Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Glen Garrod, Director of Adult Social Services

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**28 January 2014**
Subject:	**Better Care Fund submission document: 'first-cut'**

Summary:

The attached 'Better Care Fund' (BCF) document is a first-cut submission which satisfies the requirements of the National guidance. It represents the collective ambition of the health and social care community in Lincolnshire to further improve services and establish a more sustainable financial base in an integrated environment.

The BCF was previously termed the Integration Transformation Fund (ITF) until December 2013, and before that DoH transfer funds which was the subject of a report to the Informal Executive of the County Council on 19 February 2013, to CCGs and the Health and Wellbeing Board during 2013.

This report illustrates the core elements of the BCF, the connection between this BCF document and the Lincolnshire Sustainable Services Review and the process and timetable for production. The report builds upon previous presentations to the Health and Wellbeing Board that detailed early versions of the submission document. It is necessary for the Health and Wellbeing Board to agree a 'first-cut' submission that describes how Lincolnshire intends to meet the national requirements in terms of:

1. spend of the BCF allocation in 2014/15, 2015/16;
2. the performance we expect to achieve;
3. the level of pooled budget (health and social care) we expect to reach.

The document has two parts provided as a national template: Part 1 describes the overall **Plan Details**, an agreed **Vision and Schemes** – 'Early Implementers', how the submission meets **National Conditions** and finally, identified strategic **Risks**.

Part 2 describes the performance measures to be used and the agreement on the use of the BCF in 2014/15 and 2015/16. Critically it also seeks to reflect the level of ambition to

pool budgets across both health and social care.

Actions Required:

The BCF has been produced as a collective exercise between senior officers representing all four CCGs and the County Council.

1. Members are asked to note and comment on the content of the attached BCF submission document.

2. The Health and Wellbeing Board is asked to formally agree the BCF 'first-cut' submission to NHS England by 15 February 2014 to meet the national conditions.

3. Further, the Health and Wellbeing Board is asked to agree to receive a further report concerning the BCF as the final submission at the meeting of the Board on 25 March 2014.

1. Background

In June 2013, the Chancellor announced a £3.8bn pooled fund to encourage the integration of health and social care services. This coincided with the Government's announcement to identify a number of 'integration pioneers'. In October early national guidance was produced detailing how the then ITF would be allocated and what it included. In December the newly titled final BCF guidance was produced.

In Lincolnshire an initial bid to become an Integration Pioneer proved unsuccessful. In parallel a Sustainable Services Review was commissioned, with the support of PWC, and Phase 1 has been concluded. This was presented to the Health and Wellbeing Board in late 2013 by Tony Hill, Director of Public Health. It has also been formally agreed by all four CCGs and the Executive of Lincolnshire County Council.

The connection between this BCF document and the LSSR 'Blueprint' is critical. In other words if the LSSR is a 5 year plan to transform health and social care in Lincolnshire then the BCF describes the first two years of that plan. It is also where national policy and local ambition coalesce.

In addition, NHS England provides a representative from the Area Team that participates in both the Health and Wellbeing Board and the LSSR Governance Board where both BCF and LSSR have been presented. The Area Team representative also agreed to act as a critical friend in the development of the BCF submission attached. Furthermore, we are currently negotiating with the Area Team details of primary care spend so that this can be considered for inclusion in pooled budget arrangements supporting neighbourhood team development. As such we will need NHS England to support the level of ambition described in the attached Part 1 and 2 submissions.

The BCF planning (attached) and, technical guidance includes a number of requirements. In general these are both performance related (5 national and 1 locally determined from a prescribed list) and, require a considerable level of pooling of budgets. Failure to adhere to these will reduce the expected financial allocation to Lincolnshire from the BCF fund.

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The value of the BCF in Lincolnshire in 2014/15 is £15.4m. In 2015/16 the value of the fund will reach just under £53m. This incorporates an allocation to help underwrite the costs of implementing both the Care Bill from 2015, and the 'Dilnot Reforms' (how people will be charged for adult social services for which they are eligible).

The Task Group identified below has senior representatives from each of the four CCGs and includes their Chief Finance Officers. It is chaired by the Director of Adult Social Services with other colleagues from LCC covering Children's Services, Public Health, Performance and Finance.

The following timeline describes the stage of evolution this document has arrived at and, what is expected to happen next. As Members will see the timescales are short.

DATE	GOVERNANCE PROCESS
12.11.2013	Task Group
28.11.2013	Task Group
10.12.2013	Health and Wellbeing Board
18.12.2013	Task Group
06.01.2014	Task Group
13.01.2014	Task Group
14.01.2014	Informal Executive of LCC
16.01.2014	Task Group
22.01. 2014	South West CCG Board
22.01.2014	West CCG Board
23.01.2014	East CCG Board
30.01.2014	South CCG Board
28.01.2014	Informal Health and Wellbeing Board
05.02.2014	Health and Wellbeing Board
15.02.2014	**First cut submission of Lincolnshire BCF to NHS England**
19.03.2014	West CCG Board
25.03. 2014	Health and Wellbeing Board
26.03.2014	South West CCG Board
27.03.2014	South CCG Board
27.03.2014	East CCG Board
27.03.2014	Overview and Scrutiny Management Committee
01.04.2014	Formal Executive of LCC
04.04.2014	**Final version submitted to NHS England**

2. Conclusion

The BCF submission is a 'first-cut' to satisfy nationally prescribed requirements. The final BCF submission has a deadline of 4 April 2014. However, it is the collective view of health and social care colleagues to go as far as possible in this 'first-cut' submission so as to satisfy NHS England and therefore reduce the level of work required for the final submission. This is in order to protect officer capacity to progress the LSSR and, the development of the 'Early Implementers'.

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It is important to note that this BCF must reflect the aims and objectives in the Health and Wellbeing Strategy and respective CCG planning documents. It must also reflect key factors in the JSNA. The level of 'read-across' must therefore be high.

Notwithstanding the above this BCF submission represents a cornerstone upon which the LSSR builds. It also further facilitates the shared ambition across health and social care organisations and more firmly bind us together in a way not previously seen in the County.

2. Consultation

In addition to the above, regular updates have been provided on the development of the BCF to the LSSR Governance Board, to the monthly meetings between the Chief Officers of the 4 CCGs and the Corporate Management Board of the County Council and, to the Informal Executive of the County Council.

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	NHS England Planning Guidance
Appendix B	Better Care Fund – Part 1
Appendix C	Better Care Fund – Part 2

5. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Glen Garrod, who can be contacted on 01522-550808 or glen.garrod@lincolnshire.gov.uk.

