generic findings, not precise or analytically driven	The current status quo has been summarised in the BCF but is outlined in depth in the JSNA including health needs, how neeeds will change, mosiac modelling and population segemntaion. The JSNA is a live document that is updating all the time hence the lanuage in our BCF submission. See JSNA link http://blackpooljsna.org.uk/core-documents/	No longer a risk - if the following action is put in place (enter action in box below) Suggest cross reference to other plans is added to BCF Part One.	Addendum containing health need areas identified in JSNA cross referenced to BCF Plan schemes in part one to be provided	28-Nov-14
7	Narrative	Top Risks	N4-The plan does not sufficiently explain how the overarching vision will be achieved	The plan lacks certain details required to provide assurance of delivery.	Interdependencies are not recorded in the BCF but in the Unscheulded Care Strategy and the CCG 5 year plan. The 5 year plan and Project Brief document also describe the programme management office which hold and monitor a detailed project plan and report through the FCAB	No longer a risk - if the following action is put in place (enter action in box below) Suggest cross reference to other plans is added to BCF Part One.	addendum of further information to be provided linking other plans	28-Nov-14
8	Narrative	Top Risks	N5-The plan is not aligned	Interdependencies of other initiatives not clear.	The CCG 5 year plan outlines the interdependencies with other initiatives and cross organisational plans. Also see priority 7	No longer a risk - if the following action is put in place (enter action in box below) Suggest cross reference to other plans is added to BCF Part One.	addendum of further information to be provided linking outcomes listed in 5 year plan	28-Nov-14
9	Narrative	Top Risks	N7-There is unsufficient detail as to how the schemes will be delivered	Insufficient analysis and targeting of the impact of schemes on secondary care reductions.	see unscheduce care strategy, Fylde Coast reselience plan and project brief, new models of care. Between them , these documents describe how schemes imact one another. They describe a coherent vision which is aligned with BTH of moving care from the acute to community setting (see also BTH FT plan on a page)	No longer a risk - if the following action is put in place (enter action in box below) Suggest cross reference to other plans is added to BCF Part One.	addendum of further information to be provided linking outcomes listed in 5 year plan and benefits identified as part of the planning process to part one BCF plan	28-Nov-14
10	Finance	Top Risks	F3-Schemes are not financially evidence-based or financially modelled adequately for full benefits realisation	See question 6a – difficult to cross reference savings in tab 4 to annex 1. Potentially large (favourable) discrepancy regarding schemes A&B - possible timing issue as BCF numbers are for 2015/16 only.	The development and implementation of extensivist services is designed to link existing out of hospital services together more effectively than now and overall to have a bigger impact on NEL admission reduction. The schemes in annex 1 refer to those that already exist. The extensivist service is in the process of being designed for implementation from late in 2014/15. The local health and social care economy expects to deliver a higher level of NEL admission savings over the next three years than identified in the BCF. We have pitched our submission on the national expectation pending agreement locally on the actual impact from extensivist services.	No longer a risk - no further action required	no further action required	complete
11	Analytics	Top Risks	A3-P4P: contextual information indicates that the non-elective plan may be under or over ambitious	Dependant on check of baseline from 2a. – may also affect 2d (A5 Top) Q1 plan is higher than projected trend due to Q1 baseline used for the plan. Cannot cross check with any detail of reduction in activity from the	The CCG has assessed the progress of NEL admissions in 2014/15 and has revised the baseline to reflect higher than planned actual performance as part of a process to ensure that our estimates are realistic. We have used actual outturn figures for Q4 2013/14 and Q1 2014/15 with an estimate for the remaining six months of 2014. We have had to change our original financial estimates to take into account the recent rise in NEL admissions. All schemes apply to NEL admissions, but as indicated in row 10 above, the advent of an extensivist service will join them together better and have a greater overall effect in reducing them. The	No longer a risk - no further action required	no further action required	complete
12	Analytics	Top Risks	A4-P4P: the overall level of ambition is not consistent with the quantified impact of the schemes contributing to a reduction in non-elective admissions	Detail is not available in tab4 - all schemes are amalgamated and applied as one reduction to NEL admissions.	The narrative in the cells above explains why we have not looked to quantify the imapct of each scheme in the financial tables.	No longer a risk - no further action required	this will be delivered as part of the refresh of financial plans 2015/16 No further immediate action	complete
13	Analytics	Top Risks	A4-P4P: the overall level of ambition is not consistent with the quantified impact of the schemes contributing to a reduction in non-elective admissions	Schemes detailed in Part 1, Annexe 1 do not seem to be cross-referenced with Tab 4, HWB Benefits Plan, Part 2.	See above.	No longer a risk - no further action required	this will be delivered as part of the refresh of financial plans 2015/16 No further immediate action	complete
14	Finance	Further Risks	F8-Insufficient funding for critical schemes	Question 4b – unable to cross reference expenditure plans (tab 3) to annex 1 costs	as requested in the template we included the costs in the expenditure plan but did not duplicate these in annex 1 as it did not request us to do so.	No longer a risk - no further action required	no further action required	complete
15	Finance	Further Risks	F9- Unrealistic savings	Savings from reducing residential admissions (tab 6) not reflected in the summary of benefits (tab 4) (5c)	See rows 10 and 11 above.	No longer a risk - no further action required	no further action required	complete
16	Finance	Further Risks	F9- Unrealistic savings	Reduction in delayed discharges (-18%) is ambitious (tab 6) – query on call (5d).	awaiting council information	No longer a risk - if the following action is put in place (enter action in box below) Info from Council to be obtained and reviewed by review team.	council to provide information to clarify ambition and provide home of choice policy work summary	28-Nov-14
17	Finance	Further Risks	F9- Unrealistic savings	No savings shown for 2015/16 (see 5a and 5b) – almost certainly a data entry error	this is a data entry error. All savings are 2015/16 onwards. We have not planned for 2014/15 savings in the BCF	No longer a risk - if the following action is put in place (enter action in box below) Amend Part Two to correct error.	error to be corrected and resubmit part 2	28-Nov-14
18	Narrative	Further Risks	N8-Insufficient documentation of the risks	Identified Risks are high level; no identification of scheme level risks. Pooled funding amount has not been quantified. No analytics or modelling presented. No articulation of a plan of action or risk sharing arrangements across the systems.	The individual scheme risks are outlined in the individual business cases which are embedded in the CCG 5 year plan the schemes relating to the Extensivist and Enhanced Primary Care are being managed through the Fylde coast Programme Management office as outlined in the Project Brief, new models of care document and the CCG 5 year plan.	No longer a risk - if the following action is put in place (enter action in box below) Cross reference BCF plan to individual business cases.	matrix to be provided to cross refernce business case risks	28-Nov-14
19	Narrative	Further Risks	N9-Insufficient evidence of engagement	Not clear what ongoing forums exist to engage with the range of providers (other than fortnightly meetings with BTH). Not clear if the implication of BCF delivery is reflected in their operational plans.	see TOR SCG and Fylde Coast Commissioning Advisory board/ HWBB has membership from CCG/ Acute and community Trust/ Mental Health Trust and Blackpool Council and they meet monthly. The BCF vision is replicated in the Provider plan, see BTHFT Plan on a Page	No longer a risk - no further action required	no further action required	complete
20	Analytics	Further Risks	A7-Supporting Metrics: the level of ambition for a given metric is not consistent with the quantified impact of the schemes contributing to it	Quantified impact of supporting schemes in tab 4 are amalgamated into one for 14-15 only and applied to reduction in NEL admissions. There are no details of schemes relating to the set metrics. There are no schemes applied to 15-16 on tab 4.	see priority 11 and 17	No longer a risk - no further action required	no further action required	complete
21	Analytics	Further Risks	A8-Supporting Metrics: contextual information indicates that the plan(s) may be under or over ambitious	Residential admissions – low level of ambition for both years (planned increase for 14-15 and decrease less than statistical improvement for 15-16) considering very low projected change in 65+ population. Reablement – low level of ambition considering very low projected change in 65+ population. [DToCs – plans seem over ambitious compared to previous trends and	awit BCC response	No longer a risk - if the following action is put in place (enter action in box below) Info from Council to be obtained and reviewed by review team.	council to provide information to clarify low ambition or suggest if this could be stretched	28-Nov-14
22	Analytics	Further Risks	A9-Supporting Metrics: under or over ambitious plans are not explained fully or appropriately	Planned increase in % residential admissions in 14-15 (rate is RAG rated green). No details provided in tab 4 – HWB Benefits Plan. DToCs – Red rating for Q1 and Q2 14-15 – mitigated by reason given – 'amended to take account of the additional delays due to the addition of nurse led unit data'. Can be seen that the Baseline Q1 and Q2 figures are low and that there was a step change starting Q3 13-14.	Awaiting BCC response	No longer a risk - if the following action is put in place (enter action in box below) Info from Council to be obtained and reviewed by review team.	council to provide information to clarify low ambition or suggest if this could be stretched	28-Nov-14
23	Analytics	Further Risks	A10-Supporting Metrics: information provided on Patient Experience Metric is not valid	i. There is no patient experience metric described. ii. local metric not listed in the technical guidance; the chosen metric does not meet the criteria described – more information is required.	There was no natrional metric at the time of initial submission, in the refresh we choose to stick with the origonal metric of the NHS number. This was supported by NHS England at the time.	No longer a risk - no further action required	working with NHS England to redefine this metric to demonstrate how it will deliver improvement in patient experience	28-Nov-14
24			A11-Supporting Metrics: information	i. No metric described.	see priority 23	No longer a risk - no further action required		28-Nov-14

24	Analytics	Further Risks	provided on Local Metric is not valid	[ii. All criteria for the metric are met]		No longer a risk - no further action required	working with NHS England to redefine this metric to demonstrate how it will deliver improvement in patient experience	
25	Analytics	Further Risks	A11-Supporting Metrics: information provided on Local Metric is not valid	i. No metric described. ii. Not obviously linked to a scheme in Part 1 – Annex 1 that I can see.	The local metric is not being funded directly from the BCF, in line with the technical guidance it is therefor not detailed in Annex 1, part 1. the plan can be provided if required.	No longer a risk - no further action required	working with NHS England to redefine this metric to demonstrate how it will deliver improvement in patient experience	28-Nov-14
26	Area	Category	<Please select applicable risk>			<Please select Risk Status>		
27	Area	Category	<Please select applicable risk>			<Please select Risk Status>		
28	Area	Category	<Please select applicable risk>			<Please select Risk Status>		
29	Area	Category	<Please select applicable risk>			<Please select Risk Status>		
30	Area	Category	<Please select applicable risk>			<Please select Risk Status>		

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Andy Roach, Blackpool Clinical Commissioning Group
Relevant Cabinet Member	Councillor Eddie Collett, Cabinet Member for Public Health
Date of Meeting:	3rd December 2014

DEVELOPMENT OF NEW MODELS OF CARE- EXTENSIVIST

1.0   Purpose of the report:

1.1   To provide an update on the development and progress against plans to deliver New Models of Care.

1.2   The attached clinical design document is a summary of the clinical blueprint document that was developed by the Extensivist Clinical Redesign Team. Where possible, the document uses pathway-based flow diagrams to describe the processes/tasks that will be undertaken by the Extensivist team in relation to core activities and condition-specific care programmes.

1.3   This document will be used to inform the creation of a Service Specification and a Full Business Case.

2.0   Recommendation(s):

2.1   To note progress to date on the development of new models of care.

3.0   Reasons for recommendation(s):

3.1   The delivery of the Extensivist Services is a key element of the Better Care Fund Plans. The Board has a key role in the delivery of the Better Care Fund Plans.

3.2a   Is the recommendation contrary to a plan or strategy adopted or approved by the Council?   No

3.2b   Is the recommendation in accordance with the Council's approved budget?   Yes

3.3   Other alternative options to be considered:

None, the report is by way of a progress update.

4.0   Council Priority:

4.1   The relevant Council Priorities are:

- Safeguard and protect the most vulnerable
- Improve health and well-being especially for the most disadvantaged
- Deliver quality services through a professional, well-rewarded and motivated workforce

5.0   Background Information

5.1   The Extensivist Service will provide pro-active and co-ordinated care wrapped around the patient with a single point of access.

5.2   The service will be fundamentally orientated toward supporting patients to have the confidence and knowledge to manage their own conditions.

5.3   Once the patient has consented to be part of the service, full clinical responsibility will pass form the GP to the Extensivist.

5.4   The Extensivist service is provided by a team of clinicians and non-clinicians skilled in supporting patients with complex needs and having clear accountability on behalf of the system for providing and co-ordinating this care.

5.5   Regular contact with a health coach (recruited for the individual's emotional intelligence) and effective use of telehealth approaches will be some of the elements that will make the service feel very different.

5.6   It is expected that this approach will result in significantly improved patient experience, with patients being empowered to manage their own health and having an increased sense of wellbeing as a result.

5.7   For the system this should also result in patients having fewer unnecessary outpatient consultants and investigations, and fewer planned and unplanned hospital admissions.

5.8   Phase 1 of implementation will be comprised of two services, at Lytham and Moor Park primary care centres, each serving between 500-600 patients.

| 5.9 | Does the information submitted include any exempt information? | No |

5.10 **List of Appendices:**

Appendix 7a: Fylde Coast Extensivist Service Summary

6.0 Legal considerations:

6.1 None

7.0 Human Resources considerations:

7.1 None

8.0 Equalities considerations:

8.1 None

9.0 Financial considerations:

9.1 None

10.0 Risk management considerations:

10.1 None

11.0 Ethical considerations:

11.1 None

12.0 Internal/ External Consultation undertaken:

12.1 None

13.0 Background papers:

13.1 None

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Extensivist Model of Care – Summary Report

(Based on Clinical Blueprint v.11)

Chapters

Last amended: 14th November 2014

1. Outline of key features of service for agreement

This summary report based on the care model blueprint (v11) provides an overview of the following key details and assumptions around the Extensivist Model of Care:

- We will establish two initial Extensivist services on the Fylde Coast as part of phase 1 of the programme
- They will be initially focused on the frail elderly populations with multiple long term conditions
- The services will cover:
  - Lytham, St Anne's and Ansdell neighbourhood – at Lytham Primary Care Centre
  - North and Far North Blackpool neighbourhoods – at Moor Park Primary Care Centre
- They will be:
  - Planned between July 2014 to January 2015
  - Launched in February 2015
  - Then supported by roll out of the next group of services to cover phase 2 of the programme from April 2016

An overview summary of the model is provided below for context.

- The Extensivist Service will provide pro-active and co-ordinated care wrapped around the patient with a single point of access
- The service will be fundamentally orientated toward supporting patients to have the confidence and knowledge to manage their own conditions
- Once the patient has consented to be part of the service, full clinical responsibility will pass from the GP to the Extensivist
- The Extensivist service is provided by a team of clinicians and non-clinicians skilled in supporting patients with complex needs and having clear accountability on behalf of the system for providing and coordinating this care
- Regular contact with a Well Being Support Worker (recruited for the individual's emotional intelligence) and effective use of telehealth approaches will be some of the elements that make the service feel very different
- We expect that this approach will result in significantly improved patient experience, with patients being empowered to manage their own health and having an increased sense of wellbeing as a result
- For the system this should also result in patients having fewer unnecessary outpatient consultants and investigations, and fewer planned and unplanned hospital admissions

2. Patient Cohort/Target Population

The cohort of patients will be defined by those who will benefit most from the care offered by this tailored service and will be identified by a combination of pro-active data analysis and local GP knowledge to ensure that patients are identified pro-actively (ahead of unnecessary admission or crisis) as much as possible.

The patient cohort, based on the Aristotle risk stratification tool, is defined by the following criteria:

Age	>= 60	It should be noted that this will need to be evaluated during the proof of concept, as there is a concern that the age of entry may need to be lowered in order to have greatest impact in neighbourhoods with low life expectancy.
Long term conditions	>= 2 of the following: Coronary Artery Disease Atrial Fibrillation Congestive Heart Failure COPD Diabetes Dementia The following are NOT to be included: Cancer Chronic Kidney Disease Epilepsy	CKD has been excluded since the Clinical Redesign Team considers it to be associated with aging and/or medication regimes linked to other LTCs. Therefore, it is considered to skew the risk of future admission, and could result in patients with 1 LTC + CKD being included. Epilepsy has been excluded since the Clinical Redesign Team considers that NICE guidance should be followed in relation to management of this condition by a neurologist.
Predicted risk of non-elective admission within the next 12-months	Risk >= 20	Patients with a score of >=30 appear to already be users of secondary care activity, with evidence of multiple A&E attendances and NEL admissions. Patients with a score of 20 – 30 appear, in the majority, to be managed outside of secondary care. Therefore, selection of a risk score of >=20 should address those patients who are currently accessing secondary care services as well as offering a service that will prevent future high intensity use.

Use of these criteria will result in the following numbers of patients in each proof of concept location:

	Risk Score										Total Patients	Total Extensivist Patients
	0-10	10-20	20-30	30-40	40-50	50-60	60-70	70-80	80-90	90-100		
Lytham	583	405	269	153	67	48	35	24	14	3	1601	613
Moor Park	685	463	272	150	85	68	37	28	20	12	1820	672

Assuming an uptake rate of 75% (half way between the Swedish and US care models) each service will be managing approximately 500 patients.

It should be noted that the referral criteria will be reviewed as part of the evaluation of the proof of concept services.

3. Extensivist Service Team & Activity

3.1 Service Ethos

The service ethos outlines the values and attitudes of the people who will work in the Extensivist service. It is what will set this service apart from others and will help it deliver the level of care this blueprint outlines. The service ethos for the Extensivist service is:

- The Extensivist service will bring together insightful, emotionally intelligent, and empathetic health professionals. They will listen to patients and act as their advocate and enabler throughout their Extensivist care term
- The staff will balance leadership, autonomy and independence with team working to provide the best all round care effectively for their patients
- The ideal candidates will be motivated to provide comprehensive complex care in this evolving environment, whilst being flexible and innovative within this service

3.2 Team Overview

The core clinical team is comprised of staff in three roles: clinic leaders, clinical care coordinators and Well Being Support Workers. There will also be a number of wider team members bringing specific clinical or care skills to the team to support care planning, provision of care and development of core skills within the team.

The Extensivist team will be required to work in a significantly different way from staff in the majority of health and care services today

In order to achieve this staff will be recruited for their:

- Emotional intelligence and empathy
- Leadership, resilience and the ability to influence
- Drive to act as patient advocates
- Ability to work in a team and balance input from a range of sources
- Comfort with uncertainty and motivation to innovate

3.3 Core roles

The table below sets out the core team roles:

Note that role and function descriptions, along with qualifications and professional requirements have been developed for each of these roles.

