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Report of the Directors of Public Health, Adult and Community Services and Finance of Bradford MDC, and the Director of Collaboration and Chief Officers of the CCGs to the meeting of the Health and Wellbeing Board to be held on 24th November 2015.

Subject: Working Better Together - A Whole System for Health and Social Care

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Summary statement:

This report updates the Board on work that is being undertaken together to take us closer towards delivering our vision for 2020 of a sustainable health and care system. This work is focused on enhancing health and wellbeing and accelerating an improvement in outcomes for the local population through integrated commissioning and delivering new models of care. The report updates the Board on the work that is being planned to build upon the Better Care Fund, as well as expanding our joint commissioning arrangements to secure better integration of health and care services. It also serves as a progress report on the tasks commissioned at the Board's development sessions.

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1. SUMMARY

This report updates the Board on work that is being undertaken together to take us closer towards delivering our vision for 2020 of a sustainable health and care system. This work is focused on enhancing health and wellbeing and accelerating an improvement in outcomes for the local population through integrated commissioning and delivering new models of care. The report updates the Board on the work that is being planned to build upon the Better Care Fund, as well as expanding our joint commissioning arrangements to secure better integration of health and care services. It also serves as a progress report on the tasks commissioned at the Board's development sessions.

2. BACKGROUND

The 5 year forward view was signed off by the Health and Wellbeing Board in July 2014. It is a strategy for the Bradford District & Craven health and care system which is designed to deliver our collective vision to create a sustainable health and care economy that supports people to be healthy, well and independent. It describes how health and care services for the people of Bradford District & Craven need to change over the 5 years from 2014 to 2019, and sets out how we envisage this will be achieved. It recognises this is a time of unprecedented prolonged financial challenge to the health and social care sector, twinned with rapidly rising demand, as well as acknowledging this a huge opportunity to create a system that operates in a way better suited to the 21st century. Working together across the health and care system we need to move from looking at how we merely address the financial challenge in the system to looking at how we collectively utilise available resources in a more efficient and effective way. In order to deliver the ambitions of this plan we are working to shift activity and resources into different parts of the system and are working together across numerous work-streams to secure its implementation. This is being done through transforming and integrating health and care services through establishing new models of care (see Appendix 1), supported by commissioners working together and providers coming together to form alliances to bring different services together - like hospitals, social care and GPs – so that they work in a more joined up way.

The Bradford and Airedale Health and Wellbeing Board has agreed to lead the work on system change to improve outcomes and ensure that the local health economy remains sustainable as public sector budgets reduce up to 2020. Specifically the Health and Wellbeing Board has agreed to work towards the establishment of a total pooled joint commissioning budget and a single prioritisation process that will help to ensure that the right services and interventions are funded to improve health and wellbeing outcomes for the District.

The Board acknowledged that this was a long term objective and that we should aim for this to be the position within five years. Recent Health and Wellbeing Board development sessions have challenged the health and care system to align commissioning plans and resources in 2016 to move us towards this objective and utilising the Better Care Fund framework is seen as one of the key mechanisms to achieve this.

3. REPORT ISSUES

3.1 **Pooling budgets through the Better Care Fund**

From April 2014, CCGs and the Local Authority have been required to work together to manage funds through the Better Care Fund. The fund is intended to act as a catalyst towards change in health and social care. The CCGs and the Local Authority developed a Better Care Plan, signed off by the Health and Wellbeing Board to set out to how they will use the money that is transferred to a pooled budget specifically for the provision of integrated care. Locally, this is £37.3m and is comprised of aligned existing funding to support the development of an integrated system of community based care and in particular, intermediate care to support people to regain and maintain their health, wellbeing and independence

Pooling budgets makes it easier to commission and deliver the health and wellbeing services people need against a common set of outcomes for their population. Instead of having to deliver highly specified services that target narrow outcomes against fragmented budget codes, providers can personalise interventions according to the best interests of individuals and respond much faster when needs change.

