Updated July 2014

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.

- PLAN DETAILS

  - 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

  - 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

- **Related documentation**

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

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.

		Joint-Adult-Health-S ocial-Care-and-Housir 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

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

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

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;

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)**

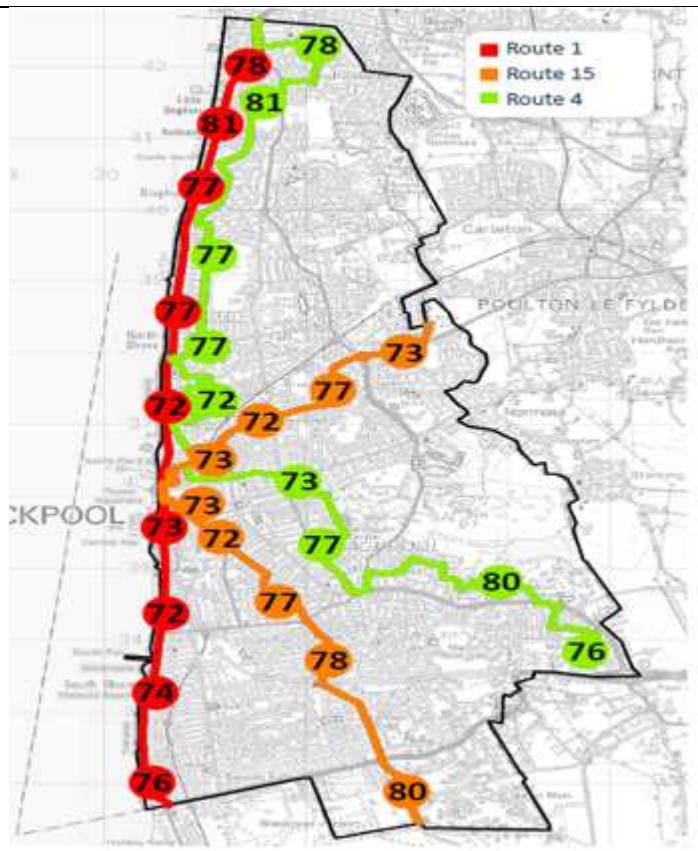
Deprivation and Transience

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).

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

- 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.

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

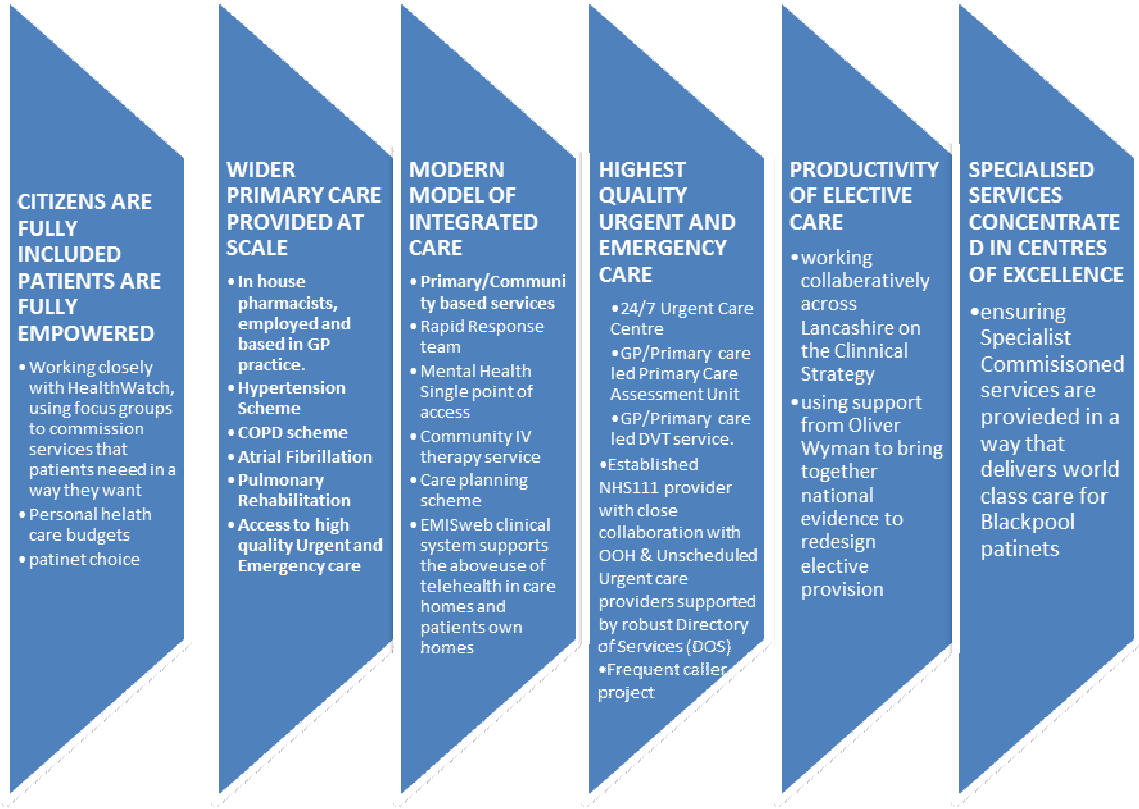
The following integrated schemes are in place and will be further enhanced by the development of the BCF.