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Better Care Fund planning template – Part 1 (V12)

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

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Lincolnshire County Council**
Clinical Commissioning Groups	**West CCG**
	East CCG
	South West CCG
	South CCG
Boundary Differences	**The population of Lincolnshire is 740,158. The GP registered population of the four CCGs combined is 761,002. The distribution of the CCG population is as described below in boundary details**
Date agreed at Health and Well-Being Board:	**28-Jan-14**
Date submitted:	**<dd/mm/yyyy>**
Minimum required value of ITF pooled budget: 2014/15	**£15.4m**
2015/16	**£48.4m**
Total agreed value of pooled budget: 2014/15	**£70.8m**
2015/16	**£197.3m**

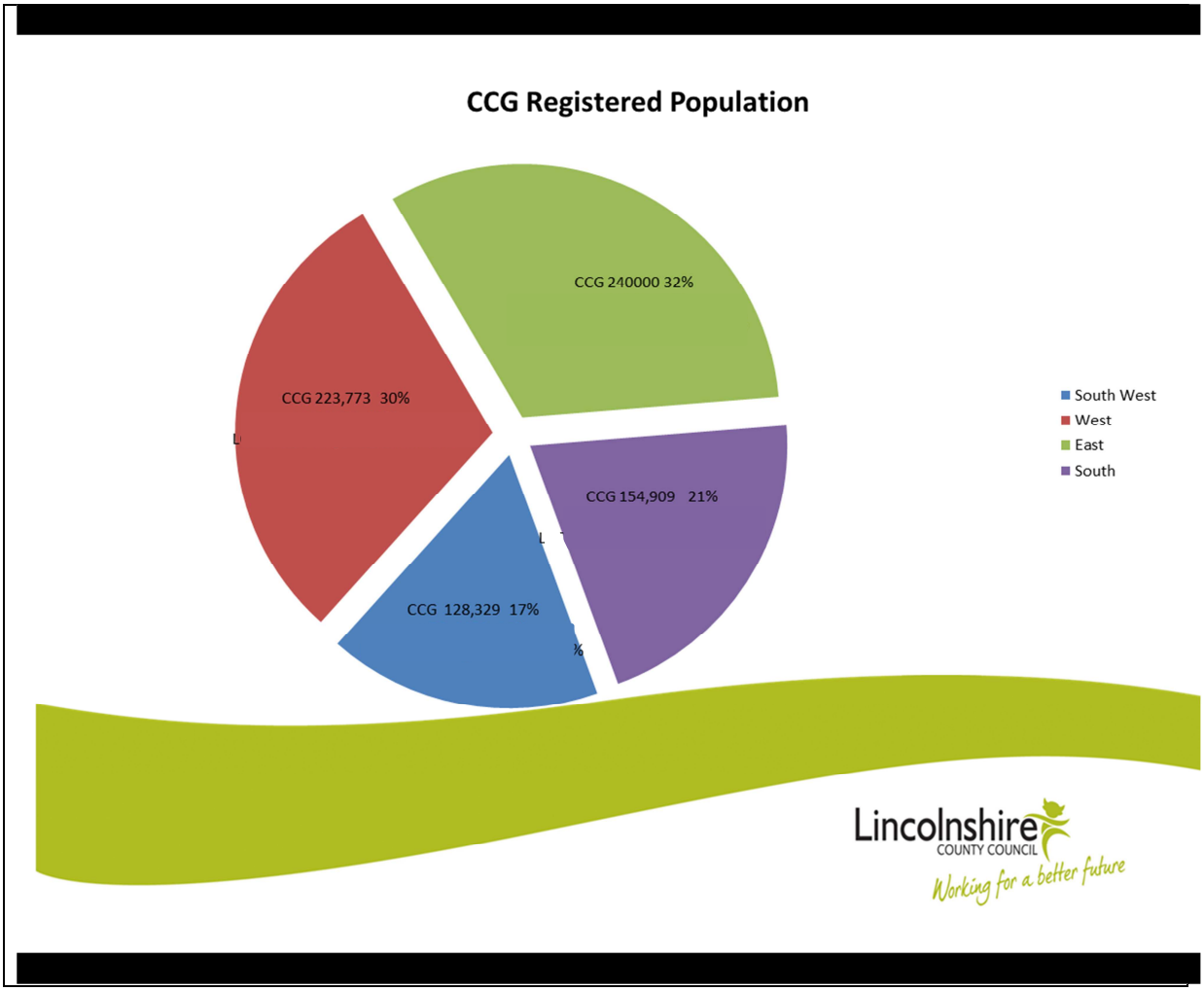
Boundary Details - how we propose to deal with the different populations between CCGs and LCC
As part of the work supporting the Blueprint detailed analysis suggests there are significant issues to address across Lincolnshire but also across the four Clinical Commissioning Groups. Modelling has taken place to understand current utilisation of service but more significantly what will be required in five years' time. Demographic trends lead us to believe that the population will age rapidly, with the West and South West ageing most.

The number of children in Lincolnshire is projected to grow by 10%, most in the East, at the same time the number of births is projected to fall, particularly in the West. We also know that the volume of patients leaving the County for inpatient treatment is significant and therefore Lincolnshire is dependent on out of area providers, such as Peterborough, for inpatient services. There are also no significant net inflows of patients from outside the county into Lincolnshire.

Whilst the LSSR Blueprint is described as an overarching clinical and social care strategy for consistent outcomes, quality and safety of services, some services will have to be enhanced further to support demographic changes in differing areas or provided slightly different in the operation delivery. These will be most profound in the care of the elderly and children's care, dependent on the area especially around the model for proactive care.

Consideration of the interface with other reviews outside Lincolnshire is being undertaken especially with the knock on effect of the Peterborough, North and North East Lincolnshire and North Nottinghamshire reviews to ensure they read across.

Finally, the LSSR is also building on the current initiatives that Lincolnshire is undertaking, especially Shaping Health for Kesteven, to ensure that both patients and the wider population recognise one health and care system but with local issues within it, and that no one falls through any gaps that might appear due to boundary difficulties and the impact that the LSSR has with other reviews.



b) Authorisation and sign-off

Signed on behalf of the Clinical Commissioning Group	South West Lincolnshire
By	Allan Kitt
Position	Chief Operating Officer
Date	<date>

Signed on behalf of the Clinical Commissioning Group	West Lincolnshire
By	Sarah Newton
Position	Chief Operating Officer
Date	<date>

Signed on behalf of the Clinical Commissioning Group	East Lincolnshire
By	Gary James
Position	Chief Operating Officer
Date	<date>

Signed on behalf of the Clinical Commissioning Group	South Lincolnshire
By	Gary Thompson
Position	Chief Operating Officer
Date	<date>

Signed on behalf of the Council	Lincolnshire County Council
By	Tony McArdle
Position	Chief Executive
Date	<date>

Signed on behalf of the Health and Wellbeing Board	<Name of HWB>
By Chair of Health and Wellbeing Board	Cllr Sue Woolley
Date	<date>

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

The Lincolnshire Sustainable Services Review (LSSR) included the three NHS Provider Trusts within Lincolnshire as stakeholders from the beginning. They are United Lincolnshire Hospitals NHS Trust, Lincolnshire Community Health Services NHS Trust, and Lincolnshire Partnership NHS Foundation Trust. In addition, the East Midlands Ambulance Service NHS Trust have been involved throughout. The review document is attached below in Related Documentation.

Social Care providers, housing providers and third sector providers have also been involved in the production of the LSSR. Additionally, an approach to securing ongoing engagement with the large and diverse independent social care and housing provider market is under discussion that will utilise the Executive Board of Social Care providers (called 'Linca') to support the work of delivering the LSSR which subsumes this two year plan. It is also intended that these delivery vehicles will also incorporate local preparations for the advent of both the 'Care Bill' and social care funding reforms.

Primary Care Providers are represented on the LSSR Programme Board by the Chairs of the four Clinical Commissioning Groups, South West, South, East and West. The ambulance service is represented by East Midlands Ambulance Services who also have a seat at the Board. Each provider organisation has two representatives at the Board to ensure both organisational leadership as well as clinical, this is usually the Trust Chief Executive and the Trust Medical Director.

Everyone in the Health and Social Care economy needs to understand, believe and support the delivery of the LSSR Blueprint and a model of integrated care for the future. All service provider organisations are expected to cascade information of what is happening at the LSSR Board as well as to be able to discuss the Blueprint to ensure transparency and consistency of message and also get feedback or concerns from their staff and share with the programme team and Board.

In the development of the blueprint, constituent organisations tasked professionals and representatives from 3rd sector and carer groups across Lincolnshire to work together to

co-design, how care will be delivered in the future.