Locally, prior to the Better Care Fund we had already pooled a number of specific budgets including those for community equipment services, and children's communication aids. This provides a shared set of goals and priorities across commissioners and provides a framework for risk sharing, and overall improves service delivery with streamlined assessment processes and response times.

The Board's discussion of how to accelerate progress on the scale and pace of our joint commissioning activity has led to the proposal to develop the Better Care Fund further from 2016-17 with the intention to:

1. increase the scope and scale of the Better Care Fund
2. secure better use of resources through collaborative decision making
3. design new models of care that support improvement in outcomes through both commissioner and provider collaboration

In respect of the scope and scale of the BCF discussions are taking place across the CCGs and CBMDC on an initial expansion of the Better Care Fund to support improvement in the quality of care commissioned, to enable care to be personalised, reduce duplication and produce better value for the system. An initial assessment has scoped out an opportunity to create a BCF in excess of £200m which is broken down into 5 categories:

- keeping people well in the community,
- active support and recovery,
- independent living solutions,
- long-term high support

- adult inpatient medical emergency admissions.

Monitoring the expenditure trends across the whole BCF should enable us to understand the interdependencies between the different elements of the budget and incentivise spending on lower level interventions in an attempt to reduce high cost interventions including emergency hospital admissions.

Improved joint governance arrangements will need to be in place and are being worked through ready to be in place by March 2016 to support shared decision-making about pooled funds. Additionally an overarching Section 75 agreement for 2015/16 is about to be signed off which defines and governs how resources pass between the Council and the CCGs. This Section 75 agreement:

- Covers all key areas where resources transfer between CCGs and the LA;
- Clearly identifies the resources which transfer;
- Provides clarity on the responsibilities of each partner;
- Provides flexibility for adding/removing services where applicable.

With regard to the better use of resources through collaborative decision making, where greater collaboration is agreed this will sometimes, but not always, be facilitated by a Section 75. The current Section 75 agreement includes:

- Administering continuing healthcare contracts
- Contract compliance, resilience and domiciliary care (pooled budget)
- Integrated carers services
- Community equipment services (pooled budget)
- Stroke info and support service
- Alcohol services commissioning
- Joint Mental Health strategic commissioning
- Joint Learning Disability Strategic Commissioning
- Domestic and Sexual Violence Services (pooled budget)
- Children's communication aids (pooled budget)
- CCG and public health commissioning and contracting

The intention is also that operational managers and staff from across different services will be brought into closer day to day working arrangements to join-up practice and share knowledge and expertise of these key areas of practice to enhance the quality of services to improve outcomes.

In respect of new models of care, Appendix 1 details the design work being undertaken to support an improvement in outcomes.

3.2 **Commissioning processes to support system wide transformation health and care**

`Accountability arrangements are critical to any system. They set the framework for strategic decisions about how services are provided and to whom, the quality of those services and whether the funds available are well spent. They determine how much say local people and users have alongside regulators and national and local politicians. Weak, poorly designed accountability arrangements are likely to lead to strategic or service quality failures or poor value for money.'
Nuffield Trust, Reconsidering accountability in an age of integrated care, July 2015

Strategic commissioning is one of the key products of the Health and Wellbeing partnership arrangements with the emphasis on `making a difference to our customers' through a clearly articulated vision and set of priorities as set out in the 5 year forward view. The overall objective is to establish an` accountable care system' for Bradford District and Craven through new ways of procurement and contracting which in turn would lead to changes in the models of providing services. It is envisaged that much of the current, operational commissioner activity would sit within these new models of care and therefore one consequence would be the need to create a smaller, more strategic commissioning function. This requires different ways of working across the commissioners, including pooling of resources and different sets of behaviours which are currently being worked through via outline principles and terms of reference for a commissioner alliance for Bradford District and Craven which were shared at the October 2015 Health and Wellbeing Board Development session.