1. Rapid Response Team - 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. Mental Health Single Point of Access - The service operates as a single point of access to all adult mental health services in the Blackpool locality.
3. Primary Care Mental Health - 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. Richmond Fellowship 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. Community IV therapy service
6. Acute Visiting Service - 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. Frequent Caller Project and Paramedic Pathfinder - Reducing frequent 999 callers and NEL admissions – link with care planning scheme
8. Care Planning Scheme - SpoA for care plans and co-ordination for HCP HCEMISweb, the clinical system, supports the above and sharing of key clinical information
9. Established NHS111 provider with close collaboration with out of hours& Unscheduled Urgent care providers supported by robust Directory of Services (DOS)
10. Better self-management programme for COPD patients, with the 'my breathing book' and care planning to implement prophylactic interventions when exacerbation of the condition is taking place.
11. A full care home management team, 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. Dedicated health staff, nurses and AHPs 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. Community equipment - This is a virtual service which enables rapid access to equipment in a patient's home.
14. Increase use of Telehealth 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. Empowerment 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. North West Ambulance Service schemes to reduce the number of conveyances to A&E departments.



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?

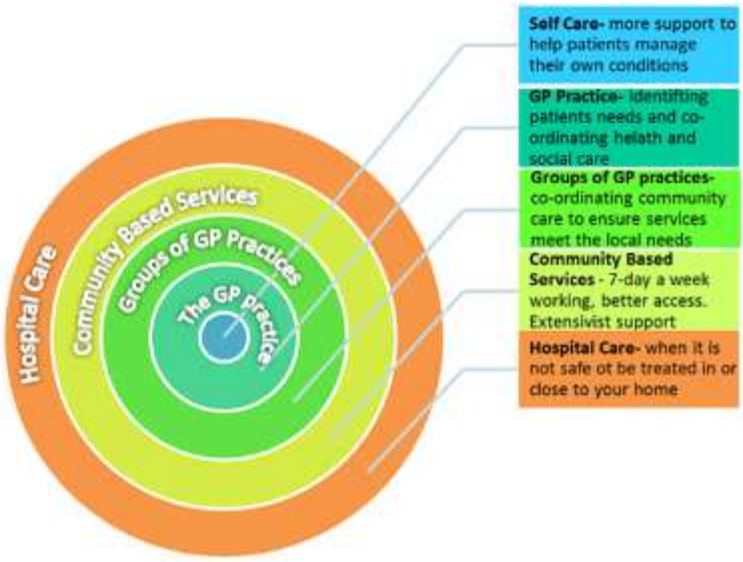
By 2019…

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.



