Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of

Glen Garrod, Director of Adult Care

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**11 September 2014**
Subject:	**Better Care Fund Final Re-submission**

Summary:

The value of the Better Care Fund (BCF) in Lincolnshire in 2014/15 is £15.4m. In 2015/16 the value of the fund will reach £53.3m. This incorporates an allocation (£2m) to help underwrite the costs of implementing both the Care Act from 2015, and the 'Dilnot Reforms' (how people will be charged for adult social services for which they are eligible). It also includes a capital element (£4.9m) for IT investment (to support Care Act implementation and, Disabled Facilities Grant (DFG) funding to be passported to District/City Councils. The value of the DFG element is £3.1m. It is important to note that the majority of BCF funding in 2015/16 is from existing spend in health and social care and as such is NOT new money.

There is no clarity about the longevity of the BCF and what the financial envelope and expectations will be in 2016/17. The expectation is that following the national elections in May 2015 further guidance will be provided.

As with the previous BCF submission in April 2014 a group of officers including senior representatives from each of the four CCGs and their Chief Finance Officers has been meeting during July, August and September with senior officers in Adult Care, finance and an LHAC representative to produce this revised submission. It is important to note that this version contains gaps which are still in production. Most notably Part 1 Section 5 **Risks and Contingency** and Annex 2 - **Provider Commentary** (ULHT). The remaining document (Part 1, 2 and Scheme Descriptions) is largely complete with some final iteration yet to be provided.

The areas of risk most noteworthy refer to the risk associated with non-achievement of the 'pay-for-performance' metric which is a 3.5% reduction in non-elective admissions during the calendar year 2015 and, the more general financial pressures in both health and social

care systems as far as the funds identified for pooling are concerned. Further explanation of these will be provided at the Health and Wellbeing Board along with how they are beginning to be addressed.

The Executive of Lincolnshire County Council also received and endorsed an earlier version of the attached BCF re-submission on 2 September.

Actions Required:

1. Members are asked to note and comment on the content of the attached BCF final submission: Part 1 and Part 2 (Appendix B).

2. Delegate to the BCF Task Group any final iterations between today's meeting and 19 September 2014.

3. Agree the document as attached for submission on 19 September 2014.

1. Background

The approach taken in Lincolnshire to obtain consensus regarding the use of the Better Care Fund (BCF) in 2015/16 followed a route laid down by Government which was intended to see local submissions signed-off by Ministers in June 2014. The submission document (BCF Part 1 and 2) was approved by the Health and Wellbeing Board on 25 March 2014 (Appendix A) along with the agreed allocations in 2014/15 which were also detailed for the Health and Wellbeing Board on 10 December 2013.

The policy direction nationally for 2015/16 was changed however, in direct consequence of NHS concerns related to the allocation of funding (notably the NHS element of the £3.8bn) and whether this would deliver improvements and efficiencies required, notably in the acute sector. Subsequently, CCGs were contacted direct by NHS England on 4 June requiring them to resubmit their 2 year plans, by 27 June, in light of concerns raised.

This meant that Ministers were not prepared to sign off BCF submissions in June and announcements were made to the effect that new BCF submissions would be required and a new deadline established. Revised guidance was issued on 25 July and the indicative deadline for resubmission of the BCF has been changed several times. On 28 July the Government advised Health and Wellbeing Boards that they were required to re-approve and re-submit BCF documents against a substantially changed BCF template by 19 September. The new deadline is expected to coincide with Ministers' need to sign off agreed submissions by early October 2014.

The new template was finally issued 4 August. This new document which has been further amended (eg to Part 2) shifts the emphasis from pooled budget arrangements towards service developments that will deliver a substantial reduction in emergency (non-elective) admissions at acute hospital sites. The 'pay-for-performance' element which was originally part of the BCF, was withdrawn, and then re-introduced but only in relation to the performance expectations around emergency admissions.

It is worthy of note that both the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) have voiced their "opposition" regarding the national policy changes to the BCF and, the reorientation of the pay-for-performance element towards emergency admissions and the acute NHS sector.

The performance measure has also changed from 'avoidable' emergency admissions to emergency admissions. This materially increased the challenge for health and social care communities. In addition the new BCF template requires a section to be completed by the Chief Executive (CEO) of the local Acute Trust to say they recognise and agree the expectations and performance targets set out in the BCF submission. In Lincolnshire this presents its own particular set of challenges. Whilst the Acute Trust CEO is required to complete a section of the BCF it is the four CCGs and the County Council that remain the signatories along with the Chair of the Health and Wellbeing Board.

There are considerably greater risks to this revised approach. Not least of these is that failure to achieve the desired performance against emergency admissions (a 3.5% reduction in 2015/16) runs the risk of up to £3.7m (very worst case scenario) of the £48m for Lincolnshire potentially being redirected towards the acute sector. This would reduce the ability of the BCF to support Adult Care, deliver against the requirements of the Care Act and, support (invest) in the shift of care from acute to primary/community as envisaged in Lincolnshire Health and Care (LHAC).

This adds to the existing risks to the BCF on non- delivery of real reductions in the spend on acute hospital care along with further efficiencies from community providers since CCGs require that in order to balance the impact of the BCF that real savings of £9m were generated principally from acute care. This makes real reductions in the spend (at ULHT principally) a requirement as early as 2015/16 if we are to deliver the shared agenda.

Notwithstanding the above as with the previous BCF submission the 'early implementers' are unchanged: Neighbourhood Teams, Intermediate Care, 7 day working and 'Wellbeing'/prevention remain vitally important and form a strong link with the wider LHAC programme. These have been added to so, for example with schemes for Carers and Children with mental health needs so that there are now 7 detailed scheme descriptions in Annex 2 to Part 1. The financial components and their allocation have also not changed as detailed in the original BCF submission in April 2014.

The deadline for BCF submissions is 19 September and, given the timetabling of Health and Wellbeing Board meetings this was the only available option for sign-off if Lincolnshire was to meet the prescribed deadline.

The report has also been presented to the Executive of the County Council on 2 September following receipt of legal advice that this was a necessary precursor to the Health & Wellbeing Board.

2. Conclusion

As was stated in the original BCF submission this final BCF re-submission seeks to represent the combined and shared ambition across the health and social care community in Lincolnshire. The consequence of this BCF is that shared and improved performance, an extensive level of pooled budget and significant service integration will follow commensurate with the intentions of LHAC.

The effect of national policy changes has caused some additional requirements which shift some of the focus of the BCF towards admission avoidance and, commentary on the BCF re-submission by the CEO of the Acute NHS Trust (ULHT). There are additional risks in this approach given the re-introduced pay-for-performance element and, the level of financial risk at two levels:

1. Failure to meet the admission avoidance metric required could mean up to £3.7m of the BCF is removed from existing plans and potentially redirected to acute sector pressures.
2. Failure to meet the £9m savings target which is the gap between the level of pooled budget available and the current spend by the end of 2015/16 will also require consensus on how this specific risk will be managed across health and care organisations.

Governance of the BCF is currently expected to be through the Health and Wellbeing Board, and the Joint Commissioning Board. The connection to the LHAC Programme Board will also need to be maintained.

3. Consultation

Key aspects of the BCF are subsumed within the LHAC programme. During Phase 1 of LHAC a degree of consultation took place with representative bodies from the health and social care community and those representing groups of service users and the wider public. Phase 2 – the design phase - of LHAC has provided more extensive consultation during Summer 2014. There has also been a senior consultant from LHAC on the group helping with the BCF re-submission.

It has not been possible to consult widely and in public specifically addressing this BCF re-submission. This is due to the national policy changes as detailed in this report, the timetabling and the level of prescription.

The detail below identifies which fora have/will be utilised in progressing this BCF re-submission:

10 July:	BCF Task Group
22 July:	Joint Commissioning Board
5 August:	BCF Task Group
6 August:	Corporate Management Board (CMB) – LCC
19 August:	Joint Commissioning Board (CMB and 4 CCGs)
20 August:	CMB
2 September:	Executive – LCC
2/3 September:	BCF Task Group
3 September:	Corporate Management Board (CMB) – LCC
3 September:	BCF Task Group
11 September:	Health & Wellbeing Board
19 September:	SUBMISSION DEADLINE

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Lincolnshire BCF first submission - April 2014
Appendix B	Lincolnshire BCF revised re-submission - September 2014

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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Updated September 2014 - VERSION KH11 (050914)

Better Care Fund planning template – Part 1

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

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

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

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.**
Date agreed at Health and Well-Being Board:	**11/09/2014**
Date submitted:	**19/9/2014**
Minimum required value of BCF pooled budget: 2014/15	**£15.4m**
2015/16	**£48.4m**
Total agreed value of pooled budget: 2014/15	**£70.8m**
2015/16	**£197.3m**

b) Authorisation and signoff

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

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

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

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

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

Signed on behalf of the Health and Wellbeing Board	Lincolnshire Health & Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Sue Woolley
Date	

c) 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**
First BCF Submission dated 4/4/14	

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

Partners across the health and social care system in Lincolnshire have been working together to develop and realise a shared Vision in the Lincolnshire Health & Care programme (LHAC). This was previously known as the Lincolnshire Sustainable Services Review or 'LSSR'.