Through the design of new models of care we are exploring the development needs for commissioning as we create a strategic commissioning response to the new models of provision.

Specifically, through collaborative arrangements via Bradford Health and Care Commissioners, the Local Authority and CCGs are working towards developing stronger and deeper integration of health and social care and are working through the options as set out above.

This will create a more joined-up approach to planning and commissioning across out-of-hospital care, and support efforts to deliver more integrated, person-centred care. Amongst the benefits of being able to deliver better integrated care through resource pooling, there will be risk and benefit share opportunities, greater openness and a feeling of fairness through better buy-in to commissioning decisions from all member organisations, as they feel able to be fully involved and have the opportunity to contribute. This will create the potential for further opportunities to integrate – even if we start small we can expand the scope later. Ultimately our new commissioning arrangements will move us towards our 2020 vision.

Work will need to take place with legal representatives of respective organisations to ensure that processes are agreed that comply with all legal and statutory requirements.

3.3 **Joint financial planning and prioritisation framework**

An outline Joint Finance Strategy was produced during summer 2015 by the Finance Directors of the Council, the CCGs and the acute Trusts. The outline strategy was shared with Health and Wellbeing Board members at the October development session where it was agreed that the Directors of Finance would consider where further efficiencies could be made within current arrangements and systems across health and social care during 2016-18. This work was to include consideration of whether any further integration activities or programmes could be developed through the expansion of the Better Care Fund to create a BCF plus programme in 2016/17. See Section 3.1 above.

Further work is still required to deliver efficiencies across the rest of health and social care. The joint Financial Director groups has begun to scope the potential for further cost reductions in 2016-18 and concludes that these would need to be found through:

1. Action taken by the individual organisations to seek further efficiencies in costs that are within each organisation's control

All organisations are delivering internal efficiencies to meet their own statutory requirements. The FDs will also look at the opportunities to share common costs, but the initial conclusion is this will not yield cost reductions at the scale that will be needed.

2. Action taken at the operational interfaces between organisations. Areas worthy of consideration include:

- capacity to enable hospital discharges;
- optimising the use of personnel across system boundaries;
- cross-system support to people with learning disabilities.

Achieving significant escalation of cost savings across organisational boundaries would require a clear, system-level vision and services to engage with what these efficiencies would look like, with additional system-wide resource to facilitate planning and delivery.

3.4 **Alignment and streamlining of key strategic Health and Wellbeing documents**

The Joint Health and Wellbeing Strategy and the Five Year Forward View for health and social care across Bradford District and Craven are to be brought together to provide a single, shared vision and set of priorities to guide the improvement of health and wellbeing outcomes. . The aim is to streamline existing documents to provide clear messages that can be reflected in the other strategies and plans to enable them to align their contribution

with the common, whole system outcomes.

4. FINANCIAL & RESOURCE APPRAISAL

A full financial and resource appraisal will be undertaken as the development of the whole system approach progresses.

5. RISK MANAGEMENT AND GOVERNANCE ISSUES

A risk register will be established to ensure that the Health and Wellbeing Board is aware of system-level risks where these are not able to be mitigated at Programme Board level and require escalation to Strategic Board level.

6. LEGAL APPRAISAL

6.1 This initial legal appraisal has been undertaken by the Council. The first issue that will need to be addressed is whether the organisation has the legal powers to participate in the Commissioner Alliance. Section 1 of the Localism Act 2011 allows the Council to do anything that individuals generally may do subject to the limitations set out in the same Act and any prohibitions on activities contain in other legislation. In addition the Council's Constitution (Article 13) allows the Council and the Executive to enter into joint arrangements to deliver services. The other participants will need to provide assurances that they have similar powers and are not prohibited from entering into an agreement to facilitate the Commissioner Alliance.