Position	Role / responsibilities
Extensivist	- Senior medical team leader - Lead care planning - Work with the multi-disciplinary team to manage all the needs of frail elderly patients with complex needs

	• Ensure continuous service improvement • Clinics will have two "Extensivists": one Consultant and one GP, so their skill sets can complement one another in the running of the clinic
Advanced Practitioner	• Make differential diagnoses • Coordinate patient care • Take a leadership role within the team • Be required to lead and oversee swift reaction
Care Coordinator (function) ‑ Nurse (coordinator role) ‑ OT (coordinator role) ‑ Physiotherapy (coordinator role) ‑ Social worker (coordinator role) ‑ Pharmacist (coordinator role) ‑ Dietician (coordinator role)	• Coordinate patient care • Deliver specialist care in-line with individual training (e.g. as an OT) • Sub-specialists will cover the most complex patients with the disease they specialise in within their case load • Sub-specialists will also be a source of expertise for the team and the other care coordinators • Provide expert input into the care plan development and review process • Provide specialist patient care • Any sub-specialties not covered within the Clinic team will be provided through a linked service • Staff will be recruited from a range of backgrounds (including nurses, therapists, pharmacists and social workers) and collaborate on providing care for patients in parallel with their case-load role –the numbers and mix of backgrounds within each team will be driven by the needs of the local cohort of patients • N.B. Social workers also responsible for forming links with social care teams
Well Being Support Worker	• Build a strong supportive relationship with the patient • The point of contact for the patient and their family/ carer • Responsible for self-management support (patient activation) • Bridge the gap between the clinician and the patient • Assist in navigation of the health and social care system

Core team administration

Position	Role / responsibilities
Service Manager (could fulfill the analyst role as well)	• Manage the operations of the service (performance management) • Report performance via the management infrastructure • Support continuous improvement

Analyst	• Conduct regular analysis of performance • Complete bespoke analysis to support service improvement • Additional tasks TBD during implementation and iterated through proof of concept
Administrator(s)	• Support the day-to-day operations of the clinic • Cover reception and incoming calls • Supporting processes regarding clinical information e.g. collection from GPs • The number of administrators per clinic depends on the extent to which technology is used by the clinic and patients • Additional tasks TBD during implementation and iterated through proof of concept

3.4 Training and development

Education and training will be at the core of the operating approach, and the service will seek to develop a specific Extensivist training programme for all roles in the team, to support expansion and maintain the pipeline of staff for the service.

For all the staff joining the Extensivist clinic, there is a base level of training they would all benefit from. This will set them up with the skills and the confidence required to treat patients with complex health problems.

Patient facing elements:

• CBT and behavioural support- to be apt at dealing with and understanding patients with mental health issues
• How to support patients with dementia
• End of life planning- including how to handle emotional support
• Patient activation and motivation

Other elements:

• A general understanding of all the main conditions the patient cohort may have- to be in a position to understand their needs and refer effectively within the Extensivist team
• Leadership training – for all staff
• Team working and principles of continuous improvement
• Use of IT systems, including EMIS and home monitoring systems

3.4.1 Specific role qualifications, competencies and training

Role	Competencies, training and qualifications
Extensivist	• Competency- using input and support from specialists to develop specialist type skills in managing diabetes, CHF, COPD, CKD and mental health in target patient group
Advanced	• Qualification- V3000 non-medical prescribing

Practitioner	• Competency- Willingness and motivation for self-development and upskill e.g. if they have not completed the Advanced Practitioner course, a willingness to complete this course or learn some of these skills, especially in specialist type skills in managing diabetes, CHF, COPD, CKD and mental health NB- completion of this course is not a requirement for appointment to this role
Care Coordinator	• Qualification- V3000 non-medical prescribing Specialist qualification in COPD, diabetes, heart failure nursing, or dementia specialist skills • Competency- Willingness and motivation for self-development and upskill to acquire the specialist skills
Well Being Support Worker	• Advocacy training- how best to represent their patients in front of the rest of the Extensivist team, as well as linked and wider services • Competency- Willingness and motivation for self-development and upskill

3.5 Service Activity

The core hours of the Extensivist service are:

Full Service	Monday to Friday 8am – 7pm	See below for definition
Out of Hours	Saturday / Sunday / BHs 9am – 1pm	See below for definition
No extensivist service	All other hours	See below for definition

3.5.1 Full Service

This is when all members of the team are on duty, including senior clinicians such as the Extensivist or the Advanced Practitioners.

5pm until 7pm is popular for elderly patients who are either being transported by working family members or elderly patients whose family members are required for additional information/ input into assessment.

It is felt that by pro-actively managing patients more intensively during core hours there would be less impact on services outside of these times.

3.5.2 Out of Hours

Well Being Support Workers and Care-Coordinators will be available during this time, with clear protocols regarding escalation to wider services where required.

During these hours the clinical care co-ordinator would be the most senior clinician on duty within the team and would be the main point of contact for unwell patients and for co-ordinating the care provided by linked services.

3.5.3 No Extensivist Service

It is felt that the requirement for input from the team overnight would be minimal. The point of contact for unwell patients and linked services would be the FCMS Care Co-ordination service.

For the out of hours period a copy of all care plans for these patients would be made available to FCMS. This care plan would be extensive regarding care requirements and out of hours actions and will be reviewed regularly to ensure current.

A discussion would need to be held with NWAS to discuss the care plans and any specific issues this may cause for the ambulance service as well as agreeing who to deal with out of hours.

3.5.4 Evaluation

A full review of the opening hours will be undertaken as part of the evaluation, including patient and carer views on suitability.

4. Core service design

The Clinical Redesign Team has produced the following flow charts to provide a high level overview of how patients will be referred, assessed, managed and then stepped-down from the service.

4.1 Patient identification, Referral & Enrolment

Figure 1: Patient identification, Referral & Enrolment Flowchart for Extensivist Service

For the purposes of the proof of concept it has been agreed that only the patient cohort's identified through the risk stratification tool will be referred into the service (as outlined in Section 2 which details the proposed referral process once the service is rolled out beyond the proof of concept phase.)

4.1.2 End-state process (different from the proof of concept process)

Patients may come to the service through several routes:

Recruitment channel	Process
GP Referral	• The Extensivist Service's primary source of referrals will be primary care. GPs in the area will be provided with detailed information on the service and how to refer into it. GPs will use their clinical judgement to identify those patients with the greatest needs. • Once a patient is identified and has agreed to a referral into the service, they can be referred to the service wither via an electronic referral form through the EMIS clinical system or with a single phone call direct to the Extensivist clinic. • GP practices will also be provided with assistance to set up internal processes to identify the most appropriate patients for referral e.g. utilising local risk scoring tools.
Secondary Care Admission	• Hospital specialists will be able to refer patients into the Extensivist service (e.g. after an A&E or a non-elective admission) with the consent of the patient's GP. The process for secondary care referrals is illustrated in diagram 1. • To facilitate a smooth referral process through secondary care standing agreements and referral protocols will be set-up with GPs wherever possible.
All Other Services (e.g. Community matrons, district nursing, rehab teams, therapy, etc.)	• Where community service personnel encounter an Extensivist appropriate patient, they inform the patient's GP • The Extensivist team approaches the patient's GP who can 'opt-out' or arrange to obtain initial patient information sharing consent • Upon GP agreement the Patient Engagement and enrolment process is initiated. The process for secondary care referrals is illustrated in diagram 1. • To facilitate a smooth referral process through these service standing agreements and referral protocols will be set-up with GPs wherever possible.

In addition to the above, data-driven approaches will be used to ensure potential patients are not 'missed'. The Extensivist team will use regular data reports to identify appropriate patients who are not currently enrolled. The GPs of these patients will be approached to assess whether the patients should be referred. Each patient's GP will retain the right to not refer the patient in discussion with the Extensivist team.

Following referral, the Extensivist team will use available data (via information sharing across the system) and referral details to evaluate the appropriateness of the referral and respond within 24 hours to confirm whether the patient has been accepted for assessment. The patient engagement and recruitment process will then be initiated by the Extensivist team.

2. Patient Assessment Flowchart
for Extensivist Service
High Level Process Map
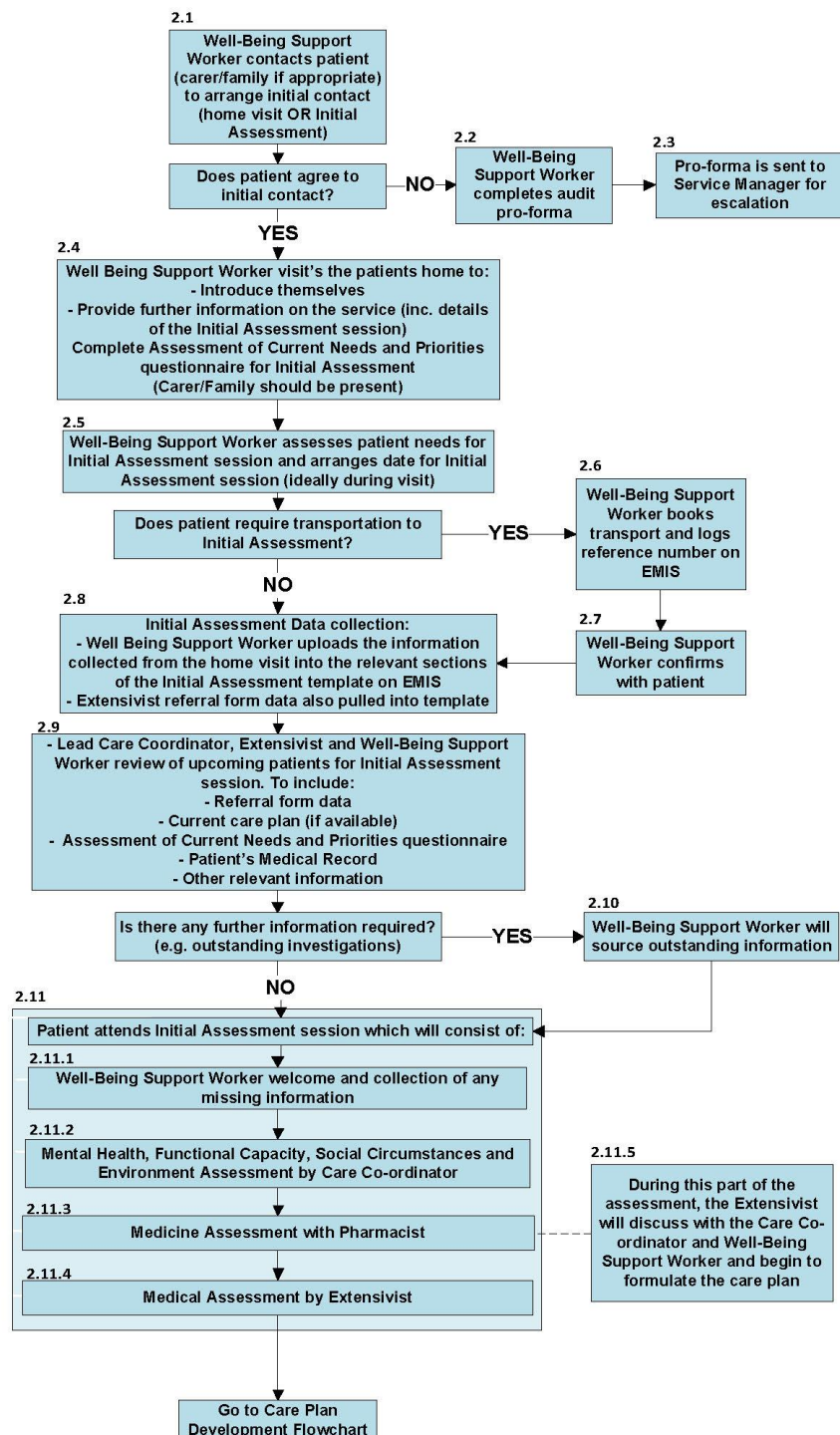
Figure 2: Patient Assessment Flowchart for Extensivist Service

NHS
Blackpool
Clinical Commissioning Group

Blackpool Teaching Hospitals NHS
NHS Foundation Trust

NHS
Fylde and Wyre
Clinical Commissioning Group

Once a patient is accepted for assessment the formal engagement and enrolment process commences after patient consent has been obtained for their information to be shared between healthcare services with the Extensivist Clinic. Patients may opt-out at any point during this process.

The first introduction will be by the Well Being Support Worker who will visit the patient's home and provide further information on the service. The Well Being Support Worker will also collect and record information to be fed into the assessment and care plan development process.

The initial assessment will be done at the Extensivist clinic (where possible). New patients will receive a comprehensive assessment, built on principles developed by the British Geriatric Society and using evidence based cognitive, social and physical assessment tools to ensure that unnecessary and conflicting pre-existing medications and care delivery are removed.

Existing care plans will be reviewed as part of this process. These existing care plans will be superseded by the care plan developed by the Extensivist team and agreed by the patient.

A key element of information gathering will be discussion of the patient's goals and aims. This part of the process will be completed by the Extensivist in order to allow them to use their clinical judgement to support patients in aiming to become as independent as possible.

4.3 Care plan development

3. Care Plan Development Flowchart
for Extensivist Service (High Level Process Map)

3.1
Post – Initial Assessment Session

3.2
Extensivist tasks Well-Being Support Worker/Administrator to book follow-up appointment with patient (inc. transportation if required).
Includes allocating slot in next available MDT Huddle

3.3
Extensivist Team initial opinion is sent to GP through EMIS for information

3.4
Multi-disciplinary Team (MDT) Huddle for New Patients

3.4.1
MDT Huddle for New Patients led by Lead Care Coordinator who decides who to include from:
- Well Being Support Worker
- Extensivist
- Pharmacist
- Social Care
- Relevant Specialists according to patients goals or needs
(In person or via teleconference)

3.4.2
MDT Huddle for New Patients meet to:
- Review the Initial Assessment data
Identify the patients key service requirements inc. condition programmes and other requirements
- Define the delivery mechanism (location, personnel involved, equipment) for each requirement
- Agree the care plan

3.4.3
Administration: Care plan documented by Well Being Support Worker using EMIS Care Plan template. This will include:
- Set objectives
- Broader care activities inc. patient activation
- Key information for personnel needing to view the plan
- Information to help plan and coordinate the patients care delivery
- Monitoring and care delivery activities (inc. frequency and content of ongoing assessments)
- Identify triggers when a patient is in 'crisis' and the intervention required

3.5
Will patient benefit from further input from the Extensivist Service?

NO → Go to Patient Transfer Flowchart

YES

3.6
Lead Care Co-ordinator and Well Being Support Worker meet with patient to discuss progress on top 3 goals and agree the care plan. This will be confirmed with a joint contract being signed by all present. This will include clear guidance on what to do in crisis moments, frequency of contact and goals

3.7
Patient receives a hard copy of their care plan and any follow up appointments are booked (inc. transportation if required)

3.8
The Extensivist will now take over full clinical responsibility for the patient. Their GP will be informed of this.

3.9
Care Plan is uploaded to GP, Secondary Care, NWAS and Ongoing Care Providers systems. Includes alert being built into these systems to flag up whenever patient is in contact with them

Go to Care Plan Delivery Flowchart

Agreed 3rd November 2014 (v1.8)

Figure 3: Care Plan Development Flowchart for Extensivist Service

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The Extensivist team is responsible for planning and coordinating the full range of each patient's care as well as a large proportion of its delivery (dependent on conditions and severity). The care plan development process is therefore undertaken by a multi-disciplinary team, with composition based upon the needs of the patient. The team will include the patient's Well Being Support Worker, Care Coordinator and Extensivist, as well as other health and social care professionals, identified by patient's goals or needs. This team will meet either in-person or via video-conference to review the information collected and agree the care plan.

During the meeting the team will identify the patient's key service requirements incorporating condition programmes and other requirements (e.g. social care) to create a complete picture. The delivery mechanism (location, personnel involved) for each action in the care plan is then defined. This is conducted taking account of the patient's needs, mobility and preferences. Wherever possible care will be delivered in the patient's home. Additionally the team will aim to minimise the number of different personnel involved in each patient's care, they will therefore aim to utilise core team members as much as possible, engaging linked or wider services personnel only as required.

The care plan must then be clearly explained, reviewed, agreed and signed by the patient (and/or any other key stakeholders such as carers) in a care plan discussion meeting before it is enacted.

The care plan covers medical, psychological and social aspects of a patient's health and has very clear instructions for the patient, their carer and other health and social care professionals regarding actions to be taken and services to be accessed under normal circumstances and in times of exacerbation or crisis. The care plan will:

- Provide a tool for the patient and their care team to set objectives and agree the plan
- Include broader care activities such as education (to contribute to patient activation), exercise and social activities
- Provide key patient information for health and social care personnel who need to view it
- Act as a tool to help plan and coordinate all the patient's care delivery
- Define how each element of care will be delivered (e.g. by the core Extensivist team or a linked service)
- Identify the monitoring and care delivery activities that need to be put in place while a patient's health is within agreed 'stable' parameters (including the frequency and content of ongoing assessments)
- Identify the triggers which define when a patient's condition has exacerbated or the patient is in 'crisis' and intervention is required and provide a suitable action plan
- Define protocols for the required intervention for each trigger

4.3.1 Patient consent and enrolment

Once the care plan has been agreed by the patient and following agreement by all parties, the patient is officially enrolled into the Extensivist service and their GP is alerted.

It is at this stage that the Extensivist takes on full clinical responsibility for the patient. Up until this point clinical responsibility will have remained with the GP.

4.4 Care Plan Delivery

4. Care Plan Delivery Flowchart
for Extensivist Service (High Level Process Map)

4.1 Care plan includes the following:
- Set objectives
- Broader care activities inc. patient activation
- Key information for personnel needing to view the plan
- Information to help plan and coordinate the patients care delivery
- Monitoring and care delivery activities (inc. frequency and content of ongoing assessments)
- Identify triggers when a patient is in 'crisis' and the intervention required
- Identify triggers for transfer from the Service

4.2 Patient/Carer/Families

Patient

Family/Carer

4.3 Extensivist Team

Well Being Support Worker | Care Co-ordinator | Advanced Practitioner | Extensivist

4.4 Other care providers

4.5 Linked Services

4.2.1 Will follow Patient Self Management Plan that sets out goals, what the task will involve, frequency and contact details for each.

4.2.2 Will help patient follow Patient Self Management Plan that sets out goals, what the task will involve, frequency and contact details for each.

4.2.3 Agreed Self Monitoring

4.2.4 Will help patient Self Monitoring

4.2.5 Visit the Extensivist clinic to receive care, although other personnel may visit the clinic to deliver care (e.g. therapists) Care may also be provided in the patients home if necessary

4.2.6 - Will help/support any visits to other care locations to if specialist input is required (e.g. Outpatient clinic) and will accompany patient if required.

4.3.1 Work with Care Coordinator to:
- Ensure patient interactions are efficient, convenient and not duplicative
- Track delivery against the plan and making sure delivery activities occur, investigating if they do not
- Escalate any concerns to Care Co-ordinator
- Help organise with patient any visits to other care locations if specialist input is required (e.g. Outpatient clinic) and may accompany patient if identified as a goal.

4.3.2 Work with Well Being Support Worker to:
- Design care plan
- Coordinate delivery of goals
- Escalate deviation of goals
Track outcomes Plan for discharge
- Co-ordinate with linked services
- Contact patient to record any clinical monitoring requirements and then relay the information to the right people at the right time.

4.3.3
- Receive patients with problems, making an assessment of their health care needs.
- Screen patients for disease factors and early signs of illness.
- Make differential diagnoses using decision-making and problem solving skills.
- Order investigations and prove treatment and care both individually, as part of a team, and through referral to other agencies.
- Have a supportive role in helping people to manage and live with illness.
- Have the authority to admit or discharge patients from their caseload, and refer patients to other health care providers as appropriate.
- Work collaboratively with other health care professionals and disciplines.

4.3.4
- Provide input to the initial multi-disciplinary assessment of patients referred to the service, and will work with colleagues to generate a complex care plan.
- On-going medical input
- The medical input will be prompted by the management plan or in response to concerns raised by other members of the team.
- Include patient review and liaison with acute trust staff in the event of patient admission

4.4.1 Care Plan will be viewable by GP, Secondary Care, NWAS and Ongoing Care Providers to allow them to manage and escalate problems should the patient come into contact with them.

4.5.1 Care Plan will be viewable by GP, Secondary Care, NWAS and Ongoing Care Providers to allow them to manage and escalate problems should the patient come into contact with them.