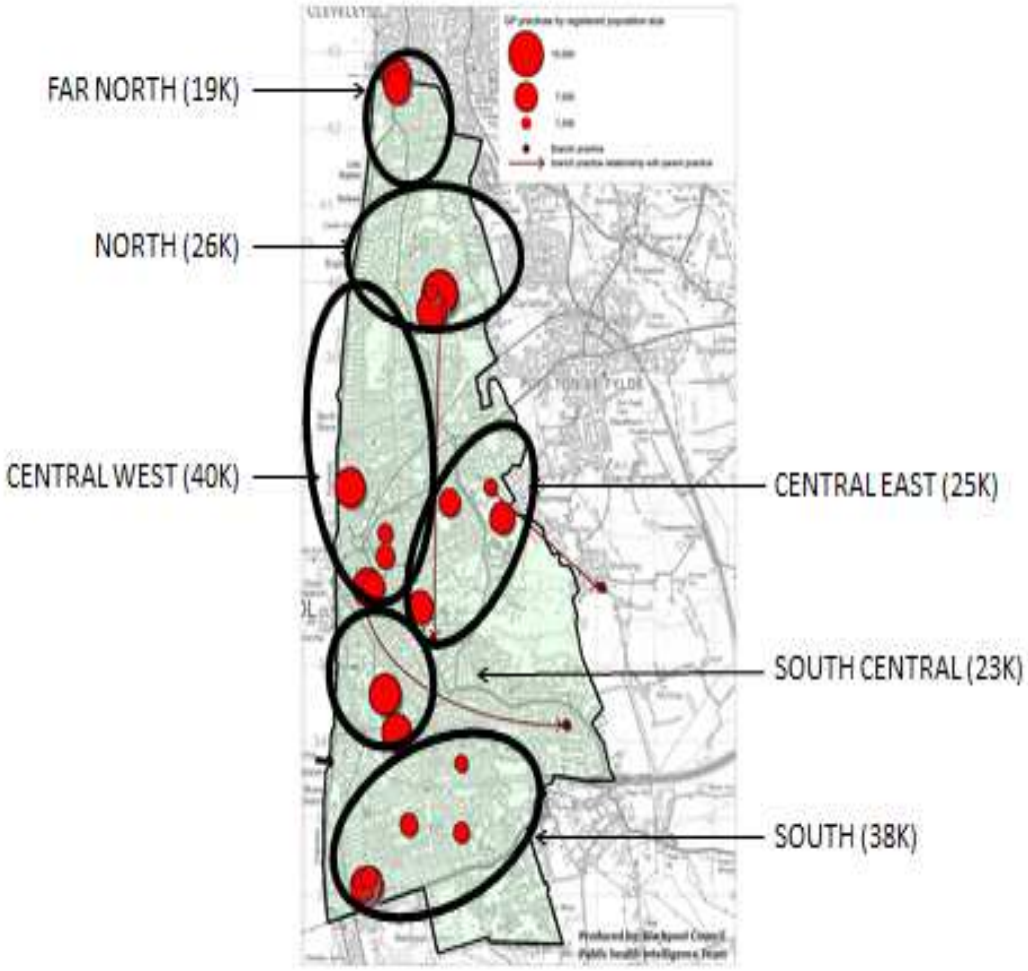
The Extensivist model, which focuses care on patients with the most complex needs. We anticipate from experiences of this model in other health economies that this model will facilitate better management of patients who may not only have multiple physical health needs but whose care becomes more complex 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.

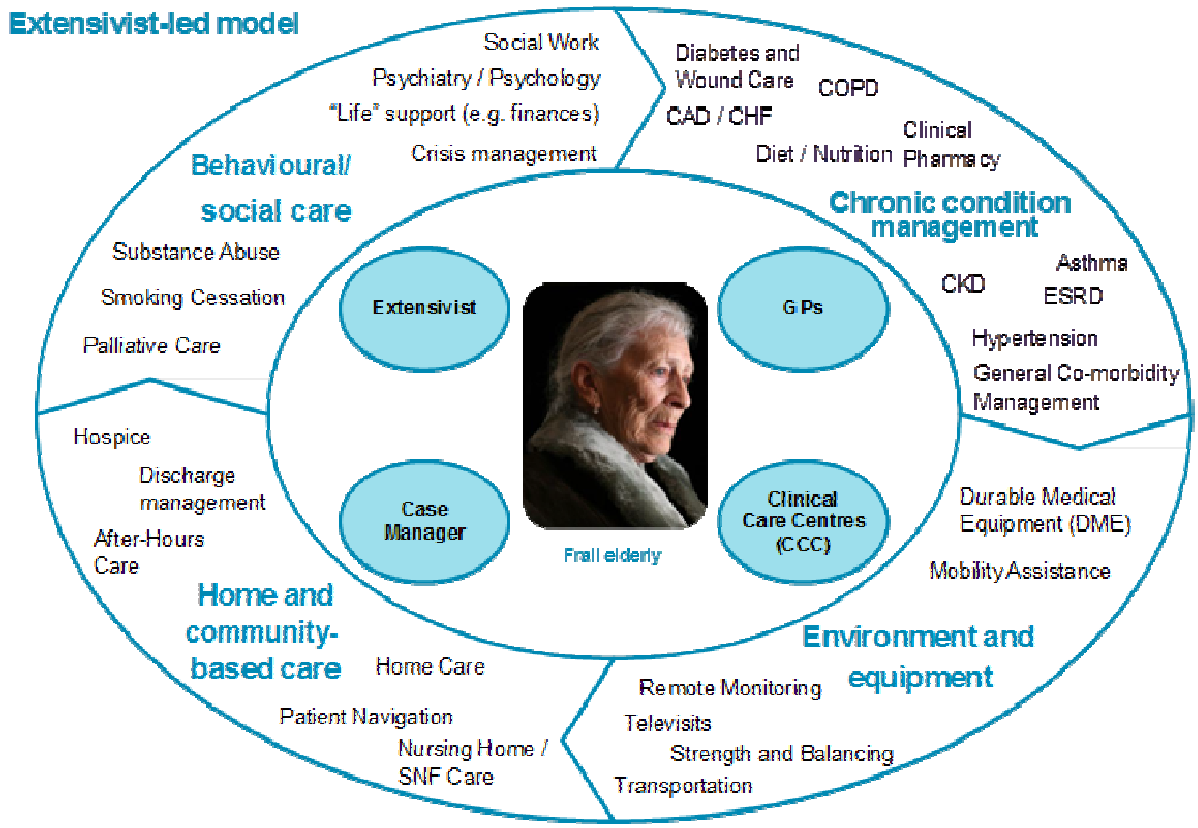
The neighbourhoods will be based on groups of GP practices covering populations of 20,000 to 40,000, and will take account of health, social care and voluntary resource and estate available to deliver seamless and comprehensive care.