6.2 The second issue is whether the individual representatives of the organisations have delegated authority to take decisions on behalf of their organisations. Bradford Council sets its budget annually at Full Council and allocates funding to each department for the provision of its services. Article 14 of the Council's Constitution gives delegate authority to officers to implement decisions of the Council. This would include the allocation of budgets to deliver services. Similarly each CCG has to submit a financial and operational plan to NHS England approved by each CCG Governing Body. The individual CCGs whilst being authorised to spend their resources as they sit fit to deliver their objectives have to ensure all NHS constitution standards and other statutory obligations are fulfilled. Each participant will need to ensure that their representative has the necessary authority to take decisions as part of the Commissioners Alliance that will bind their organisation.

6.3 All parties will need to understand the legal and governance framework within which each participant undertakes their commissioning and procurement activities. Bradford Council and the CCGs must comply with all legislation that applies to Local Authorities and the NHS respectively in terms of securing value for money and in particular the European Union Procurement Regulations relating to public

sector contracts. In addition Council officers must exercise their delegated authority in accordance with the Council's agreed budget and policy framework and comply with the Council's Contract Standing Orders and Financial Regulations and CCG officers and clinical leaders have a similar governance framework through their CCG constitutions with which they have to comply. To ensure that any joint commissioning and procurement is undertaken with the permitted framework of each participant, processes will have to be agreed that comply with all these requirements as well as any others that apply to other organisations.

6.4 Clarity about where decisions are to be taken is needed. If it is proposed that they are taken by the Health and Wellbeing Board then the Terms of Reference of the Board as set out in the Council's Constitution will need to be amended to reflect the additional responsibility. This will then address the issue of delegated authority in relation to the Council as it is a sub-committee of Full Council and, as such, if Full Council agrees the amendment to the Constitution then that is the delegation from Council to the Board. CCGs will need to establish the authority to do this through their constitutions and their schemes of delegation amended accordingly.

6.5 Consideration will also need to be given to the position of providers who sit on the Board as they may have a conflict of interest if they are to participate in decisions about which services should be commissioned where they may also be the providers of those services.

6.6 Full legal appraisal will be needed in relation to the further development of the Better Care Fund and Section 75 agreement and other specific issues as identified as the proposal is developed.

7. OTHER IMPLICATIONS

7.1 EQUALITY & DIVERSITY

An Equality Impact Assessment will be undertaken following the full report to the Health and Wellbeing Board at the December 2015 Board meeting.

7.2 SUSTAINABILITY IMPLICATIONS

The system change work that will continue throughout 2015-16 and beyond provides an opportunity to further embed the principles of sustainable development to contribute to a sustainable financial footing for the future provision of healthcare.

7.3 GREENHOUSE GAS EMISSIONS IMPACTS

The UK health and care system contributes 32 million tonnes of CO2 per year. The impacts are often attributable to pharmaceuticals, energy, travel and transport, waste and anaesthetic gases. There are three notable areas which have opportunity to address greenhouse gas emissions (carbon footprint);

- Good lifestyle habits
- Redesigning services
- Integrated working

Close attention to buildings, energy, waste, procurement and commissioning and travel and transport would allow improvement on current levels of greenhouse gas emissions.

7.4 COMMUNITY SAFETY IMPLICATIONS

None

7.5 HUMAN RIGHTS ACT

None

7.6 TRADE UNION

None

7.7 WARD IMPLICATIONS

None

7.8 AREA COMMITTEE ACTION PLAN IMPLICATIONS (for reports to Area Committees only)

Not applicable.

8. NOT FOR PUBLICATION DOCUMENTS

None.

9. OPTIONS

None

10. RECOMMENDATIONS

The Health and Wellbeing Board supports the principles outlined in this report 'Working Better Together- Developing a Whole System Approach to Health and Social Care. Further reports are to be brought to the next Board meeting.