Over 80 Health and Care professionals have been involved in co-design by taking part in three workshops providing their inputs and sharing their experience and insights on the four care design groups. These came together with a Health and Care Summit early in October 2013 where nearly 200 attendees met to bring the blueprint together. Social Care providers and third sector providers attended the Care Summit in addition to the health organisations identified above.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

The LSSR Blueprint document is now at the end of Phase 1 (design stage). Phase 2 will develop a more detailed planning model. The LSSR Board is keen to have strong levels of engagement.

Health Watch Lincolnshire is a member of the LSSR Programme Board and the care design groups also included Lincolnshire Carers and the Young Carers Partnership. Stakeholder engagement has included inviting a range of designated patient organisations to take part in the four care design groups as well as a large presence at the Health and Social Care Summit. Staff from the programme team have attended service user meetings, discussions have taken place with St Barnabas Hospice (as the leading third sector provider of 'end of life care') and visits have been undertaken to all the District Councils across Lincolnshire. The key objective of Phase 1 was to be open and transparent about the process but not to discuss in depth the outputs. These will become more detailed in Phase 2. Communication teams have worked hard to brief as many of the population as possible with weekly proactive media briefings and newsletters.

At the end of further design work in Phase 2 - anticipated for April 2014, there will follow a formal process of public engagement for three months (May, June, July). We are currently seeking options on how best to ensure this period of public engagement will satisfy a level of scrutiny across both health and social care communities.

e) Related documentation

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

Document or information title	Synopsis and links
Attachment 1 - Lincolnshire Sustainable Services Review.	Previously circulated
Attachment 2 – LSSR JHWS Matrix Summary	 LSSR JHWS Matrix Summary.docx

2) VISION AND SCHEMES

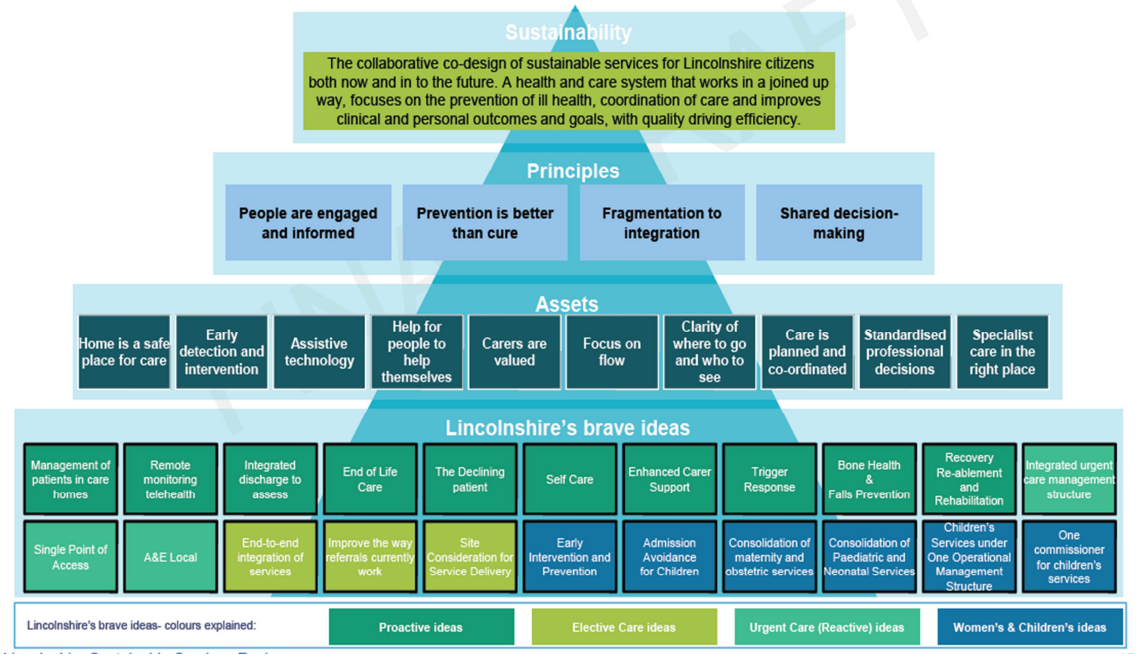
a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

We have drawn on best practice both within the UK and further afield.The following diagram best represents our collective ambition to transform health and social care services in Lincolnshire. We will build services that better serve the people of Lincolnshire, improves health and social care outcomes and the 'customer' experience. In doing this we will be organisationally agnostic so that form will truly follow function. This will be our collective mindset from which we will secure a sustainable financial base into the long term.

The diagram below provides on one page the golden thread between Lincolnshire's goal of the design of sustainable services in the future model through key principles, use of assets and brave ideas:



Aims and objectives
Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

There is already significant congruence between the priority themes, objectives and measures in Lincolnshire's Joint Health and Wellbeing Strategy (JHWS) and the objectives and outcomes being pursued through the LSSR and this Better Care Fund Programme.

Our JHWS was developed on the basis of priorities identified during the comprehensive stakeholder engagement undertaken by the local Health and Wellbeing Board in developing its JSNA. The table below identifies the degree of existing congruence across the JHWS, LSSR and BC programme.

Lincolnshire Sustainable Services Review (LSSR) mapped to Lincolnshire Joint Health and Wellbeing Strategy (JHWS)

	Promoting Healthier Lifestyles	Improve the health and wellbeing of older people	Delivering high quality systematic care for major causes of ill health and disability.	Improve health and social outcomes for children and reduce inequalities	Tackling the social determinants of health.
Proactive Ideas	X	X	X		X
Elective Care Ideas	X	X	X	X	
Urgent Care Ideas		X	X		
Women's and Children's Ideas				X	X

A fuller analysis of the congruence described above is included as Attachment number 2 (see above).

The Health and Wellbeing Board already has influence and oversight of the extent to which the commissioning plans of all the health and social care commissioners, and other public bodies like district councils, are driving towards the outcomes, objectives and measures within the JHWS. The tracking of delivery of these intentions is supported by a suite of measures selected from the national outcomes frameworks for the NHS, Adult Social Care and Public Health. The Board performance manages achievement in the short term against these measures.

A summary of the mapped measures as they stand is provided in the table below, it is proposed that measures identified in this BCF proposal would be added to the outcomes pursued through JHWS and JSNA once agreed.:

Joint Health and Wellbeing Strategy Outcomes mapped to LSSR Themes and National Outcomes Frameworks