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.

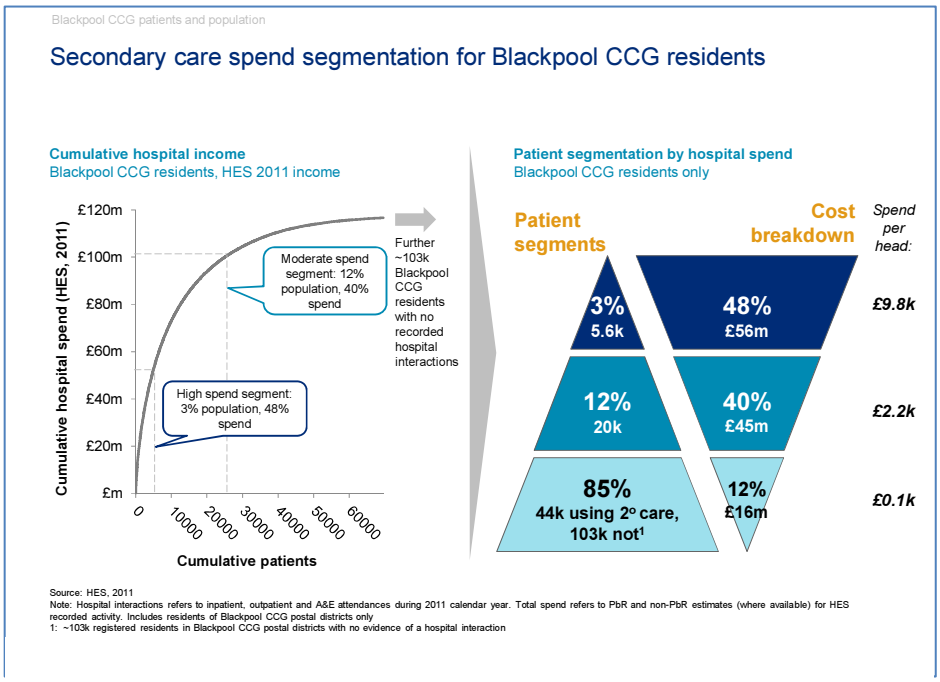
3) CASE FOR CHANGE

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

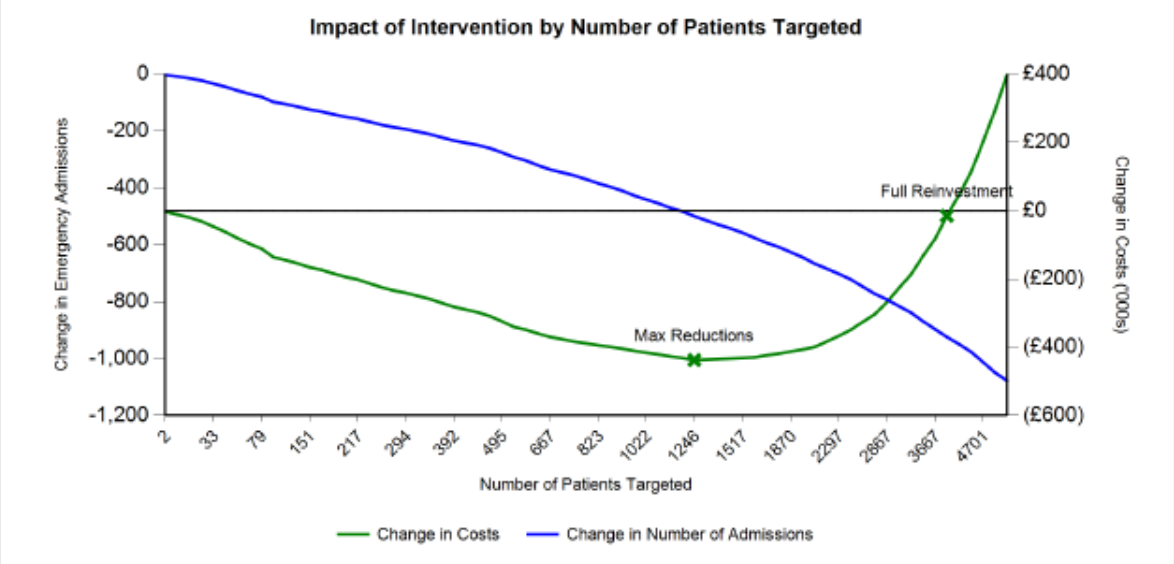
NHS Midlands and Lancashire Commissioning Support Unit