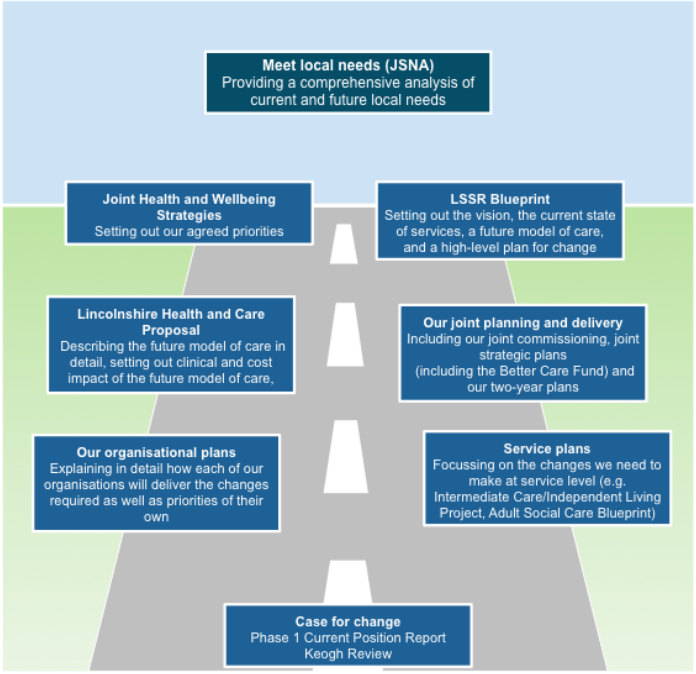
Pricewaterhouse Coopers (PwC) have operated as our strategic partner throughout. Their Care Market Re-Set approach has been used – see section 8.

Phase 1 in 2013 developed a draft blueprint that was approved by all relevant commissioner and provider governing bodies.

Phase 2 has developed that blueprint further through Care Design Groups and Expert Reference Groups that have been informed by local evidence of needs in the JSNA and priorities in the HWBS. A comprehensive evidence bank has been built up of best practice locally, in other parts of the UK and across the world to inform redesign options. The LHAC Phase 2 Status Update section 2.5 contains more detail and examples of the evidence base used.

There has been comprehensive engagement as set out in section 8 and 5 year plans have been developed in the context of LHAC.

The simple relationship between the JSNA, JHWS, LHAC, BCF and other plans is shown below.



This partnership working within LHAC has produced a Vision which was discussed by the LHAC Board at its meeting on 3rd September 2014.

A sustainable and safe health and social care economy for Lincolnshire.
Lincolnshire residents will have access to safe and good quality services, which focus on keeping them as well as possible to reduce the need for unnecessary hospital care. This is likely to mean delivering more care in the community. The key principles for delivery of this vision are; people are engaged and informed; services move from fragmentation to integration; a focus on proactive care rather than reactive care; shared decision-making with decisions based on evidence and; quality improvement where possible.

By 2018/19 we will:

- Be on a trajectory to a stable and financially sustainable position
- Deliver integrated, personalised proactive care through multi-disciplinary neighbourhood teams
- Focus on outcomes, safety, quality and experience
- Deliver measureable results
- Develop innovative roles to attract staff and address recruitment issues
- Work with the public, statutory and voluntary services to support individuals, families and communities in maintaining and improving their own wellbeing.

To do this we will:

1. Continue to develop our partnership working with all agencies to deliver better system wide outcomes facilitated through our agreed Concordat and shared criteria for success.
2. Link to the Joint Health and Wellbeing Strategy aims in particular; help people lead a more healthy and independent life; make the lives of older people better; help people with long-term illness or disability to get good healthcare and make sure all children get the best possible start in life.
3. Provide more care in the community – including elective care – with patients able to access the right care in the right place at the right time by the right person.
4. Work with NHS Area Team, CCGs and the LMC to support the development of General Practice delivered at scale which will be pivotal to the new model of care.
5. Provide access to a safe and efficient network of urgent care when this is needed which is responsive and able to deliver rapid access to specialists, diagnostics and follow on care.
6. Identify work programmes required to enable this change i.e. transport; technology; estates; workforce and contracting considerations.

We recognise that in order to deliver our vision we will have to take tough decisions within the health and social care community which, of necessity includes engagement with local residents. However, the changes will be clinically led and evidence based.

In the Blueprint developed in Phase 1 of this work 22 interventions were identified for sustainable services. In Phase 2 we have actively worked with over 250 staff and patient and carer representatives and engaged with a significant number of others throughout the process. We will continue to engage local people and our care professionals to understand what these services need to look like in more detail. In this update we present the emerging options that have been developed to date for 4 distinct service areas; Urgent Care; Elective Care; Proactive Care and services for Women and Children. We will continue this work to understand what the future configuration of services needs to be and establish a Lincolnshire model of integrated care.

Our work will align with all required assurance processes notably Planning and Delivering Service Change for Patients.

What comes next

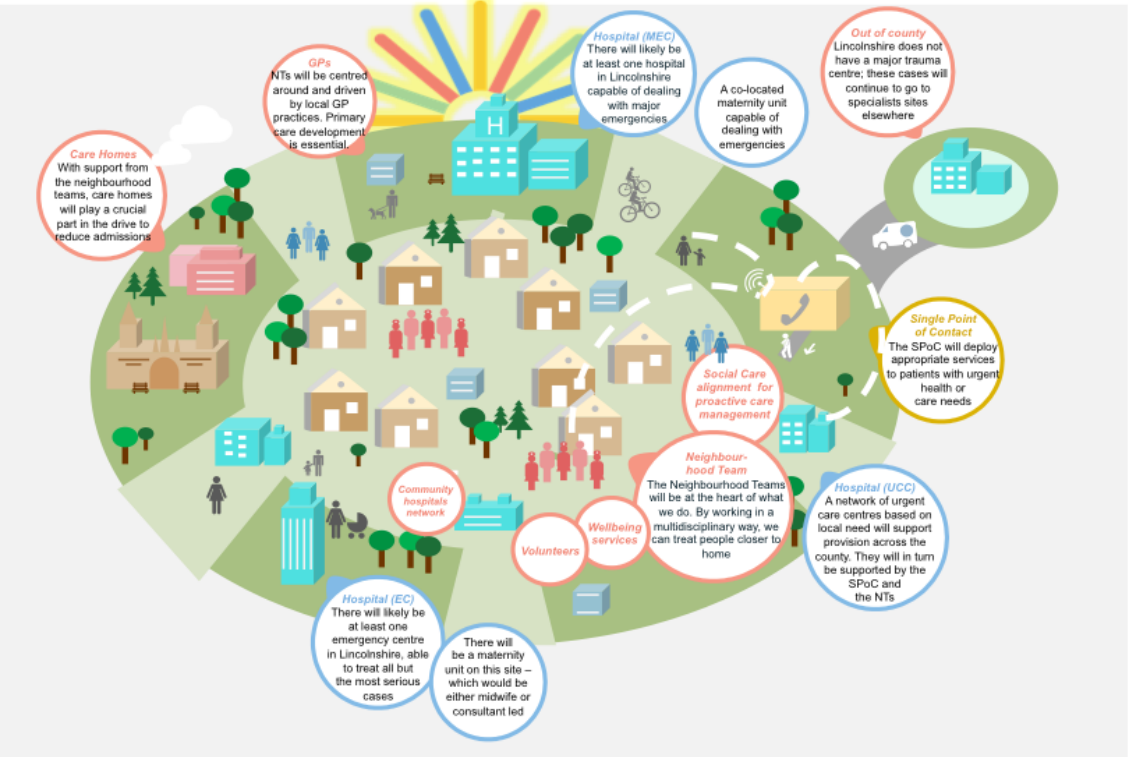
There are three key areas for immediate development:

1. We have launched the first 4 early implementer neighbourhood teams (NTs) during August with the next 4 in the autumn
2. Developing Community Hospitals to deliver as many services locally as possible and support the NTs
3. Develop proactive care pathways to support delivery of as much care locally as possible.

That will mean:

- The outcomes of this work will inform commissioners' development of specifications and inform ULHT's clinical strategy and future implementation requirements
- Undertaking on-going public and staff engagement and public consultation when required
- Continuing our work with Expert Reference Groups (ERG) to develop sustainable models of care
- Developing the LHAC Phase 2 Update into a Proposal for Change
- Establishing a clear work programme for the remainder of 2014/15 (shown in section 4a) focussed on delivering where possible quick results as well as developing clear commissioning intent for the implementation of developing proposals.

The next diagram shows a simple graphical view of this Vision.



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

The high level description of outcomes in the table below is extracted from the LHAC Phase 2 'plan on a page'. More detail is in individual workstreams and in Annex 1.

Outcome				
Short (14/15)	4 Early Implementer Sites with multi-disciplinary neighbourhood teams (NTs) launched in summer 2014 caring for between 10,000 and 50,000 high risk patients using risk stratification and case management. Remaining teams rolled out through phased approach proactively caring for 718,000 registered patients by end of 2014/15.	Design of improved Single Point of Contact produced. Detailed consideration of changes to site configuration produced in line with above.	Specialties identified for early end-to-end integration. Plans developed for improving referral processes and considerations for site consolidation.	Admission avoidance & care coordination improved by pathway development delivered through community teams. Considerations for site consolidation outlined.
Medium (15-16)		Number of acute beds reduced in line with updated projected forecast reductions Single Point of Contact operational.	Improvements to referral process reduce elective activity by 20%. Increased level of community provision of elective procedures.	Paediatric admissions ↓ by e.g. 5% to 3% (national average) Consolidation considerations reviewed /consulted upon Single management / commissioning structures
Long (17-19)	Interventions e.g. SPoC delivering against BCF KPIs (tbc in line with national indicators and local review of stretch targets) e.g. • 15% ↓ in urgent admissions over 75s • 20% ↓ residential & nursing placements (tbc following updated review of local data by ASC) • %↓ tbc 91 day readmissions (as an indicator of successful reablement) • % ↓ tbc in 30 day intermediate care beds • Reductions in activity transferred to system objectives which will be validated by service areas and approved through the finance and ops groups	Care standards met. Workforce issues resolved. Reduction in number of sites providing elective care to improve quality & care closer to home.	Enhanced quality of maternity, obstetrics and paediatrics through consolidation. Improved ability to meet college guidelines / NICE recommendations etc. Improved model for community teams to reduce W&C admissions provide more care in community based services and to improve quality.	