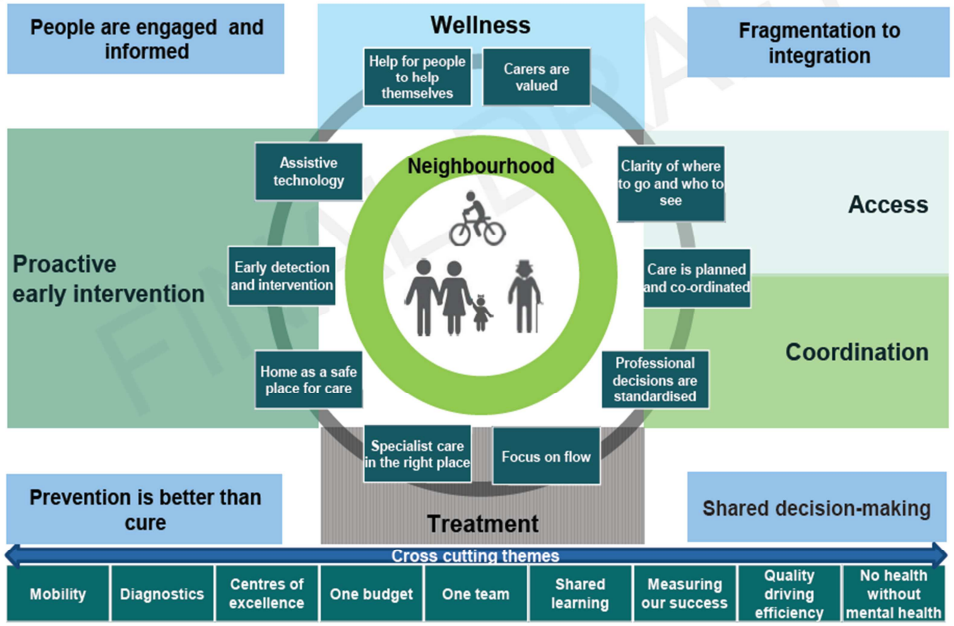
JHWS - Theme	JHWS - Priority	LSSR Overlap	Outcome Measures
Promoting Healthier Lifestyles	Reduce the number of people who smoke	Proactive, Elective Care	PH 4.7 / NHS 1.2 Mortality from respiratory diseases
Promoting Healthier Lifestyles	Reduce the number of people who are overweight or obese	Proactive, Elective Care	PH 4.4 / NHS 1.1 Mortality from all cardiovascular diseases
Promoting Healthier Lifestyles	Support people to drink alcohol sensibly	Proactive, Elective Care	PH 4.6 / NHS 1.3 Mortality from liver disease
Improve the health and wellbeing of older people	Change how we spend our money to enable more older people to stay safe and well at home	Proactive, Elective Care, Urgent Care	ASC 2B / NHS 3.6i Older people still at home 91 days after discharge from hospital
Delivering high quality systematic care for major causes of ill health and disability	Reduce unplanned hospital admissions for people with Chronic Obstructive Pulmonary Disease	Proactive, Elective Care, Urgent Care	PH 4.7 / NHS 1.2 Mortality from respiratory diseases
Improve health and social outcomes for children and reduce inequalities	Increase access for parents to good information and support throughout their child's life	Elective Care, Women's and Children's	PH 4.1 / NHS 1.6i Infant mortality
Tackling the social determinants of health.	Support more vulnerable people into good quality work	Proactive, Women's and Children's	PH 1.8 / NHS 2.2 Employment for those with a long term health condition

Each theme of the JHWS has a named Board sponsor who is supported by a consultant level public health specialist and these individuals are tasked with supporting implementation planning and delivery of their themes across the complex commissioning and delivery systems that exist in Lincolnshire. The LSSR and BCF activity that will support JHWS delivery have already been accepted by the Health and Wellbeing Board and LSSR implementation is accepted as a key mechanism by which the planned JHWS benefits will be delivered for local people.

As the BCF proposals are based on the LSSR work already completed, the Board will 'absorb' the BCF activity into its expectations and performance management of the delivery of the JHWS and bend its weight and influence to actively align its other programmes of work to this as a key delivery vehicle for wider strategy. A key feature of this would be the adaptation of our IT based and inherently dynamic approach to JSNA to move to providing the intelligence for planning and performance management of the activities and interventions within the BCF programme.

Our JSNA constantly evolves and adoption of the BCF activity into the delivery programme for the JHWS as described above will ensure that the JSNA moves to support the activity. See also Attachment 2.

The diagram below details, on one page, the elements which have been described across all four care design groups and reviewed by the Programme Board to form the proposed future model of care. This model is intended to encompass the full spectrum of physical, mental health and social care services across Lincolnshire.



b) Description of planned changes
Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

The timeframe in which we plan to begin to deliver transformation to health and social care services in Lincolnshire takes place over three years and has already begun with Phase 1 and the publication of the Lincolnshire Sustainability Review. Phase 2 will see further detailed planning before a formal period of public consultation takes place around May 2014 for a period of three months. Please see the diagram below for further detail.

We have carefully selected five 'Early Implementers' that are seen as central to securing early progress against the LSSR. They will also help ensure we are well placed to meet the requirements for performance improvement against the BCF national targets and our locally selected target. In addition these Early Implementers are intended to build on some of the pre-existing infrastructure that exists and which require further development if they are to secure profound improvement to outcomes, quality and sustainability – as such they provide early momentum and opportunity for learning. Finally, they have been chosen as pre-requisites to creating the opportunity for substantial reductions in acute beds which in turn frees-up resources for further primary/community based capacity – with the expectation that this will produce a virtuous cycle.

The Early Implementers are:

1. The development of **'neighbourhood teams**' at a number of locations reflecting GP clusters.

Mr A is 27 and has low level needs not eligible for social care support, but is identified through our triggers that he could benefit from a brief spell of support. Mr A will be assessed to identify what support and equipment he could benefit from.

Mr A feels isolated and alone, often having episodes of low self-esteem and depression, his GP referred him to the Wellbeing Service to receive support from a worker that would give him confidence to improve his social connection with his peers and community.

Mr A's assessment noted he sometimes struggled to take his medication as prescribed and the Wellbeing Service sourced some assistive technology that could aide him in taking his medication.

Mr A identifies caring for his ageing mother as a particular stress for him. The Wellbeing Service assess Mrs B and notes she has early stages of dementia and is becoming increasingly frail. Mrs B receives assistive technology that:

- *Helps her remember to take her medication;*

- *Installs a monitored fire safety sensor that connects to the Wellbeing Service Monitoring Centre and assure a proportionate and timely response is made to any alarms.*

2. The Development of a pooled budget and jointly commissioned **Intermediate Care Layer**.

Case Study: Admission Avoidance. GP Out of Hours Referral.

Mrs A is visited by the Out of Hours GP on a Saturday. She is an 84 year old lady with a recent history of falls. The GP identifies a need for support to avoid hospital admission, and contacts the Combined Independent Living team.

An Assessor visits the same day and makes a full assessment of Mrs A. The following day, Sunday, a bed lever, raised toilet seat and toilet surround are delivered. A zimmer frame is also provided, and 16 days after commencement Mrs A is discharged, recorded as feeling much better with improved appetite and one call a day from a home care provider. She is advised to contact the local team if she needs further help.

3. **Seven-Day Working** which will begin in the Acute Sector but be developed into community where appropriate.

4. **Prevention** which will incorporate a number of short term projects funded by the BCF and the developing 'Wellbeing' service led by Public Health colleagues. It will also need to include young people – notably regarding the implications of 'Support and Aspiration'.

5. **Enablers** notably estates, organisational development and IMT.