4.6 'Crisis' or deviation from care plan? → YES / NO

YES → Go to Patient in Crisis Flowchart

4.7 Monthly case-note review by Advanced Care Coordinator

Quarterly review by Extensivist with Well Being Support Worker/Care Co-ordinator input

Care plan to be updated? → NO / YES

4.8 Will patient benefit from further input from the Extensivist Service? → YES / NO

4.9 Administration: Care plan updated by Well Being Support Worker (with support from clinicians) using EMIS Care Plan template.

4.10 Patient receives a hard copy of their updated care plan at next contact with Extensivist team member

4.11 Updated Care Plan is uploaded to GP, Secondary Care, NWAS and Ongoing Care Providers systems

Go to Patient Transfer Flowchart

Draft 3rd November 2014 (v1.8)

Figure 4: Care Plan Delivery Flowchart for Extensivist Service

4.4.1   Ongoing care provision

Ongoing care will be driven by regular, planned interactions focussed on delivering a patient's goals and maintaining them in a "stable" or "on plan" state. There will also need to be mechanisms for escalation if a patient experiences a rapid deterioration or crisis

These ongoing "stable" or "on care plan" interactions will be focussed on pro-actively driving dynamic delivery of the patient's goals as set out in their agreed care plan, through four components:

- Patient empowerment: led by the Well Being Support Worker, patients will receive training and support to build the confidence and skills to better manage their own health. This will include signposting to relevant voluntary sector services to assist with their empowerment.
- Care delivery: provision of a proportion of the central elements of care for the patient to make best use of each patient contact e.g. provision of foot checks, COPD physiotherapy etc.
- Monitoring: patient confidence building and care delivery will be underpinned by ongoing monitoring. Well Being Support Workers and care coordinators will be expert in supportively monitoring patients to ensure that goals are met while continuing to build patient confidence in managing their own care
- Care coordination: ensuring that all elements of care required by the patient are in place and operating appropriately, e.g. community nursing and social care support is in place, patient education sessions are booked and attended, that blood tests are carried out etc.

Rapid escalation to resolve issues proactively forms the remainder of ongoing provision, this will be achieved through:

- Daily "huddle" meetings where previous day and same day priorities will be discussed with the extensivist.
- "Swift reaction" time for clinical team members to arrange escalation for patients who may be about to enter crisis
- Weekly MDT Huddle meetings, where the patient's whole core team meet with any specialists (likely by videoconference) to discuss complex cases and agree courses of action in an integrated fashion.

4.4.2 Care coordination

Patients in the Extensivist service receive a range of care services from the Core Extensivist team, care programme teams and through linked and wider services e.g. ensuring that community nursing and social care support is in place, patient education sessions are booked and attended, that blood tests are carried out etc.

One of the key roles of the Extensivist core team is to ensure that these care delivery services are coordinated. This role is fulfilled by the Well Being Support Worker and the Care Coordinator who work as a team for their patients to:

- Use 'Smart' scheduling to ensure patient interactions across providers and settings where necessary are efficient, convenient and not duplicative.

- Track delivery against the plan and make sure planned care delivery activities occur, investigating quickly and correcting if they do not.
- Ensure care provision personnel have all the information they need to do their job effectively
- Try and provide the majority of care for the patient outside of hospital where possible

4.4.3 Care plan delivery

Three major categories of care plan delivery are described in more detail in this section:

1. Delivered in the Extensivist Clinic
2. Delivered elsewhere
3. Delivered in the patient's home

4.4.3.1 Delivered in the Extensivist Clinic

Patients will visit the Extensivist Clinic regularly to receive care. Care activities will mainly be delivered by the Advanced Practitioners and Care Coordinators. These activities will align with the specialities of these personnel which include OT, physiotherapy, nursing, etc. Well Being Support Workers may also be involved in simple care delivery activities where appropriate.

Where necessary or possible other personnel may visit the Extensivist Clinic to deliver care and education to Extensivist patients. For example, a specialist may conduct a session in the clinic to provide specialist input for a number of Extensivist patients.

4.4.3.2 Delivered elsewhere

Where necessary patients may visit other locations. For example, if the demand for specialist input is too low to justify a session in the Extensivist Clinic, patients may see the specialist in an outpatient clinic, potentially accompanied by their Well Being Support Worker (if consent is received) either in person or via video conferencing.

4.4.3.3 Delivered in the patient's home

Where necessary, care will be delivered in a patient's home. Where possible this will be delivered by Extensivist core team members at the same time as other activities (e.g. monitoring). Where necessary other personnel will be engaged via linked and wider services (e.g. Community nursing).

4.4.4 Monitoring & Coaching

The first aim of the monitoring activity is to ensure the Extensivist Team keeps track of patient goals and objectives so they can be adjusted and updated as required. The second aim is to ensure the Team stays up-to-date with developments and new information so that they can:

- Meet a patient's needs more effectively.
- Identify emerging factors that could negatively impact upon a 'stable' patient's health outlook, intervening as necessary.
- Detect deterioration and instigate appropriate action.

- Monitor the patient's progress versus the care plan objectives.
- Identify when patients should step-down from the Extensivist service.

The second category of monitoring will focus on physical, psychological and social 'triggers'. These are pre-defined events or criteria / thresholds (e.g. HbA1c levels) which indicate attention or intervention is required. Triggers to be monitored may include:

- Non-compliance with treatment / care plan (e.g. 2 non-compliance events in 1 week)
- A change in social circumstances (e.g. a carer falls ill)
- A non-elective admission/999 call/A&E attendance
- A prompt for medication or to attend appointments outside of the patient's care plan

For each patient the care plan will define the trigger events, thresholds and associated interventions (e.g. a 1kg weight gain in 2 days in a heart failure patient triggers a medication review or discussion by the Extensivist team). Wherever possible a graduated response will be used so that triggers are referred to and dealt with by the Well Being Support Worker (particularly where a pre-defined protocol exists). Where the care plan does not include a protocol Care Coordinator or Extensivist opinion is more likely to be required. Over time, it is expected that the service will 'learn', improving and adding to the pre-defined protocols.

Monitoring activities fall into 3 major categories, each described in more detail in this section.

1. Information collected alongside care delivery activities
2. Actively contacting the patient
3. Patients contacting the Extensivist clinic

4.4.4.1 Information collected alongside care delivery activities

- Patients will be interacting with a number of care providers
- Personnel interacting with the patient will be asked to collect key information for the Extensivist clinic, the Well Being Support Worker will coordinate this activity
- Telemonitoring can be used as a source of passive information collection from the patient

4.4.4.2 Actively contacting and coaching the patient

- The objective of this activity is to supplement the above as necessary to ensure the Extensivist team remains up-to-date with the patient's wellbeing
- The Care Plan will specify the amount of contact needed to stay up-to-date
- The Well Being Support Worker will lead on this as main point of contact and may use telephone as well as in-person contact

4.4.4.3 Patients contacting the Extensivist clinic

- It is important patients can contact the clinic easily whenever they have concerns
- The first point of contact will be the patient's Well Being Support Worker
- Telemonitoring can send alerts to the Extensivist team without patient input e.g. if they have not gone to bed yet, if their blood pressure is too high/ too low etc.

4.4.5 Huddle

Two types of 'Huddles' will exist within the Extensivist service:

- Daily 'Huddle' is a meeting of the core Extensivist team held every day in the Extensivist clinic. The purpose of the Huddle is to discuss previous day and same day priorities with the Extensivist with emerging issues actioned in a timely fashion enabling the team to intervene effectively. It is important to note that, in urgent situations, patients may be discussed outside the Huddle to avoid any delays – the Huddle is intended as an enabler of rapid action and must not be a barrier to this.
- Weekly MDT Huddles are larger meetings which will discuss ongoing patient related priorities, new patients requiring care plans to be finalised and patients suitable for 'step down' from the service. The patient's whole core team will meet with any specialists (likely by videoconference) to discuss complex cases and agree courses of action in an integrated fashion.
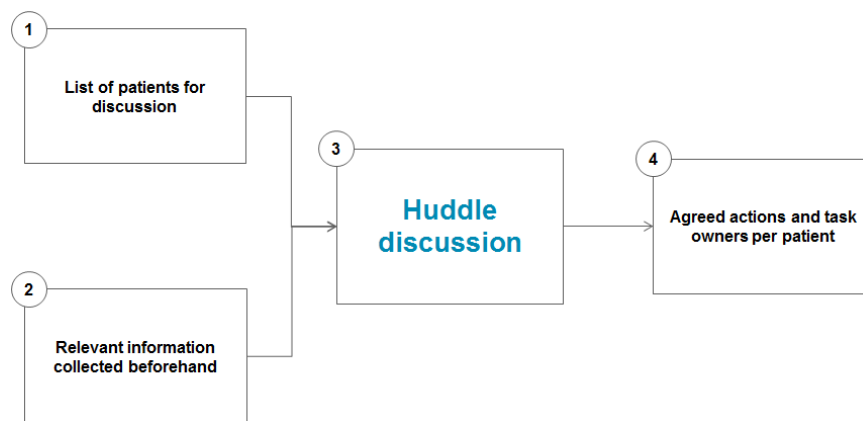
4.4.5.1. List of patients for discussion

Patients are selected for discussion by members of the core team based upon monitoring activities (usually the Well Being Support Worker). If a trigger is detected or attention is required for an alternative issue the patient can be added to the Huddle agenda for the next morning.

4.4.5.2. Relevant information collected beforehand

The Well Being Support Worker for each patient to be discussed will collect the information required for the Huddle, this will include:

1. The Patient's current care plan

2. Details of the issue or trigger

3. Other new information (e.g. specialist input)

4. Recommended actions (developed in collaboration with the Care Coordinator or others)

This information is collected in a timely fashion so that it can be shared live during the meeting.

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4.4.5.3. Huddle discussion

The meeting will need to be highly action orientated and efficient. A chair-person will be nominated for each Huddle and will be charged with ensuring the meeting runs efficiently and to time.

The Huddle will be conducted in a meeting room with audio-visual and conferencing equipment enabling personnel to view information in-person, or remotely if necessary. The IT system must also support efficient real-time note taking and virtual attendance. The attendees at the Huddle will be:

- Extensivist
- Advanced Practitioners
- Care Coordinators (for relevant patients)
- Well Being Support Workers (for relevant patients) updates record/ records actions

The team will work through each patient on the agenda assessing the information, agreeing the actions and assigning ownership. It is expected that most patient discussions will take 1-2 minutes, with more complex cases taking 3+ minutes.
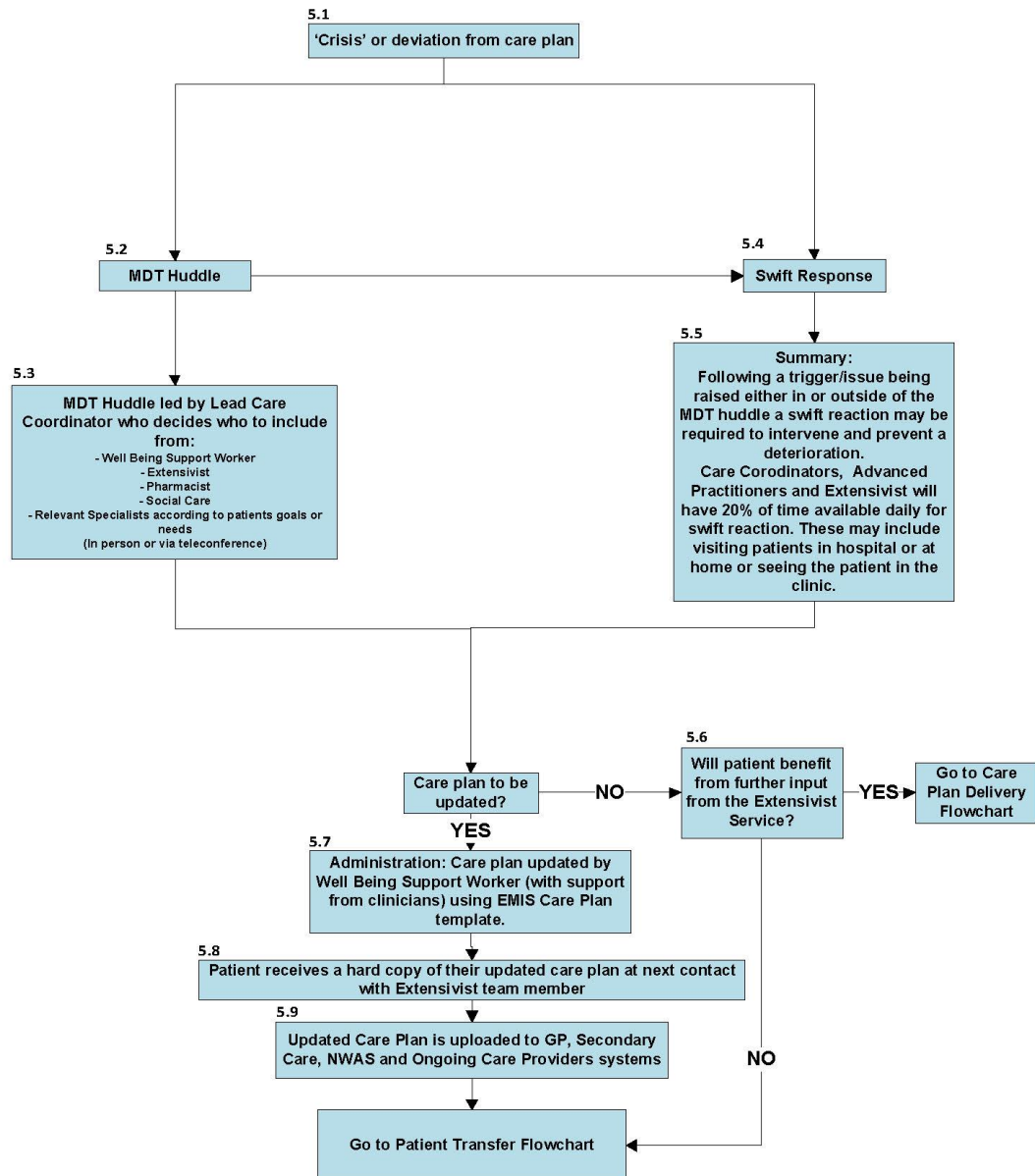
4.4.5.4. Agreed actions and task owners per patient

Clear responsibilities for actions will be defined during the Huddle. Following the meeting, the patient's Well Being Support Worker will ensure all actions are carried out as agreed.

Actions may include rapid intervention, making use of core Extensivist personnel's dedicated "Swift reaction" time (see the Swift reaction section). Additionally, as a less immediate action, the patient's care plan may need adjustment. In this case, the patient is passed on for multi-disciplinary discussion and care plan adjustment (see the Care plan adjustment section)

4.5 Patient in Crisis

Figure 5: Patient in Crisis Flowchart for Extensivist Service

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Clinical Commissioning Group

Blackpool Teaching Hospitals NHS
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NHS
Fylde and Wyre
Clinical Commissioning Group

Following a trigger / issue being identified or a Huddle (Note: a Huddle is not required to launch a swift reaction), a swift reaction may be required to intervene and prevent further patient deterioration or an unplanned event. To ensure the Extensivist team can respond quickly in these situations, the Care Coordinators, Advanced Practitioners and Extensivist will have time allocated every day for 'Swift reaction'.

Initially it is estimated that 20% of personnel time will be allocated to 'Swift reaction', this will be adjusted in response to learnings from the proof of concept. This time will be kept available until the beginning of each day and will be scheduled with interventions which arise during the morning Huddle and throughout the rest of the day. These may include (not exhaustive):

- Visiting Extensivist patients in hospital to be involved in treatment decisions and discharge planning
- Visiting Extensivist patients at home to deliver urgent care

Following a Swift reaction intervention, the patient either:

- Returns to the 'on care plan' status

- Requires further action, approved by an appropriate member of the Extensivist team

- Is put on the huddle list for the next morning to define next steps

- Requires a care plan adjustment- likely in most cases

Note: In the case where patients have had an unplanned hospital admission staff will in-reach and rapidly deliver changes to the care plan to allow the patient to come home more quickly, while ensuring that their care is appropriate for any change in their situation
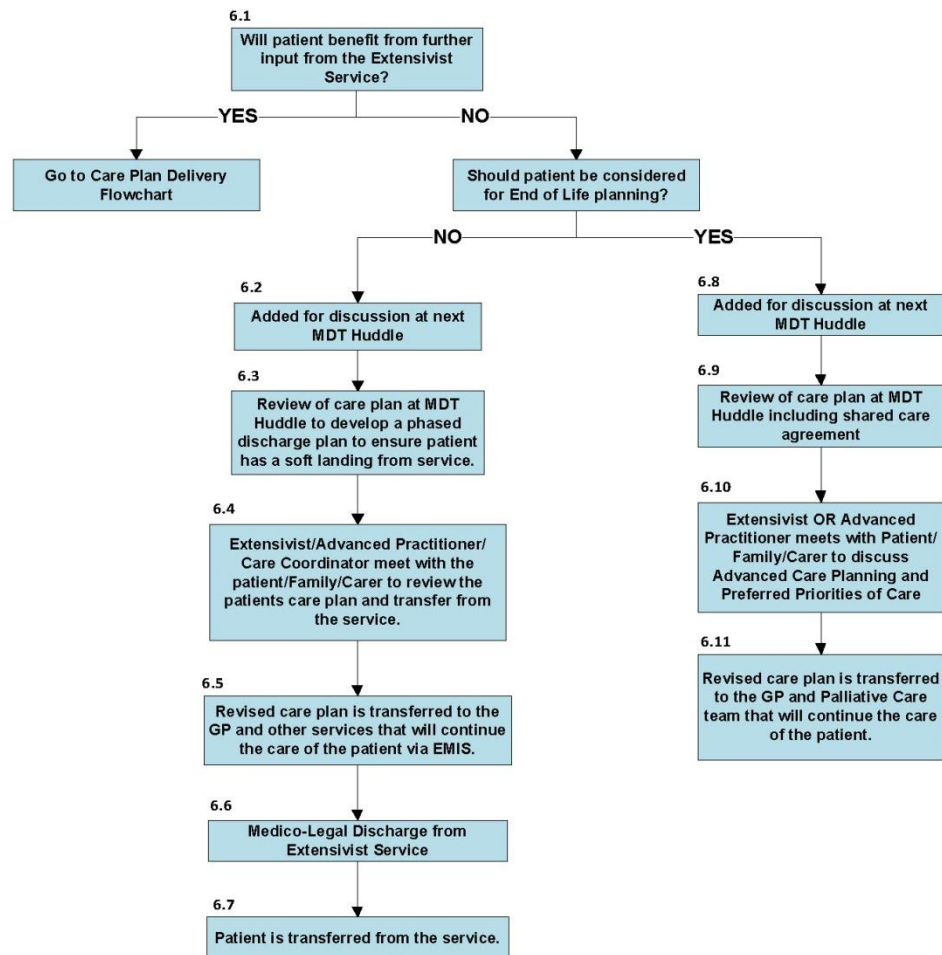
4.5.1 Care plan review and adjustment

Following a Huddle or other event a patient may be referred for Care plan review and adjustment. In this situation a process similar to the original care plan development process is conducted. The Well Being Support Worker collects the updated information; a multi-disciplinary team is then convened and develops an updated care plan which is then discussed and agreed with the patient.

A patient's care plan may also require changes when a goal or objective needs adjustment. In this case a more simple process led by the Well Being Support Worker is completed in collaboration with the patient and any other relevant personnel.

6. Patient Transfer Flowchart
for Extensivist Service (High Level Process Map)

6.1
Will patient benefit from further input from the Extensivist Service?

— **YES** → Go to Care Plan Delivery Flowchart

— **NO** → Should patient be considered for End of Life planning?