11. APPENDICES

12. BACKGROUND DOCUMENTS

None

Appendix 1

New Models of Care – Bradford District and Craven

1. A national programme of Vanguard sites have been set up which is the beginning of widespread, person-centred change which need to demonstrate they are viable models for reform in a tough financial climate. The vanguard areas will join up mental health, primary care, community nursing, hospitals, pharmacy and social care. Nine are primary and acute care systems, while fourteen are multi-specialty community providers (GP practices coming together with hospital specialists, community services, nurses and pharmacists to offer primary and specialist services). Thirteen are acute care collaboration vanguards which will link together local hospitals to improve their clinical and financial viability. Six – aim to enhance health in social care focus the total care system. There is substantial investment to secure change and tailored support for each area on everything from clinical workforce redesign to digital technology and patient empowerment. The learning will not just be about the specifics of particular models, but about leadership for system-wide cultural change.

2. Five areas of health and social care have been chosen as vehicles to shape, and take forward, our vision for an over-arching new model of care across the District. The work taking place surrounding these five programmes will equip the system leaders with a valuable insight into the change management process required and the best way of deploying our transformation resources. These are seen as a signal of our collective determination to inject pace and resources into testing out its ambitions for developing an accountable care system – one which breaks new ground in the way health and social care is commissioned and delivered across Bradford, Airedale, Wharfedale and Craven. To test this vision as robustly and effectively as possible, the following cross-section of programmes have been selected:

    - Better Start Bradford and Looked After Children
    - Airedale, Wharfedale and Craven (New Models of Care Programme)
    - Cardio-vascular disease
    - Diabetes
    - Enhanced Care in Care Homes (Vanguard status) –

3. These are workstreams of the Integration and Change Board which will closely follow all the principles of the Vanguard to ensure the five programmes make the best possible contribution to the next steps in the creation of an accountable care system. Below is a summary of some of the work being undertaken:

3.1. <u>Airedale, Wharfedale and Craven New Models of Care (NMoC) Programme</u>

3.1.1 This is a key enabler in re-shaping the health and social care services delivered across Airedale, Wharfedale and Craven (AWC) and in delivering against the 'Right Care' vision as set out in the district's Five Year Forward View. Synonymous with all populations, the residents of AWC have significant degrees of variation in their health and social care needs. Implementing innovative modes of care provides the opportunity to meet these needs, reducing demand on an already overstretched care economy. Health and social care partners across AWC are working collaboratively to improve and integrate services as the primary mechanism for reducing avoidable demand on the system, improving patient outcomes, and generating the necessary efficiencies required to ensure financial sustainability of the local care economy.

3.1.2 The NMoC programme seeks to achieve these objectives through the delivery of 4 key projects (see figure 1):

a) Complex care

If people have more than one health condition and need extra help to live independently we say that they have 'complex needs'. People with complex needs will be selected by their GP practice and with their agreement will receive more support from a new 'complex care team'. The complex care team will have a number of different professionals working in it including a doctor, nurse, mental health nurse pharmacist and a personal support navigator who will act as the link with social workers. A business case and service specification for the Complex Care service has been developed and approved. Local providers of clinical services have been invited to participate in the delivery of this service. The Personal Support Navigator (PSN) role of the service will be commissioned separately by BMDC. The complex Care service will be piloted for 12 months. A formal evaluation will take place and to determine the medium to long term future of the service.

b) Enhanced care

Some people don't have complex needs, but have a long term condition, like diabetes or asthma, and more can be done to help them manage it. The aim is to provide people and their families with more targeted support and help them set personal goals, such as being able to play football or feeling less anxious. Individuals requiring enhanced care may also have mental health or social care issues which affect their daily living and means they need to access a range of care health and service frequently. In AWC there are some schemes known as 'Enhanced Primary Care'. These are testing out different ways of providing enhanced care. The learning from these will inform the type of Enhanced Care service that will be offered in the medium to long term in AWC.