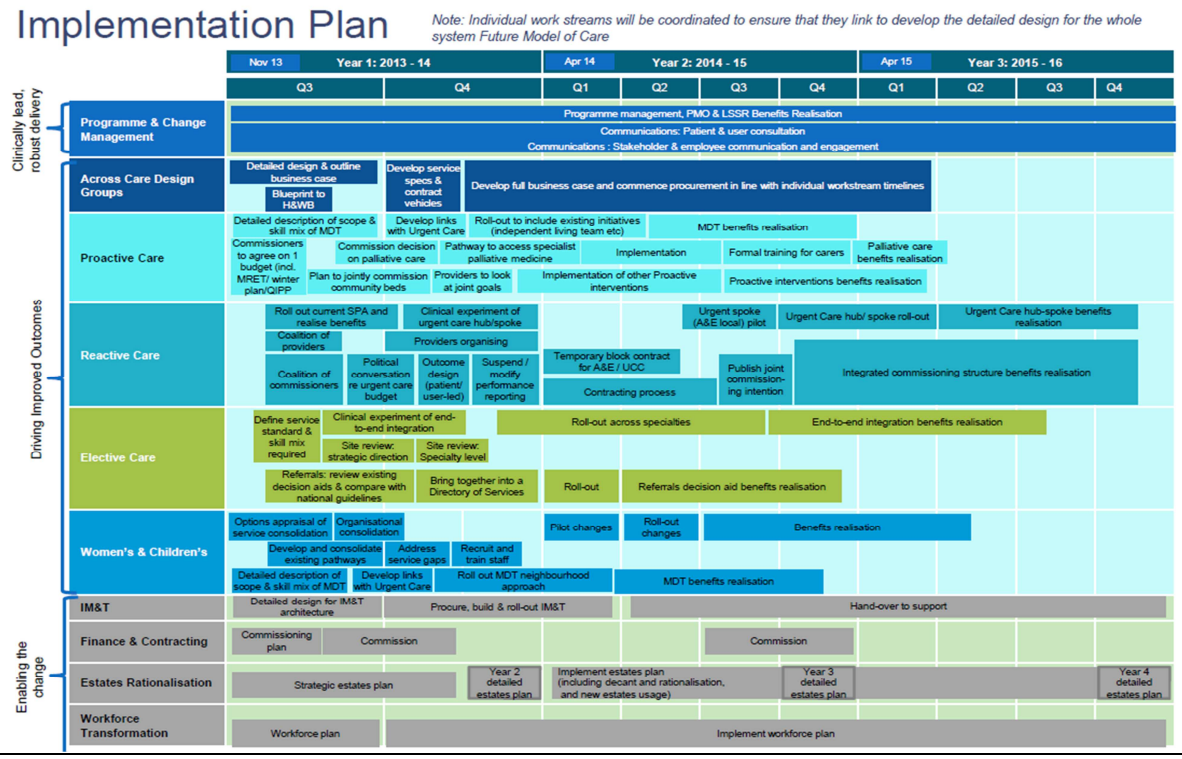
Part 2 of this submission details the allocation of BCF funds against each of the above. They will also facilitate further pooling of budgets beyond what we have already achieved.

The examples given above describe a number of new and pre-existing initiatives. However, our ambition is to increasingly combine services, based on a clear understanding of what works best and where synergies can be obtained. This will mean the merging of currently disparate services that may exist across several organisations. We will progress single service configurations through a collective approach to commissioning, for example in creating shared access points and in the further development of intermediate care services. We will remain organisationally agnostic.

The Joint Strategic Needs Assessment, Health and Wellbeing Strategy and current plans are fully embedded within our Sustainability Review, there is evidence for this assertion in the documentation attached to this BCF Plan. In addition a thorough analysis of Adult Social Care was undertaken during 2012/13 entitled '14Forward'. The resulting analysis was incorporated into the Sustainability Review. Furthermore, any plans in production such as for people with autism and, those with dementia will be shaped to reflect the ambition of our Sustainability Review and what we intend to achieve collectively.

The Health and Wellbeing Board will have overall responsibility for ensuring a high degree of consistency and congruence between our developing knowledge of local communities, their needs, wishes and aspirations, coupled with a clear understanding of

what good looks like. The Health and Wellbeing Board will be supported by a small number of Delivery Boards for aspects of this plan. Led by senior officers from both health and social care organisations and with dedicated programme support to ensure resources and skills are brought together for best effect.



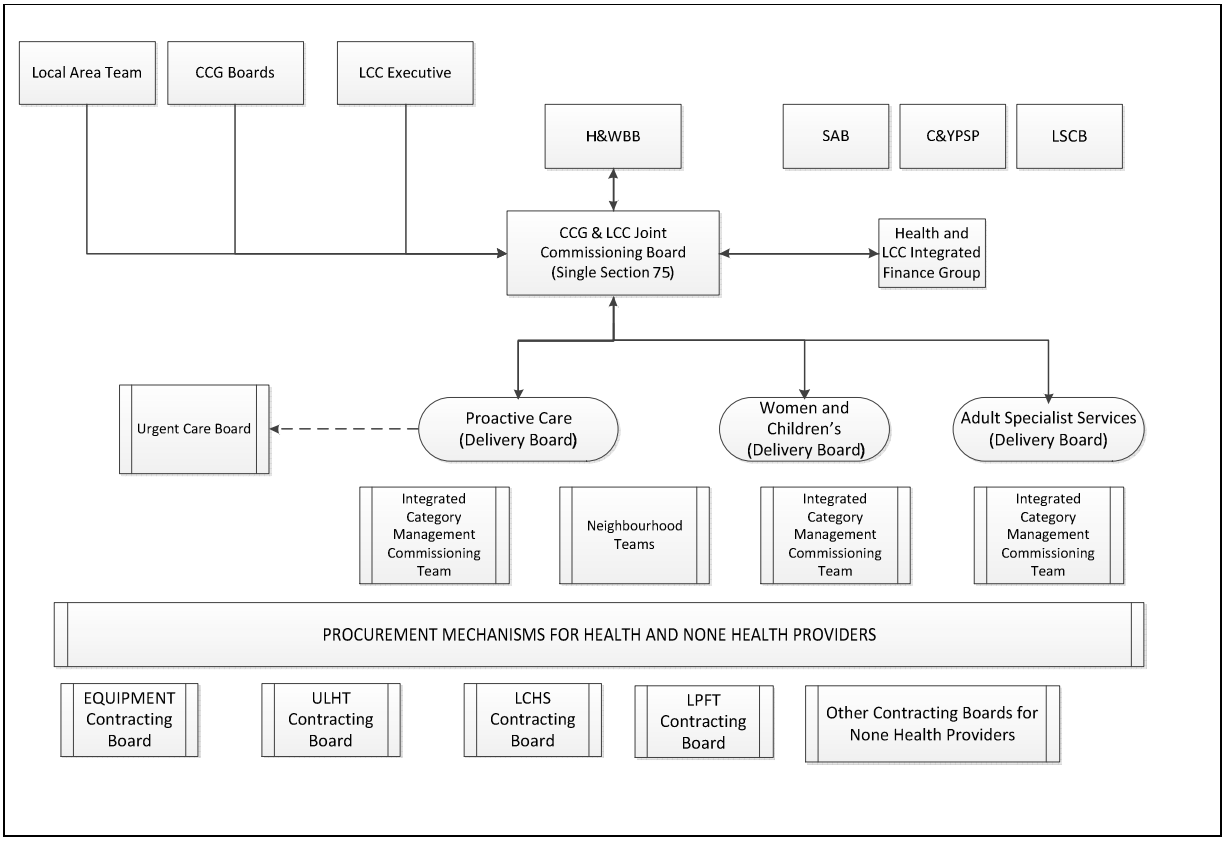
c) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The LSSR Blue print defines Lincolnshire's vision for service reconfiguration including very significant reduction in acute bed capacity from the acute sector by 2016/17 and the strengthening of community based services with extended 7 day working wrapped around Neighbourhood teams. This objective is consistent with the national requirement to reduce emergency admissions by 15%. Performance metrics for this are in Part 2 and will be completed once the national dataset is available. Years 2014/15 and 2015/16 are key transitional years during which time momentum for change must be galvanised into targeted delivery. Failure to deliver will result in a significant financial gap across Lincolnshire Health and Social Care Services. For the two transitional years focus is being given to commencing a reduction of acute hospital bed capacity by further preventing avoidable acute hospital admissions, reducing delayed transfers of care and ensuring that the valuable acute sector facilities are utilised to best effect for those most in need of specialised acute hospital care. Implementation of the Urgent Care Board strategy will be critical to support the delivery of targets. Due consideration is being given to the acute sector clinical strategy which is currently undergoing early clinical consultation.

d) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes



3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

Our working definition has several elements to it. These are:

1. That the current eligibility to Adult Social Care will be maintained at substantial and critical.
2. Section 75 agreements, whether existing or new, will not reduce or impact negatively on performance or quality of adult social care services in securing agreed levels of future funding and performance.
3. The design of new models for commissioning and supplying social care services will not detrimentally affect performance against ASCOF (notably those detailing hospital discharge, personalisation and reviews); from the baseline of March 2013.