NO branch:

6.2 Added for discussion at next MDT Huddle

6.3 Review of care plan at MDT Huddle to develop a phased discharge plan to ensure patient has a soft landing from service.

6.4 Extensivist/Advanced Practitioner/ Care Coordinator meet with the patient/Family/Carer to review the patients care plan and transfer from the service.

6.5 Revised care plan is transferred to the GP and other services that will continue the care of the patient via EMIS.

6.6 Medico-Legal Discharge from Extensivist Service

6.7 Patient is transferred from the service.

YES branch:

6.8 Added for discussion at next MDT Huddle

6.9 Review of care plan at MDT Huddle including shared care agreement

6.10 Extensivist OR Advanced Practitioner meets with Patient/ Family/Carer to discuss Advanced Care Planning and Preferred Priorities of Care

6.11 Revised care plan is transferred to the GP and Palliative Care team that will continue the care of the patient.

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Figure 6: Patient Transfer Flowchart for Extensivist Service

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Blackpool Teaching Hospitals
NHS Foundation Trust

Fylde and Wyre
Clinical Commissioning Group

The aim of the Extensivist team is to help each patient reach a point where they no longer need the intensive support provided by the Extensivist service. As a patient's health stabilises and improves, their Well Being Support Worker, Care Coordinator and Extensivist will monitor the patient and determine whether they still require the Extensivist Service. This is not as simple as when the patient has achieved all their objectives as the patient may still benefit ongoing higher level care. If it is decided the patient can be transferred out, the extensivist will meet to develop a phased transfer plan. The aim of this process is to ensure the patient has a 'Soft landing' when they leave the service. The development process will include detailed discussions with the patient (and carer if appropriate) and their GP to ensure their care plan is transitioned smoothly. The GP will be consulted on the discharge plan, probably by a phone call, and when the plan is agreed the GP will be notified when the patient has been transferred out of the Extensivist Service and returned to their care.

Patients entering End of life care will have a different transition. Please see the End-of-life care programme section for details (section 5.7)

4.6.1 Agreed Exit Criteria

The Clinical Redesign Team is keen to ensure that the extensivist service has well-defined exit criteria in order to ensure that the service is providing appropriate levels of support to those patients who can benefit from being enrolled with the service, and in order to maintain a manageable number of patients at any given time.

Having considered the success criteria of the extensivist service, the Clinical Redesign Team agreed the following exit criteria:

1	**End of Life Care**	
a	End of Life Care	The anticipatory care plan is at EoLC stage and all tasks can be effectively completed within primary care. It is anticipated that this will be c.25% attrition rate in a 12-month period.
2	**Patients who are making successful progress within the extensivist service**	
a	Goal achievement	The patient is demonstrating consistent achievement (across a 3-month period) of the goals identified in their care plan.
b	Risk of admission	The patient's risk of admission within the next 12-months falls below that defined in the referral criteria. Given that the patient's age will increase, and their LTC will not be removed, the driving factors in reducing the risk score will be: - A reduction in 999 calls Likely to be influenced - A reduction in A&E attendances Likely to be influenced - A reduction in NEL admissions Likely to be influenced - A reduction in OPD activity May be influenced - A reduction in EL activity Unlikely to be influenced
c	Required level of input	The patient can be effectively supported by one or more services outside the extensivist service.
3	**Patients who are NOT making successful progress within the extensivist service**	

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a	Goal achievement	The patient is NOT demonstrating consistent achievement (across a 3-month period) of the goals identified in their care plan.
4	**Relocation of patients**	
a	GP practice register	The patient leaves the practice register of GP practices assigned to the extensivist service.
5	**Patient / carer choice**	
a	Patient / carer choice	The patient and/or their carer selects to opt out of the service.

5. Care programmes (6 common LTCs, Dementia and End of Life Care)

5.1 Care programmes – common elements and overview

The purpose of the Extensivist service is to deliver and coordinate individualised holistic care for complex patients. In order to achieve this and deliver the best care for each specific LTC the patient lives with, the Extensivist service will develop individualised care plans for patients that draw on a number of core programmes for the most common co-conditions. These programmes will differ from single condition programmes provided in EPC models because they will be specifically designed for the individual mix of co-morbidities and wider needs of each patient.

The core principles upon which the care programmes are all built:

- Care will be wrapped around the patient at all times – driven by the Extensivist team as the core coordinating service providing this holistic whole person care service
- The Extensivist team will provide the ongoing care through a core general skillset within the team (provided by the clinical care coordinators, advanced practitioner and Extensivist) – this will prevent patients being "referred out" to specialist services and reduce the risk of their care being fragmented again
- Specialist input will be essential in managing the most complex patients, and in identifying the most appropriate therapies and treatment ceilings in these cases. The relationship between the Extensivist specialists will be as "teammates" in delivering the best possible care plan for patients, overall decision making will sit with the Extensivist team but they may invite the specialist to care planning "MDTs" to deliver the best plan. Part of this relationship will involve training and development for the Extensivist team staff – so that they develop their understanding of what is possible for each condition and increase the range of skills in their "core" skillset allowing specialists more time to manage higher acuity/less stable patients
- Certain conditions will require interventions and management that need specific skillsets (e.g. vascular intervention for foot problems) that can only be provided by specialist staff. A key role of the Extensivist and Advanced Practitioner is in identifying the point to refer for specialist input – to ensure that patients receive the best possible treatment available for their conditions. These referrals will be managed as per the core elective intervention process [see section 6.1].
- A final central offering to patients is lifestyle support and management – this will be essential for all condition programmes and the offering will be consistent for all programmes. Disease education will also be offered alongside this and this will be specific to each condition

**Extensivist team
Condition
programme elements**

Disease
education

MDT Care
planning

Patient

"Huddle"
Proactive care

Lifestyle
support

Swift response
clinics

Ongoing visits
and care

**Specialist input to
care planning**

- Referral criteria developed to
  identify when specialist input is
  required for care planning
- Visits to specialists will be
  coordinated by the care
  coordinator and may be at clinics
  provided in the Extensivist site
- Opinion sought in relation to
  decision to intervene, e.g. device
  therapy for CHF

**Specialist
care**

**Emergency care
(linked service)**

- Emergency care available as a
  linked service in cases where
  there is imminent threat to life

- Note: some services may
  be of high enough volume
  to be brought in to the
  Extensivist team, e.g.
  wound care

**Specialist support
for complex cases**

- Specialist staff may support ongoing
  management if the patient requires,
  e.g. complex insulin regimes
- Support often "virtual" in the form of
  advice to the Extensivist team
- Specialist interventions provided by
  external staff if Extensivist agrees as
  part of the care plan

This section could be read as a series of "single disease" models of care, but it is not intended to be that way. The core principles are built to achieve a model that provides "whole person" care while delivering the specific needs of individual conditions. In this sense the condition programmes could be thought of as a set of protocols for the most common conditions managed by the Extensivist team.

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Programme element	Diabetes	Cardiac Conditions (CHF, CAD, AF)	Chronic Kidney Disease (CKD) and ESRD	COPD	Dementia	End of life
Enrolment	Pre-existing diagnosis automatically enrolled – all patients have severity and stability defined on entry to service					Through core Extensivist process – ongoing visits to monitor and identify point at which to discuss
	Glucose testing for all patients on first enrolment to Extensivist service then annually	CHF - All patients screened for relevant symptoms/signs and if heart indicated offered blood test for measurement of BNP.	Pre-existing diagnosis as CKD stage 3 or higher, and renal function test on enrolment	TBD	Initial screening to be completed in the Extensivist clinic	
Care planning	Extensivist to drive care planning through standard processes and only request specialist input if criteria are met All care plans have the aim of achieving or maintaining stability of the given condition Referral criteria: TBD, but will take account of NICE guidance etc.					Care planning, advanced care planning and ceilings of treatment – core process
Lifestyle management	Provision of programmes for smoking cessation, diet and exercise Patients to participate actively in these programmes					Information and education, discussion of priorities
Ongoing monitoring	Core patient monitoring for all conditions: BP, Renal Function, Respiratory, mood, mobility plus: TBD Less frequent care: vaccinations, medications review					• Review of symptoms • Medication optimisation • Additional support (voluntary sector) • Psychological support • Spiritual support
	• Glucose, HbA1c • Insulin management • Foot checks • Eye checks • Liver function • Specialist input to complex insulin regimes	CHF - Three core elements: • Weight monitoring • Blood pressure monitoring • specific symptom monitoring	• Blood pressure • Urinalysis and MSU • Serum creatinine and eGFR • FBD and electrolytes and lipids and glucose Cognitive impairment- monitored	Regular checks and tests: •Peak Flows •BP •ABGs TBC	•Guidance and assistance from appropriately trained individual on a regular basis •Personnel trained in behaviour management	
Timely escalation	Ability to access emergency care, out of hours care as per linked services processes					

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	• Insulin initiation and dose changes • Medication • Foot problem resolution and intervention • Wound care • Escalation to vascular and eyes specialists (referral criteria TBD)	CHF - As condition changes in level of severity consideration of adjustments in: •Monitoring strategies •Medical therapy •Consideration of surgical interventions	• Fluid overload, metabolic bone disease and acidosis • Anaemia • Depression • Falls and fractures • Cognitive impairment Escalation to specialist: criteria TBD	For unstable patients or patients with recognised disease progression additional care will need to be provided: •NMPs •Uptitration •Sx control •Consideration for intervention	Escalation to specialist clinician for individuals with highly complex needs	• Preferred priorities of care discussed • End of life care at home (through DNs) • Referral to specialist/ hospice: criteria TBD

5.2 Care programme: Diabetes

5.2.1 Agreed Local Pathway for Extensivist Service (based on National Map of Medicine Pathway)
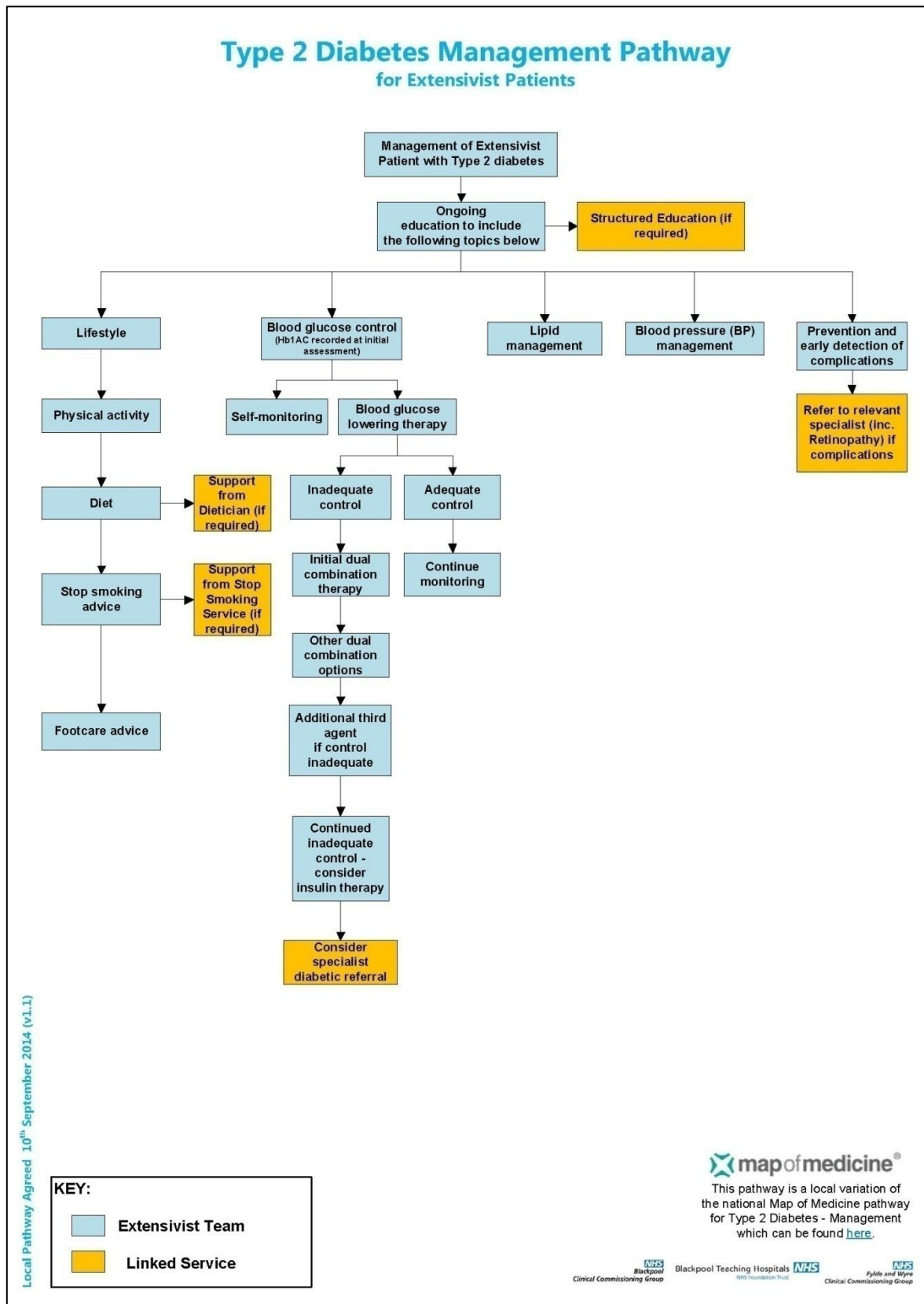
Figure 7: Local Diabetes Pathway for Extensivist Service

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5.2.2 Specific care programme components

The specific components of the diabetes condition programme are set out in the table below. The core principles and approach to managing the condition with the patient will be in line with that described in the introduction to the condition programmes section [section 4.1].

Programme element:	Provided by:		
	Patient	**Extensivist team**	**Specialist input**
Enrolment		• Pre-existing diagnosis • Fasting glucose, and glucose tolerance test on enrolment to Extensivist then every 12 months	
Care planning	• Partner in developing care plan	• Led by Extensivist through MDT	• Referral criteria for specialist opinion: <mark>TBC</mark>
Lifestyle management	• Participate in lifestyle management, including smoking cessation, diet and exercise	• Provision of programmes for smoking cessation, diet and exercise	•
Ongoing monitoring and checks	• Disease education programme • Blood sugar testing • Blood pressure testing • Feet sensation monitoring	Regular checks and tests: • HBA1c • Foot care/ foot assessment • FBC • Fasting lipids • Fasting sugar Insulin maintenance • Renal function • Liver function tests • Urinary dip Annual/less frequent: • Medication review • Vaccinations (including flu jab)	• Support with complex insulin regimes as defined in care plan
Timely escalation and intervention		• Insulin initiation and dose changes • Medication • Foot problem resolution and intervention • Wound care e.g. leg ulcers	• Referral criteria for specialist input at this stage: <mark>TBC</mark> Note: referrals to cover both • Vascular • Eyes

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5.3 Care Programme: Cardiac Conditions (CHF, CAD, AF)

5.3.1 Agreed Local Pathway for Cardiac Conditions (CHF, CAD, AF) for Extensivist Service
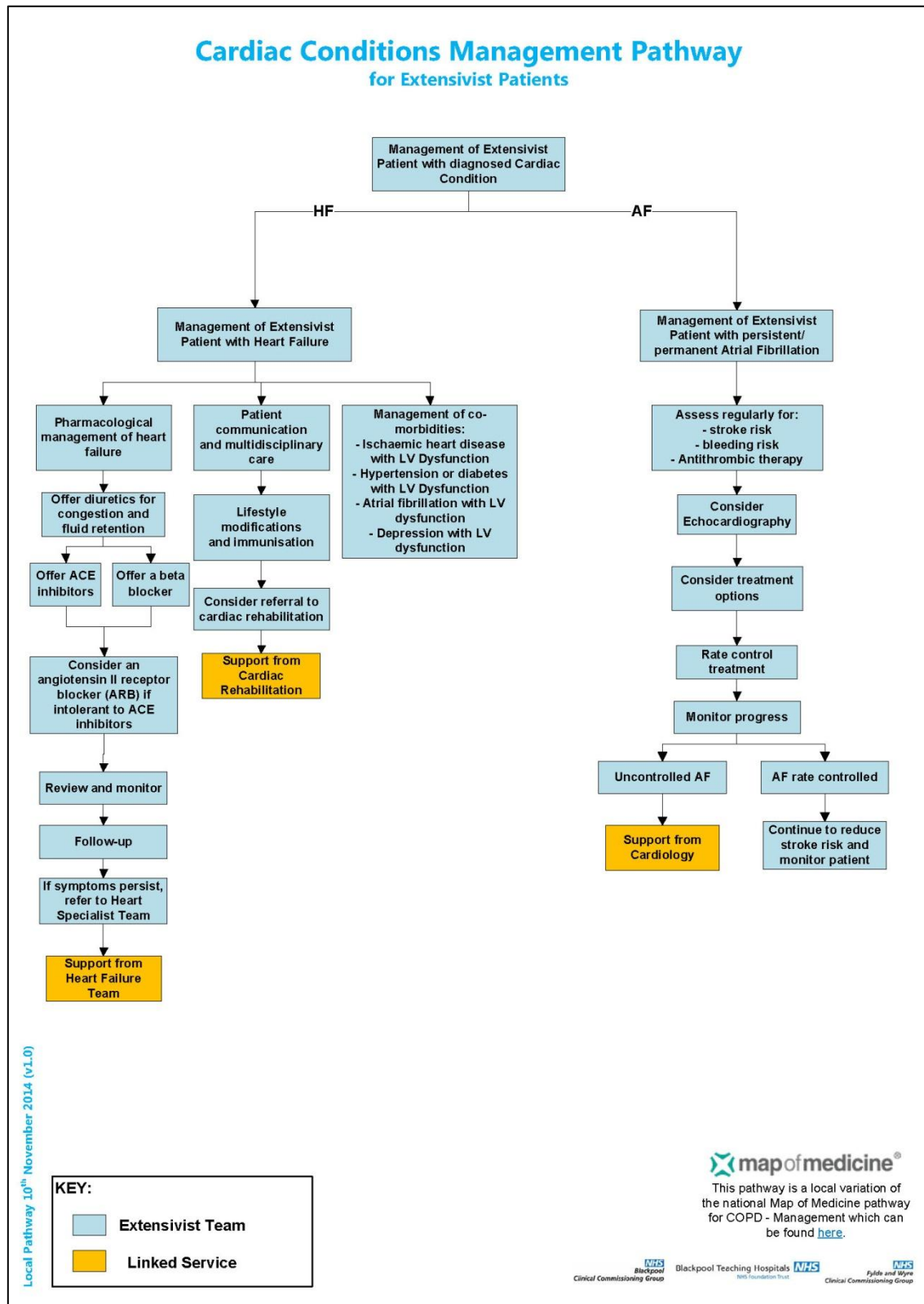**(based on National Map of Medicine Pathway)**

Figure 8: Local Cardiac Conditions (CHF, CAD, HF) Pathway for Extensivist Service

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5.3.4 Specific care programme components

The specific components of the CHF condition programme are set out in the table below. The core principles and approach to managing the patient will be in line with that described in the introduction to the condition programmes section [section 4.1].

Extensivist patients with CHF will benefit from

1) Early, accurate diagnosis, with detailed condition specific care plan

2) Condition specific education and surveillance strategies, delivered by the Extensivist team Well Being coach in line with the care plan, supporting improved patient engagement, stability and early recognition of change in condition.

3) Immediate access to specialist CHF teams in response to triggers identified in care plan or unexpected events requiring specialist assessment.