Metrics to evaluate changes in these and other outcomes are in development through ERGs.

These are based on a variety of different sources including NHS, Adult Social Care and Public Health Outcomes Frameworks; JSNA; and alignment with Better Care Fund Planning and Phase 1 assumptions and aims.

Currently the outcomes are based around five broad areas: patient outcomes; activity outcomes; financial outcomes; process outcomes and system outcomes. Alongside these areas there has been consideration of the performance management of transformation and the potential for outcomes based commissioning as the programme develops.

We are also seeking to take account of the Sustainable Development Strategy for the Health & Care System 2014-20.

Specific metrics for BCF interventions are covered in the relevant sections.

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

The overall Vision and a range of potential options to deliver that Vision in a financially sustainable way are set out in the LHAC Phase 2 update and summarised in section 1(a) above.

Some of those potential changes will require NHS assurance and formal public consultation before decisions by commissioners of services. We anticipate that will happen in the first half of 2015.

Some can be proceeded with now. BCF focuses on several aspects of the early work, particularly the three key areas for early development to achieve the LHAC Vision:

1. Launch of the first 4 early implementer neighbourhood teams (NTs) during August with the next 4 in the autumn
2. Developing Community Hospitals to deliver as many services locally as possible and support the NTs
3. Develop proactive care pathways to support delivery of as much care locally as possible.

For further information please also see the individual scheme description.

3) CASE FOR CHANGE

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

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 began with Phase 1 during 2012/13 and the publication of the Lincolnshire Sustainability Review. Phase 2 – our current phase - will see further detailed planning before a formal period of public consultation takes place during 2015 for a period of three months. Please see the diagram below for further detail.

In our first BCF submission we identified savings arising from a combination of pooled budgets and 'Early Implementers' that are seen as central to securing early progress against LHAC. 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 in our first BCF submission were:

1. The development of **'neighbourhood teams**' across Lincolnshire reflecting GP clusters. Initially four sites have been developed at the beginning of August, a further four will commence in October and the remainder covering Lincolnshire during the first half of 2015.

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 both in the Acute Sector to reflect recent policy exhortations to help reduce mortality in hospitals (which rise at the weekend) and to facilitate improved operation of discharge – notably for frail elderly. Furthermore, we anticipate that all 'early implementers' will develop to reflect the necessity of 7 day

working for improved outcomes for people.

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'.

   Lincolnshire is on a clear trajectory for the implementation of a population level prevention and early intervention service, starting initially with a Wellbeing Service that includes virtually limitless capacity for assistive technology expansion, 24/7 monitoring and response management and on the ground proactive and reactive service capacity of 2500 rising to 3500 service users in the first year. Phase 2 will see an ongoing expansion of the reach of this service into self-funding populations and the addition of community equipment and housing adaptation (DFG) interventions into a better coordinated system by 2016.

Case Study – Preventing an escalation of need.

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 aid 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.*

The examples given above describe a number of new and pre-existing initiatives. In addition, and with this BCF re-submission we have also added further schemes that are detailed in section 4d and in the detailed scheme descriptions in Annex 1.

In addition to the development of new service arrangements Pooled Budgets will be developed for specialist services ie, for people with a learning disability and mental health needs. We anticipate being able to increase the effectiveness of services in consequence and, to deliver a saving.

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.

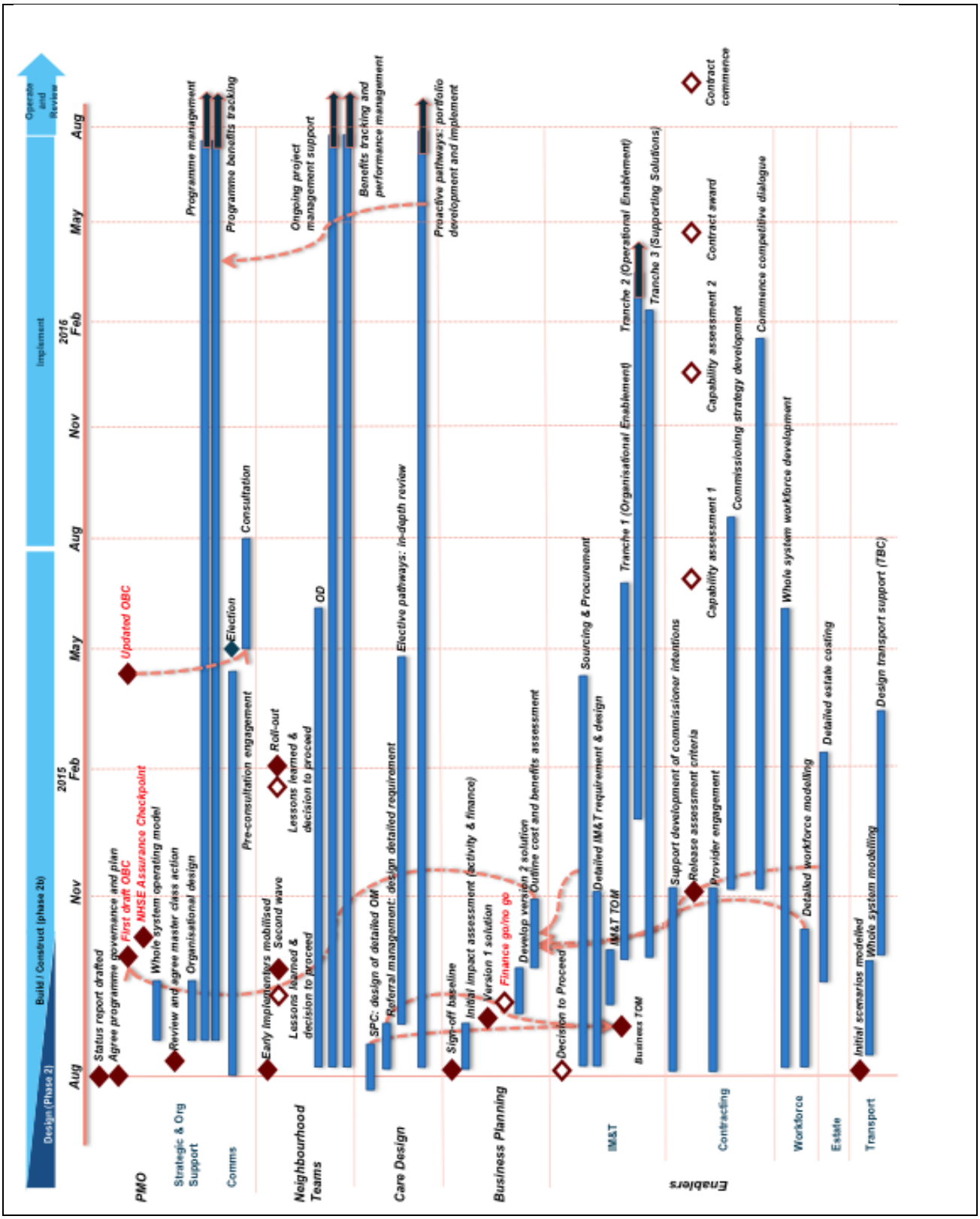
Our ambition is to increasingly combine services, based on a clear understanding of what works best and where synergies can be obtained. This will mean the merging of currently disparate services that may exist across several organisations. We will progress single service configurations through a collective 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 LHAC, 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 LHAC and what we intend to achieve collectively, eg by building on existing community resources and capacity to prevent escalation of need and more costly interventions.

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.

