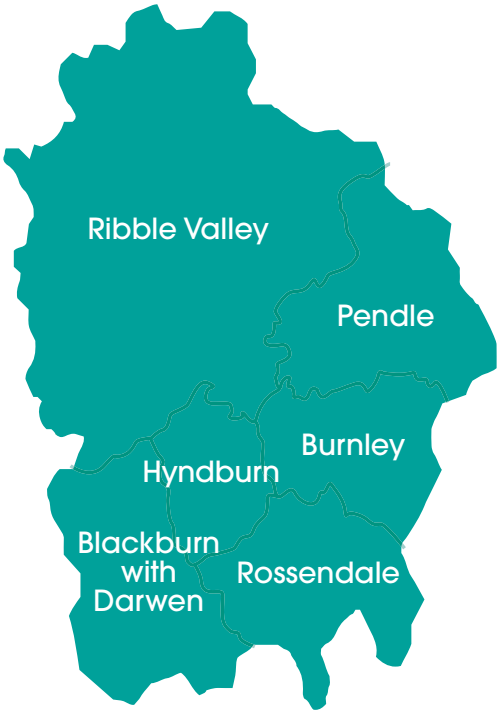
Winter 2017



Draft Pennine Plan:

Our Proposals for Improving Health, Care and Wellbeing in Pennine Lancashire

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

Foreword

We are proud of the health and care services we have in Pennine Lancashire. Our doctors, nurses, and wider health and care staff provide high quality care for people who live and work here.

We are equally proud of our communities and how residents across the area come together to provide friendship, encouragement and support to each other. Around 114,000 residents volunteer at least once per month, providing support and care to individuals and families across our communities.

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

In planning Together A Healthier Future we want to harness everything that is good about Pennine Lancashire; our people, our communities, our volunteers, our open spaces and our services. We want to put you and your family at the centre of everything we do and provide health and care around your needs, and not those of organisations. Over the last year we have been working with residents, volunteers, doctors, nurses, health and care professionals, community workers and others to develop our plans for change. We have listened to what people have had to say and we have developed a number of proposals which are set out in this document. There are plenty of opportunities for you to have your say and to help develop and refine these proposals to ensure that they meet the needs of all of us.

We can make our services the best they can be. Our doctors, nurses, pharmacies and other health care professionals can work better together in our neighbourhoods and we can improve hospital and urgent care services by providing more support in communities. We can do all of this, but we need everyone's help to make this work. We need everyone to look after their own health as much as they can, to make healthy choices in their lives, use services appropriately and support their families and friends to live healthy lives. Only by doing this will we all be able to achieve a Healthier Future.

Across health and social care we have more than £1 billion to spend each year, and we must make every penny count. We know that any discussion about change can be difficult and create uncertainty but we also know that when everyone is involved, we can achieve the best change.

We believe if we all work together we can overcome the challenges we face. Everyone has a role in making Pennine Lancashire a healthier place.

Graham Burgess

Chair: Pennine Lancashire Integrated Health and Care Partnership

Executive Summary

Delivering health and care across Pennine Lancashire is complex and confusing for professionals, patients and their families. This restricts our ability to provide excellent care and, in many cases, is financially unsustainable. As organisations who are responsible for, or have an interest in delivering health and care services, we have agreed to work together to remove this complexity.

We want to ensure we provide care in the right place, at the right time and as one team. We call this an Integrated Health and Care Partnership, and locally we call our system The Pennine Lancashire Integrated Health and Care Partnership.

The Partnership represents all the health and care organisations in Pennine Lancashire, along with local councils and voluntary, community and faith sector services. It is focussed on striving to achieve the best health and wellbeing outcomes for our population and making a positive difference to people's lives. We have agreed a shared vision which is:

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

We have worked with the public and our staff to design and refine eight statements that we believe will help us achieve our vision. We have called this the Pennine Pledge as it sets out both how as individuals we can help ourselves and our families and, as organisations, how health, care and wellbeing services should be delivered in the future.

Pennine Lancashire Benefits framework

Our Partnership has achieved a lot already, but we want to go further and work in a way that means we can all focus on our shared vision and the outcomes we want to deliver for everyone in Pennine Lancashire. We have agreed that, from 1 April 2018, we will become an Integrated Care Partnership.
This means we will:

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

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

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

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

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

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

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

We are proud of our ambition for Pennine Lancashire, and whilst we acknowledge that the challenges are great, we are committed to improving the health and wellbeing of our residents, transforming the quality of care delivery and ensuring that health and care organisations operate within their financial means.

Contents

1.0 Introduction

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

Dr Phil Huxley
Chair of East Lancashire Clinical Commissioning Group.

1.1 This draft Pennine Plan is a discussion document.

It sets out our response to the challenges we face and we are seeking your views about our proposals. You can read more about how we developed these proposals on our website.

1.2 Nationally the Government has asked health and care leaders in each area to come together to transform services and ensure they are affordable. These are called Sustainability and Transformation Partnerships.

Pennine Lancashire is one of five Local Delivery Partnership (LDP) areas that make up the Healthier Lancashire and South Cumbria Sustainability and Transformation Partnership (STP).

More details about the Lancashire and South Cumbria STP can be found at www.healthierlsc.co.uk. In Pennine Lancashire we have called our Local Delivery Partnership 'Together A Healthier Future.'

1.3 We are already working together as an Integrated Health and Care Partnership in Pennine Lancashire.

This means all health and care organisations are working together to achieve the best health and wellbeing outcomes for our population and make a positive difference to people's lives.