Programme element:	Provided by:		
	Patient	Extensivist team	Specialist input
Enrolment		• Pre-existing diagnosis • Upon enrolment all patients will be screened for relevant symptoms/signs and if heart indicated offered blood test for measurement of BNP. The result will trigger referral to rapid access heart failure diagnostic clinic (HFDC) according to the NICE 2010 guideline	
Care planning	• Partner in developing care plan	• Led by Extensivist through an ongoing 'care planning escalation process'	• Referral criteria for specialist opinion: TBC
Lifestyle management	• Participate in lifestyle management, including smoking cessation, diet and exercise	• Provision of training programme for management of CHF • Provision of programmes for smoking cessation, diet and exercise	
Ongoing monitoring and checks	• Weight gain • BP • Ability to lie flat overnight • Simple list of other symptoms to prompt reporting	Three core elements: 1) Weight monitoring 2) Blood pressure monitoring 3) specific symptom monitoring Regular check-ups at Clinic: • patient condition review (to include pulse check +/_ECG, renal function, medication monitoring and review, and confirmation of progress against the care plan) • The frequency of each check will be set through protocols developed by the CHF team	• Support with complex care regimes as defined in care plan • In certain cases specialist interventions will be required. These will be agreed by the Extensivist with specialist input and then scheduled as an elective procedure and carried out in line with the "specialist intervention" wider services protocols found in section 5.8

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	and implemented through the care plan	35
Timely escalation and intervention	As condition changes in level of severity consideration of adjustments in: • Monitoring strategies • Medical therapy • Consideration of surgical interventions • The clinical care coordinators carrying out reviews will be skilled in the management of multiple conditions and able to understand the interactions between CHF and other common comorbidities, particularly COPD.	• Referral criteria for specialist input at this stage: <mark>TBC</mark> • CHF specialist nurses will provide input and support in these cases, including reviewing complex patients

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5.4 Care Programme: Chronic Kidney Disease (CKD) and End Stage Renal Disease (ESRD)

5.4.1 Agreed Local Pathway for Chronic Kidney Disease (CKD) for Extensivist Service (based on National Map of Medicine Pathway)
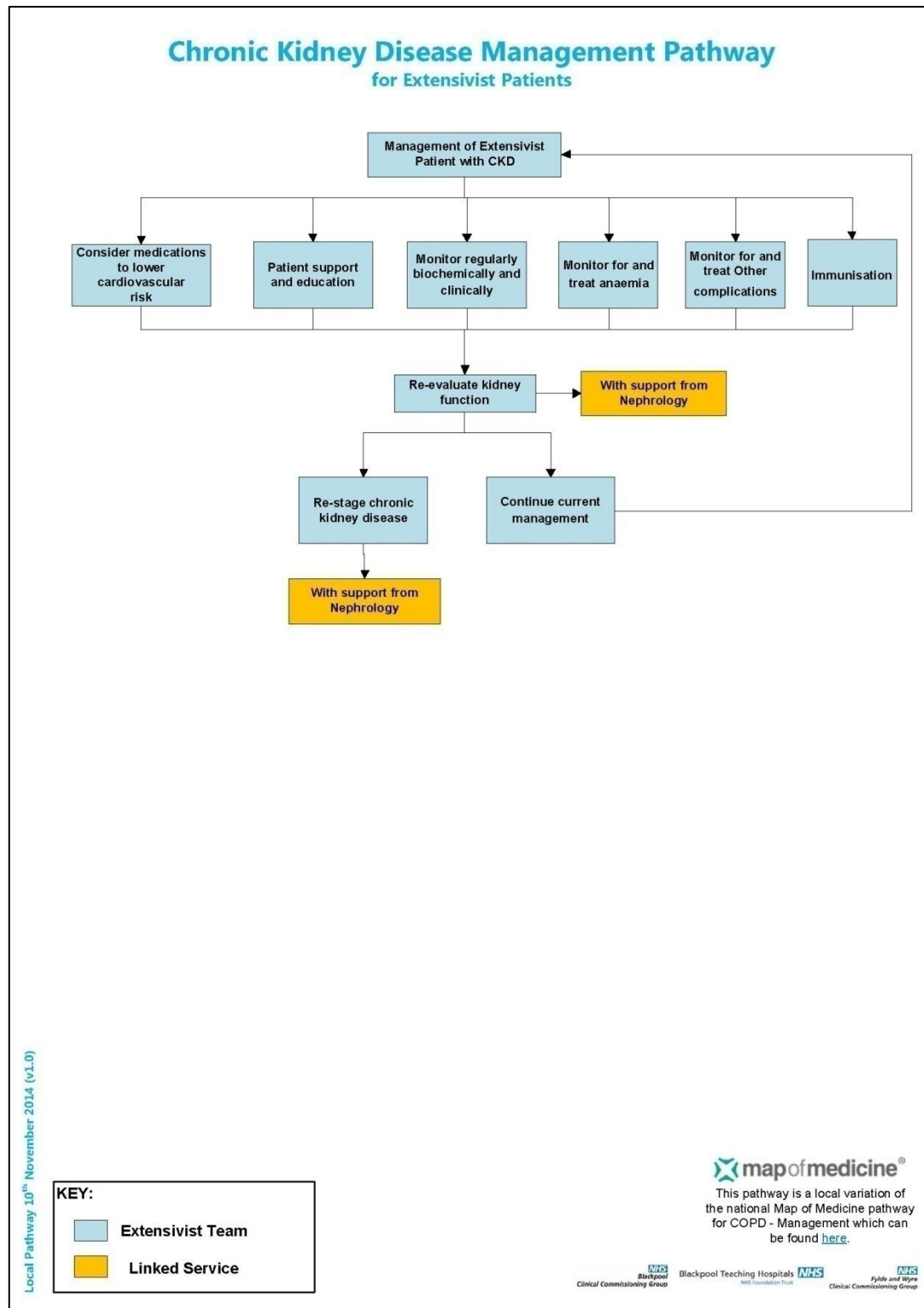

Figure 9: Local CKD Pathway for Extensivist Service

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5.4.2 Specific Care Programme Components

The specific components of the CKD programme are set out in the table below. The core principles and approach to managing the patient will be in line with that described in the introduction to the condition programmes section [section 4.1].

Programme element:	Provided by:		
	Patient	**Extensivist team**	**Specialist input**
Enrolment		• Pre-existing diagnosis of CKD Stage 3 or higher • Renal function testing on enrolment (serum creatinine, eGFR and proteinuria)	
Care planning	• Partner in developing care plan	• Led by Extensivist either as part of enrolment or through an ongoing care planning escalation process (when patient reaches CKD stage 4 or 5) • Will need to include consideration of common complexities in management of CKD patients	• Referral criteria for specialist opinion: CKD Stage 4 or 5: criteria TBD
Lifestyle management	• Participate in lifestyle management, including attending group classes on: Management of co-morbidities, diet and exercise programmes	• Provision of programmes for managing co-morbidities, diet and exercise	
Ongoing monitoring and checks	Monitoring of the following with support from Well Being coach • Mobility • Cognitive impairment- monitored by family/ carers • Mood	Regular checks and tests: • Blood pressure • Urinalysis and MSU • Serum creatinine and eGFR • FBD and electrolytes and lipids and glucose • Frequency of checks depends on patient situation and presence of risk factors e.g. diabetes Annual/ less frequent: • Renal function testing in annual check up	• Referral criteria for care planning input and support with decision to initiate dialysis: TBD • Referral criteria for Support with complex medications TBD • Provision of dialysis
Timely escalation and intervention		• Fluid overload, metabolic bone disease and acidosis • Anaemia • Depression • Falls and fractures • Cognitive impairment- can be wrongly attributed to ageing instead of CKD	• Referral criteria for specialist input is subject to disease progression and when increased stages of CKD are entered into, criteria: TBD

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5.5. Care Programme: Chronic Obstructive Pulmonary Disease (COPD)

5.5.1 Agreed Local Pathway for Chronic Obstructive Pulmonary Disease (COPD) for Extensivist Service (based on National Map of Medicine Pathway)
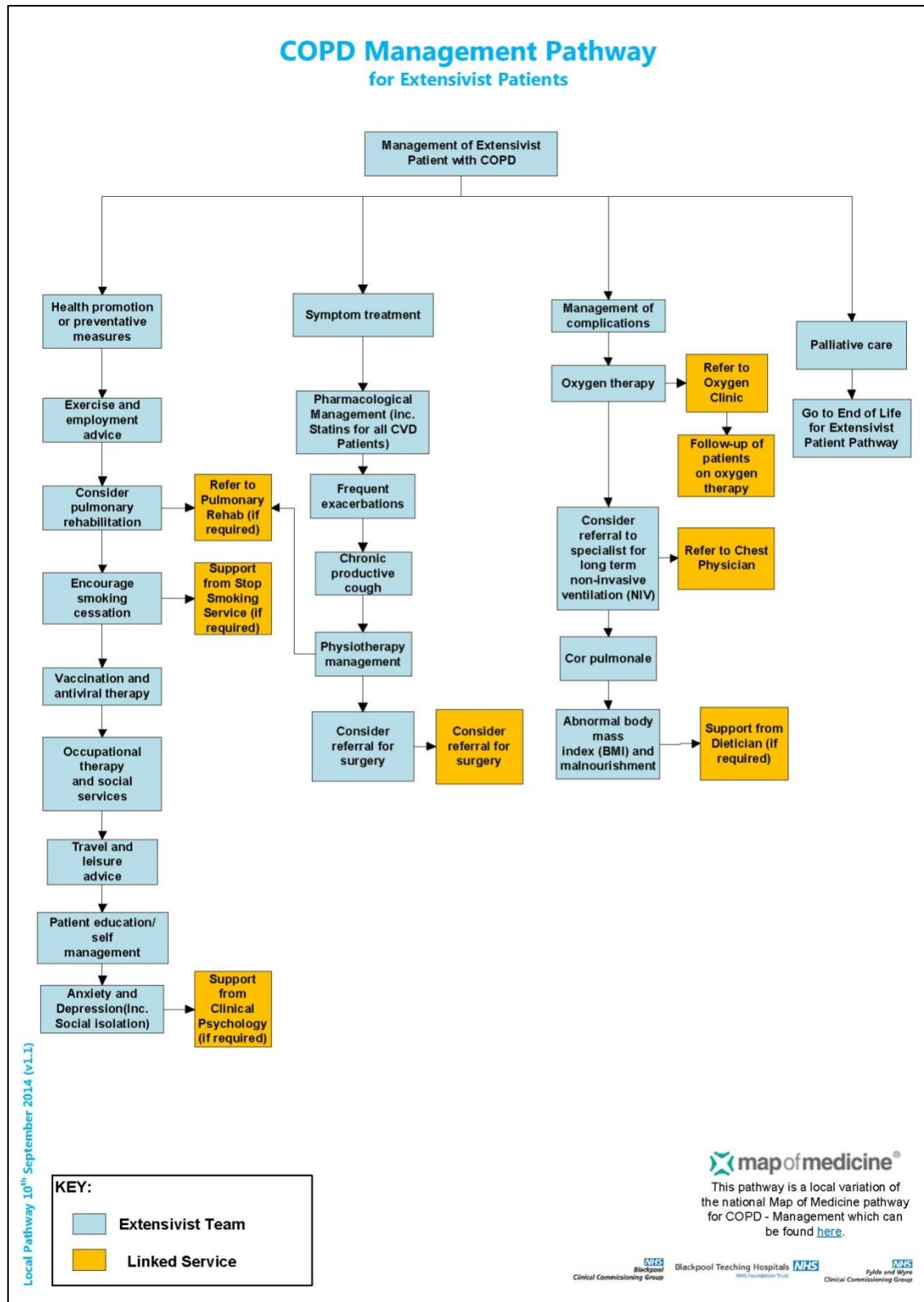

Figure 10: Local COPD Pathway for Extensivist Service

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5.5.2 Specific Care Programme components

The specific components of the COPD programme are set out in the table below. The core principles and approach to managing the patient will be in line with that described in the introduction to the condition programmes section [section 4.1].

Programme element:	Provided by:		
	Patient	**Extensivist team**	**Specialist input**
Enrolment		• ???	
Disease education	• Patients as advocates/mentors	• Well being Support Worker	• Community/third sector resources
Lifestyle management	• Participate in lifestyle management, including attending group classes on: Management of co-morbidities, diet and exercise programmes	• Provision of programmes for managing co-morbidities, diet and exercise	
Regular ongoing self-monitoring of disease control	• Patients provided with equipment/ technology to self-monitor and report readings to the clinic – peak flow meters	Regular checks and tests: • Peak Flows • BP • ABGs TBC Annual/ less frequent: • ??? For patients where telemonitoring is not a suitable / preferred approach regular monitoring will be carried out by the care team (Nurse with specialist skills)	
Regular check-ups		• Nurses with specialist skills • Check progress against care plan • Identify any need for change in plan, e.g. deterioration requiring titration of inhalers, steroids and prescription of antibiotics • Confirm patient understanding of self-monitoring	• Referral criteria for specialist input is subject to disease progression and when exacerbations of COPD
Well-being, lifestyle and behaviour change support	• Patients provided with equipment/ technology to support behaviour change	• Assessment and advice for well-being, lifestyle and behaviour, incl: • Diet • Exercise • Smoking • Depression • Medication effectiveness monitoring	

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| Timely escalation and intervention | Advanced Practitioner Extensivist Triggered by changes in patient state and/or increased care utilisation e.g. A&E visits, non-elective admissions For unstable patients or patients with recognised disease progression additional care will need to be provided: NMPs Uptitration Sx control Consideration for intervention | • Referral to specialists i.e. Respiratory Physician or COPD Nurses if req. |

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5.6 Care programme: Dementia

5.6.1 Agreed Local Pathway for Dementia for Extensivist Service
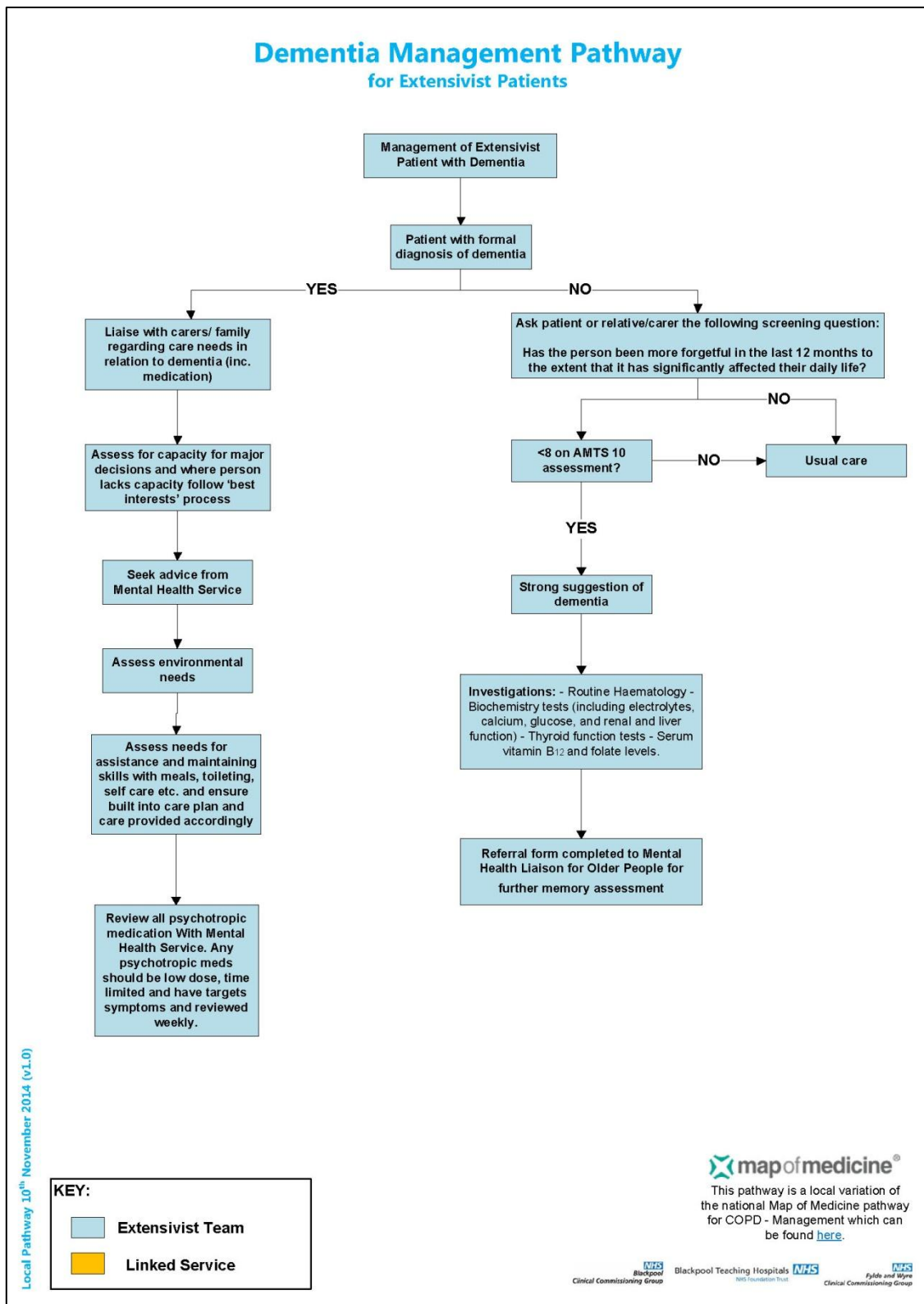
Figure 11: Local Dementia Pathway for Extensivist Service

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5.6.2 Specific care programme components

The specific components of the Dementia programme are set out in the table below. The core principles and approach to managing the patient will be in line with that described in the introduction to the condition programmes section [section 4.1].