Each Delivery Board and ultimately the Health and Wellbeing Board will monitor progress to ensure this definition is observed.

Please explain how local social care services will be protected within your plans.

We recognise that there is little protection for either Health or Social Care services unless we take a profound step towards integration as detailed in our Sustainability Review. Only in this way are we likely to secure services to meet Health & Social Care needs in Lincolnshire. The Executive of the County Council expect that Social Care Services will be maintained as we develop more pooled budget arrangements based on agreed and shared outcomes. The County Council will continue to monitor performance and outcomes using benchmarking data, trend analysis and ASCOF. Adult Care has a robust and comprehensive quality assurance system in situ that will also ensure services are not impaired as the proposed changes in this plan and the Sustainability Review progress. Our approach to transformation is to ensure that there is stability in areas of core health and social care provision. Through the Sustainable Services Review we will implement transformation in an incremental way so there is a risk management approach to change management and social care services will be protected. To enable us to plan change whilst protecting vulnerable clients, we will utilise some ITF funding to protect services so there is stability through change management.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

The Urgent Care Board has responsibility for the development of 7 day services - initially concentrating upon the Acute Sector in recognition of the new guidance for 7 day hospital services. However, it is expected that wider application of 7 day working in community settings will also grow.

ULHT: In order to take the move to seven day working in unscheduled care forward across all sites operated by the Trust a number of key pieces of work have been identified:

In November 2013 a broad cross section of clinical leaders (supported by senior managers) met to outline which medical, diagnostic, therapeutic and support services need to be available to support seven day unscheduled care. This built on work done in 2011 to define a set of standards for unscheduled care that has already resulted in the redesign of a number of services and mortality reduction.

Building upon this dialogue and taking account the draft standards for 7 day working published by NHS England; guidance from learned bodies (eg Royal colleges and Professional organisations), and experience elsewhere across the NHS a framework is being developed setting out the services required to deliver unscheduled care services across ULHT. In turn each hospital site within the Trust providing unscheduled care will be required to develop proposals for the delivery of those elements of service on their site. This will ensure consistent standards of service across the Trust whilst allowing for site-specific approaches to delivery

Once proposals for delivery have been developed they will then be the subject of scrutiny by a multi-disciplinary group leading this initiative for the Trust. The purpose of the scrutiny will be to:

- Ensure that the model of delivery is capable of delivering the benefits in terms of mortality reduction, improved patient experience and reduction to length of stay
- Ensuring that any proposed increase to the cost of delivery is justifiable. It should be recognised that the principal objective of this initiative is to deliver the benefits set out in section 2. That said it must also be noted that the move to seven day working for unscheduled care will not, of itself, increase income to the Trust. Therefore, in addition to ensuring that any increased cost of delivery is justifiable the Trust will also:
  - Explore with commissioners the scope for either recurrent or non-recurrent financial support to assist with any increased costs that cannot be accommodated within a national tariff structure that is not based on a model of 7 day working across the NHS
  - Explore the financial benefits of reducing length of stay, contractual penalty avoidance, etc that may be made possible by these changed ways of working.

Ultimately the business case for a move to seven day working setting out both costs and benefits will need to be approved by the Trust Board.

It is recognised that any move to seven day working within Lincolnshire hospitals will bring greatest benefit if it is part of a move to seven day working across all organisations and agencies that provide care to the people of Lincolnshire either in hospital, their own homes or other settings.

Discussions are underway with neighbouring NHS organisations (Ambulance, Community & Mental Health service providers) as well as Social Services to explore what change may be necessary within their service delivery to maximise the benefits delivered through this initiative. A move to seven day working for unscheduled care across the hospitals operated by ULHT is a significant and important development for both the public and staff affected. It is therefore important that communication is timely and effective. The key audiences identified are:

- The media and general public

- Public leaders, eg MP's, Health and Wellbeing Board and Health Overview & Scrutiny Committee
- Neighbouring organisations across the Health Community
- Staff-side organisations
- Employees of ULHT

Communication will take place with each of the audiences identified.

The Trust is committed to at least one site within the Trust commencing the delivery of seven day unscheduled care services in April 2014, with all other sites operational by the end of June 2014

LCHS: Lincolnshire Community Health Services are committed to delivering high quality, safe services throughout the 7 day working week.

To achieve this in the longer term, the organisation intends to undertake significant transformational change in the way services are delivered. This has been detailed in our 5 year QIPP programme, which was approved by the Trust Board in December 2013. Two of the five themes within the programme are associated with improving productivity and releasing additional clinical by utilising existing resource more effectively. A wider consultation process across LCHS will be commenced in April 2014 in line with the QIPP Programme, to address the workforce changes necessary to continue the delivery of high quality patient services throughout the 7 day week.

In the shorter term, immediate actions have been taken to restructure elements of the community nursing resource to work across both the 7 day and 24 hour periods in support of the programme of admission reduction schemes being trialled in the county. Initial funding is in the process of being secured to support particular elements of the trial, which is being viewed as a 'proof of concept' model. The recruitment drive supporting these schemes has been based on a seven day working week, signalling a shift in the organisation's commitment towards a goal of standardising all future clinical appointments throughout the trust.

In addition the organisation has introduced an attendance management tool which supports front-line staff to maximise their capacity and performance manage attendance across a 7 day period, 365 days of the year. This has been supported by the implementation of a roster policy which embeds the principles of improving working lives, whilst ensuring that safe levels of staffing are available to maximise and sustain the delivery of services in the community. Performance management of attendance across community teams is now being formally monitored via internal processes, with significant challenge being applied to areas where there is evidence of in- efficient utilisation of available resource. This is particularly pertinent in times of predicted peak activity.

A review of our existing community work force is being undertaken, which will be shared with the Trust Board and Health and Social Care Commissioners in early 2014 and is underpinned by detailed service line reporting evidence. The aim of this review is to ensure a baseline for safe staffing levels are established in the community. Pending the outcome of the review, there may be the potential for some movement of key clinical personnel around the county or indeed evidence of additional investment being required to support a robust community service provision.

In parallel work is being under taken to review our current and future workforce planning, to recruit and retain a much more flexible workforce which can be fully utilised according to need such as; maximising bed occupancy, reducing length of stay and the management of increasingly complex patients being cared for in the community. The organisation also intends to implement new ways of working which require employees to work across a number of geographical areas as well as over seven days per week. This will ensure the future workforce is able to deliver the ambitions of the organisation's clinical strategy and be underpinned by the introduction of annualised hours contracts as well as the availability of a more robust bank system to supplement the existing workforce in times of increased need.

PRIMARY CARE: A short while ago, the Area Team (AT) communicated with CCGs regarding 7 day working in Medical practices to support winter pressures. However CCGs had already formulated their plans, including the use of any additional funding to support winter pressures elsewhere in the system.