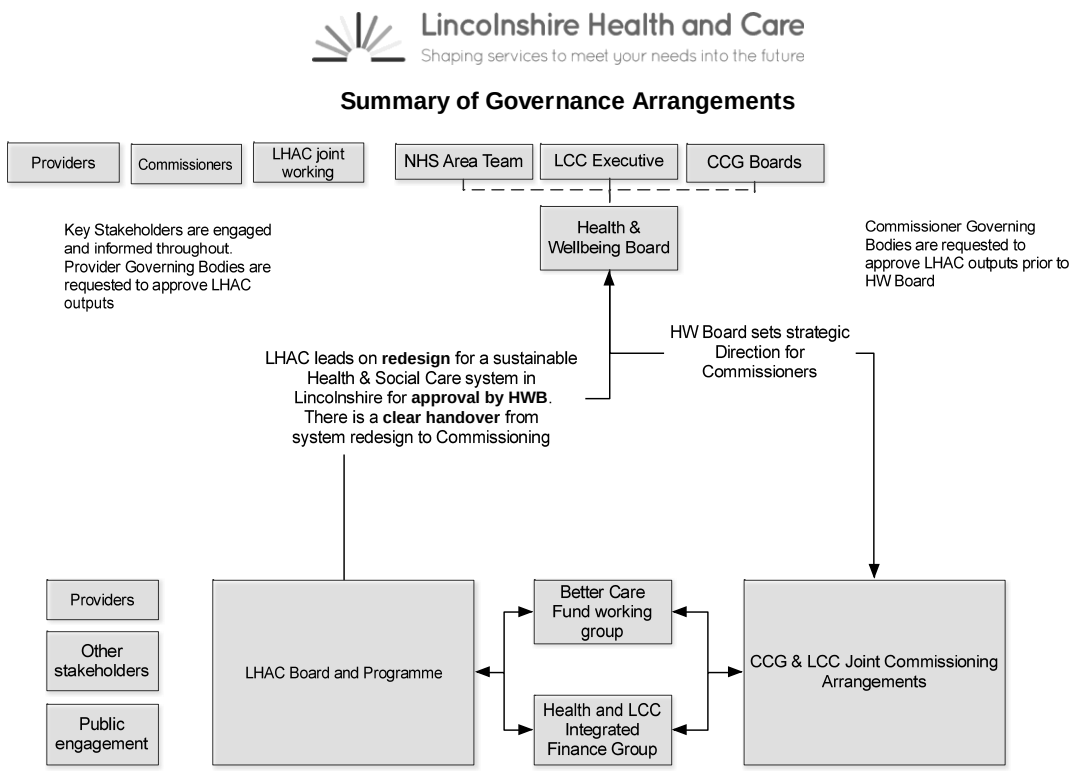
4) PLAN OF ACTION

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

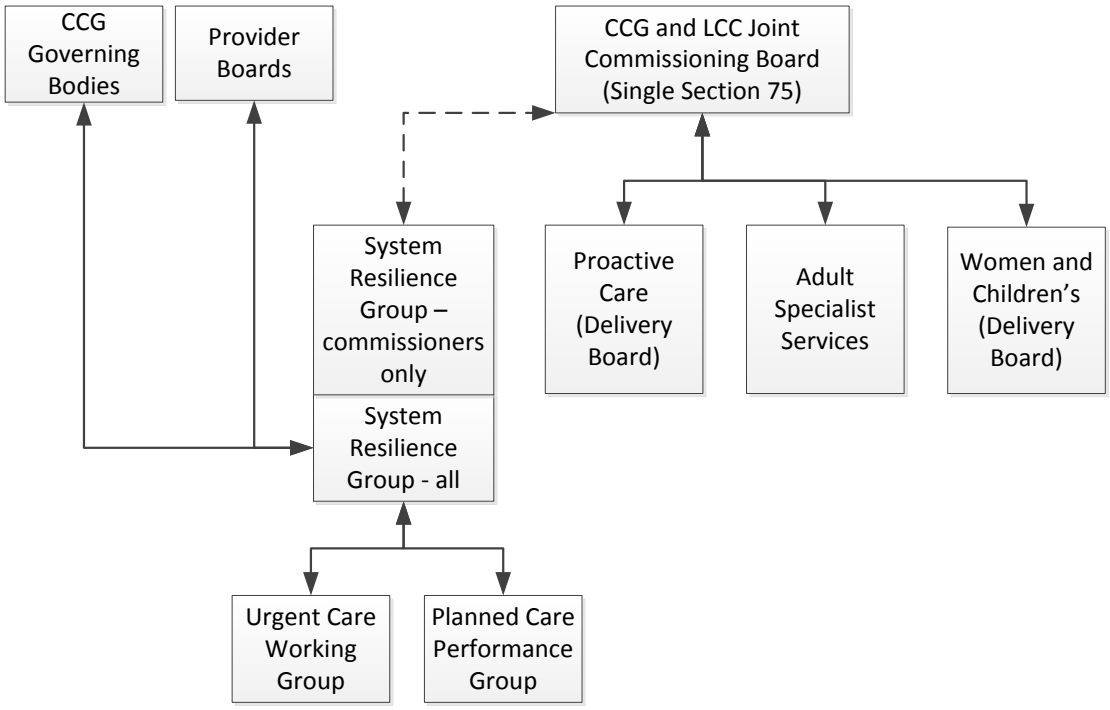


b) Please articulate the overarching governance arrangements for integrated care locally

Lincolnshire's arrangements are summarised diagrammatically below.



Note: The following detail describes the configuration of joint commissioning arrangements.



Key points to note are that:

The LHAC programme is the vehicle for developing an integrated vision for a sustainable health and care system locally. The LHAC Board and all activity within the programme includes commissioners (CCGs, County Council and NHS Area Team), providers (ULHT, LCHS, LPFT, EMAS and LinCA) and other stakeholders (Healthwatch, LMC) using the PwC Care Market Re-Set approach (see diagram in section 8).

The LHAC Board provides leadership and oversight of the programme and makes recommendations to the various governing bodies.

Formal decisions around commissioning are made by the relevant governing bodies.

The CCGs, NHS Area Team and County Council come together in Joint Commissioning arrangements with oversight from a Joint Commissioning Board and detailed work through four Delivery Boards covering Adult Specialist Services, Women & Children's Services, Proactive Care and System Resilience Board. These arrangements were put in place following LHAC Phase 1 and are still developing.

Care was taken in Phase 2 to ensure that the Delivery Boards for Joint Commissioning mapped onto workstreams, CDGs and ERGs for LHAC.

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

Management and oversight of the BCF is by the Joint Commissioning arrangements described above.

Topic Area	Pro-active Care	Women and Children's	Adults Specialist Services
BCF Early Implementers:			
Neighbourhood Teams	✓		
Seven Day Working	✓	✓	✓
Prevention	✓	✓	
Intermediate Care	✓		
Enablers	✓	✓	✓
Joint Dementia Strategy	✓		✓
Joint Autism Strategy		✓	✓
Joint Carers Strategy	✓	✓	
Pooled Budget Targets (2015/16) – estimated	79.7m	5.5m	112.1m
BCF Performance Targets:			
Permanent Admissions of Older People to Residential Care	✓		
Proportion of Older People still at home following Reablement/Rehabilitation	✓		
Delayed Transfers of Care	✓	✓	✓
Emergency Admissions	✓	✓	✓

Patient/ Service User Experience	✓	✓	✓
Proportion of People feeling supported to manage their Long-term Conditions	✓		

The above table provides additional clarity concerning which Delivery Board in the governance structure previously described would take lead responsibility for the "early implementers" within the BCF, the pooled budget figure to be achieved in 2015/16 and relevant BCF performance targets described in Part 2 of this submission. Furthermore, lead responsibility for commissioning strategies is detailed.

Each Delivery Board is expected to work with colleagues in other boards to ensure where overlaps exist these are collectively managed.

d) **List of planned BCF schemes**

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

Ref no.	Scheme
1	Intermediate Care
2	7 Day Services
3	Neighbourhood Teams
4	Wellbeing
5	Specialist Services Pooled Budget
6	Carers
7	Women's and Children's

5) RISKS AND CONTINGENCY

a) Risk log

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

There is a risk that:	**How likely is the risk to materialise?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**

Better Care Fund Risk Assessment

Risk No	Risk Description		Inherent Risk Score		
	Risk Source	Risk Consequences and mitigation	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. Funding for phase 2 and phase 3 has been identified and the external consultancy has now been sourced which will provide additional capacity. The County Council has also added capacity to secure necessary progress.	1	4	4
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. Phase 2 which will provide the necessary design is shortly to commence. Public Health has commissioned a new Well Being Service that will form part of the overall prevention 'offering'. This is due to begin 1/04/14.	2	4	8
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. A robust governance structure with joint commissioning responsibilities will assist in securing necessary service levels and quality. Further, both NHS and Social Care Providers are engaged in the phase 2 work and overall governance of LSSR.	2	4	8
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. The financial effect of new legislation has been reported. The government have indicated that the full cost of implementation will be fully funded.	2	4	8
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. The earlier analysis in phase 1 and the detailed design work in phase 2 are supported by an external consultancy which provides a level of analysis and modelling based on best practice elsewhere.	2	4	8

b) Contingency plan and risk sharing

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

The Joint Commissioning Board will oversee the development of a contingency reserve which will adequately cover the risk associated with the 3.5% reduction and support the implementation of the BCF. A dedicated joint task and finish group is specifically considering the risk agenda and will ensure alignment with the ambitions of LHAC. From this work the resources will be identified through profiling of investments and active management of individual project slippage. The contingency reserve will be reviewed on a quarterly basic by the JCB and adjusted based on the level of residual or emerging risk in particular from the "pay for performance" element of the BCF.

As a principle at the beginning of the financial year the contingency reserve will be sufficient to cover a " worst case" scenario for the "pay of performance" element of the BCF i.e. no income received, but will be reduced in line with the reduction in risk derived from achievement of the targets.

The risk associated with wider health and social care pressures entailed within the anticipated pooled budget arrangements are currently being negotiated across health and social care partners – notably within Joint Delivery Boards. A blended set of options are under-development to include savings arising from pooled budgets, reduced overheads in NHS providers, efficiencies delivered as a result of integration and decommissioning activity where outcomes are not sufficient to warrant continuation.

We will build on our existing use of Section 75s to embed a clearer understanding of risk and contingency.

We have already detailed the costs falling to Adult Care as a result of the Care Act and future funding reforms. We estimate for 2015/16 approximately £2.8m will be needed though the true figure in Lincolnshire over 10 years is likely to reach in excess of £100m. For 2015/16 the allocation of £20m to protect Adult Care will incorporate £2.0m. Additional resources are anticipated from Government to underwrite care Act costs at least in 2015/16. There is no guidance available for what will happen after this date.

We are currently working with the County Council's network to reinforce the point to Government that the funding figures currently being used are not sufficient to cover the true costs of these new legislative requirements.

6) ALIGNMENT

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

Alignment is being secured in a number of ways:

1. The lead senior officer (an Assistant Director) in Adult Care with responsibility for implementation of the Care Act from April 2015 is also heavily involved in both BCF and LHAC programmes. For example he is on the Proactive Care Joint Delivery Board which has responsibility for progressing Intermediate Care Services and our Carers Strategy. He also line manages a senior Adult Care officer involved in the development of Neighbourhood Teams.
2. The Adult Care lead for performance management and development of new ICT systems and a new client database is a member of the core team developing a risk stratification tool in support of Neighbourhood Teams – to identify at risk groups in local communities. She is also closely involved in the production of the metrics detailed in Part 2 of this submission.
3. The senior finance officer from Adult Care is part of the finance group generating the financial detail in Part 2. He also oversees the BCF finance spreadsheet on behalf of the health and social care community.
4. Further the DASS is a member of the LHAC Programme Board, the Joint Commissioning Board and co-chairs two of the four Delivery Boards. He was also the lead for production of the previous BCF and for this submission is further supported by a CCG Chief Officer.

The above help ensure a high degree of symmetry between plans detailed in this BCF submission and those within the wider care and support agenda. Additionally a number of joint strategies and service developments have been produced (such as Wellbeing – led by colleagues in Public Health) or, are in the process of being produced such as Autism that will work to satisfy the requirements of this BCF and the wider LHAC agenda. Two examples – carers and dementia – are provided as links in Section 7 a. v.