Programme element:	Provided by:		
	Patient	Extensivist team	Specialist input
Diagnosis		• Initial screening to be completed in the Extensivist clinic • Extensivist team to refer for diagnosis • Care coordinator to track referral to ensure action is completed • Care coordinator to complete feedback loop	• Formal diagnosis to be complete within Memory Assessment Service • CT scans likely to be completed elsewhere
Enrolment		• ???	
Support for ongoing management	• Partner in developing care plan	• Provided by Extensivist core team members through ongoing interactions • Guidance and assistance from appropriately trained individual on a regular basis • Personnel trained in behaviour management	• Community/third sector resources
Care planning input	• Partner in developing care plan	• Specialist input into care planning discussions (without other service delivery) • Extensivist team seeks input in particular cases • In the Extensivist clinic at scheduled planning discussions & huddles or via video-conference or Skype • Care Coordinator schedules specialist attendance at meetings	• Specialist expertise in dementia care planning
Managing Medication	• Partner in developing care plan	• Extensivist team to refer for review	• Expertise in dementia medication review • Review of medication • Recommendation on alterations
Timely escalation and intervention		• Extensivist team refers to specialist • Care Coordinator ensures interactions are incorporated into the patient's care plan	• Escalation to specialist clinician for individuals with highly complex needs • Specialist service delivery skills e.g. complex behaviour management

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5.7 Care Programme: End of Life Care

5.7.1 Agreed Local Pathway for End of Life Care for Extensivist Service
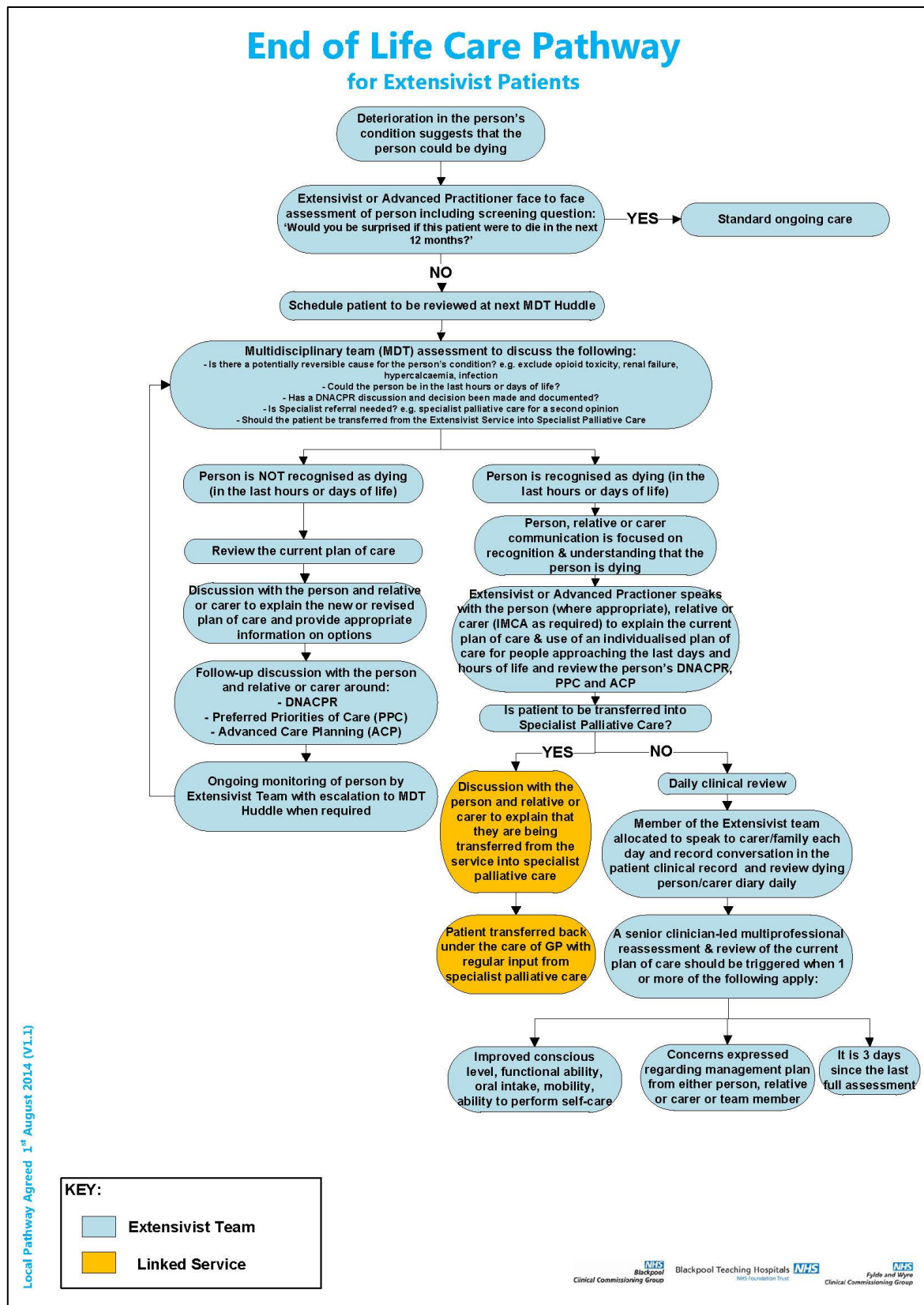
Figure 12: Local End of Life Pathway for Extensivist Service

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5.7.2 Specific Care Programme Components

Programme element:	Provided by:		
	Patient	**Extensivist team**	**Specialist input**
Enrolment	• Partner in developing care plan	• Screening during on-going visits – with escalation to MDT discussion for change in care plan (including discussion with patient and carers)	
Care planning	• Partner in developing care plan • Provide priorities of care	• Led by Extensivist through MDT process • Must be driven in partnership with patients and carers • Agree ceilings of treatment (inc DNACPR)	
Information and support	• Patients are signposted to further information regarding all aspects of EoL care	• Appropriately trained individuals to signpost patients, carers and families to appropriate information	
Ongoing support and checks		• Review of symptoms and pain management • Medication optimisation	• Additional support (voluntary sector) • Psychological support • Spiritual support
Timely escalation and intervention		• Provision of securely stored "just in case" drugs in line with care plan and protocols (TBD)	• End of life care at home (through DNs) • Out of hours non-clinical support (Night service) • Referral criteria for care planning input, specialist palliative care support, and hospice: criteria TBD

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6. Linked and wider services

The Extensivist Clinic will operate collaboratively with multiple linked and wider services as part of their care of their patient cohort. These services can be grouped into three areas:

6.1 In hospital

6.1.1 Emergency care

This specification has been written in the context of a core Extensivist service that is functioning properly, delivering pro-active care through regular contacts with patients significantly reducing the need for urgent attends and admissions at hospital.

Extensivist patients will nevertheless require input from acute trust, ambulance and out of hours based urgent and emergency services on an unplanned basis at any point during their care with the Extensivist service. It is essential that patients have access to urgent and emergency services when they need them, and that these are strongly linked with the Extensivist service.

The key components of the urgent and emergency care services are access to senior clinicians, at point of urgent need, who can assess patients and decide upon and instigate therapy to make them stable and safe, and access to highly specialised clinicians and equipment for specific urgent needs including stroke, MI, trauma and emergency surgery.

These services will be provided by ambulance, acute and out of hours services, in each case seeking an opportunity for discussion with Extensivist staff if the need would more appropriately be met by the Extensivist team in an urgent appointment on the same day or next morning.

Communication between the Extensivist service and urgent and emergency services will be achieved through use of existing IT systems (EMIS and ERIS) that provide the opportunity for any clinician to see and understand key elements of the Extensivist programme and a clear programme for escalation to the Extensivist service.

Where patients have been admitted to hospital there will be an immediate flag on the ES IT system to allow for swift commencement of the core care plan adjustment process at the next huddle to speed discharge and ensure patients are brought home as quickly as is appropriate.

6.1.1.1 Patient or carer perceives the patient to be in a life threatening situation and calls 999

The patients care plan will specify likely scenarios when phoning 999 is the correct course of action. In these situations, or any other situation, where the patient or carer feels that a life threatening emergency exists then phoning 999 is the correct course of action.

A flag on the NWAS data base (ERIS) would alert the ambulance service that a care plan exists. The function of the care plan in these situations is purely to give information about the patients relevant medical history, current medication, adverse drug reactions and anticipatory care arrangements. This information would be of value to the paramedic on site at the patients home and would also be available within the Emergency Department.

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6.1.1.2 A clinician has decided that an acute hospital admission is required but the patient does not have immediate life threatening symptoms or signs.

In this situation there is time for the admitting clinician in the community or in A&E to contact the most senior clinician on duty within the Extensivist Team and discuss the most appropriate course of action. This could include admission to an acute hospital bed or a community based in-patient bed.

The patient could then be admitted directly to the most appropriate hospital ward if no acute management of diagnostics are required, or be seen within a Clinical Decisions Unit (or Frail Elderly Unit) if a further work up prior to admission to the ward is required.

Upon admission to the ward the Extensivist Team would be contacted in order to facilitate the commencement of an "in-reach" service.

6.1.1.3 Patients being discharged from A&E

The Extensivist Team should also be alerted if patients were being discharged from A&E so that the patient could be discussed at the following days huddle.

An IT solution needs to be developed so that the Team are aware of such a situation and also to facilitate the sharing of information.

6.1.2 Outpatient Specialist Consultations

The Extensivist service will have patients within it who by the complex nature of their needs will be attending specialist outpatient clinics. These patients and others may at some point require input from an outpatient specialist consultation or a review of their ongoing requirement to attend outpatient services.

Some of the ongoing support for patients requiring outpatient specialist consultation will be provided by appropriately trained members of the Extensivist clinic team (the Extensivist, Care Coordinator or other clinical team members).

Where necessary the Extensivist or appropriate team member will make a referral to a specialist for review and advice, e.g. diagnosis, management opinion, specific intervention request. Specialist outpatient consultations will in the majority take place in a secondary care setting.

The consultation should be performed by the specialist with the most appropriate level of expertise (for example orthopaedic consultation request to senior orthopaedic clinician not via normal musculoskeletal pathway).

Whenever referrals to other personnel are made the Care Coordinator will monitor to ensure the any actions generated are carried out and then complete a feedback loop to ensure details of the interaction and any findings or outcomes are fed back into the Extensivist team and care plan. Significant findings may be reviewed at the Extensivist team huddle to determine whether a care plan review and update is required, with specialist personnel invited to care planning meetings if required.

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6.1.3 Diagnostic Services: Radiology and Pathology

Extensivist patients will require a range of investigations to support their management.

Requesting: Whilst many of these will originate from medical staff, requesting rights for some investigations will be available to senior clinical non-medical staff (e.g. advanced practitioners) by prior arrangement with the provider and following agreed protocols.

Access: the majority of pathology and radiology will be provided by or through Blackpool Teaching Hospitals NHS FT. On site plain radiology and ultrasound is available at some of the primary care centres being used by the Extensivist Service, although access times are variable. Near patient blood testing is also available at primary care centres and local testing will be used where appropriate.

However, the turn around time needed for each investigation will have to be decided on a case by case basis. It is expected that the majority of testing will be done by BTH at the Victoria Hospital site, although blood and most microbiology specimens will be taken in extensivist premises or at the patient's residence. Most will use current access arrangements for primary care investigations.

Investigations needing a quicker that routine turnaround time will be arranged individually (e.g. radiology reporting).

6.1.4 Elective Admissions

The Extensivist service will have patients within it who by the complex nature of their needs will be admitted electively for example for procedures or investigations.

The Extensivist team will need to be aware of any planned admissions for any reason into any clinical setting. The team will need information regarding the reason for admission and the outcome of such admissions (including any complications or reasons to prolong the admission if for example due to an acute deterioration).

It may be appropriate in certain circumstances to review the necessity of the planned admission with the patient and the clinical team overseeing the admission.

Dependent upon the nature of the elective admission the Extensivist team may be required to provide additional care for the patient. For example, if a patient is planned for a procedure a period of optimisation of health may be required prior to admission. Additionally if a patient is undergoing pre-operative assessment the Extensivist team will require details of the outcome of that assessment. If the assessment leads to a postponement of an intervention then the Extensivist team will require details of what criteria is required for the patient to be eligible to receive the intervention.

When a patient is electively admitted the Care Coordinator will monitor the progress of the patient and then complete a feedback loop to ensure details of the interaction and any findings or outcomes are fed back into the Extensivist team and care plan. Significant findings may be reviewed at the Extensivist team huddle to determine whether a care plan review and update is required, with specialist personnel invited to care planning meetings if required.

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Ultimately the Extensivist team with the patient should make the final decision on the appropriateness of the need for elective admission and fitness for an intervention.

6.1.5 Rehabilitation/Continuing Care

During their care term in the Extensivist Service, some patients will be admitted to acute care wards in hospitals. These patients will need overnight and care provisions during the transition between hospital and their return to home life with their normal level of Extensivist care. These transition services will take one of two forms depending on the situation of the patient:

1) Patients who need rehabilitation after an acute care stay e.g. stroke, will have beds and specialist nursing provided in a community location, as well as access to medical opinion on a planned basis

2) Patients who are awaiting placement in residential care will be provided a nursing home bed equivalent with general nursing care in a community location

A third potential type of continuing care is for patients with special clinical needs who may require 1-2 days in an environment with higher provisions of care than could be achieved within their homes. The Extensivist Service does not intend on admitting any patients without a clinical need. The emphasis will instead be on care provided in the patient's home. However it is realised that this level of service at home may not be viable, especially during the start-up months of the service, and therefore this third type of community admission remains a possibility.

6.1.6 Hospital Discharge Team

There will be two cohorts of patients that the hospital discharge team will interact with:

1. Existing Extensivist patients with an active care plan – where the Extensivist team will provide the hospital discharge function, but may need specific input in relation to continuing health care assessment or equipment provision
2. Patients identified as requiring referral to the Extensivist service in secondary care – these will be discharged to a referral to the Extensivist service in line with the secondary care referral process set out in section 3.1.1

For both types of patients the major drivers of need for the target cohort are:

- Continuing health care assessment:
- Equipment Provision:
- Safe transfer of care:
- Transport – linked to discharge

6.1.6.1 For existing Extensivist patients

Extensivist team patients will require effective discharge planning should the patients' health needs result in admission to hospital. The majority of care co-ordination and agreement of an expected

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date of discharge (EDD) to support effective discharge and safe transfer of care to home or another setting will continue to be provided by the hospital discharge team but with support from appropriately trained members of the extensivist team, either by in-reach into the ward area, attendance at board or ward rounds and attendance at MDT meetings. This can be effectively facilitated by Skype or tele-conference or face to face communication. The extensivist team will be responsible for continuing to have on-going dialogue with the patient's relatives/carers whilst the patient is in hospital.

They may be called upon to support the clinical care coordinator by providing continuing healthcare assessments or equipment provision, working in partnership with the Extensivist team.

6.1.6.2 For patients requiring referral

The hospital discharge team will lead on their normal functions in supporting discharge as set out above, with a referral to the Extensivist team carried out in line with the process set out in section 3.

Please note: This will not feature in the proof of concept phase of the programme.

6.2 Out of hospital

6.2.1 Primary Care

Extensivist patients will require input from Primary Care upon enrolment to the Extensivist service, through input to initial care plans (sometimes provided virtually via provision of notes and care plans, other times in person) as well as remaining the patients registered practice for when they are discharged back to primary care and enhanced primary care models. These key interfaces are described through the enrolment and discharge processes within the core Extensivist service, see sections 3.1 and 3.3 of this document.

A proportion of Extensivist patients will stabilise and see sufficient improvement in their health to be discharged from the service. In this case they will be discharged back to an Enhanced Primary Care model as they will still have ongoing needs in management of their Long Term Conditions. Patients will access this service through the core Extensivist discharge process.

6.2.2 Specialist Therapies

The term Specialist Therapy Services includes MSK Physiotherapy, Podiatry, Speech and Language Therapy, Nutrition and Dietetics and the Podiatric Foot and Ankle Surgery Team.

Whilst all clients under the Extensivist Team will not require access to all the Specialist Therapy Services as part of their care plan it is acknowledged that the Extensivist cohort of patients are likely to need episodic intervention from these services to effectively manage their physical, social and psychological wellbeing.

Patients who are being cared for by the Extensivist Team may also require input from the Specialist Therapy Services to manage effectively specific problems and so improve their health and reduce the necessity for hospital admission. Once a patient is referred into any of these services a 'shared care' arrangement would effectively be in place whereby the referring clinician from the Extensivist Team would monitor patient progress against defined goals which have been agreed between patient and Specialist Therapy Service Clinician. It is unlikely that the specialist nature of this care will be provided by the Extensivist Team yet as this team develops this may become a possibility with appropriate training and supervision from specific Specialist Therapy Services.

In order for this shared care to work effectively, it is essential that communication links between the Extensivist Team and the Specialist Therapy Service are effective and that a shared patient record and comprehensive care plan is in place. The Care Coordinator from the Extensivist Team will monitor any shared care arrangements, as described above, with any changes in the patient's condition being fed back to the Extensivist team and reflected in the care plan where necessary. Any significant changes may be reviewed at the Extensivist team huddle to determine if a review of the care plan is required, with Specialist Therapy Service clinicians being invited to care planning meetings as required.

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6.2.3 Mental Health – Community Based

Extensivist patients may require a range of specialist mental health services to effectively manage their mental health needs. The majority of ongoing support for patients with low level needs will be provided by appropriately trained members of the Extensivist clinic team (the Extensivist, Care Coordinator, Other clinical team members or Well Being Support Worker), either in the clinic or at the patient's home (or via video link or Telephone). To ensure Extensivist team interactions continue to support patients in managing their mental health, team members will receive training in behavioural interventions and support for Dementia, Depression and Anxiety.

Where necessary the Extensivist or Care Coordinator will make a referral to other personnel for specialist input, e.g. for diagnosis of dementia, or for consultation around treatment planning for patients with more complex needs (for example where Community Mental Health Team service is required). Wherever possible these specialists will visit the Extensivist clinic (potentially via a regular scheduled in-clinic session) or the patient's home. If this is not possible patients will visit other facilities. Whenever referrals to other personnel are made the Care Coordinator will monitor to ensure the action is carried out and then complete a feedback loop to ensure details of the interaction and any findings or outcomes are fed back into the Extensivist team and care plan. Significant findings may be reviewed at the Extensivist team huddle to determine whether a care plan review and update is required, with specialist personnel invited to care planning meetings if required.

There may be patients for whom it is appropriate to access longer term support from Specialist Mental Health services e.g. depression in parallel to the Extensivist intervention. In these situations the Extensivist team will ensure that the care plan reflects both elements of intervention and that there is excellent liaison and communication between services.

There may be patients for whom an acute MH admission might be required. In these situations the Extensivist team will ensure that they in-reach to the acute setting (as they would for any acute medical admission). The Care Coordinator will provide input into care and discharge planning and participate in any multi-disciplinary meetings as appropriate.

6.2.4 Social Care

The Extensivist team will be integrated with social care providers supporting the social care needs of the identified cohort of people with multiple and/or complex health conditions. The social care aspect of the core team will support them across traditional boundaries such as primary and acute health care, community and residential care, and chargeable social services. The service will be responsible identifying patients that require social care input during the initial assessment stage and as part of their ongoing care. The Extensivist service will need both social and health models of intervention and processes to ensure that people receive the right support at the right time.

6.2.5 Community Nursing

The Community Nursing Service includes District Nursing and Community Matrons. There are both generalist and specialist Community Matrons in various parts of the Fylde Coast.

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Patients who are being cared for by the Extensivist Team may require input from the wider community nursing services to effectively manage their general nursing requirements. Many of these patients will already be known to the Community Nursing Service. It is envisaged that ongoing general nursing support for these patients will be provided by appropriately trained members of the Extensivist Team either in the Extensivist clinic or at the patient's home. However, there may be circumstances when a 'shared care' arrangement would be more appropriate – for instance, where the patient requires daily injections or regular dressings. In such cases, the District Nurse would visit the patient at home on a regular basis unless the patient was having contact with the Extensivist Team on that day, in which case a member of the team would carry out the required intervention.

In order for shared care to work effectively, it is essential that communication links between the Extensivist Team and the District Nursing Team are effective and that a shared patient record and comprehensive care plan is in place. The Care Coordinator from the Extensivist Team will monitor any shared care arrangements to ensure the required interventions are carried out and any changes in the patient's condition are fed back to the Extensivist team and reflected in the care plan where necessary. Any significant changes may be reviewed at the Extensivist team huddle to determine if a review of the care plan is required, with Community Nursing being invited to care planning meetings as required.

The role of the Community Matron is more aligned to the enhanced primary care model and it is unlikely that patients under the care of the Extensivist Team will also receive care from the Community Matron Service. A patient may transfer from a Community Matron's caseload into the care of the Extensivist Team for a period of time and later move back to the care of the Community Matron once the critical episode is over. In other cases, patients may be referred to the Community Matron Service by the Extensivist Team once they have been stabilised as part of the enhanced primary care model. In any case, the Community Matron should be involved in the care planning and effective links between the Community Matron and the Care Co-ordinator are essential to ensure a smooth handover either into or out of the Extensivist service.

The Community IV Therapy Team will provide IV therapy treatment to patients who are under the care of the Extensivist Team providing they meet the access criteria for the service. This treatment may be carried out either in the IV Therapy suite at South Shore Primary Care Centre or in the patient's home. Where a patient requires more than two infusions per day, a shared care model may be put in place. The Care Co-ordinator will be responsible for liaising with the IV Therapy Team and feeding progress back to the Extensivist Team. The IV Therapy Team will be involved in multi-disciplinary discussions concerning the patient if required.