1.4 Our Vision for Together A Healthier Future is:

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

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

1.6 We have a resident population of over 531,000, 21% of whom are under 16 years old and more than 17% of residents are from Black or Minority Ethnic (BME) Groups.

One of the boroughs, Blackburn with Darwen, has one of the youngest populations in England, and half of all school-age children belong to BME communities. The Pennine Lancashire population will grow a little over the next ten years. By 2035 the proportion of people aged 65+ will increase from 13% to 17% and the number of residents aged 85+, currently almost 11,000 people (2.1% of the population), is set to double.

1.7 Pennine Lancashire is a great place to live and work. Public services are of high quality, and have delivered significant improvements to people's lives, but there is always room for improvement.

Additionally, there are increasing pressures being placed on these services and demand for services is out-stripping the money we have to pay for health and social care. But we also know about the excellent work that goes on in our neighbourhoods by people and communities working together.

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

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

Our Challenges

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

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

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

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

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

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

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

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

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

500+
ATTENDANCES PER DAY AT A&E

30%
OF VISITS COULD HAVE BEEN PREVENTED

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

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

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

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

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

Pennine Lancashire Commitments

We will create an effective, integrated, person and family centred Locality Services Model, incorporating NHS, Social Care, Primary Care and the voluntary, community and faith sector. This will be capable of managing the escalation of demand in neighbourhood and community settings, keeping people safe and well in their own homes.

We will transform urgent and emergency care to ensure that the people of Pennine Lancashire with urgent care needs will receive a highly responsive service that delivers care as close to home as possible. Those with serious or life-threatening conditions will be treated in centres with the very best expertise and facilities in order to maximise their chances of survival and a good recovery.

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

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

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

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

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

Pennine Lancashire Principles

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

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

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

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

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

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

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

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

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

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

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

Pennine Lancashire Health and Wellbeing Improvement Priorities

Healthy Lungs – including a focus on:

- Chronic Obstructive Pulmonary Disease
- Respiratory illness for children and young people

Healthy Hearts – including a focus on:

- Stroke
- Diabetes

Healthy Minds – including a focus on:

- Crisis mental health
- Mental health and substance misuse
- Psychological support for long term conditions

Cancer – including a focus on:

- Prevention and earlier diagnosis
- Treatment and care
- Living with and beyond cancer
- Patient experience
- Pathway redesign and waiting times

End of life – including a focus on:

- Providing high quality palliative and end of life care

Healthy Children and Young People – including a focus on:

- Accidents and injuries (including road traffic accidents)
- Nutrition and physical activity (incorporating dental health, obesity and low weight)
- 0-25s complex physical needs and long term conditions
- 0-25s complex psychological/social needs
- Infant mortality

Musculoskeletal – including a focus on:

- Osteoporosis and bone frailty
- Pain Management
- Osteoarthritis

Frailty – including a focus on:

- Falls
- Effectively identifying and supporting people who are frail

1.13 We are proud of our ambition for Pennine Lancashire, and whilst we acknowledge that the challenges are great, we are committed to improving the health and wellbeing of our residents, transforming the quality of care delivery and ensuring that health and care organisations operate within their financial means.

1.14 At the heart of Together A Healthier Future is the idea that we can all work together as individuals, communities, neighbourhoods, volunteers, health and care workers and organisations to improve our health and wellbeing.

We have used a series of events with people and staff, to design and refine eight statements that we believe will help us achieve our vision. We have called this the Pennine Pledge as it set outs both how as individuals we can help ourselves and our families and, as organisations, how health, care and wellbeing services should be delivered in the future. This is shown in the diagram below:

Pennine Lancashire Benefits framework

Note: Full details of the how we will measure progress towards the Pennine Pledge are set out in our Benefits Framework are provided on our website.

1.15 We have worked with many people over a long period of time to really consider how best to create this plan. Our Solution Design approach and engagement work is described in detail on our website. We believe that our New Model of Care is the best approach to improving the health and wellbeing of all who live and work in Pennine Lancashire but we are keen to hear your views on our proposals – have a look at how to have your say in Section 14.0.

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

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

2.0

The Pennine Lancashire Place-Based Prevention Framework

"Preventing avoidable illness, hospital admissions, long-term loss of independence and poorer quality of life, is not just common sense, in the long run it's the only way to balance the books."

Dominic Harrison
Director of Public Health, Blackburn with Darwen

Place Based Prevention

Healthy Communities are created when:

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

And where:

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

are mobilised to support good health for all

2.1 If we are serious about achieving our Vision, for all of to us to have healthy and long lives, we must invest significantly in prevention activities which we know work.

Our approach is to create healthy communities, both placed-based communities and communities where people share a common identity or like-minded interest. We will also ensure we take preventative action across all stages of life and all stages of both wellness and illness, for us all to lead healthier lives. We will do this through The Pennine Lancashire Prevention Framework (also referred to as The Framework), which underpins the New Model of Care.

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

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

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

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

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

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

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

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

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

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For Pennine Lancas

1. All organisations leading by example by signing up to and implementing a healthy lifestyle charter.
2. Give all health and social care staff and the public a greater voice.
3. Give children and young people a voice and making sure they have a say in changes that take place.
4. Create an environment for change to happen, through mobilising communities, enabling movements to grow and having an ongoing programme of celebration of learning.
5. Build a toolkit of practical approaches that can support people-led movements to develop and drive change.