CCG Selected: Blackpool CCG
Assessment Period: Jun-12 - Jun-14
Community Mation 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

		GP Practice Level Summary		
	Selected Cohort Only	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[4]	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[5]	£28,877,069	£33,518,489	£33,518,489	£33,518,489
Average Cost per Emergency Admission over Last 12 Months[5]	£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)[6]	£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	



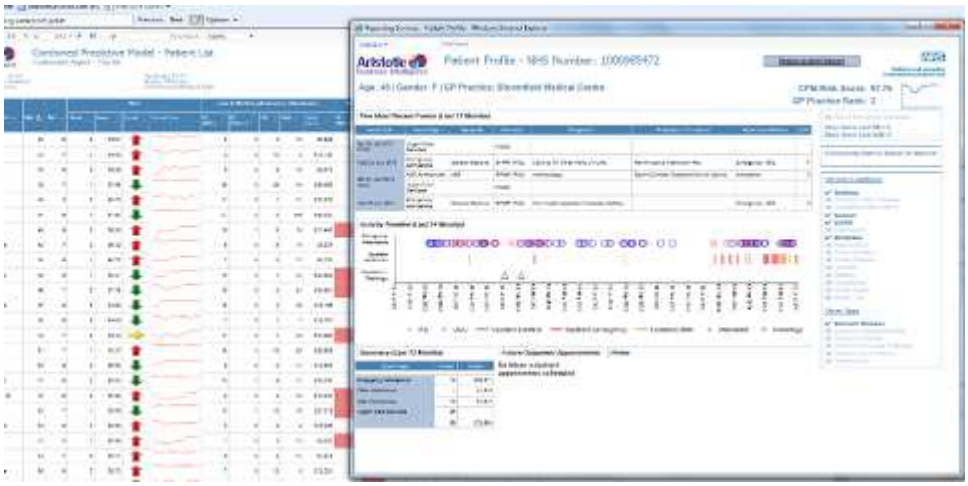
[4] The expected number of emergency admissions multiplied by the intervention impact, for targeted patients
[5] These figures exclude block contract costs, and any spells where cost information is not yet available
[6] The expected reduction in emergency admissions multiplied by the expected cost per 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 • Headstart • Fulfilling Lives	 2014 - 2024 Sept 2014 - 2021 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.

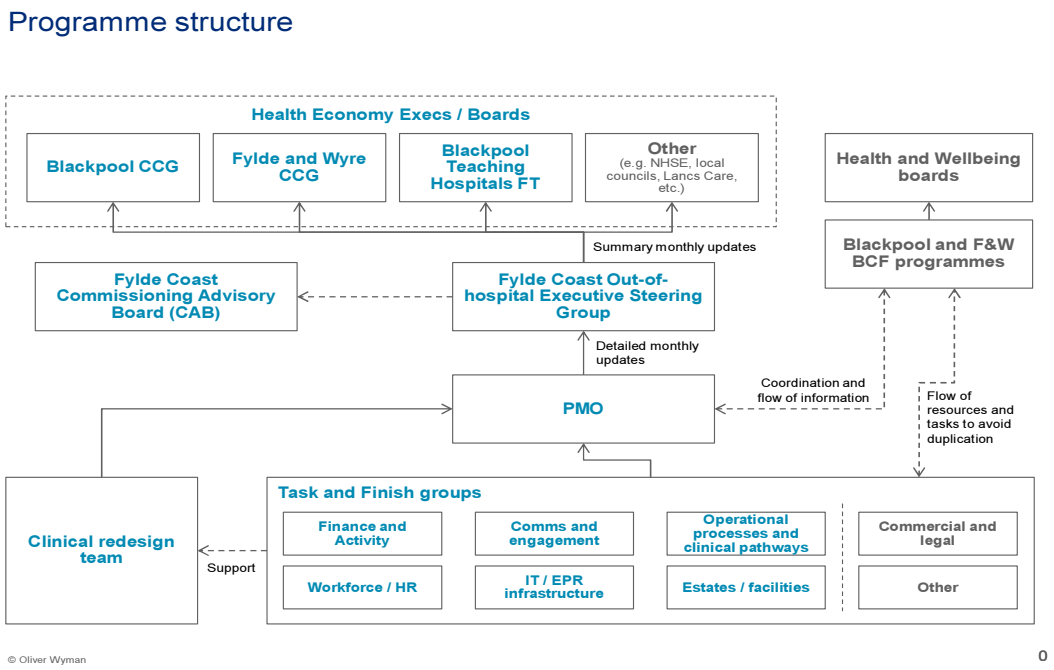
BCF Workstreams to deliver the 'project' the BCF Programme Board created five principal workstreams: **Design, Delivery & Estates, HR & Workforce, ICT/Shared Information, Finance** and **Communications**. Due to the cross-over in functions and to maximise opportunities for joint working, the BCF workstreams 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