This work is, and will continue to be, enhanced and supported by other work being undertaken in the economy which includes;

- better coordination of resources being commissioned / delivered to citizens
- quality assurance work to ensure that community suppliers of domiciliary and residential care are delivering at an acceptable standard
- the continued building of good relationships across the public, voluntary and independent sector though joint strategic and operational meetings
- supporting residential care and community providers to support people to prevent unnecessary hospital additions
- continued work in delivering best utilisation of the community hospitals and other none acute bed based capacity
- Making Every Contact Count by partner agencies,
- developing health and social care predictor tools to start to activity support citizens and prevent the escalation of preventable ill health
- undertaking a fundamental review and recommissioning of the Intermediate Care layer and associated expenditure within 2015
- developing a new Community Support Framework for implementation May 2015

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

Organisational arrangements and key fora such as the joint commissioning infrastructure: H&WBB, Joint Commissioning Board and Joint Delivery Boards will oversee and monitor activity and planning to ensure alignment. LHAC and its core assumptions will be the common thread across all commissioning and provision assumptions.

A single set of service planning assumptions including detailed project level benefit plans has been produced and forms the basis of the BCF submission, CCG 2 year plans (some assumptions have been refined since the Blueprint phase of LHAC), the five year strategic plan currently being redrafted and the system resilience plan are also aligned. Provider alignment is being supported through the "turnaround group" which is ensuring alignment of provider activity and income assumptions.

See also Section c.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

All four CCGs have had approval of their expression of interest in co-commissioning of primary care: a committee in common is being established between all four CCGs and NHSE Area Team to oversee the development which will initially focus on quality improvement and alignment of plans and incentives. NHSE AT have been fully involved in LHAC and the Care Design Groups (CDGs) who have, for example designed the neighbourhood team model which places general Practice at the centre of the team. There is an in- principle agreement about the intention to pool resources to commission neighbourhood teams across CCGs, LCC and NHSE AT.

Discussions are already well advanced regarding the development of a local neighbourhood team Health and Care Hub at Sleaford, bringing a significant range of services closer to home for the population; this includes an expansion of primary care and supports a federated approach for practices, who will be providing extended levels of primary care response over the winter as part of the resilience plan.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

a) Protecting social care services

i) Please outline your agreed local definition of protecting adult social care services (not spending)

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

1. That the current eligibility for Adult Social Care will be maintained at substantial and critical in line with the requirements anticipated from implementation of the Care Act.
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.
4. Each Delivery Board and ultimately the Health and Wellbeing Board will monitor progress to ensure this definition is observed.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

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 LHAC. 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 protected as much as possible as we develop more pooled budget arrangements based on agreed and shared outcomes. Notwithstanding this ambition, further reductions to Government funding to the County Council will inevitably lead to some reductions in Adult Care. 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 detailed in this plan and LHAC are progressed.

Our approach to transformation is to ensure that there is stability in areas of core health and social care provision. Through LHAC 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 people, we will utilise some BCF funding to protect services so there is stability through change management.

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

Agreement has been reached with the 4 CCGs concerning the allocation of the BCF in 2015/16 which helps secure the necessary level of investment in adult social care services. Of the monies available £20m will be allocated for this purpose which represents approximately 40% of the total revenue available.

We estimate the cost of the Care Bill and future funding reforms will be £2.8m in 2015/16. The sum agreed in 4 above includes a large portion of this requirement. However, beyond 2015/16 there is no clarity of future funding. See also 'Risks'.

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

Currently the Care Act and the draft regulations are being considered by an Implementation Programme within the Adult Care Directorate of the County Council. The main focus of the current work is a detailed gap analysis between current and future practices and the financial implications of implementing the changes required, once the regulations have been finalised in Oct / Nov 2014 work will be accelerated to ensure compliance for April 2015. The Care Act and Implementation Programme work is on the agenda of the Councils Corporate Management Board, Joint Commissioning Board and Clinical Commissioning Group Board and Formal and Information Council Executive meetings.

NB. The financial pressure of implementing the Act Care is highly likely to extend further than the £2m currently identified in the BCF.

v) Please specify the level of resource that will be dedicated to carer-specific support

We see improved support to carers as a key component of our preventative work. An additional £200k has been allocated from the BCF in 2014/15 to support targeted groups of carers such as those elderly carers supporting profoundly learning disabled individuals and those supporting a relative with dementia. Additionally, a revised joint Carers Strategy has been produced and the reconfiguration of existing services is expected to further improve "our offer" to carers in Lincolnshire. As noted previously the Lincolnshire Carers and Young Carers Partnership (LC&YCP) was involved in the production of Phase 1 of the LSSR and is involved in Phase 2.
http://www.lincolnshire.gov.uk/residents/adult-social-care/strategies/joint-carers-strategy-2014-18/122162.article

We have also produced a joint Dementia Strategy and an accompanying action plan. One of the key actions is the creation of a Dementia Family Support Service that will also provide much needed support to carers to help deliver a number of BCF metrics.
http://www.lincolnshire.gov.uk/residents/adult-social-care/strategies/joint-dementia-strategy-2014-%E2%80%93-2017/121668.article

Carers is also referred to as a dedicated scheme in Annex 1.

It is worth pointing out that the County Council has decided to fully protect the carers' base budget despite considerable additional financial cuts to local government in the next three years. This in itself indicates a level of commitment and recognition from the Executive of the importance of supporting carers.

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

The County Council already has significant financial pressures both in 2014/15, 2015/216 and the following financial years. We have been conducting a Fundamental Budget Review across the council that has explored almost on a Zero Based Budget approach the need to invest funding in each and every council service area. This exercise has been ongoing for a number of months, and whilst ongoing, much of the work has been completed and each service area has been allocated savings targets for the four years from 2015/16 – 2018/19.

Within this work, Adult Care has had to make various assumptions about demographic pressures, budget pressures, implications of the Care Act, the need to ensure appropriate funding to service providers, etc. One element within those assumptions has been the extent to which BCF funding can address the budget pressures within Adult Care. The Council in its Fundamental Budget Review has taken account of agreements earlier in the year with CCG colleagues on the extent to which BCF funding would be available to support Adult Care – and was satisfied with the allocation of such funding.

The newly proposed 'pay-for-performance' arrangements have thrown another problem into an already difficult financial situation. The uncertainty it results in, means that we are having to have further (and ongoing) discussions with CCG colleagues around the funding available to meet Adult Care budget pressures.

The uncertainty (specifically around the pay-for performance element) means that we are having to re-address both cash flow issues but more importantly investment decisions that took many meetings earlier in the year to resolve. One key risk resulting from this is the potential delay (or abandonment) of certain investment schemes that would contribute to the delivery of the ambitions of the Lincolnshire health and care community.

b) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

See also the relevant scheme description in Annex 1.

The Lincolnshire health and social care community, is fully committed to working in partnership to secure sustainable high quality seven day services, in line with the LHAC Blueprint.

The multi-agency Lincolnshire System Resilience Group will oversee the development of 7 day services. 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 or in their own homes. The approach being taken by each of our main providers is set out below.

United Lincolnshire Hospital Trust

In order to make the move to seven day working in unscheduled care, across all ULHT sites a number of actions have already been taken. 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. 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. This will ensure:-

- 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.

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.

Lincolnshire Community Health Services

LCHS 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.

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. 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 inefficient 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. 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 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.

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 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.

Primary Care

The walk in Centre in Lincoln provides 7 day a week 8am to 8pm access to primary care. Out of hours GP access is commissioned from Lincolnshire Community Health Services. A number of Community Pharmacies throughout Lincolnshire provide services 7 days a

week. There are also a number of dental practices that provide 7 day a week services.

The CCG will work closely with NHS England's Leicester and Lincolnshire Area Team who commission primary care services, to ensure the emerging Primary Care Strategy, is fully aligned and supports the implementation of the Lincolnshire Strategic Services Review. Expressions of Interest for co-commissioning of Primary care from each CCG have been approved by NHS England and a "Committee in Common" is being established to oversee the arrangements between individual CCGs and NHSE; the priority will be ensuring Quality and Safety and ensuring coordinated commissioning of Lincolnshire Health and Care in particular the central position of Primary care in Neighbourhood teams.

Lincolnshire County Council

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.

Generally

We recognise the need for a step change in seven day working across the health and social care community in Lincolnshire. This necessary development is proceeding through the Urgent Care Board. In particular there is an expectation that neighbourhood teams and intermediate care (both early enablers) will operate on this basis. The wellbeing service which forms the bedrock of our preventative 'offer' has been re-commissioned and commenced across Lincolnshire on 1 April 2014.

It is also expected that the provider landscape will change to improve the level of integrated provision where several providers working more closely together can deliver a much stronger, more efficient, customer-centric response. As such commissioners and providers are working together to ensure our approach is 'organisationally agnostic'. This will be a feature in a number of early-implementers such as a new integrated care layer and neighbourhood teams.

c) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

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

ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

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 April 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 explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.

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 for high risk populations

i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

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 professional 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 and 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 social 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.

It is recognised that the advent of the Care Act and funding reforms affecting adult social care are best addressed through the development of robust integrated services. The alternative would be for Adult Care to consider these changes in isolation. In this way we expect 'early implementers' to address for example the increased capacity requirements arising from these national initiatives. One example would be in the development of neighbourhood teams to ensure they can accommodate the anticipated growth in assessments required.