1. Ensure our New Model of Care is capable of preventing and detecting disease and illness as early as possible and provides care and support within communities.
2. Support communities to take action to make their local environment healthier, such as access to local greenspace, allotments and active travel (cycling and walking).
3. Enable children to have the best start in life and put children and young people at the heart of the new accountable care system.
4. Establish local support groups for people with long-term conditions to help them to continue to live independently, and to particularly reduce their risk of loneliness.
5. Provide easily accessible information for local people to enable them to lead active and healthy lives e.g. through sport, volunteering, etc.

1. Ensure as many services as possible are accessible and where appropriate, delivered via digital means, starting with Prevention & Public health services (including obesity/healthy weight, smoking, drugs and alcohol, sexual health and mental health).
2. Establish a digital referral system for Social Prescribing options in all GP practices.
3. Establish an on-going programme of digital awareness training for all NHS/Social care staff and patients/public.
4. Establish effective shared care platforms and system-wide information governance arrangements to ensure information is accessible for everyone who needs it.
5. Work with ORCHA and other voluntary and commercial agencies, to encourage everyone to use Digital Apps and other technology to improve and manage their health and wellbeing.

1.Develop a wider approach to health governance through new Health and Wellbeing partnership arrangements.
2. Develop social movements for health that address key drivers of ill health in Pennine Lancashire (child poverty, poor housing/ landlords, hidden sugar in children's food, etc.).
3. Support the development of Scrutiny Committees to review actions defined within this prevention Framework, particularly for health, social care and children's related matters.
4. Develop a "Resident's Jury" Programme to review key themes of this prevention framework and make recommendations for action.
5. Ensure that patient representatives and disease specific reference groups are actively engaged in clinical pathway redesign.

1. Develop and support local community initiatives for self-help and local action at neighbourhood level through programmes such as 'Well North' and other Asset Based community development projects.
2. Work with District and first tier Councils to develop a single infrastructure/entry point for wellbeing related volunteering across Pennine Lancashire.
3. Establish a bidding network to work together, with support from the health and care system, to gain funds from national sources and make community grants available for health and wellbeing activities within the local neighbourhoods.
4. Establish a primary care Social Prescribing Programme capable of diverting up to 10% of current primary care prescribing costs to voluntary and community sector infrastructure investment over 3 years.
5. Establish a digital register, accessible at local levels, of all community support capacity available across Pennine Lancashire.

1.All local councils will develop an explicit Health in All Policies (HIAP) strategy.
2.All local councils will review arrangements and capacity for Health Impact Assessment (HIA) of current and future policies.
3.All local councils will scrutinise their HIAP strategy and approach through health scrutiny.
4.All local councils will develop an explicit Health and Housing Strategy and approach.
5.All local Councils will develop an approach to the health development as an outcome of planning, transport, and economic development policy.

Healthy organisations and institutions need to be a part of communities to help people make healthy life style choices. Healthy settings promote health for individuals, enable them to gain access to services and support a more engaged and interactive community.

1.Create a healthy settings programme to develop and support health promoting settings in homes, communities, towns, hospitals, care homes, workplaces etc.
2. Develop East Lancashire Hospitals Trust Hospitals as Health Promoting Hospitals.
3. Enable a Pennine Lancashire Health Promoting Schools Programme.
4. Develop and register Pennine Lancashire Care homes as Health Promoting Care Homes.
5.Ensure that each Local Authority area has at least one Healthy Streets initiative.

The overall aim is for both health and social care systems to move from the current 'detect and manage' model to a 'predict and prevent' model of investment and outcome delivery. Investment and provision needs to re-focus on the next generation of children and young people to reduce the onset of adult disease and prevent future avoidable illness.

1.Every Clinical Service Redesign and Clinical Pathway to have comprehensive, evidence based approaches to both prevent and manage disease incidence *(the number of newly diagnosed cases of a disease)* and disease prevalence *(a measurement of all individuals affected by disease at a particular time)*.
2. Develop system wide Risk Profiling Tool that covers cause of disease, risk and prevention as well as common practice identification and management.
3.Create a programme to move 10% of current primary care medications prescriptions onto a social prescribing model linked to the local community and voluntary, community and faith sector.
4.Create and support expert patient/disease support groups and ensure they are digitally linked and have access to professional support.
5.Each NHS and social care organisation will develop an approach to Sustainability/One Planet and commit to reducing their carbon footprint.

Everyone has the right and duty to manage their own health. People need support to take charge of their own health and wellbeing through education on self-care, lifestyle changes, accident prevention and relevant and up to date information about the right care, support and treatment for them.

1. Support people to improve their own health through health promotion communications and digital campaigns across Pennine Lancashire.
2. Promote responsible use of NHS services through a targeted campaign of public education and information about how/where to access relevant services.
3. Promote self-care and management of minor illness, particularly through community pharmacies and wider sources of support for self-care such as dentists and optometrists.
4. Promote new self-care and self-management skills for people of all ages.
5. Continue and expand targeted self-care support programmes for people who frequently use services.

1. Develop a training programme in public health prevention for NHS, social care and where relevant other public services staff.
2. Develop a Make Every Contact Count (MECC) programme across the health and care system.
3. Review and upgrade staff health promotion and occupational health programmes in Pennine Lancashire.
4. Develop a universal approach to Mental Health First Aid training for all Pennine Lancashire public sector staff, and members of the community.
5. Ensure that all basic training undertaken in Pennine Lancashire's further education institutions, for health and care staff, includes
modules for population health/public health/prevention.

3.0

A New Model of Care for Pennine Lancashire

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

Graham Burgess
Chair of Blackburn with Darwen
Clinical Commissioning Group

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

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

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

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

3.4 Hearing from, and working with, people who have experience of these priorities, either themselves or through their family, will be a key part of our work and we will ensure that people have opportunities to contribute to the future direction of our Health and Wellbeing Improvement Priorities.