- List of planned BCF schemes

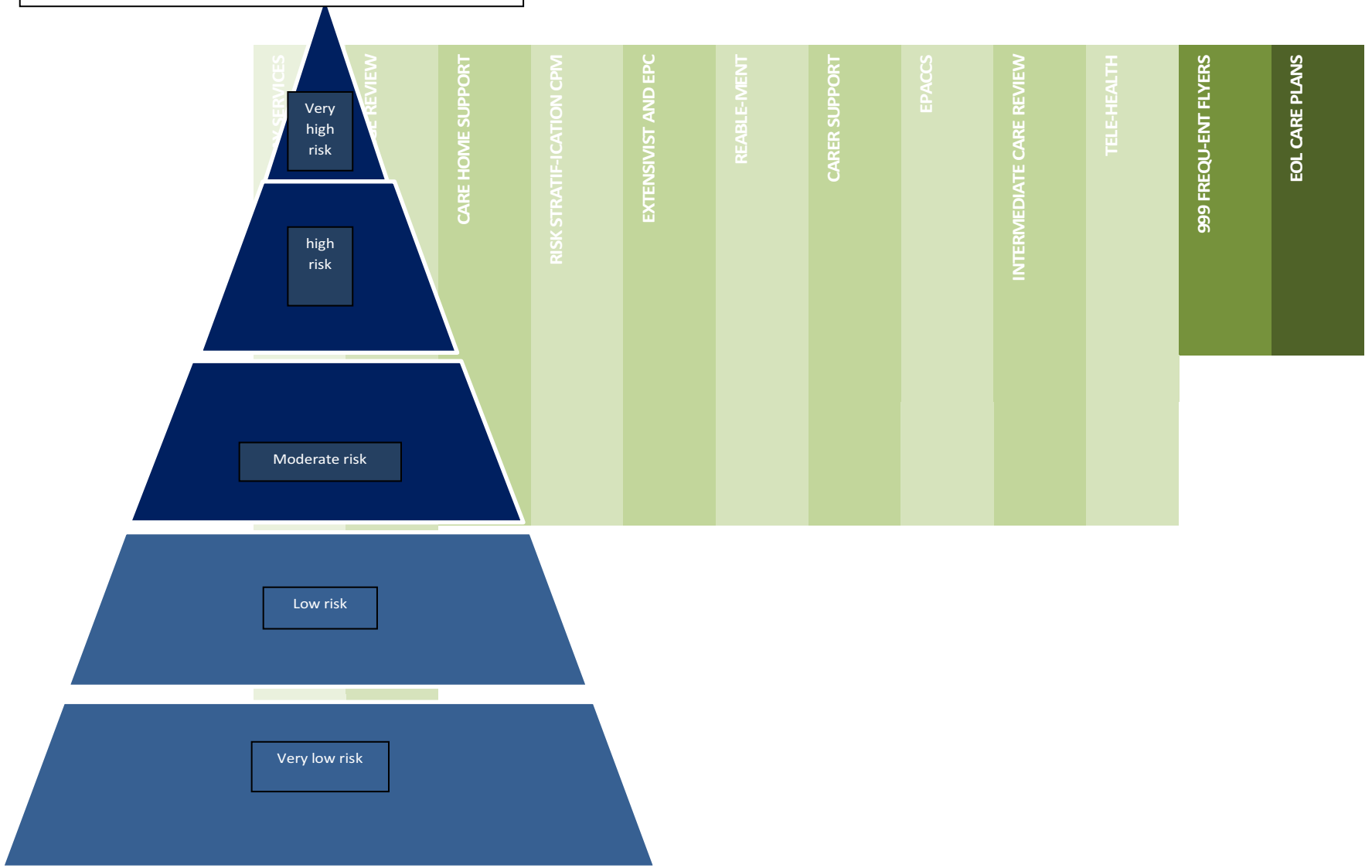
Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

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 Under development /planning Implementation	**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**
EPaCCS															
End of Life Care plans															
Care Homes Support scheme															
Implement hospital discharge															
Review urgent and emergency 7 day working															
Improvement carers services															
Risk stratification care co-ordination															
999 frequent															
Increasing re-ablement															
Implement intermediate care review															
Increased use of telehealth															
New Models of Care															

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 ~~t~~he 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