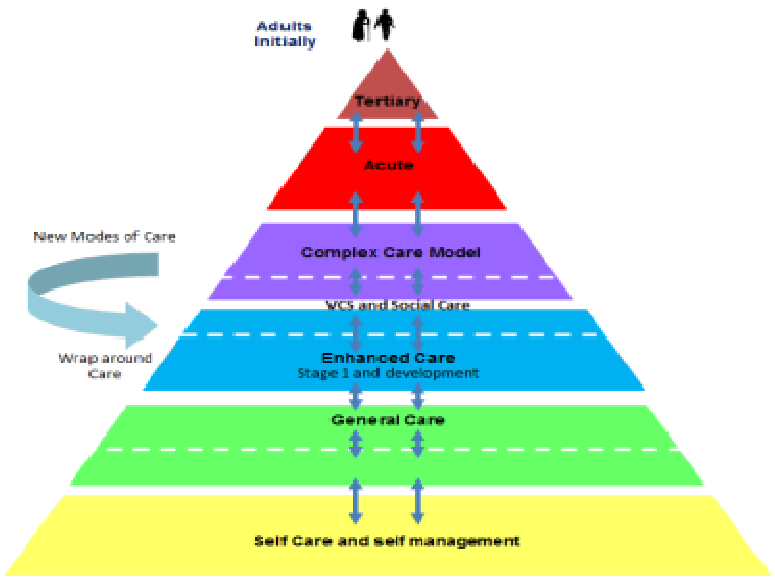
c) Wrap around (integrated community care)

Care will be 'wrapped around' people. This means that services like community nursing, end of life care, therapy services and social care will be joined up to work together for the needs of the patient and their family. Each person's care will be personalised to their needs, not a one size fits all approach. This means listening to the patient and their family about what is important to them. This 'wrap around' care will support people who are being cared for by the complex care team or who are getting enhanced care. People will receive care in their own home so that they can live independently at home for as long as possible. This is no different to how people currently receive care, but people will be supported for a longer length of time and their care will be more joined up.

d) Self-care

Self-care is about helping people to live healthy lives, to avoid them becoming ill in the first place and supporting people to look after their health. Self Care is about the actions people can take to manage their physical, mental, emotional and spiritual health and wellbeing. It is about helping people to feel more confident about managing their health; so that they know when they need to see a health professional and they feel more in control of their health. There is a Bradford District wide Self Care Programme that is supported by local delivery within AWC. The aim is promote better ways of making sure a key part of everything we do.

Figure 1



3.2 Enhancing Health in Care Homes (Vanguard)

One of the new care delivery models highlighted as delivering the above referred to triple aim was Airedale NHS Foundation Trust's innovative nursing and residential care home telemedicine service. The success of the service to date and interest shown nationally led to the team at Airedale NHS Foundation Trust and its partners submitting a bid for the Enhanced Health in Care Homes in order to demonstrate how such a service can be replicated for the benefit of a much wider population. This is now one of the national Vanguard Programme new models of care for providing Enhanced Care in Care Homes. It will initially focus on:

- Multi-agency support for people in care homes and to help people stay at home
- Using new technologies and telemedicine for specialist input
- Support for patients to die in their place of choice.

3.2.1 The ambition is to improve the lives of those living in care homes by using technology to take the expertise that they need into their homes, rather than expect them to come to us. This way, their home becomes the default care setting, not a GP surgery, outpatient clinic or emergency department.

3.3 NHS Bradford City and NHS Bradford Districts CCG New Models of Care

a) Commissioning Complex Care - Bradford City CCG and Bradford Districts CCG

The Out of Hospital Programme works with patients, service users, existing and potential providers to commission a Complex Care Service (CCS) which will operate across the population served by Bradford Districts and City CCGs. CCS will deliver a fully integrated accountable care system with no boundaries between services. Its purpose is to provide optimal care to people with complex needs as a result of frailty, long-term condition/s, chronic disability or complex needs arising from ill health.

It will support all adults in need of the service in their own homes, including those who live in care homes. Workforce management and developments will enable skill mix within CCS to match the needs of the people it serves rather than being determined by professional or organisational structures. It will therefore include medical (GP and consultant), advanced health practitioners, nursing, Allied Health Professions, social care, care navigation and case management, mental health and wellbeing services and any other services determined by need.