It is very important that all aspects of the patient's care are captured clearly in the care plan and that the care plan is shared with all services providing care to the patient. The Care Co-ordinator will play a pivotal role in ensuring that the care plan is clear, comprehensive and shared appropriately and that communication between the Extensivist team and the wider linked Community Nursing Service is timely and effective.

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6.3 Specialist

6.3.1 Mental Health – Specialty

Extensivist patients may require a range of specialist mental health services to effectively manage their mental health needs. The majority of ongoing support for patients with low level needs will be provided by appropriately trained members of the Extensivist clinic team (the Extensivist, Care Coordinator, Other clinical team members or Well Being Support Worker), either in the clinic or at the patient's home (or via video link or Telephone). To ensure Extensivist team interactions continue to support patients in managing their mental health, team members will receive training in behavioural interventions and support for Dementia, Depression and Anxiety.

Where necessary the Extensivist or Care Coordinator will make a referral to other personnel for specialist input, e.g. for diagnosis of dementia, or for consultation around treatment planning for patients with more complex needs (for example where Community Mental Health Team service is required). Wherever possible these specialists will visit the Extensivist clinic (potentially via a regular scheduled in-clinic session) or the patient's home. If this is not possible patients will visit other facilities. Whenever referrals to other personnel are made the Care Coordinator will monitor to ensure the action is carried out and then complete a feedback loop to ensure details of the interaction and any findings or outcomes are fed back into the Extensivist team and care plan. Significant findings may be reviewed at the Extensivist team huddle to determine whether a care plan review and update is required, with specialist personnel invited to care planning meetings if required.

There may be patients for whom it is appropriate to access longer term support from Specialist Mental Health services e.g. depression in parallel to the Extensivist intervention. In these situations the Extensivist team will ensure that the care plan reflects both elements of intervention and that there is excellent liaison and communication between services.

There may be patients for whom an acute MH admission might be required. In these situations the Extensivist team will ensure that they in-reach to the acute setting (as they would for any acute medical admission). The Care Coordinator will provide input into care and discharge planning and participate in any multi-disciplinary meetings as appropriate.

6.3.2 End of Life
This summarises the Extensivist programme's linked end of life services not provided by the core Extensivist team through the End of Life Care programme (See Section 5.7). The patient will be referred out to the End of Life Care service when the patient is deemed to be in the red care bundle. End of life care is support for people who are approaching death. It helps them to live as well as possible until they die, and to die with dignity. It also includes support for their family or carers.

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End of life care includes palliative care. If the patient has an incurable illness, palliative care will help to make them as comfortable as possible by relieving pain and other distressing symptoms, while providing psychological, social and spiritual support for them and their family or carers.

This section focusses on the specific elements not provided by the Extensivist team:

- Specialist palliative care input to care planning
- Hospices
- Specialist palliative care provided at home
- Additional support, psychological support, spiritual support for patients and carers

A patient has the right to choose where they want to receive care and where they want to die. The palliative care team provide end of life care to patients and their families in hospitals, care homes, hospices and at home.

The identification, discussion and signposting for patients at end of life will be delivered by the Extensivist care programme team. Once identified, appropriately trained members of the extensivist team will follow the North West End of Life Care Model which includes having the conversation with patients and carers/families and discuss and amend their care plan accordingly. These discussions will include deciding preferred priorities of care and advanced care planning. The Extensivist or Advanced Practitioner will also review symptom management, optimise medications and agree ceilings of treatment (inc. DNACPR). The extensivist team will also signpost patients to palliative care services (inc. hospice care) for complex patients, social care support, psychological support and spiritual support.

Report to:	**Health and Wellbeing Board**
Relevant Officer:	Delyth Curtis, Director of People (Statutory Director of Children's Services)
Relevant Cabinet Member	Councillor Ivan Taylor, Cabinet Member for Children's Services
Date of Meeting	3 December 2014

CHILDREN'S IMPROVEMENT PLAN UPDATE

1.0   Purpose of the report:

1.1   This report is to:
- Provide an overview of the new Improvement Plan for Children's Social Care following the Ofsted inspection in July and subsequent 'Requires Improvement' judgement;
- Provide an overview of the proposed governance arrangements for the plan and Improvement Board;
- Provide an overview of the timeline for developing the plan;

2.0   Recommendation(s):

2.1   To note the report.

2.2   To agree that the actions identified in the plan are the right ones to deliver the improvements required by Ofsted

2.3   To support the proposals for future arrangements, including the recommendation that the Children's Partnership takes responsibility for monitoring the overall progress of the plan and reporting back to the Health and Wellbeing Board as appropriate.

3.0   Reasons for recommendation(s):

3.1   The Children's Improvement Plan contributes towards the delivery of two of the current Joint Health and Wellbeing Strategy priorities:
- Early help and family support
- Safeguarding and domestic abuse

3.2a   Is the recommendation contrary to a plan or strategy adopted or   No
approved by the Council?

| 3.2b | Is the recommendation in accordance with the Council's approved budget? | Yes |

3.3   Other alternative options to be considered:

None

4.0   Council Priority:

4.1   The relevant Council Priorities are:
- Tackle child poverty, raise aspirations and improve educational achievement
- Safeguard and protect the most vulnerable
- Improve health and well-being especially for the most disadvantaged
- Deliver quality services through a professional, well-rewarded and motivated workforce

5.0   Background Information

5.1   The Children's Improvement Board was established in July 2012 as a requirement of the Ofsted Notice to Improve and subsequent intervention from the Department of Education, following the Ofsted inspection of children's safeguarding services, which were judged to be inadequate. Its purpose was to support effective and sustainable improvement of services, through the delivery of an action plan that was developed in response to the Improvement Notice.

5.2   The Improvement Board has effectively overseen the implementation of the first Improvement Plan through monitoring, challenging and supporting the actions in the plan, which have been delivered by the Council and its partners. When all of the actions were signed off by the Board in November 2013, a Transition Plan was developed which ensured that these actions were embedded into existing scrutiny and monitoring arrangements.

5.3   In July 2014 the Council and Blackpool Safeguarding Children's Board were re-inspected and judged to 'require improvement'. The inspection report was published in September 2014 and it was subsequently agreed with the Department for Education that the Improvement Board will remain in place for a minimum of six months; until the Department for Education is assured that a robust plan for sustained improvement is being delivered, which will lead to improved outcomes for children and young people in Blackpool.

5.4 **Improvement Plan**

The inspection report sets out a number of priority and immediate actions and areas for improvement. These sub-headings have been carried across to the new action plan, and have been mapped against actions from the current plan to ensure that there is a smooth transition to the new plan and no outstanding actions are lost.

5.5 The new plan has been developed according to the six themes of the previous plan to ensure consistency. Priority and immediate actions and areas for improvement have been allocated to a theme depending on the content of the action. The plan is attached at appendix a.

5.6 The six themes are:
1. Performance Management
2. Quality Assurance
3. Improving Front Line
4. Partnership Working
5. Scrutiny
6. Communications

5.7 The new plan has an additional column, identifying which partner agencies/organisations are responsible for delivery, monitoring and scrutiny of the action plan. We are engaging with partners in the development of their actions and the plan was approved at the Children's Improvement Board on 14 November. A copy of the plan is attached at Appendix 7a.

Timeline

5.8 The new plan must be submitted for approval to Ofsted on 15 December 2014.

5.9 **Monitoring the plan**

The plan is monitored by the Children's Improvement Board and actions are agreed as complete and 'signed off' at the meetings. Progress on actions is also reported and scrutinised at the Board meetings.

5.10 **Governance arrangements**

The final column in the plan is 'scrutiny'; this column identifies the Board/Panel/Partnership that has responsibility for scrutinising the actions and ensuring that they are delivered and monitored appropriately. To ensure that there is a sufficient level of cross-scrutiny of activity, an additional column will be added to set out a second layer of scrutiny, the Board/panel in this column will be responsible for scrutinising those in the previous column.

5.11   Early consideration is also being given to the potential development of a Board that will act as a replacement for the Improvement Plan, but will meet less frequently, once there is no longer a requirement for Department for Education intervention.

Does the information submitted include any exempt information?   No

5.12   **List of Appendices:**

Appendix 8a: Children's Improvement Plan

6.0   Legal considerations:

6.1   None

7.0   Human Resources considerations:

7.1   None

8.0   Equalities considerations:

8.1   None

9.0   Financial considerations:

9.1   None

10.0   Risk management considerations:

10.1   None

11.0   Ethical considerations:

11.1   None

12.0   Internal/ External Consultation undertaken:

12.1   In developing the plan, extensive involvement of key partners and stakeholders has taken place. This includes consultation with staff through the Shadow Improvement Board and a Staff Conference that was held at the Winter Gardens on 5 November 2014, which attracted over 200 attendees from Children's Services to give their feedback on the plan.

13.0   Background papers:

13.1   None

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THEME 1 - PERFORMANCE MANAGEMENT   THEME LEAD : DOMINIC TUMELTY

No	Raised before?	Action for Improvement	Action Lead	Milestones (Process and Application)	Partner Action	Partner Lead	Milestone Delivery Dates	Expected outcome	Link to evidence	Scrutiny
Care Leavers										
1.1		**Priority for Immediate Action** Leaving Care service improvement plan needs to be developed. Needs to include: - PA's caseloads. Supervision and support, education and training to 16 - 18 yr. olds and preparation for independence. - Pathway Plans need to be in place by 16 yrs & 3 months. - Pathway Plans need to be SMART.	Dominic Tumelty	Review Personal Advisers caseloads			14th November 2014	Manage caseloads which enables personal advisers to deliver consistent, responsive and planned interventions		Corporate Parenting Panel
Looked After Children										
				Develop and implement systems monitor and report on the use of pupil premium to ensure it is used to improve attainment						
1.3				Schools to target Pupil Premium Plus funding to improve children's attainment						
1.4		**Action for Improvement** Implement robust systems to monitor the use of pupil premium grant to ensure it is used effectively to improve attainment	Carl Baker	Virtual school officer to analyse the impact of the Pupil Plus Premium funding and good practice to be disseminated across school partners				Pupil premium is tracked across all Blackpool schools and data used to challenge performance at school and LA level		Corporate Parenting Panel
1.5				Review completion rates and devlop an incremental plan to target the increased completion of PEPs						
1.6				Review completion rates and devlop an incremental plan to target the increased completion of PEPs Ensure that pupil premium is only released on the completion of an agreed PEP	Revised school PPP funding release procedure to be developed within the Business Support Team	Hilary Shaw	Dec-14			
1.7				Further CPD developed for all social workers regarding pupil premium support linked to qualitative targets for children			Nov-14			
1.8		**Action for Improvement** Take steps to ensure more looked after children attend a good or better school	Dominic Tumelty	Retain a careful oversight of judgements in relation to schools in Blackpool with regard to attendance by looked after children	Virtual school and school improvement team to provide current information to inform decision making	Carl Baker		More looked after children attend 'good' schools		Corporate Parenting Panel
Children in Need of Protection										
1.9	**Immediate Action 2 (PW)** Ensure that legal advice is timely to consider those children and young people subject to repeat child protection plans where circumstances are not improving	**Action for Improvement** Collate and analyse information about children living in families where there is parental mental ill-health, substance and alcohol misuse	Dominic Tumelty	Refreshed JSNA / CSNA data used to inform service planning	To undertake a review of the JSNA and CSNA to ensure that they are accurately assessing need and prevalence in order to inform service planning and commissioning	Arif Rajpura	13th March 2015	Information about children living in families where there is parental ill health, substance and alcohol misuse is captured, recorded and used to inform service planning in all cases		JSNA Strategic Group
Leadership, Management and Governance										
1.10	**DFE Recommendation 2 (PM)** Build on the improvements to data recording and reporting to use social care data to inform decision making.	**Action for Improvement** A robust performance management framework for services to looked after children and care leavers should be developed, which is overseen by the Improvement Board and regularly scrutinised by the Corporate Parenting Board	Dominic Tumelty	Looked after children / care leavers performance reports with improved analytical commentary reported and scrutinised through the Corporate Parenting Panel and Children's Improvement Board			13th March 2015	Quality performance reports are in place and robust arrangements in place for challenge and action at the Board and Corporate Parenting Panel		Corporate Parenting Panel

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THEME 2 - QUALITY ASSESSMENT THEME LEAD : LINDA EVANS

No	Raised before?	Action for Improvement	Action Lead	Milestones (Process and Application)	Partner Action	Partner Lead	Milestone Delivery Dates	Expected outcome	Link to evidence	Scrutiny
Care Leavers										
2.1		**Priority for Immediate Action** Leaving Care service improvement plan needs to be developed. Needs to include: - PA's caseloads. Supervision and support, education and training to 16 - 18 yr. olds and preparation for independence. - Pathway Plans need to be in place by 16Yrs&3 months. - Pathway Plans need to be SMART.	Dominic Tumelty	All Personal Advisers will receive supervision in accordance with Children's Services Policy			Oct-14	Improved supervision arrangements of Personal Advisers		Corporate Parenting Panel
2.2			Dominic Tumelty	Ensure pathway plans are effective in setting out desired outcomes and are SMART	Packages of support from partner agencies should be formally recorded and agreed within pathway plans	All	16th January 2015	QA framework demonstrates pathway plans are effective and meet standards		Corporate Parenting Panel
Looked After Children										
2.3		**Action for Improvement** Ensure all looked after children are given the opportunity to participate and their voice is used to inform decision making and planning	Dominic Tumelty	Ensure the involvement of looked after children informs plans through a refreshed participation model			31st December 2014	Looked after children are actively participating and their views captured and used		Corporate Parenting Panel
2.4	**Improvement Notice 6 (PM)** Ensure that performance management systems are reviewed -focusing on management oversight and the role of the Independent Reviewing Officers - and any recommendations made as	**Action for Improvement** Senior Mangers and IROs need to promptly challenge the lack of progress on plans , including the failure to complete PEPs and health assessments. This includes timely and prompt use of the Issues Resolution Process	Linda Evans	Embed the issues resolution process and ensure that timescales are adhered to	Children Social Care to respond to the resolution process	Dominic Tumelty	16th January 2015	Senior Managers and IROs are consistently scrutinising plans and escalating concerns as necessary and all looked after children have PEP and health assessment in place	Issues resolution process	BSCB
Leadership, Management and Governance										
2.5	**Immediate Action 5 (IFL)** Improve the timeliness and quality of supervision for social workers and ensure recording is clear and specific with detailed actions to be followed.	**Action for Improvement** Take steps to ensure reflective supervision is consistently available to all, recorded effectively and ensures current interventions are resulting in improved outcomes for children	Linda Evans	All social workers and personal advisers will receive supervision in accordance with Children's Services Policy which offers them the opportunity to reflect. Annual supervision survey, supervision audit activity and case reviews to be used to demonstrate			Oct-14	Measures demonstrate consistent and effective supervision is in place for all social workers and Personal Advisers	Children's Workforce Development Employer Standard 5	BSCB
2.6	**DFE Recommendation 2 (PM)** Build on the improvements to data recording and reporting to use social care data to inform decision making.	**Action for Improvement** A robust performance management framework for services to looked after children and care leavers should be developed, which is overseen by the Improvement Board and regularly scrutinised by the Corporate Parenting Board	Linda Evans	Review the existing quality assurance frameworks and audit programme to include qualitative information that focusses on outcomes for children			16th January 2015	Improved quality assurance framework and audit programme in place		BSCB

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THEME 3 - IMPROVING THE FRONT LINE   THEME LEAD : DOMINIC TUMELTY

No	Raised before?	Action for Improvement	Action Lead	Milestones (Process and Application)	Partner Action	Partner Lead	Milestone Delivery Dates	Expected outcome	Link to evidence	Scrutiny
Care Leavers										
3.1		**Priority for Immediate Action** Leaving Care service improvement plan needs to be developed. Needs to include: - PA's caseloads. Supervision and support, education and training to 16 - 18 yr olds and preparation for independence. - Pathway Plans need to be in place by 16Yrs&3 months. - Pathway Plans need to be SMART.	Linda Evans	Consult with and ensure the involvement of care leavers so their experience and voice informs plans through a refreshed participation model	OWD to provide development opportunities for care leavers	Linda Dutton	31st December 2014	Clear voice of the child evidenced in plans	Children's Social Care Workforce Development Action Plan	Corporate Parenting Panel then BSCB
3.2			Dominic Tumelty	Personal Advisers need to adopt more effective use of motivational approaches and be persistent in ensuring more care leavers are engaged in EET - particularly with the disengaged and vulnerable	The Connexions Service to present their development plans and update on progress	Merle Davies	14th November 2014	Outcomes for care leavers show consistent improvement in Education, Employment and Training	KLOEs	Corporate Parenting Panel
3.3			Dominic Tumelty		The Virtual School needs to develop plans to support Personal Advisers to identify training or learning opportunities for 16-18 yrs.	Carl Baker	16th January 2015		Apprentice Action Plan	Corporate Parenting Panel
3.4			Dominic Tumelty	Review pathway plans in place and take immediate corrective actions	All partners contribute to pathway plans as requested - for example in preparation for independence	All	16th January 2015	Every young person has a pathway plan by 16 years and 3 months	Children's Workforce Development Plan Employer Standard 6	Corporate Parenting Panel
Looked After Children										
3.5		**Action for Improvement** Improve the quality of assessments prior to children returning home so that clear and robust plans are in place	Dominic Tumelty	Embed and refresh practice standards through focussed workshops with all staff including risk management, with a focus on consistent oversight by operational managers	Children's Workforce Development Group to arrange and assist in facilitation of practice development sessions	Linda Evans	Operational Managers 16th January 2015 All staff 13th March 2015	Assessments and care plans consistently meet practice standards		Corporate Parenting Panel
3.6		**Action for Improvement** Improve the quality of care planning and care plans themselves to consistently provide timely support to children moving to permanence	Dominic Tumelty							Corporate Parenting Panel
Children in Need of Protection										
3.7		**Action for Improvement** Embed the Getting it Right Framework (GIR) to ensure partners understand their responsibilities in respect of early help and thresholds	Linda Evans	Consult with and ensure the involvement of children and young people so their experience and voice informs plans through a refreshed participation model			31st December 2014	Clear voice of the child evidenced in plans avoiding the over reliance of self reporting from parents		BSCB
3.8	**Immediate Action 2 (IFL)** Improve the quality of information and analysis within assessments, including risk and protective factors to promote effective planning and decision making and ensure that all assess	**Action for Improvement** Improve the quality of assessments. Ensure they are child focussed, take into account risk and protective factors, individual needs including those arising from race and ethnicity	Linda Evans	Embed and refresh practice standards through focussed workshops with all staff including risk management, with a focus on consistent oversight by operational managers	All partners should contribute relevant information to the assessment process within required timescales	All partners	Operational Managers 16th January 2015 All staff 13th March 2015	Quality of assessments is consistently high and take account of children's differences		BSCB
3.9	**Immediate Action 2 (PW)** Ensure that legal advice is timely to consider those children and young people subject to repeat child protection plans where circumstances are not improving	**Action for Improvement** Ensure prompt arrangements are made to progress Legal Planning Meetings where identified risks are not diminishing	Dominic Tumelty	Review and monitor the arrangements for Legal Planning Meetings to ensure that they are timely and the risk of drift is minimised. Process to be implemented to track progress.			16th January 2015	All cases meet legal planning timeline and ensure prompt and timely decisions		Children's Management Team