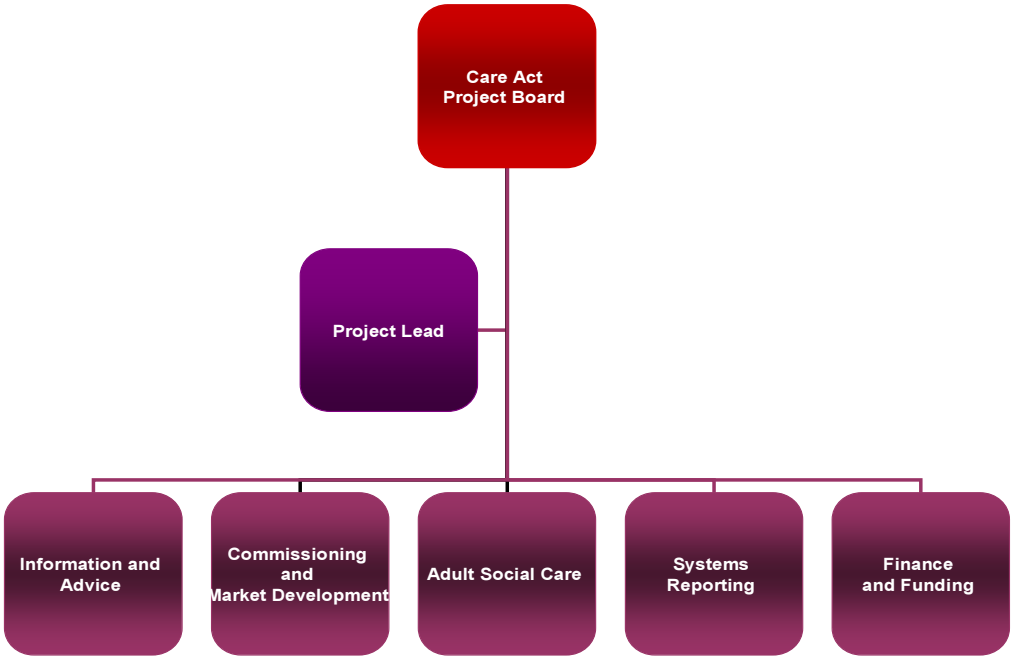
iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the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



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.

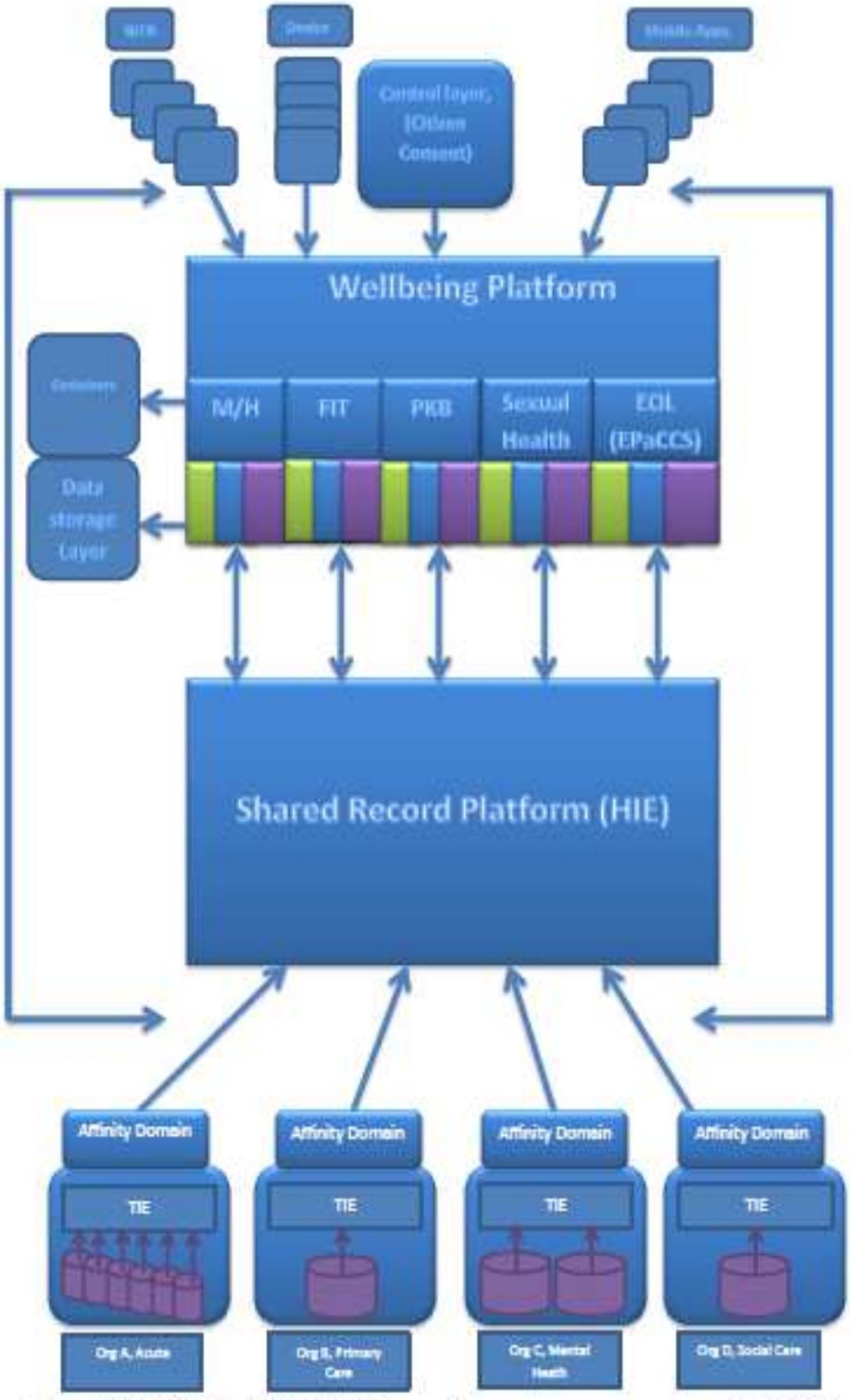
Blackpool Council social care system Core Logic Frameworki already allows the recording of NHS Numbers . A joint project has been established with the Council and the NHS with the purpose of securely sharing data with frontline workers in both Primary Care, Social Work and with other integrated services.The 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/337739/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 <u>Extensivist</u> • 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