See also the section above regarding seven-day working.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

There are already joint health and social care teams for adults with mental health needs and those with profound learning disabilities. The development of Neighbourhood Teams across Lincolnshire which began in August will address the need for joint assessments and care planning with lead professionals allocated for older people. See also detailed scheme description.

iii) Please state what proportion of individuals at high risk already have a joint care plan in place

As described above for people with mental health and learning disability needs there are existing structures and processes to secure joint care plans. The approach to the development of Neighbourhood Teams in Lincolnshire is to target those most at risk within local populations utilising both health and social care risk stratification tools. At present it is not possible to identify the precise proportion of the population though work is underway to provide this. See also detailed scheme description.

8) ENGAGEMENT

a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

Patients, service users and the public have been engaged through the LHAC programme based on a Stakeholder Engagement Strategy and Communication Strategy. The purpose of that engagement has been threefold: to develop emerging options that respond to and reflect their views and feedback; provide opportunities for questions, comments and other input; prepare stakeholders for change.

There is a strong relationship with Healthwatch Lincolnshire, who sit on the LHAC Board in an 'advise and challenge' capacity. An indicator of the involvement of Healthwatch is that they have recently decided to modify how they operate in order for them to facilitate more effective engagement with LHAC.

Engagement activity has covered the full range from street engagement with the general public, to MP meetings, presentations to Boards and Councillor groups (county and districts), engagement with Healthwatch localities groups, carers and patient groups and local grass roots organisations. We have placed articles in county-wide partner publications that go to all households, as well as setting up a dedicated website with live updates on the programme which has had over 6,000 unique hits since going live. The website contains an interactive map plotting our engagement and summaries of them all.

See www.lincolnshirehealthandcare.org and follow the link to 'Have Your Say'.

The first phase of engagement focused on asking a wide range of questions to get feedback and comment on the current health and social care system as well as hearing views on where improvements could be made. The material gathered through engagement has been fed back at a number of key points into the design work to inform the CDGs and Expert Reference Groups. Engagement was a feature of each CDG and the Care Summit where the top themes from public engagement were fed back to the audience. These were:

- Waiting times for appointments and referrals
- Lack of information sharing (between professionals and between professionals and patients/carers)
- Not knowing what support is available
- Lack of continuity of care (particularly into and out of hospital)
- Positive feedback on good quality care and support

In addition to this qualitative work, GEMS has run a quantitative survey using several channels. The survey asked individuals to rank a pre-defined set of priorities that included; quality, safety, cost, choice and distance. A free text box was also available at the bottom for general comments to feed into the qualitative data collection. As of the beginning of July there have been over 800 surveys completed. Interim results were fed into design. Final results are currently being analysed and will be fed back into the programme.

Future involvement will include continuing engagement on similar lines. The current emphasis is on awareness of Neighbourhood Teams.

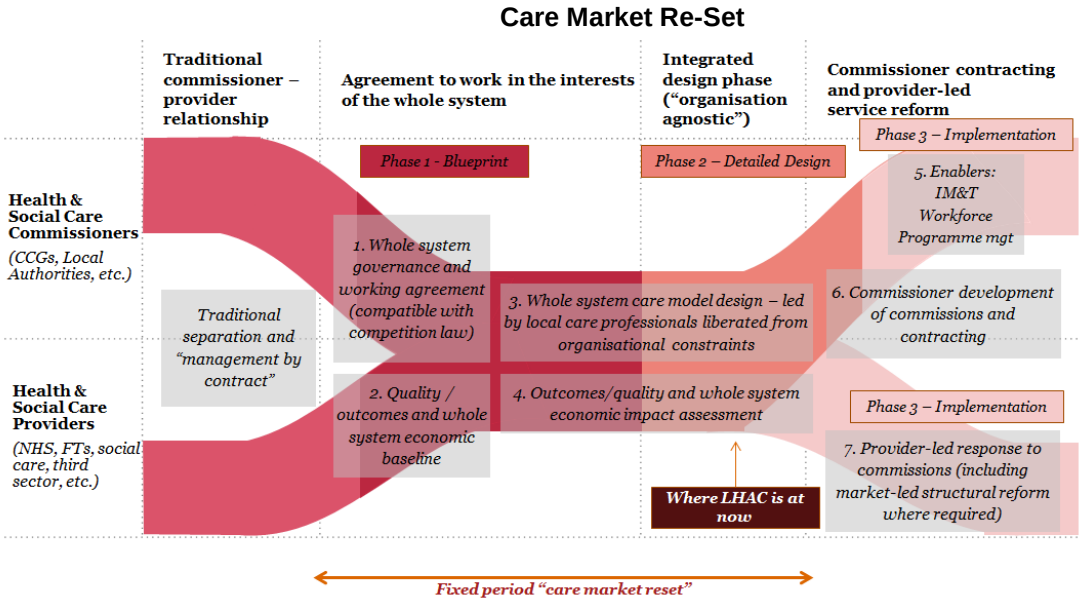
There will be formal consultation with the public at an appropriate time and following NHS assurance.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

i) NHS Foundation Trusts and NHS Trusts

The LHAC vision and operating model options are being generated using the PwC 'care market re-set' approach which, broadly, brings commissioners and providers together in an 'organisationally agnostic' way to focus on whole system improvements. A concordat that every Board member signs up to underwrites working together in this way.



Each of the local providers (ULHT, LCHS and LPFT together with EMAS regionally) has two seats on the LHAC Board and is represented on the LHAC Operations Board. Each of their Boards approved the Phase 1 draft blueprint.

Providers nominated clinicians and managers to be part of Care Design Groups in both Phase 1 and Phase 2 of LHAC. These Care Design Groups (CDGs) were typically 20-40 strong. Their purpose was to generate ideas and options for the LHAC vision and how to achieve that vision. Outputs from the Phase 1 and Phase 2 CDGs were shared on a wider basis in two Care Summits (each of which were attended by a wide range of stakeholders).

The work of CDGs has been taken forward in smaller Expert Reference Groups (ERGs) that include provider nominees.

Commissioners and providers have also come together to look at key enablers including workforce, transport, estates, information management & technology and contracting.

A workforce summit and briefings have included all providers.

In addition, four all-day drop-in sessions were held around the county in July.

Additional sessions are now being organised within provider workplaces.

ii) Primary care providers

CCGs are one of the driving forces behind LHAC and members of the LHAC Board have been briefing their members. Briefings have been held for practice managers.

Primary Care providers have been part of CGS, ERGs, Care Summits, workforce and drop-in sessions etc. in the same way as other providers.

The LHAC Board responded to comments at the May 2014 Care Summit by inviting the LMC to join them, which has been very successful. A special countywide interactive session for GPs was held in July and more are planned.

iii) Social care and providers from the voluntary and community sector

The County Council's DCS and DASS are members of the LHAC Board, which is chaired by the DPH. Social care and public health have been involved in the same way as other commissioners and providers.

There is a local political dimension with these services and regular informal briefings take place with the Leader of the County Council, the Portfolio Holder for these services and the Chairman of the Health & Wellbeing Board. There is formal and informal engagement with the Health Scrutiny Committee and HWB. Local MPs and District Councils are also briefed and engaged.

Voluntary and community sector providers agreed to be represented on the LHAC Board by the Lincolnshire Carers Association (LinCA). Again, they are involved in all aspects like other providers. This also provides an opportunity for LinCA to comment and be involved in matters such as winter planning.

Investment in engagement summarised in this section will continue but with a shifting emphasis towards implementing change.

A selection of comments made by a range of stakeholders …

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

LHAC 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 3.5% in 2015/16. Performance metrics for this are in Part 2. 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 as identified in LHAC Phase 1. For the two transitional years focus is being given to commencing a reduction of acute hospital bed capacity by further preventing non elective

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.

In 2014/15 ULHT will begin the progress of reducing beds so that a fundamental shift from acute to primary can begin. It is expected that a minimum of 78 beds will be permanently removed from acute provision in Lincolnshire to be built on in subsequent years as the effects of the early enablers and LHAC Phase 2 begin to take effect along with a review of A&E provision and the clinical pathways, for example frail elderly where we anticipate generating greatest efficiencies.

We fully expect that the consequences of LHAC and service remodelling will enhance our ability to reduce non-elective admissions beyond the 3.5% target proposed for 2015 once the changes have been introduced. As such our ambition with respect to this particular metric into 2016 will grow.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Scheme name
Intermediate Care
What is the strategic objective of this scheme?
- To improve pathways of care and outcomes in the community for patients who have an escalating health or social care need, and who would benefit from additional support in either their own home (or usual place of residence) or an intermediate care bed by: o Helping people avoid going into hospital unnecessarily o Helping people to be as independent as possible after a stay in hospital and o Preventing people from having to move into a residential home until they really need to. o Facilitating a transfer from hospital to avoid any unnecessary delays - To contribute to a 3.5% reduction in emergency admissions across Lincolnshire by ensuring that the range of resources available at the intermediate tier is robust and flexible thus facilitating easy ongoing patient referral by health and social care professionals.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Background and current position: In the Spring of 2014 a full review of Intermediate care across Lincolnshire was commissioned by the Proactive Care Board (a joint commissioning forum). For the purposes of the review, both bed based and community based services were analysed. This demonstrates that Lincolnshire has a high diversity of intermediate tier services across the region, comprised of bed based and community based services. However there is a degree of fragmentation of provision. Largely commissioners are supportive of the ongoing developments by providers, and have a good working relationship with them, but there are some issues around the scope, definition and number of services available which causes confusion - particularly amongst GPs hoping to make referrals into the service as an alternative to hospital admission. Intermediate Care bed based provision in Nursing and Residential homes is not consistent across the County and bed occupancy is low compared to benchmarked data from the National Audit 2013/14. Bed availability in the South West (SW) is reported as being poor which has a knock on effect on patient flows from acute care

in that area.

30 Day beds are provided as a means of providing positive, goal orientated pathways of care for patients in the post acute period, but the report demonstrates failure to adhere to these referral protocols. Data demonstrates an average of 14% of patients die in 30 Day beds - and hugely escalating costs over the last 2 years, with a 20% increase to £2.9m for 2013/14. Most patients (55%) stay exactly 30 days; with a further spike in discharges at day 60 – indicating a reactive response to moving patients through the system, rather than proactive management with clearly defined care planning.