Apart from dental services, the AT only commission 'core' services from primary care contractors. CCGs and Local Authorities commission any additional services. That being said, and with the national imperative for 7 day working, NHS England has just launched the 'Prime Minister's Challenge Fund: Extending Access to General Practice' We already have a number of Community Pharmacies throughout Leicestershire and Lincolnshire that provide services 7 days a week. The Pharmacy Needs Assessment (PNA) that is led by the Local Authority will no doubt include the need for availability of services over 7 days in future iterations. We also have a number of dental practices that provide 7 day a week services. Currently the Primary Care Strategy is under development and will include 7 day working.

The GMS Contract Changes for 2014/15 include some that may impact in this area, particularly the named co-ordinating GP. There will also be a new DES to cover admission avoidance/pro-active case management etc. We are awaiting further details and plans for this service will need to dovetail with CCG plans.

LCC: Adult Care will continue to meet the demand for assessment activity over seven days a week. This will be delivered by the Council's Customer Service Centre (CSC), neighbourhood teams, Emergency Duty and Hospital based staff who are able to work weekends and bank holidays to meet varying demands. LCC supports a joint reablement service with health partners working across the whole county 7 days a week this supports hospital avoidance and discharges. This has easy links to all providers and their access points to ensure a seamless health and social care response.

LPFT: Lincolnshire Partnership Foundation Trust (LPFT) has an on-going commitment to ensuring high quality, easily accessible and timely health and social care service provision across Lincolnshire. This is currently being achieved by a combining a number of established and newly developed services with continued innovation and partnership working always high priorities. The Single Point of Access for LPFT now provides one dedicated contact number for all Trust services and is available 24 hours a day, 7 days a week. 7 day services are provided by the Crisis and Home Teams, Rapid Response Teams and the Lincoln HIPs team to both provide care in the community, early discharge and admission avoidance. These services closely link to on-call medical staff, the wider Trust services such as the Integrated Community Mental Teams (7 days a week when required) and the wider health and social care community including the Emergency Duty

Team (EDT).

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

The NHS number is used as the primary identified for correspondence between health and social care.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

We can confirm that we are committed to adopting systems based on Open APIs and Open Standards.
In social care we have procured a new case management system from Core Logic for implementation in January 2015. The software solution will implement a multi-agency case management system for social care that will act as an enabler to countywide, joint service delivery and empower greater flexibility and efficiency via secure, shared data services.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

There is an overarching Information Sharing Protocol agreed between the Health and Social Care Community in Lincolnshire which includes consent, access and security procedures, subject access requests, protocol management procedures, data protection and Caldicott requirements.

The Local Authority uses GCSX e-mail in all patient identifiable exchanges of information. Mandatory training must be completed before individual accounts are authorised and managers are required to complete an Information Sharing Agreement audit providing details of the information to be shared.

The Local Authority also completes the IG Toolkit self-assessment on an annual basis.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

In Lincolnshire we have a pooled budget agreement between Lincolnshire CCGs and Lincolnshire County Council from which an integrated Assessment and Care Management Team is funded and hosted by LCC for Adults with a Learning Disability aged 18+. Each case is open to a lead officer who is responsible for assessing the Health and Social Care needs of citizens. As at 30/11/2013 there were 1,700 open cases for adults with a learning disability aged 18+, representing 12% of the total number of adults supported in Lincolnshire (14,000 current adult clients – all ages and client groups).

LCC also has a section 75 agreement in place with Lincolnshire Partnership Foundation Trust (LPFT) that enables LPFT to deliver LCC's Social Care Assessment and Care Management Function. This is delivered as part of an integrated Community Mental Health Team (CMHT). This is predominately for people aged 18 to 64 at this point. LPFT have also developed a Single Point of Access (SPA) for Mental Health Services and there are opportunities to expand this initiative to all clients groups across Lincolnshire. Currently there are 600 open cases to the LPFT CMHT which represents 4% of total cases in Lincolnshire" (expressed as a % of 14,000 from above).

In Lincolnshire a new pathway was created in November 2013; all adults at risk of a hospital admission are referred to a multi-agency contact centre where the adult is assessed based on all available information by an appropriate health / social care professional into a pathway for the right support to enable the person to remain in their own home or as close as possible. In Lincolnshire; for this winter, the commissioners have in place 2 contact centres based on the prime need of the person being either Physical or Mental health. The contact centres provide a 24 hour a day, 7 day service across the County to all Health and Social Care Professionals.

The lead professional will remain involved until either the adult is no longer in need of support at which point the Lead professional role would transfer to the Adult's GP Practice; or the lead lrofessional role is passed to an Adult Care practitioner to undertake a statutory Adult Social Care assessment of need.

The Lincolnshire Urgent Care Working Group has oversight of the overall quality assurance and performance for this new pathway and support systems will be provided from contact centre data which includes response times, waiting times, abandoned calls. Customer experiences are gathered ongoing by all providers with some individual patient experiences shared across Health and Social Care to demonstrate the effectiveness and monitor the outcomes for each patient.

The special educational needs reforms which come into place in September 2014 require health, education and social care to radically transform and streamline the system for SEN assessments. Statements will be replaced with an aligned assessment process and an integrated education, health and so vial care plan from birth to 25 years

The BCF will support improved cooperation between the social, education and health system so there is a shared understanding and integrated processes for delivering our statutory services under the new legislation.

4) RISKS

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

We have undertaken a Risk Assessment which is detailed below. We would highlight the level of resource invested in securing adequate capacity to ensure progress in both this BCF (notably with respect to the "Early Implementers") and the LSSR. Specifically, three senior appointments have been made to add capacity to the Delivery Boards identified in Section 2d (this included two jointly appointed Assistant Director grades). Health and Social Care commissioners along with the Area Team have added to this capacity by commissioning highly respected and skilled organisations to work alongside us. In phase 1 for example, PWC were commissioned to provide support and expertise.

Better Care Fund Risk Assessment

Risk No	Risk Description		Inherent Risk Score		
	Risk Source	Risk Consequences	Probability	Impact	Score
001	Lack of capacity to transform and integrate will result in failure to maintain current performance and customer satisfaction, or failure to achieve integration	Investment in phase one of a county-wide review of the Health and Social Care Economy (Lincolnshire Sustainable Services Review) is completed and has provided an holistic view of key areas and high level models for integration. Non-recurrent funding for phase two will provide the necessary investment in capacity and infrastructure to support detailed mapping and impact analysis of models identified in phase one	3	4	12
002	An improved integrated pathway focused on prevention and keeping people safe in their homes is achieved but fails to deliver key performance improvements across health and social care economy resulting in reduced funding and an insufficient financial envelope to support core activity	Modelling from phase one of the services review considered key data, but includes a number of assumptions. This data will be further detailed in phase two allowing develop development of co-directed detailed business case and informed decision making	3	4	12
003	Service providers, voluntary sector and community groups are unable to respond adequately to the re-modelling of commissioned services to achieve the vision	Phase two of the sustainable services review has a strong focus on consultation and collaboration and will build on the co-design of phase one across the provider and community landscape to fully understand and plan for the required level of support and investment to deliver an integrated vision.	3	4	12
004	The anticipated financial impact of the care bill which has planned Royal Ascent in 2014 in not fully quantifiable although financial modelling and planning have been undertaken to an extent. This has potential to impact on the delivery and sustainability of current plans	An initial impact assessment has been completed and has been considered during phase one of the sustainable services review by Adult Care. Future planning needs to consider the risks and benefits of the bill to ensure a sustainable model is developed	3	4	12
005	The model chosen for an integrated health and social care system in Lincolnshire does not deliver sufficient whole systems base budget savings and the forecast deficit is not mitigated	The health and social care system re-design planned for in the Lincolnshire Sustainable Services Review has to demonstrate not only improvements for customer outcomes and experience, but sufficient radical re-engineering to deliver a balance budget across the Health and Social Care Economy.	3	4	12