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THEME 3 - IMPROVING THE FRONT LINE   THEME LEAD : DOMINIC TUMELTY

No	Raised before?	Action for Improvement	Action Lead	Milestones (Process and Application)	Partner Action	Partner Lead	Milestone Delivery Dates	Expected outcome	Link to evidence	Scrutiny
Adoption										
3.10		**Action for Improvement** Improve the quality of child permanence reports	Dominic Tumelty	Embed and refresh practice standards through focussed workshops with all staff with a focus on consistent oversight by operational managers			16th January 2015	The quality of child permanence reports is consistently good	Children's Workforce Development Plan Employer Standard 6	Corporate Parenting Panel
3.11		**Action for Improvement** Life story work not in place for all children who could benefit from it	Dominic Tumelty	Ensure every child placed for adoption has a life story book by the time of the celebration hearing			13th March 2015	Life story work in place for all children placed for adoption		Corporate Parenting Panel
3.12		**Action for Improvement** Ensure the focus on adoption improvement is maintained	Dominic Tumelty	The adoption improvement action group will continue to be in place reporting to both the Board and the Corporate Parenting Panel to ensure improvements are in place and are maintained. The agency decision maker will meet with the independent chair of ado			14th November 2014	Continued progress on adoption measures		Corporate Parenting Panel
Practice Issue										
3.13		**Action for Improvement** There is a lack of urgency in completing private fostering assessments and the issue of private fostering has not been a priority to Blackpool	Dominic Tumelty	Refresh understanding of private fostering arrangements and protocols, with a focus on improving timeliness and quality of assessments. Reports to be received through the BCSB	BCSB and its partners to promote awareness of private fostering arrangements including notifications	David Sanders	13th March 2015	Timely private fostering assessments completed in line with protocols and reported through the BCSB		BSCB
3.14		**Action for Improvement** Missing from home, return home interviews are completed by social workers, but there is no overarching oversight of these to assure quality standards or to aggregate findings, identify themes and trend which could be usefully fed back into the wider work	Dominic Tumelty	Establish a mechanism for the information gained from missing from home interviews to be used effectively in establishing themes and trends	Lancashire Constabulary input required	Sue Cawley	16th January 2015	Themes and trends from missing from home information is used effectively to inform an plans and alert relevant services		BCSB

THEME 4 - PARTNERSHIP WORKING   THEME LEAD : MERLE DAVIES

No	Raised before?	Action for Improvement	Action Lead	Milestones (Process and Application)	Partner Action	Partner Lead	Milestone Delivery Dates	Expected outcome	Link to evidence	Scrutiny
Care Leavers										
4.1		**Priority for Immediate Action** Leaving Care service improvement plan needs to be developed. Needs to include: - PA's caseloads. Supervision and support, education and training to 16 - 18 yr. olds and preparation for independence. - Pathway Plans need to be in place by 16 yrs & 3 months. - Pathway Plans need to be SMART.	Dominic Tumelty	Concerted efforts should be made to enable care leavers to access university or higher education	Consider accommodation options for young people outside of term time including the Shared Lives Scheme	Delyth Curtis	16th January 2015	More care leavers accessing university or higher education		Corporate Parenting Panel
4.2			Dominic Tumelty		Virtual school to co-ordinate action to ensure priority is given to ensure looked after children achieve required entry standards for FE or University placements	Carl Baker		Attainment for looked after children improves and more care leavers access HE and university		Corporate Parenting Panel
4.3			Dominic Tumelty	Embed and promote the Staying Put Policy to ensure that all young people are given the opportunity to remain with foster carers			13th March 2015	Young people are enabled to stay with foster carers where appropriate leading to increased stability		Corporate Parenting Panel
4.4			Dominic Tumelty	Review accommodation options for care leavers that meet individual needs	Report to the Board outlining accommodation options for care leavers including housing related support	Neil Jack	13th March 2015	Secure and sustainable independent living for care leavers	Look at indicators to support this No of care leavers with sustained tenancy	Corporate Parenting Panel
Looked After Children										
4.5	**Improvement Notice 6 (PM)** Ensure that performance management systems are reviewed - focusing on management oversight and the role of the Independent Reviewing Officers	**Action for Improvement** Senior Managers and IROs need to promptly challenge the lack of progress on plans , including the failure to complete PEPs and health assessments. This includes timely and prompt use of the Issues Resolution Process	Linda Evans	Reinforcing the practice standards to ensure PEPs are consistently of a good standard and completed for all looked after children within required timescales	Ensure appropriate school staff participate in the PEP	Carl Baker	16th January 2015	Senior Managers and IROs are consistently scrutinising plans and escalating concerns as necessary and all looked after children have PEP and health assessment in place		Corporate Parenting Panel
4.6			Linda Evans		Ensure that pupil premium is only released on the completion of an agreed PEP	Carl Baker	16th January 2015			Corporate Parenting Panel
4.7			Linda Evans	Reinforcing the practice standards to ensure all looked after children have a health assessment within required timescales	Looked after children nurse service to work closely with Children's Social Care and ensure completion	Marie Thompson	16th January 2015			
4.8			Linda Evans	Develop key Performance Indicators to inform of the performance of health assessment completion	Contribute to the development of the Key PIs and agree performance measures	Marie Thompson	16th January 2015			
4.9			Linda Evans	Review the existing start to end process for the completion of health assessments to ensure its efficient and supports performance	Contribute to the review	Marie Thompson	16th January 2015			Corporate Parenting Panel
4.10		**Action for Improvement** Improve access to CAMHS for looked after children	Marie Thompson	Establish and clarify/report on the current CAMHS service offer for looked after children			13th March 2015	Young people in the CICC's views are sought are presented and used representative of the views of young people across the town		Corporate Parenting Panel
4.11			Marie Thompson	Develop a system that offers priority access for looked after children	Provide detailed information based on need	Dominic Tumelty	13th March 2015			Corporate Parenting Panel
Children in Need of Protection										
4.12	**Improvement Notice 3.2 (PW)** Work with partner agencies to review and agree thresholds for meeting statutory assessments and which set out the criteria for access to children's social care services. Ensure procedures are in p	**Action for Improvement** Embed the Getting it Right Framework (GIR) to ensure partners understand their responsibilities in respect of early help and thresholds	Merle Davies	Further consultation with partners to understand the barriers to the delivery of the Getting it Right framework through the multi professional discussion forums	Partners to actively engage in the multi professional discussion forums	All partners	16th January 2015	Improved understanding to the barriers in delivering the Getting it Right Framework which will translate into action and training	Additional Actions Children's Workforce Development Plan	Children's Partnership and BSCB
4.13			Merle Davies	Work with partners to strengthen their understanding of their responsibilities to give children and young people help at the earliest opportunity through a series of groups, workshops and briefings	Provide evidence of the early help offer and can demonstrate effectiveness in reducing escalation ensuring where there is a need robust information is provided on which decisions and actions can be made	All partners	13th March 2015	Partners demonstrate their understanding of their responsibilities to give children and young people help at the earliest opportunity. When there is need to escalate to Children's Social Care an appropriate level of information is provided		Children's Partnership and BSCB

THEME 4 - PARTNERSHIP WORKING   THEME LEAD : MERLE DAVIES

No	Raised before?	Action for Improvement	Action Lead	Milestones (Process and Application)	Partner Action	Partner Lead	Milestone Delivery Dates	Expected outcome	Link to evidence	Scrutiny
4.14			Merle Davies	Continue to reinforce the application of thresholds across partner agencies	Partners to manage cases within the thresholds and make referrals as appropriate	All partners	1st May 2015			Children's Partnership and BSCB
4.15	**DFE Recommendation 4 (PW)** Develop a consistent approach across partnerships with regards to referral arrangements and the use of thresholds to secure understanding and increase efficiency		Merle Davies	Refreshed training package delivered by Children's Services professionals and Board partners	Partner agencies engage in the training programme and delivery where appropriate	All partners	16th January 2015	Partners apply thresholds and are escalating concerns to Children's Social Care as appropriate		Children's Partnership and BSCB
4.16			Merle Davies	Report to go to Getting It Right Steering Group and Operational Group regarding referrals into and out of CRS and step down from Level 4 processes			Dec-14			Children's Partnership and BSCB
4.17		**Action for Improvement** Embed the Getting it Right Framework (GIR) to ensure partners understand their responsibilities in respect of early help and thresholds	Linda Evans	Requirement of key partners at child protection conference to be reinforced, attendance to be continually monitored and an escalation process developed	Partners to monitor the attendance of their agencies at child protection conferences and to report through the PMEG group	All partners	Attendance monitored reported quarterly through BCSB. Escalation process developed for 1st May 2015	Child protection conferences are consistently attended by all agencies involved		Children's Partnership and BSCB
4.18	**Immediate Action 1 (PW)** Ensure that core group meetings are attended by agencies involved in monitoring and driving improvements in protection for children		Linda Evans	Requirement of key partners at core groups to be reinforced, attendance to be continually monitored and an escalation process developed	Partners to monitor the attendance of their agencies at core groups and to report through the PMEG group	All partners	Attendance monitored reported quarterly through the BSCB. Escalation process developed for 1st May 2015	Core groups are consistently attended by all agencies involved		BSCB
4.19			Linda Evans	Embed the use of the core group meeting minutes template	All partners to assist at core groups and input to the minutes where appropriate	All partners	16th January 2015	Core group template is used consistently across all agencies		BSCB
Leadership, Management and Governance										
4.20			Marie Thompson	Partners to develop a clear specification for the CAMHS service which outline the access criteria						
4.21		**Action for Improvement** Ensure that the recently developed plans to tackle deficits in CAMHS performance and service provision demonstrates positive impact for children	Marie Thompson	Partners to develop a clear referral process	All partners to contribute to plans to develop improve the CAMHS service	All partners	13th March 2015	CAMHs service is accessible to all and Looked after Children are considered priority as part of the process		BSCB and Corporate Parenting Panel and Children's Partnership
4.22				Develop mechanism for routinely receiving feedback from children and young people which is used to inform service development and plans						
4.23				Develop better process for more regular information sharing across all partners						
4.24				Ensure waiting times are monitored quarterly						

THEME 5 - SCRUTINY   THEME LEAD : DELYTH CURTIS

	Raised before?	Action for Improvement	Action Lead	Milestones (Process and Application)	Partner Action	Partner Lead	Milestone Delivery Dates	Expected outcome	Link to evidence	Scrutiny
Leadership, Management and Governance										
5.1	**Peer Review Key Message 7 (PM)** Improve the linkages between commissioning and the Children's Services department and develop a commissioning approach to remodelling services	**Action for Improvement** Develop an overarching commissioning strategy linked with the looked after children strategy to support co-ordinated arrangements.	Delyth Curtis	Commissioning Strategy to be developed and consulted upon			13th March 2015	Commissioning strategy in place		Corporate Leadership Team and Children's Scrutiny Panel
5.2		**Action for Improvement** Strengthen the function of corporate parenting panel to ensure it provides robust challenge to the Local Authority and champions the needs of LAC	Councillor Taylor	Further training and development is offered to the corporate parenting panel. Membership of the panel reviewed and consideration of ongoing support needs / best practice			13th March 2015	Corporate parenting panel is conversant with their roles and responsibilities and is able to maintain the necessary level of oversight and offer challenge as appropriate		Children's Scrutiny Panel
5.3	**Improvement Notice 6.8 (Sc)** Ensure elected members of the Council are informed about and carry out their corporate parent role and meet all their statutory requirements, including statutory visits	**Action for Improvement** A robust performance management framework for services to looked after children and care leavers should be developed, which is overseen by the Improvement Board and regularly scrutinised by the Corporate Parenting Board	Delyth Curtis	Training programme developed for elected members on key subject areas	Assist in the development and scheduling of the Member training programme	Mark Towers	Programme developed by 16th January and training rolled out March 2015	Elected members feel equipped to hold officers to account and challenge in a robust fashion		Children's Scrutiny Panel
5.4		**Action for Improvement** Take robust action to recruit to staff vacancies in looked after children and leaving care services	Dominic Tumelty	Implementation of the Recruitment and Retention Strategy across Social Care	Assist in the delivery of the strategy	Linda Dutton	13th March 2015	Vacancies within the leaving care and looked after children services filled promptly		Corporate Parenting Panel

THEME 6 - COMMUNICATIONS   THEME LEAD : SALLY SHAW

No	Raised before?	Action for Improvement	Action Lead	Milestones (Process and Application)	Partner Action	Partner Lead	Milestone Delivery Dates	Expected outcome	Link to evidence	Scrutiny
Care Leavers										
6.1		**Priority for Immediate Action** Leaving Care service improvement plan needs to be developed. Needs to include: - PA's caseloads. Supervision and support, education and training to 16 - 18 yr olds and preparation for independence. - Pathway Plans need to be in place by 16Yrs&3 months. - Pathway Plans need to be SMART.	Dominic Tumelty	Broaden use of communication channels including social media for young people			31st December 2014	Improved channels of communication with care leavers enabling them to receive information, comments and feedback		Corporate Parenting Panel

THEME 7 - BLACKPOOL SAFEGUARDING CHILDRENS BOARD   THEME LEAD : DAVID SANDERS

No	Raised before?	Action for Improvement	Action Lead	Milestones (Process and Application)	Partner Action	Partner Lead	Milestone Delivery Dates	Expected outcome	Link to evidence	Scrutiny
7.1		**Priority for Immediate Action** BCSB needs to take steps to ensure that it is fully compliant with its statutory duties with all statutory partners undertaking their roles	Board Chair and Board Manager	Commission external Annual BSCB review of the Board where external challenge will ensure the Boards statutory duties are compliant(May 2015)	Partners to engage with external review as appropriate	All Board Members	May-15	The BSCB is compliant with its statutory duties. Members are aware of their roles, attend the Board(and its sub groups where appropriate)and actively contribute to the work of the Board and its Improvement Plan		BSCB
7.2				Appointment of a Schools Safeguarding Advisor funded by the Schools Forum - Post evaluation undertaken and advertised			December 2014			
7.3				Schools Safeguarding Advisor in post			Appointment anticipated February 2015			
				More proactive engagement work to be developed with schools - Programme of twilight sessions to be introduced across all schools - timetable developed	Engagement from schools with the programme of sessions. Hosting meetings and actively contributing to the programme	All Schools	Jan-15			
				More proactive engagement work to be developed with schools - Timetable in place and half termly sessions held across the year (5 per annum)			From February 2015 and as per timetable			
7.6				Development of Children and Young Peoples Sub Committee to ensure communication channels with young people have the maximum impact	School to engage with development of the committee to develop membership and mechanisms of engagement	All Schools	Mar-15			
7.7		**Action for Improvement** Ensure that all statutory partners routinely attend and contribute to the work of the Board	Board chair	Membership will be reviewed, vacant posts will be pursued vigorously by the chair and a discussion of members roles and responsibilities will take place at the first meeting with the new Board Chair in December 2014	Partners to actively contribute to the process and discussion	All partners	15th December 2014			BSCB
7.8					YOT Manager to attend future Board meetings in line with good practice.	Head of Children's Social Care				
7.9		**Action for Improvement** Monitor and evaluate the quality of early help that is offered to children and their families across the partnership	Merle Davies	Review of the current BSCB data sets - BCSB Data Set developed to identify key areas for scrutiny. .	Response from LA (early intervention programme, children's centres), health, police, schools	All appropriate Board Members	Data set developed for reporting through Board on 5th March 2015	The quality of early help that is offered to children and their families across the partnership is monitored and evaluated, with improved scrutiny arrangements that provide strengthened challenge and dialogue		BSCB
7.10			Head of Business Support and Resources	Introduction and development of better use of comparative data and benchmarking information to develop more trend analysis						
7.11			Head of Business Support and Resources and Board Manager	Improved scrutiny arrangements of the core data set - exception reporting at board and focus on tracking data / improvements into the board						
7.12		**Action for Improvement** Strengthen the range of performance information provided to the Board, to include relevant information from all partners, and ensure that evaluative commentary is provided	Head of Business Support and Resources and Board Manager	Data set development as per milestones above. Qualitative analysis for Serious Case Reviews, multi agency audit, front line surveys, issues raised from the shadow board.	Response from partners as appropriate - early intervention programme, children's centres, health, police and schools	All appropriate Board Members	Mar-15	Robust and comprehensive qualitative and quantitative performance information is provided to the Board for challenge and scrutiny		BSCB
7.13				Development of Children and Young Peoples Sub Committee to ensure communication channels with young people have the maximum impact	School to engage with development of the committee to develop membership and mechanisms of engagement	All Schools	Mar-15			

No	Raised before?	Action for Improvement	Action Lead	Milestones (Process and Application)	Partner Action	Partner Lead	Milestone Delivery Dates	Expected outcome	Link to evidence	Scrutiny
7.14		**Action for Improvement** Ensure that thresholds for the provision of early help and referrals to children's social care are understood by all partners	Board Chair	BSCB review of GIR with a multi agency conference and workshops held to review the success of the programme in conjunction with the escalation policy.	Attendance at the conference and presentation / contributions	All partners plus other key officers	Mar-15	Thresholds for the provision of early help and referrals to children's social care are understood by all partners		BSCB
7.15			Head of Business Support and Resources and Board Manager	Forward Plan and programme of work developed to capture early help initiatives and how the board will monitor and scrutinise progress through revised data sets.			Mar-15			
7.16		**Action for Improvement** Give closer scrutiny to the local authority and board partners to safeguard and promote the welfare of children and young people where:	Board Chair and Board Manager	Development of Multi Agency Blackpool Safeguarding Children's Shadow Board to be supported by the Board Chair.	All partners to engage and actively participate	All partners	Jan-15	Improved scrutiny arrangements in place to safeguard and promote the welfare of children and young people		BSCB
7.17				Good practice reinforced and developed through a formal shadowing programme of Front line Review of Services as developed with partners.			May-15			
7.18		1. they are privately fostered	Head of Children's Social Care	Raise awareness of private fostering arrangements across partners	Engage and promote awareness of private fostering arrangements	All Partners	Jan-15			BSCB
7.19			Head of Corporate Comms	Development of comms strategy.			Jan-15			
7.20			Business Manager	Establish Regular reporting into the board 6 monthly			January 2015 July 2015			
7.21		2. their parents have mental health issues or drug/alcohol misuse	Board Chair		Regular, consistent and appropriate attendance at the board from Horizon and Lancashire Care Foundation Trust	Horizon and LCFT	15th December 2014			BSCB
		3. they are known to the Youth Offending Team	Board Chair and Head of Business Support and Resources	Board to establish clear view on what information is required and how it will be reported into the Board	Develop reports and report to the board as agreed	Head of Children's Social Care	First report to the January Board			
7.23		**Action for Improvement** Hold partners to account for evaluating the impact on practice of the learning from serious case reviews	Board Chair Training Sub Committee Chair Training coordinator	Work undertaken by the Training Sub Committee to provide evaluation on the impact and learning of SCRs on the; 1. the workforce	Participate with the evaluation and reporting as required	All partners	Programme of review starts now Report back into the Board as per reporting cycle (quarterly)	Partners held to account and serious case reviews are evaluated and improvements made to process, learning and training		BSCB
7.24				2. the improvement of services and impact on C&YP and their families						
7.25			Chair Training Sub Group	Interim progress report from the Training Sub Committee			March Board			
7.26		**Action for Improvement** Ensure that the annual report of the Board describes progress against the strategic and shared priorities, the quality of multi-disciplinary practice with children and their families, and the impact of help, protection and care in their lives	Board Chair	The departure of the Chair and Board Manager has led to a delay in the publication of the Annual Report but it is now on track and approaches completion and will be approved at the next Board meetings	Contributions from Sub Committee Chairs and Agency reports	All partners	Dec-14	Annual Report published and progress against the strategic and shared priorities understood and communicated		BSCB