Development of Community based services has proceeded at pace over the last few years, however, it is imperative that these pathways of care are developed in line with an overarching strategy, as it is perceived that there are local variations in provision, which cause issues with patient flows and performance.

The emerging strategy for Intermediate Care will thus be closely linked to resilience plans for Urgent Care, and particularly supporting the planned changes in bed stock at ULHT to manage and actively support a reduction in emergency admissions.

To facilitate this, a series of proposals and recommendations are currently being discussed by the Proactive Care Board, and the outline strategy is presented below.

Headline performance issues:

- ULHT were able to demonstrate a net reduction in acute beds over the winter period 2013/14 by around 80 beds; which was supported by the increase in the range of community services supporting admission avoidance and facilitating earlier discharge (e.g. Rapid Response and Independent Living Team(ILT)). However, the increase in the number of 30 Day bed placements during that period demonstrates that discharge into these beds has clearly offset the ULHT bed base.
- A total of 1250 placements into Rapid Response services since its inception in November 2013 to date is encouraging, although this now needs to increase if we are to use it as a real means of admission avoidance. Around 50% of these patients were discharged from the service into no other ongoing service, with only a very small percentage requiring eventual admission to acute care. This caseload of patients would otherwise have required an alternative pathway, usually emergency admission to acute care. The total number of patients expected to go through the Rapid Response service on an annual basis is approximately 2,000, which will equate to 1900 avoidable emergency admissions.
- Call volumes through the Contact Centre continue to increase with extremely good performance in terms of target abandonment rates. GPs and other health and social care professionals are clearly more confident about the service with an increased number of calls now being taken for admission avoidance, although the majority of calls still originate from acute hospital wards for assistance with discharge planning, usually through the Independent Living Team.
- Recent performance data for ILT is encouraging with 174,759 contact hours and 5,823 service user episodes and both figures represent an increase on

current performance levels. A recent LCC performance board meeting reported the in-month figure for LARS on the percentage of people leaving reablement readmitted to hospital fell to 13.9%. 53.5% of patients using ILT were reabled to no ongoing service requirements which again demonstrates an effective and improving service.

- Our bed utilisation figures (to March 2014) benchmarked against national data indicates that bed utilisation is low; with 71.3% occupancy in community hospital beds and 62.7% in NH/RH beds. The national occupancy rate is 85%. This demonstrates that, despite ongoing issues with patient flows from acute care, our usage of intermediate care beds is inefficient.
- The 2013/14 cost for the LCC commissioned beds was around £1.5m, with a -6% variance on the previous year. The 2013/14 cost for LCHS commissioned beds (in NH/RH) was approx. £750k, with a 2% variance on the previous year.
- The cost of admission avoidance schemes delivered in the community (SPA, Rapid Response and extended community teams) for 2013/14 (NR pye) has been in the order of approx. £2.5m and the anticipated full cost of all schemes on a recurrent basis is in the order of £5m pa.

Emerging outline strategy:

To support and maintain a 3.5% reduction in emergency admissions across the health and social care system, the way that we provide both 'step up' and 'step down' care in Lincolnshire needs review. The number of current providers of Intermediate Care, and the range and fragmentation in the number of services and pathways, creates confusion and inefficiencies both in terms of quality, outcomes and VFM. Current options and proposals include:

- Adopt the principle of **"home first"** for all our patients, where possible, unless this is clinically inappropriate or functionally impossible to achieve. This shifts the focus away from bed-based care to providing care in the patient's own home wherever possible, through an enhanced range of community services. Ensure that all patients identified (through predictive risk planning) as having an increasing risk of deteriorating health have an **individualised care plan**, and, if admission to hospital is required, that **integrated discharge planning** is commenced on day one of admission.
- Streamlining the way that services are commissioned by moving to a **lead provider model** for Intermediate Care, with a range of subcontracted services, which will eliminate duplication and improve efficiencies. The Intermediate Care service would need to be retendered against a service specification with very clear performance outcomes and within or below the current cost envelope. This model has been successfully utilised in other areas of the UK with extremely good outcomes.
- Explore the potential for **recasting a number of beds at ULHT from acute to intermediate / step down provision**. It would be imperative that use of these beds was ring fenced for step down care immediately following an acute admission. However, this would have the following benefits:
    - Vastly reduce the requirement for discharge into expensive 30 Day beds, where quality outcomes for patients are poor, thus enabling the potential reinvestment of that funding (£2.9m for 2013/14) to other community based services;

- Enable the current NH/RH beds commissioned by LCC and LCHS to be significantly reduced or even eliminated, thus affording a cost saving (currently contract value £2.3m), and the potential for reinvestment into other community based services;
- Ensure continuity of care for patients in a safe environment which is accessible to their families and where on-going and active care, including therapies, can be maintained to improve their clinical outcomes, and chances of discharge to their own home environment;
- A reduction in the number of acute beds available and used for emergency admissions will prompt the system to manage patients in a different way but this can only be achieved if safe and robust community services exist as an alternative to admission, and the use of step down beds in ULHT wards is ring fenced to protect their use and maintain patient flows.

- Explore the **current use of community hospital beds** (*currently 151 beds in total although some beds are used for end of life care*) for step up care, to further increase the capacity for admissions avoidance, to ensure that adequate resource is available to those beds (e.g. therapies) for patients who do not have an acute care requirement and that admission protocols for step up care are protocol driven with protection of those beds to be used for that purpose only. Referral into community beds for short term step-up care (e.g. IV therapies, rehabilitation, intensive nursing) by primary and community care professionals needs to be quick and easy to facilitate.
- We have committed as a health and social care economy to the rollout and **development of Neighbourhood Teams**. However, these teams will only be successful if access to intermediate tier services is improved and referral processes are streamlined to cut out duplication and thus inefficiency.
- Maintenance and **development of the single point of access**, as a means for busy health and social care professionals to make a speedy referral for their patient is critical.
- Development of the **Rapid Response Service** across Lincolnshire to be even more responsive and take a greater case load than currently exists, which will improve and support our admission avoidance protocols;
- A full review of the **Independent Living Team**, as a good example of integrated working, across Lincolnshire with a full workforce assessment to determine what type of resource is required in the different areas of Lincolnshire. The geography of the county presents a series of challenges in terms of provision of this service but current capacity is poor especially in the West of Lincolnshire and this needs urgent review.

Anticipated benefits and outcomes:

In order to achieve the total target 3.5% reduction in emergency admissions - **2515 patient journeys** - (of which the intermediate care scheme will attribute a total of 450 during 2014/15, and 1250 during 2015/16) with a subsequent shift in the activity to community and primary care based services, beds in acute care at ULHT will have to be decommissioned. On an average length of stay of 6 days, this equates to around **40 beds**. Closing these beds to emergency admissions will ensure that the system responds differently during times of rising pressures, and that newly commissioned services in community and primary care will be used more effectively.

There is then the potential to create some step down care on acute sites which is managed and run by community teams. These beds would be clinically managed by GPs and would have the advantage of having therapies, and better nursing input than patients currently expect to receive in nursing and residential home intermediate care beds. This will improve patient outcomes, and also enable the system to release cost savings through reduced reliance on 30 day beds, and potentially decommissioning intermediate care beds in NH and RH.

Additionally, further increases in resource into our Rapid Response service (as described in the Resilience Plan), our Independent Living Team and also increased resource in the Contact Centre making it more capable of responding during times of high pressure will serve to create an intermediate tier of services which can meet the higher demand created through shifts in acute care capacity as described above. This will also be supported by the Neighbourhood Teams, the Wellbeing Service and an increase in the range of services provided on a 7-day basis – please see additional annexes for more detail about these services.

The Rapid Response service will anticipate to take a further **160 patients / month during 2014/15,** equating to a potential **960 avoided admissions (and A&E attendances**). In addition, further service developments described through the resilience planning exercise include additional integrated therapy teams which anticipate helping to **avoid a further 60 admissions / month** and the integrated discharge team, which aim to save **150 bed days / month (or 25 actual patient journeys** based on an average length of stay of 6 days). This equates to a reduction of **150 delayed transfers of care over the 6 month period Sept 2014 – Mar 2015.**

For the whole tier of services – Intermediate Care, Wellbeing, Neighbourhood Teams and 7 day services – we expect to see the following benefits (***this does not include Specialist Services or Women's and Children's***):

	2014/15	**2015/16**
Reduction in the number of Emergency Admissions	639	2342
Reduction in A&E Attendances	?	?
Reduction in delayed transfers of care	691	702
Reduction in length of stay in an acute hospital bed	150 bed days	300 bed days
Increase in number of patients seen through Rapid Response and discharge to no service	480	960
Increase in the number of patients reabled to no service for social care	457	257
Reduction in the number of patients admitted to permanent long term care	13	43

Key milestones and timescales:

Given the non-recurrent nature of the funding for the schemes described in the Resilience Plans during the remainder of 2014/15, Commissioners will confirm the transition from NR funding to respecification and recurrent funding arrangements of the intermediate tier of services during the Autumn of 2014.

While there are opportunities for making some improvements to the intermediate care service during 2014/15, and indeed our resilience planning to support winter pressures will depend on our doing so, many of the benefits described above will materialise during 2015/16 and beyond as we make whole system changes to the way that we commission these services.

Certainly during late summer / early autumn 2014 further detailed planning around the workforce requirements to boost our community based teams, i.e. rapid response, ILT and our Neighbourhood Teams will be required to determine the subsequent investment required to maintain these services and take us forward into the whole system service change during 2015/16.