Lincolnshire Sustainable Services Review (LSSR) mapped to Lincolnshire Joint Health and Wellbeing Strategy (JHWS)

	Promoting Healthier Lifestyles	Improve the health and wellbeing of older people	Delivering high quality systematic care for major causes of ill health and disability.	Improve health and social outcomes for children and reduce inequalities	Tackling the social determinants of health.
Proactive Ideas	X	X	X		X
Elective Care Ideas	X	X	X	X	
Urgent Care Ideas		X	X		
Women's and Children's Ideas				X	X

Percentage overlap between LSSR Brave Ideas and JHWS Priorities

	Promoting Healthier Lifestyles	Improve the health and wellbeing of older people	Delivering high quality systematic care for major causes of ill health and disability.	Improve health and social outcomes for children and reduce inequalities	Tackling the social determinants of health.
Proactive Ideas	50%	67%	60%	13%	50%
Elective Care Ideas	67%	78%	100%	67%	11%
Urgent Care Ideas	13%	56%	89%	22%	11%
Women's and Children's Ideas	14%	0%	12%	100%	52%

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Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
		£'m	£'m	£'m	£'m	£'m	£'m	£'m	
Scheme 1 - Neighourhood Teams - led by the Proactive Care Delivery Board			*1.6*				*49.5*	*2.1*	
led by the Proactive Care Delivery Board			*4.3*				*14.1*	*0.5*	
Scheme 3 - Seven Day Working - led by the Urgent Care Delivery Board			*0.5*				*0.8*		
Scheme 4 - Prevention -led by the Proactive Care Delivery Board			*3.3*				*10.7*		
Scheme 5 - Enablers e.g. Capital, IMT, Organisational Development, Communications			*1.0*				*3.5*		
Learning Disabilities and Mental Health led by the Specialist Care Delivery Board			*4.3*				*117.6*	*0.8*	
Others			*0.4*				*1.1*		
Total			***15.4***				***197.3***	***3.4***	

Notes

The spend has been attributed as non-recurrent to align with LSSR strategic intentions where the health and social care landscape will look very different. In line with LSSR there will be a shift of resources from acute hospitals to support re-investment in the community across health and social care.

The front sheet of the BCF submission notes 14/15 total spend of £70.8m. This is compiled from the £15.4m non-recurrent schemes and the value of the existing pooled funds arrangements under S(75) which are noted in part one of the BCF submission

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
		£'m	£'m	£'m
Local Authority Social Services		£15.40		*£85.85*
Lincolnshire East CCG			*£16.19*	*£38.08*
Lincolnshire West CCG			*£14.50*	*£32.76*
South Lincolnshire CCG			*£9.81*	*£22.30*
South West Lincolnshire CCG			*£7.90*	*£18.26*
Primary Care				
Local Authority Public Health				
BCF Total		**£15.40**	**£48.40**	**£197.3**

Notes:
The £4.9m Capital allocation of £4.9m is provisionally allocated to Disability Facilities Grants (£3m) and the Adult Care capital programme (£1.9m)

Discussions are on-going with the 7 District Councils around investment to support their current DFG programmes. Going forward, any investment will sit within the broader 'Wellnet' prevention programmes being developed.

Adult Care capital funds are extensively being invested in Extra Care with funding also available to support the IT infrastructure required to improve case management systems and implement the service/financial requirements resulting from Dilnot and the Care Bill.

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

The prime aim is to deliver the planned improvements and this will be closely monitored by the established governance arrangements outlined within the plans. The totality of the BCF contributions across health and social care are significantly above the minimum requirements of the BCF. The LSSR will lend itself to creating further opportunities for extending the pooling of resources beyond the BCF. Given the financial magnitude of collaborative commissioning it is the expectation that this provides the financial and governance platform to deliver the planned improvements.

Contingency plan:		2015/16	Ongoing
Outcome 1	Planned savings (if targets fully achieved)	£3.4m	This will be part of LSSR
	Maximum support needed for other services (if targets not achieved)	n/a	
Outcome 2	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Metrics	Metrics measurement	Delivery Board Responsible	Metrics outcome / benefit
Admissions of older people to residential care	Based on admissions to council funded permananent long term care and will be monitored through both the proactive care board	Proactive Care Delivery Board	There will be a reduction in admissions to permanent long term care over and above estimated growth in population through integrated intermediate care, neighbourhood teams, 7 day working and prevention schemes
Proportion of older people still at home over 91 days	Measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode. Data is available on an annual basis and will be monitored through the proactive care board	Proactive Care Delivery Board	An increasing number of people will be maintained to live at home through integrated intermediate care, neighbourhood teams and 7 day working schemes
DTOC from ULHT acute hospital (including health and social)	This is based on ONS Population stats for 18 years over and is measuring health and social care reasons for DTOC from main acute hospital (ULHT). The monitoring will be undertaken on a monthly basis via the unscheduled care board	Unscheduled Care Delivery Board	There will be a reduction in the DTOC over and above estimated growth in population. This will support an easing of pressures on acute hospital beds.
Avoidable Emergency Admissions	Awaiting national baseline information	Unscheduled Care Delivery Board	Although the baseline figure is not yet available intermediate care, neighbourhood teams and 7 days working should support a reduction in emergency avoidable admissions
Patient Experience Metrics	Awaiting National Metrics publication	Proactive Care Delivery Board	All the schemes should support an improvement in patient experience of health and social care
Local metric - Proportion of people feeling supported to manage their (long term) condition	This measure is based on the GP patient survey question 'In the last 6 months, have you received enough support from local services/ organisations to help manage your long term condition	Proactive Care Delivery Board	All the schemes should support an increase in the proportion of people who feel that they are supported to manage their long term conditions

Area	Delayed Transfers of Care	Emergency Admissions	Effectiveness of Reablement	Admissions to residential and nursing care	Patient and service User experience	Proportion of people feeling supported to manage their (long term) condition
Intermediate Care	x	x	x	x	x	x
Neighbourhood Teams	x	x	x	x	x	x
7 day working	x	x	x	x	x	x
Prevention				x	x	x

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical

It is the intention to use the National Metrics once it has been published

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

The monitoring and assurance of delivery will be undertaken by the Joint Commissioning Board and the under-pinning delivery Boards as outlined within the Governance section of the BCF plan. This will be undertaken on a monthly basis. The targets have been developed using historical data, benchmarking against other authorities and projections of improvements made as a result of Better Care Funding.

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-

N/A

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	816	N/A	785
	Numerator	1217		1301
	Denominator	149150		165597
		(April 2012 - March 2013)		(April 2014 - March 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	72.40%	N/A	80%
	Numerator	653		800
	Denominator	902		1000
		(April 2012 - March 2013)		(April 2014 - March 2015)
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	**131**	**128.3**	**127.2**
	Numerator	5279	6787	4487
	Denominator	575467	587782	587782
		April 2013 - October 2013	(April - December 2014)	(January - June 2015)
Avoidable emergency admissions (composite measure)	*Metric Value*			
	Numerator			
	Denominator			
		BASELINE DATA TO BE PUBLISHED JAN 2014	(April - September 2014)	(October 2014 - March 2015)
Patient / service user experience		Pending national publication	N/A	Pending national publication
Proportion of people feeling supported to manage their (long term) condition - ***Query on baseline data o/s with CCG's***	*Metric Value*	63%		64%
	Numerator	9418		9600
	Denominator	14933		15000
		July 2012 - March 2013	*N/A*	*July 2014 - March 2015*