4.0 Me and My Family

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

Encouraging and Promoting the Five Ways to Wellbeing

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

Promoting and Enabling Self Care

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

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

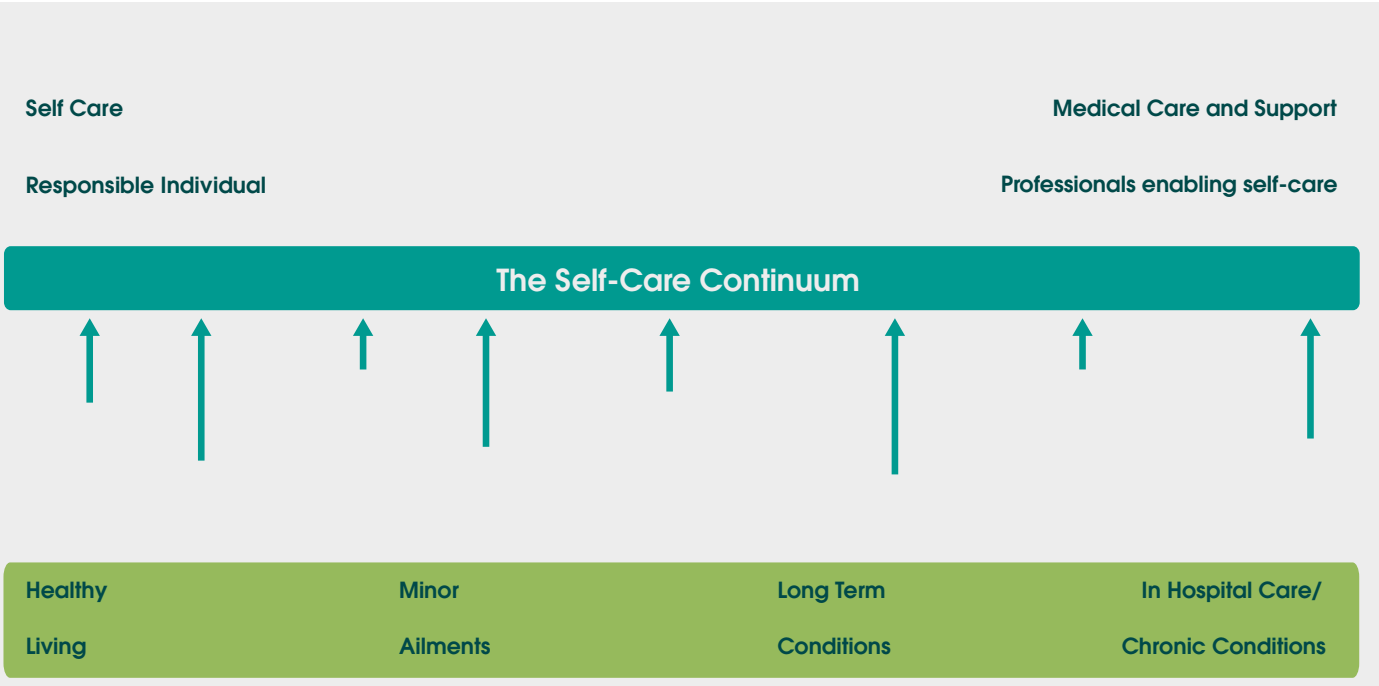
4.5 We want to promote and enable self-care at every opportunity and you will see us talk about self-care throughout our plan.

4.6 The diagram below, which has been adapted from the Self-Care Forum, helps to show this.

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

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

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



5.0 My Healthy Home

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

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

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

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

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

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

6.0 My Healthy Community

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

Professor Sir Michael Marmot,
Fair Society, Healthy Lives

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

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

- Make sure community-focused approaches, which build on individual and community strengths, become more central to our local plans for health and care
- Improve access to, and funding, for community resources, so that we are able to better connect people to practical help, group activities and volunteering opportunities, to promote good health and wellbeing and increase social participation
- Recognise the excellent work already undertaken by our communities in delivering health improvement and preventative services across our New Model of Care and help grow these further

• Develop new and innovative ways to increase participation and involve individuals and families, particularly those at risk of social exclusion, in designing and delivering solutions that address inequalities in health

- Celebrate, support and develop volunteering
- Work in collaboration and partnership with our local communities and proactively involve them and listen to them at all stages of planning and designing of services.

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

- Bring about change in the experience and delivery of health care
- Improve people's experience of disability or ill health
- Promote healthy lifestyles
- Address the wider determinants of health
- Democratise the production and dissemination of knowledge
- Change cultural and societal norms
- Bring about new health innovation and policymaking process.

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

- Understand social movements for health and recognise their value. We will improve our collective understanding of social movements and their potential, so that we are able to generate the necessary appreciation, appetite, enthusiasm and ambition across communities and organisations in Pennine Lancashire
- Build and support communities of interest which are safe havens for social movement innovation. It is important that we nurture local activists who will influence their peers and form a critical mass of support for sustained change
- Develop new models of engagement for Social Movement: We want to go beyond traditional community development approaches and work outside of our usual geographic and organisational boundaries. We must also seek to understand and work with the desires of our workforce and communities
- Leadership and culture change for social movement: We will work together to listen and respond effectively and will be willing to hear new ideas and do things differently. We know that new approaches are required that draw effectively on both the efficiency and scale of institutions and the dynamism and agility of movements.