Access will be through a single point, supported by tele-consultation. This will be the forerunner of a single point of access for all community health and social care services.

The intended outcome of the service is to enable the people it serves to remain as healthy, well and independent as possible and to reduce unnecessary dependence on health and care services, particularly acute secondary care. This will be achieved through proactive care planning, including Advance Care Plans and Emergency Care Plans driven by the wished and aspirations of the person concerned. The promotion and enablement of self-care education and skills will support a culture change in reducing dependence on traditional health and care services, with increasing support being provided through pharmacy, community and voluntary services.

Complex Care Teams will provide NHS and social care services with the capacity and capability to maintain people with complex needs at home and only utilise hospital services when absolutely necessary.

The service will support people in care homes, including investment in training and education and proactive care to ensure that care is optimised for people with very complex needs. Needs will be less likely to escalate in an uncontrolled manner enabling people to live with dignity and control over their care. It will enable people with dementia to receive care in their place of residence and minimise transfers to other settings.

The service will be delivered by 4 or 5 teams each serving a population of between 80,000 and 100,000 people. Each service will be responsive to local need and link closely to Integrated Community Services delivered at a practice/local neighbourhood level.

b) Intermediate Care

The Out of Hospital Programme is bringing all intermediate care services together to support Bradford residents within a whole system approach. Joint working between BTHFT, CBMDC, BDCFT and the CCGs to develop and strengthen Intermediate Care Services has led to the creation of a single point of access to Intermediate Care services and the expansion of those services. A new BEST Rapid Response Team will enable people at risk of hospital admission through a combination of health and care needs to remain at home with support from both the Virtual Ward and BEST.

From 2.11.15, the Intermediate Care Hub will enable step up access from community and primary care to intermediate care, including community beds. More people than before will be enabled to avoid acute admissions and to get the right support, in the right place, first time.

c) Integrated Ways of Working

Everyday integrated ways of working across general practice/community services will be the focus for the majority of people registered with City and Districts practices. This will includes preventative approaches such as Diabetes, Cardio Vascular Disease – see below.

d) Diabetes

NHS Bradford City and Districts CCGs are developing a new model of care building on the success of NHS Bradford City CCG's Bradford Beating Diabetes initiative. This aims to identify people at risk of developing type 2 diabetes and offer a range of lifestyle interventions to prevent or delay the onset, to identify all people currently undiagnosed with diabetes, and to improve outcomes for people diagnosed with the condition through improved clinical management and self-care. They are currently developing an end to end care pathway and will procure this service as a test of a new model of contracting to deliver new models of care and in particular the provider alliance elements which will require providers of care to work together in a very different way to deliver improved outcomes.

e) Cardio Vascular Disease (CVD)

Bradford Healthy Hearts is a programme with a bold and clear ambition to reduce cardiovascular events by 10% by 2020 which will result in 150 fewer strokes and 340 fewer heart attacks and Bradford Districts will no longer be the 7th worst CCG in the country. This is an integrated programme focusing on those with chest pain, heart failure and atrial fibrillation (AF). It will build on the learning and experience of the above approach to the new model of contracting and delivery of a diabetes service.

4. Additionally, there are other recently launched Vanguards as part of the national programme that span beyond our local population, but which we are part of given the geographical footprint and population flows. There is a West Yorkshire Urgent and Emergency Care Vanguard which is focused on testing new ways of working and accelerating the adoption of new models of care for Urgent and Emergency Care. For example they are focussing on reconfiguring clinical pathways for people with specialist emergency care needs, developing ways of the workforce working differently such as emergency care practitioners in primary care and by April 16 they will have developed a West Yorkshire wide emergency services mental health strategy and they are committed to expanding those things that a working well at a local level across a broader footprint such as `pharmacy first' minor ailment services.