  - to support the selection and design of this scheme
  - 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

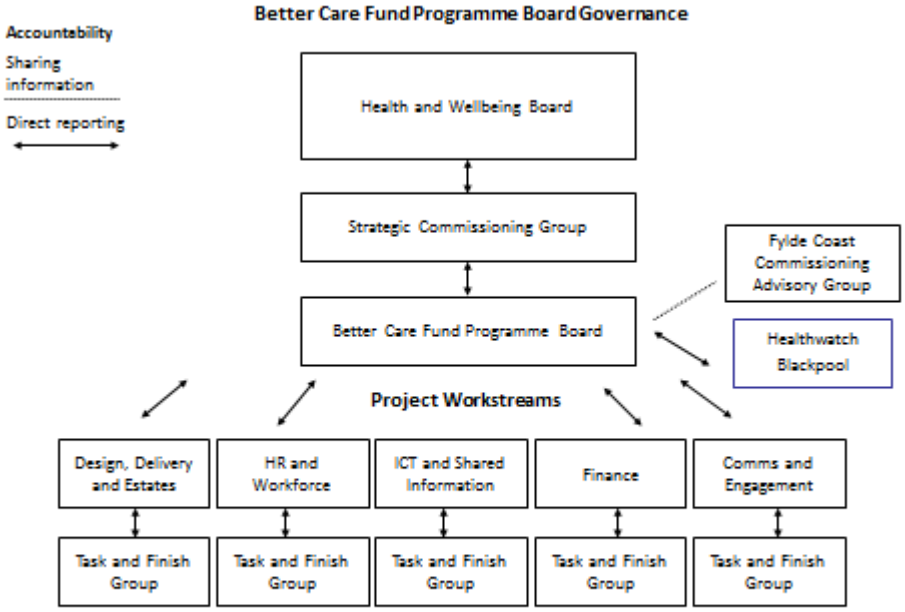
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

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

what is and is not working in terms of integrated care in your area?



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: ○ What is the model of care and support? ○ 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
- to support the selection and design of this scheme
- 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: ○ What is the model of care and support? ○ 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
- to support the selection and design of this scheme
- 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.

○ **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

- to support the selection and design of this scheme
- 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

headline metrics below

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

What are the key success factors for implementation of this scheme?

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: ○ What is the model of care and support? ○ 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

- to support the selection and design of this scheme
- 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

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

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

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

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 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: ○ What is the model of care and support? ○ 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

- to support the selection and design of this scheme
- 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
<u>National/local context and evidence base</u> 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
  - to support the selection and design of this scheme
  - 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;

- 505A&Edeflectionsperyear
- 152AvoidedAdmissions

The above equates to savings follows
505X£118=£59,590
152X£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: ○ What is the model of care and support? ○ 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
- to support the selection and design of this scheme
- 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: ○ What is the model of care and support? ○ 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 ○ to support the selection and design of this scheme ○ 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

- to support the selection and design of this scheme
- 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: ○ What is the model of care and support? ○ 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

- to support the selection and design of this scheme
- 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.