6.6 We recognise that, for the health and care system to be able to respond appropriately to emerging social movements, we need to develop our workforce to support such cultural change. Of greatest importance is leadership development at all levels to recognise, promote and move people to value and nurture social movements for health. This workforce development programme will be embedded within the wider Pennine Lancashire 'One Workforce' and organisational development programmes.

7.0 Living Happy, Healthy and Well

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

Early Years, Children and Young People

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

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

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

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

b) Parents and carers have a key influence on a child's long term health and wellbeing. We will ensure they get the best support possible, through evidence-based parenting programmes, as well as through peer support and community groups. This support will be there from before birth through into adolescence.

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

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

Physical Activity Promotion, Active Travel and Nutrition

7.5 There is strong and consistent evidence that increasing physical activity will help us live longer and improve our mental wellbeing. It has also been shown to reduce the risk of many long term conditions, including heart disease and stroke, diabetes, cancer and dementia.

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

a) Physical Activity and Active Travel

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

b) Food and Nutrition

- Promoting healthy and sustainable food choices for all: Building on local examples of good practice we will develop an 'Out of Home' food provision action plan
- Tackling food poverty and diet related ill-health across the life course by:
- Investing further in ante and postnatal support for breastfeeding, healthy introduction to solid foods and expand nutritional advice in early years settings, to ensure the best nutritional start in life
- Tackling food poverty through the development of a Food Poverty Network to identify and support the delivery of interventions to reduce food poverty across the life course
- Developing a Pennine-wide food growing programme taking a settings approach will develop a life course approach to accessing healthy sustainable food, teach life skills and encourage inter-generational activity.
- Building community food knowledge, skills and resources – Further investment in cookery clubs which are settings based and use community assets – including community buildings and volunteers and will target all ages and will include support for vulnerable adults. Investment in achieving 'Sugar Smart Pennine' status using a Pennine-wide campaign, promotions and competitions.

Adverse Childhood Experience

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

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

7.9 To address and respond to ACEs we propose to:

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

Pennine Lancashire aims to become the UKs first 'ACE Informed area' by:

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

b) To build ACE informed organisations where we are able to prevent ACEs, mitigate the consequences of ACEs through early identification and intervention and to enable our workforce to take an ACE informed approach to:

- **Develop and implement ACE informed training and digital assessment tools to identify children, young people and adults who have increased ACE scores**
- **Understand the distribution of ACEs across different population groups and understand the potential paths for recovery**
- **Integrate and incorporate knowledge of ACEs into existing strategies, policies, procedures and practice**
- **Develop ACE Informed provision, so that there is appropriate support for and management of the consequences of ACEs.**

8.0 Keeping Happy, Healthy and Well

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

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

Creating New Relationships and Integrating Across Primary Care within Communities

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

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

Access to Advice and Resources to Look After Ourselves

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

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

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

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

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

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

Identify and Act Early on Specific Health Conditions

8.10 Population screening programmes that detect cancer early are known to be cost-effective if high coverage is achieved. Unfortunately, this remains low across Pennine Lancashire. We will work to increase this coverage by raising awareness of the importance of the programmes to those people who are less likely to use the programmes, incentivise specific schemes and develop intensive targeted programmes.

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

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

Preventative Interventions That Are Known to Work Well

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

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

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

9.0 Joined-Up Care and Support

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

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

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

- Integrating health and wellbeing care at neighbourhood level, bringing together primary care (GP practices, dental practices, community pharmacists and optometrists), community healthcare, social care, wellbeing services and the voluntary community and faith sector
- Keeping people at home for as long as possible by providing a range of specialised and enhanced community services. An enhanced offer will be provided to people with long term conditions, bringing additional support to the neighbourhood health and wellbeing led care plans
- Delivering intermediate care, which is an extended model of community care which helps people to stay out of hospital following deterioration in their health and circumstances (known as step up services), as well as those that support people to get back home after spending time in hospital (known as step down services)
- Transforming urgent and emergency care to ensure that people with urgent care needs receive highly-responsive services that delivers the right care as close to home as possible.

Integrating Health and Wellbeing Care at Neighbourhood Level

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

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

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

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

9.9 Specifically our Neighbourhood Health and Wellbeing Teams will offer:

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

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

Enhanced Primary Care

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

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

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

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

9.15 Improved relationships and communication between primary care and specialist services will enable a more co-ordinated approach to care.

Specialised and Enhanced Community Services

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

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

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

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

9.19 Specialist therapy, nurses, social workers and doctors. There is an on-going need for specialist skills to deliver effective care for specific conditions. These specialists will interface with Primary Care and provide case management for those people with more complex needs, for short periods of time, until comprehensive support plans are developed. These specialist roles could include for example Gastroenterology services and Diabetes Specialist Nurses.

9.20 We will work closely with the Lancashire and South Cumbria Sustainability and Transformation Partnership to effectively align specialist services, currently provided across Lancashire and South Cumbria, to our New Model of Care. This will include:

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

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

Developing a High Quality and Sustainable Urgent and Emergency Care Service

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

- **Urgent Care** is treatment for injuries or illnesses requiring immediate or same day care but not serious enough to require an Emergency Department visit or to result in the need for a hospital admission. It can be required to prevent serious deterioration of health following the onset of an unforeseen condition or injury.
- **Emergency Care** is treatment for serious or life-threatening conditions and will always require the back up of further hospital services such as in-patient treatment or surgery, though this may not be required for every patient that attends.

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

9.24 When you or your family need to access urgent or emergency care services you are able to ring NHS 111 to speak to an advisor, who will quickly be able to direct you to the most appropriate service for your needs. In the future you will still be able to do this, but you will also be able to access a similar system on-line, via your smart phone or computer. Your information will be passed seamlessly, and securely, between all of the services that need to know your details eg between 999 and 111 and 111 and your GP. The intention is that one call will do it all and if you need to speak to another professional you (with your details) will be passed smoothly and swiftly to the correct place.

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

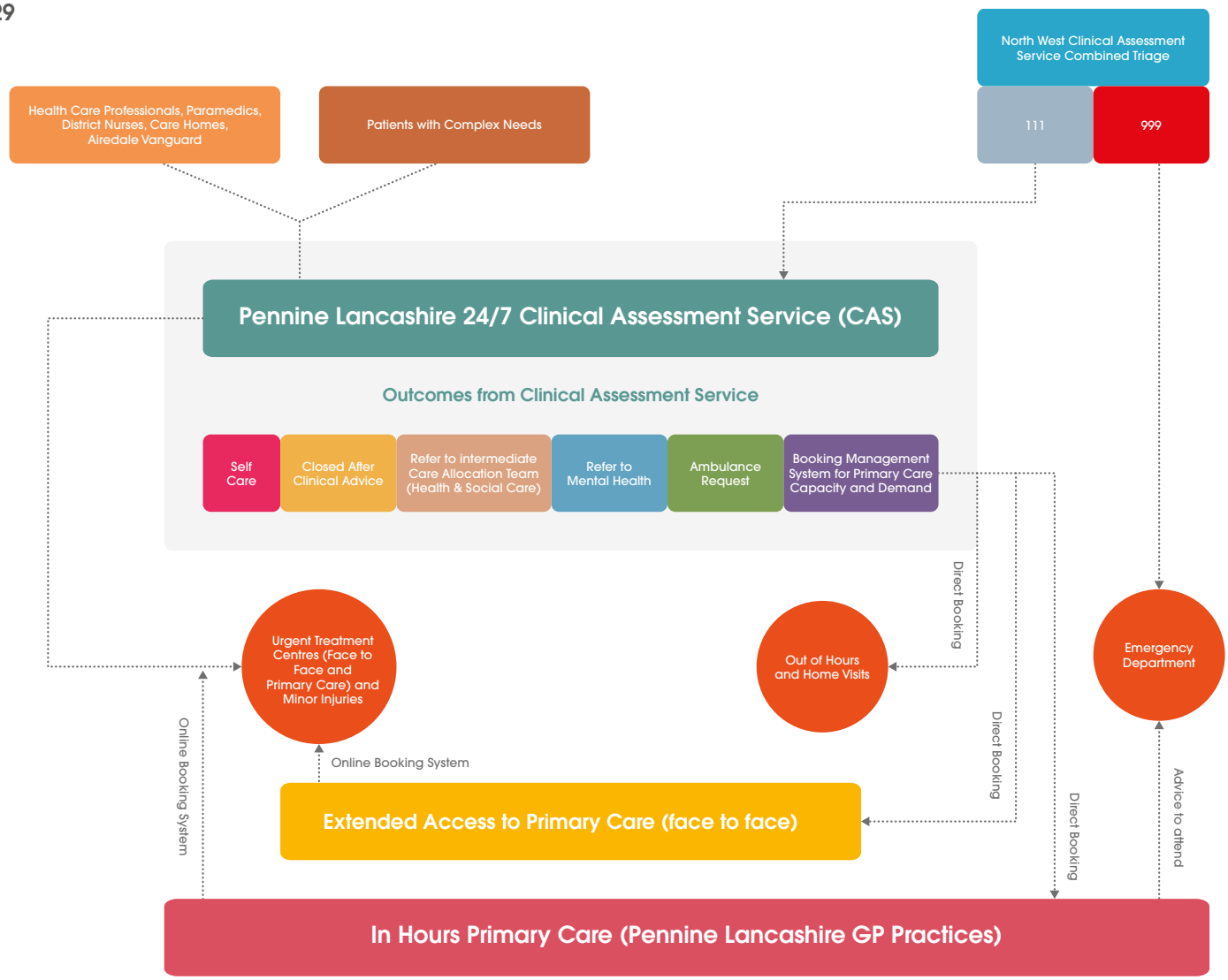
9.26 Developments will also take place within ambulance services to enhance the way that they work. Over time their services will be able to deal with more patients over the phone, directing them to appropriate services and they will be able to treat many more patients at home. Key to this will be linking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

9.27 We will also:

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

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

9.29


North West Clinical Assessment Service Combined Triage
111
999
Health Care Professionals, Paramedics, District Nurses, Care Homes, Airedale Vanguard
Patients with Complex Needs
Pennine Lancashire 24/7 Clinical Assessment Service (CAS)
Outcomes from Clinical Assessment Service
Self Care
Closed After Clinical Advice
Refer to intermediate Care Allocation Team (Health & Social Care)
Refer to Mental Health
Ambulance Request
Booking Management System for Primary Care Capacity and Demand
Direct Booking
Urgent Treatment Centres (Face to Face and Primary Care) and Minor Injuries
Out of Hours and Home Visits
Emergency Department
Online Booking System
Online Booking System
Direct Booking
Direct Booking
Advice to attend
Extended Access to Primary Care (face to face)
In Hours Primary Care (Pennine Lancashire GP Practices)

10.0 In-Hospital Care and Support

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

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

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

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

Emergency Department at the Royal Blackburn Hospital

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

Improving Patient Flow

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

- Optimise Ward Processes and transform medical, surgical and community wards. The aim is to roll out an improvement programme across all adult wards (post-assessment unit) which will include assessment and diagnostics, care planning, admission, welcome and introduction, delivery and review of care plans (multi-disciplinary working) and transfer of care. This will improve performance and patient experience
- Implement a Home of Choice policy. An acute hospital is not an appropriate setting for ongoing care once a patient has completed treatment. Through implementing a Home of Choice Policy, those awaiting a care placement or care provider while in hospital will be supported to make a timely choice to minimise the risks associated with remaining longer in hospital
- Develop a Single Discharge from Hospital Service which will support people to be discharged from hospital as soon as they can be. Our current Pennine Lancashire Integrated Discharge Service (IDS) commenced in 2015 and brings together a number of disciplines within the hospital setting including complex case managers, social care and therapies. The service supports individuals in discharge planning and arranging care and support needed upon discharge, including social care packages, reablement and rehabilitation, dependant on individual needs. We will strengthen this service and ensure that our Integrated Discharge Service will be responsible for the full implementation of system-wide Trusted Assessment, consistent and effective use of integrated discharge pathways across Pennine Lancashire and the development of a single performance dashboard

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

Elective (Scheduled/Planned) Care

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

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

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

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

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

Working within Lancashire and South Cumbria

10.11 The future provision of in-hospital care and support services (acute and specialist) will also be shaped and influenced by discussions on the wider Lancashire and South Cumbria STP footprint. East Lancashire Hospitals Trust (ELHT) Clinical Strategy is to be both a networked provider of key specialist services in conjunction with other Trusts across all of Lancashire (including stroke services, maxillofacial services, vascular services, radiology services and cancer services) and be a regional centre of excellence for specific services (for example certain urology and hepatobiliary surgery and neonatology).

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

11.0 Finance and Investment

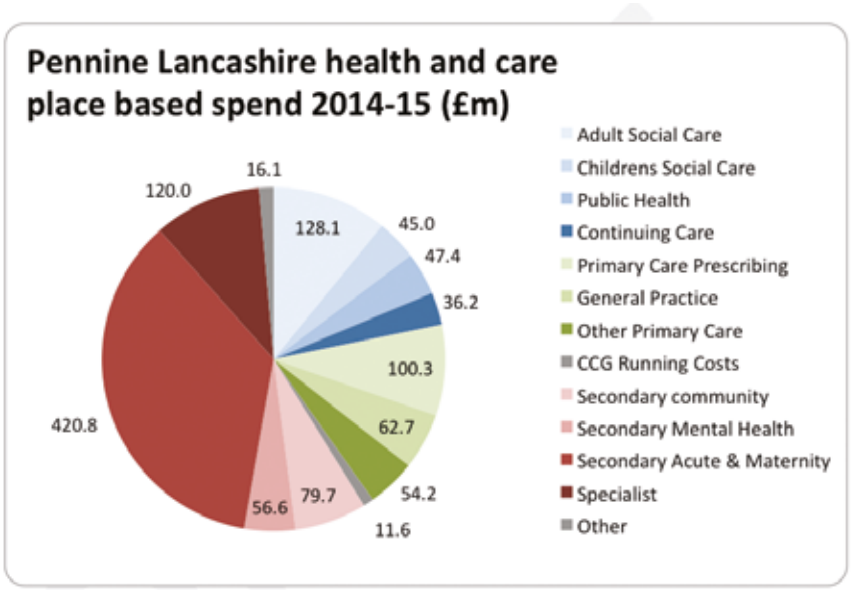
The Challenge

11.1 Over the next five years there will continue to be a significant amount of money spent on health and care interventions for the 531,000 people living in Pennine Lancashire.

11.2 Public sector spending on health and social care for the residents of Pennine Lancashire was £1.18billion in 2014/15.

11.3 After taking account of the resources that are likely to be available and the pressures that the health and social care system will face over the next five years, it is estimated that there will be a shortfall in funding of some £129 million.

11.4 This figure will continue to be refreshed and updated on a regular basis, to reflect changing funding positions, however the scale of the challenge demonstrates why radical change is needed, both in the way that services are provided but also in the way that we use those services.



The Opportunities

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

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

Improving efficiency of services we deliver

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

11.8 Benchmarking performance of our services nationally and locally has identified opportunities where savings can be made. Areas identified for improvement include for example, improving the efficiency of Accident and Emergency and outpatient activity, reducing lengths of stay in hospital for certain procedures and reducing unwanted variation in care through 'RightCare'. Our partner organisations are working hard to deliver efficiencies and productivity improvements to address these challenges.

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

Investment in Prevention and Population Health

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

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

New Model of Care through Transformation

11.12 The New Model of Care described in detail throughout this document has been, and continues to be, designed to address the triple aim outlined in our Pennine Lancashire Benefits Framework: the health and wellbeing gap, the care and quality gap and the funding and efficiency gap.

11.13 By focussing on and investing in prevention, supporting people and communities to care for themselves and each other, providing high quality out of hospital services and in doing so, freeing capacity in our hospitals to focus on acute and specialist services, we can address the triple aim and close the funding gap in the long term.

11.14 Each programme of work within the New Model of Care (including the specific Prevention Programmes mentioned above) has been through an economic modelling process to help identify the costs and the benefits expected. The economic model results are still being developed and will be included as part of the final Pennine Plan in Spring 2018.

One Public Sector Estate

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

11.16 The next phase of this work will be to review all of the buildings we own and some of those we don't, across the Pennine Lancashire footprint (public sector and wider) with a view to identifying how we can maximise the use of our buildings to deliver the New Model of Care and how we can release some estate to free up valuable funds.

Digital

11.17 Digitally-enabled transformation will improve the effectiveness and efficiency of health and social care services. The Lancashire Local Digital Roadmap identifies three broad themes all of which if delivered effectively will improve care and save money; sharing of electronic records, empowering people through the sharing of knowledge and enabling people with technology .

11.18 Within these themes and to directly address the financial challenge the following commitments have been made:

- Ensuring the transformational programme effectively exploits technology to manage capacity and demand
- Ensuring we consolidate and share IT systems to reduce cost and complexity
- Ensuring we utilise cost effective cloud-based solutions
- Ensuring we leverage procurement through scale and standardisation
- Ensuring we collectively maximise the benefits of technology.

11.19 The financial benefits and costs driven by digitisation that have been identified through the New Model of Care to date are limited but will grow as we enter the detailed design phase.

Next Steps

11.20 Following public engagement the New Model of Care will move into a detailed design phase which will further clarify the financial implications of each of the proposed programmes with a view to decisions being made regarding the affordability of the New Model of Care and any prioritisation that is required.

11.21 The financial strategy for Together a Healthier Future will be completed and include in its core principles, including delivering the best value for "the Pennine Pound", "One Public Estate" and a shared financial control total.

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

11.23 A position statement will be agreed on behalf of the six organisations within the Pennine Lancashire Integrated Health and Care Partnership which details how much we have managed to reduce the gap by and plans for any further action needed.

11.24 As we continue to move towards an Integrated Care Partnership and develop our financial strategies and plans to support this, we are also seeking confirmation of Pennine Lancashire's ability to access the following:

- Fair share of the additional transformation funding
- Funding to support social care activity
- Access to capital resources to invest in Information Management and Technology.

12.0 One Workforce

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

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

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

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

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

Current Workforce Profile

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

12.6 Work is underway to determine a comprehensive workforce profile utilising Health Education England's Workforce Repository and Planning Tool (WRaPT) alongside the Primary Care Insight tool. It is estimated that the employed workforce in health and social care, including primary care, stands at around 13,500 and alongside staff working in the 178 local care homes there is a huge volunteer workforce estimated at around 14,000.

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

12.8 Once the current baseline is established in greater detail and the New Model of Care has been determined in full, work will be progressed to model a future workforce based on required skills and competencies, enabling exploration of potential new roles, working differently and identification of any upskilling required. We will work with health and care education and training providers to make sure that the number of staff, and the skills and capabilities, we need can be met.

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

12.10 There is also a significant unpaid workforce of volunteers and carers who need to be considered to ensure we fully understand how all aspects of care and support is currently delivered and how this supports our drive towards social prescribing and promotion of self-care.

Achieving One Workforce

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

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

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

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

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

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

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

Leadership, Organisational Development (OD) and Workforce Engagement including:

- Commission wider OD Programme building on system leaders and key 100 leaders
- Develop leadership strategy based on compassionate leadership model
- Develop shared values and behaviours
- Implement joint induction
- Produce engagement toolkit
- Identify and train engagement ambassadors
- Deliver roadshows
- Undertake a baseline staff survey
- Engage staff in workforce modelling workshops.

Streamlining and Alignment Activities including:

- Establish a formal Partnership Forum with Trades Union colleagues
- Agree a single approach to managing organisational change
- Establish an agreement for a shared training and development programme
- Agree a single Occupational Health provision
- Consider provision of Human Resources and Organisational Development activity, under shared management arrangements
- Develop a single recruitment and retention strategy
- Develop a single health and wellbeing strategy for our workforce.

Workforce Transformation Activities including:

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

13

Conclusion and our Next Steps

"I think, in the future, we've got some challenges, I just think we need to work together. We need to look at the social capital, we need to make it work. I think we need to make sure everybody is consulted and everyone's getting a say. I just think that times are hard, yes they really are hard, but together we can really make a difference."

Rick Wilson
Community leader, Blackburn.

13.1 The production of this first draft Pennine Plan draws to a close our solution design work and allows us to test our vision, aims and ambitions with you as our residents, patients and staff.

13.2 Over the next two months, we want to hear from as many people as possible about our Plan. We want to know if we are heading in the right direction to bring about the changes needed for our health, care and wellbeing services and hear any suggestions you may have about how we can make things happen.

13.3 We will take your comments and use them to develop a final version of this Pennine Plan.

13.4 Whilst this is happening, we will continue to take the ideas given to us so far and develop more detailed specifications about what and how service changes could be delivered. We aim to complete this detailed work and publish our final Plan by Spring 2018.

14

Our Thank You!

14.1 We've come a long way over the past twelve months, and we would like to thank all our residents, community and voluntary groups, health care professionals and wider staff who have contributed their support, ideas and opinions to help us get this far. We hope that we continue to receive your input as we move forward.

14.2 We still have a long way to go, but we are confident that together, we can make the difference needed for Pennine Lancashire.

14.3 Throughout Winter 2017 we will be attending various community meetings, engaging through digital communication methods and having localised outreach engagement discussions with people across Pennine Lancashire. We want to make sure you have the opportunity to have your say to further develop and refine these proposals to ensure that they meet the needs of all of us.

14.4 If you haven't already joined the conversation about the future for health, care and wellbeing in Pennine Lancashire, then take a look at our website, Twitter and Facebook accounts:

Join the conversation

@ahealthyfuture_
#ahealthyfuture

together a healthier future

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