Further detailed analysis around potential changes to our bed stock across the whole system, and recasting of beds at ULHT for use as step down care immediately post acute could potentially be piloted during autumn / winter 2014/15 with a view to being re-commissioned during 2015/16.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The services described above are jointly commissioned by the four CCGs in Lincolnshire and the County Council:

- Lincolnshire West CCG,
- Lincolnshire East CCG,
- South West Lincolnshire CCG,
- South Lincolnshire CCG and
- Lincolnshire County Council.

These services are provided by:

- Lincolnshire Community Hospital Trust,
- Lincolnshire Partnership Foundation Trust,
- A range of independent Nursing and Residential Homes,
- East Midlands Ambulance Service and
- Primary care providers.

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

We have referred to and used extensively the National Audit of Intermediate Care Report 2013 (*NHS Benchmarking Network – NAIC2013*) in reviewing and developing our intermediate tier of services across Lincolnshire. We have

participated fully in the 2014 study to provide a robust benchmarking of our own intermediate care delivery against national data.

The NAIC study was extended in 2013 to include crisis response and social care re-ablement services, as well as the bed based and home based services covered in the 2012 study. The key findings from the audit remain the very wide variation between service configuration, size and performance in different localities. With the focus of service provision in the 2013 study, two Patient Report Experience Measures were developed for use in bed and home based / re-ablement services.

In addition, we have also referred to examples of national best practice in other regions in the UK, and have listened to various presentations detailing successful implementation of some of the early implementers of integrated care (e.g. Devon and Torbay, North West London, Leeds).

Some of the key findings from the 2013 NAIC report are as follows, and this has been used as evidence to support our own planning activities:

Variation in commissioning:

Nationally, the average investment in 2012/13 in health based intermediate care services was £1.9m /100,000 weighted population, and re-ablement services £0.7m per 100,000 weighted population, with large variations. The 2013 audit has highlighted wide variation in the extent of multi-agency commissioning, the scale of services provided and how intermediate care sits within the full range of health and social care services within each local area.

Patient experiences of intermediate care services:

PREMs (Patient Reported Experience Measures) were used for the first time in the audit and deemed to be very informative. Presented in the form of "I" statements as recommended by National Voices, it suggests setting the bar at 95% of patients reporting positive experiences, and reports that against this standard, IC as a whole is not yet delivering the type of service experience patients hope for.

Intermediate care capacity:

The NAIC report argues that instead of using the term "the hospital is full", "the community and social care is full" is arguably a more truthful statement. In a whole system we are vulnerable to the weakest link. The audit has demonstrated that the current provision of intermediate care is around half that required to avoid inappropriate admissions and provide adequate post acute care for older people. The 2013 audit also demonstrates that capacity is "stuck" with no change compared to the 2012 audit. It argues that the long waiting times to access the services by patients (3.4 days for bed based services; 4.8 days for home based and 4.2 days for enabling services) are caused by weak local planning.

In 2012 it was calculated that IC capacity needed to approximately double to meet potential demand, and there is little evidence to suggest that investment and capacity has increased in 2013. The pressure to fill existing IC capacity with people

leaving hospital appears to have worsened in 2013. Step up bed-based capacity aimed at avoiding hospital admissions is even more limited than highlighted in 2012.

Integration:

It is fully recognised that the current situation of silo working and fragmented health and social care services must be rectified. The audit demonstrates that a mixed picture was presented nationally, which is a fair reflection of some progress, but that there is more work to do. Crisis response teams and home based services appear to be well integrated into the wider health and social care systems with referrals received from primary, secondary and community and social care services. There are opportunities for re-ablement services to become more integrated with the whole system.

Integration at the strategic/commissioner level shows an increase across the health and social care system. In the 2013 audit sample IC services were jointly commissioned in 74% of health economies compared to 58% in 2012 and the use of formal Section 75 pooled budgets has increased from 21% 5o 32%.

Mental health provision seems woefully lacking – the proportion of mental health trained staff in any of the service models audited is very small, and only half the staff have received training in dementia care.

Diversity of provision:

The NAIC report suggests that IC services were typically delivered by small local teams – the average number of services per provider was 2.6 but the range was up to 22 different services. The audit covered approximately half the country, and identified 535 different services at the registration stage. Quality assuring all these services is thus challenging and raises concerns about the fragmentation of these services, potentially unclear routes in and out of services and lack of economies of scale.

Links between IC services and acute hospitals:

In research studies, most of the effective models for preventing people being admitted to hospital involved identifying potential patients in hospital emergency departments (ED) yet only 3% of home based intermediate care referrals, 1% of reablement and 18% of crisis response referrals came from EDs in the audit. Further, 20% of bed-based services reported an average waiting time from referral to commencement of service of 4 days or more with two-thirds of service users waiting in wards in acute hospitals.

Appropriateness of staff mix to clinical needs:

Nationally, the nursing skill mix is in line with RCN recommendations for basic, safe care but below those levels recommended for ideal, good quality care. Mental health workers are rarely included in the establishment of intermediate care teams. In addition only 51% of home based services report that all members of the team have received training in mental health and dementia care and only 34% of re-ablement services have “real and quick access” to specialist mental health skills.

The proportion of home based services relying on the service users own GP for medical cover appears high (71%) when reviewed against the levels of care being provided by these services.

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

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Key performance indicators have been described above, and in the HWB Benefits Plan, however, additional anticipated outcomes may be described using the "QIPP" (Quality, Innovation, Productivity and Prevention) framework used extensively in NHS planning and provides a means of segregating outcomes and outputs for means of benchmarking against best practice:

Quality:

- Improving clinical and social care outcomes – as per measures detailed in the NHS OF, ASCOF, PHOF – by offering a greater range of services and interventions targeted at individual patients;
- Enabling patients to feel better supported in the management of their own health;
- Improving independent – Health and Wellbeing strategy.

Innovation:

- Through introduction of a single point of access for all referrals
- Through the introduction of new technology – e.g. telehealth/telemedicine, risk stratification
- By means for integrated commissioning and new shared contractual mechanisms

Productivity:

- Reduction in unnecessary A&E attendances, emergency admissions/readmissions, DTOCs and excess bed days
- Reductions in the number of frequent fallers
- Improvements in primary care productivity
- Reduction in the length of stay of those patients requiring support type interventions
- Reduction of duplication in provision through a range of fully integrated services by means of multiple providers using a single point of access and common pathways of care
- Reduction in the number of patients admitted to long term care

Prevention:

- Improvements in outcomes for patients with long term conditions through better case management and prevention of deterioration of their condition
- Reduction in the number of falls through regular assessment
- Increased number of patients who are reabled to full independence, thus reducing reliance on long term packages of care

Patient experience:

Patient experience will be measured by ongoing participating in the NAIC. The audit introduced PREMS measures for the first time in 2013 and the results were interesting. We have surveyed our patients by means of questionnaires during the summer of 2014 and the exercise will be repeated in subsequent years as a

measure of our ongoing success.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

At a strategic level, the Intermediate Care programme in Lincolnshire is overseen and owned by the Proactive Care Joint Delivery Board (PCB), which is a joint commissioner led forum, and who regularly receive reports and proposals for development. Additionally, the Urgent Care working Group/ System Resilience Group in Lincolnshire, which has membership from all partner commissioners and providers (including acute care) also regularly review the outputs of this programme and its impact and contribution to managing urgent and emergency activity across Lincolnshire.

The PCB commissioned a full review of Intermediate Care Services in Lincolnshire during 2014, and a full baselining report was published in the summer of 2014 which details outputs and outcomes from all our intermediate tier of services, including both bed based and home based services. In addition, an academic review of the Admission Avoidance Schemes in the Spring of 2014 has also provided some evidence and support in terms of our longer term planning proposals, particularly around the contact centre and Rapid Response.

At a tactical and operational level, each CCG regularly reviews the development and oversight of intermediate care services in their own area, for example with the development of Neighbourhood Teams, bed utilisation and other outcome measures determined locally.

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

Success at a strategic level is dependent upon a number of factors, which have to be jointly owned and continually monitored by the PCB. These include:

1. Transparency in planning activities and full partnership working across the entire health and social care economy, including acute care.
2. A review of bed based intermediate care across Lincolnshire with respect to capacity and also location of provision of services. The 49 beds commissioned by LCC have been subject to a contractual review in August 2014 and it is apparent that capacity needs some urgent review.
3. Evolving Neighbourhood Teams - the development of this as a strategy as part of the Lincolnshire Health and Care Programme needs to build upon the successes - and relative capacity issues - experienced as part of the rollout of the Independent Living Team and Rapid Response services across Lincolnshire.
4. Cutting down on the fragmentation and duplication of description of services across the patch is key to building GP confidence and will help with improving GP referral rates to these services which will contribute to positive outcomes for admissions avoidance.
5. An urgent review of 30 Day Bed provision across Lincolnshire. The baselining report published in the summer of 2014 demonstrates that this service does not provide best value in terms of patient outcomes, and clinical outcomes need to be investigated further. This has to be taken in context with shifts in bed capacity and provision at ULHT.

6. Continued commissioning of the out of hospital / admission avoidance schemes (Rapid Response, Contact Centre, Extended Community Teams) as a means of ensuring that we can build upon these schemes in the future (as a forerunner to the successful rollout of Neighbourhood Teams) and providing further data to evaluate the effectiveness of out of hospital based pathways of care.
7. A regional approach to determining where economies of scale can be achieved around commissioning out of hospital pathways should be coupled with local, pragmatic flexibilities to ensure that geographical and demographic variations in demand can be met effectively.
8. Ensure that ULHT are part of all strategic planning and development of out of hospital pathways so that discharge planning from acute care is built into care planning for each patient from day one of their admission to hospital.
9. A full review of costs and outcomes for each of these services is explored in more detail during 2014.

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ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Lincolnshire BCF Scheme: 5
Scheme name
Specialist Services Pooled Budget
What is the strategic objective of this scheme?

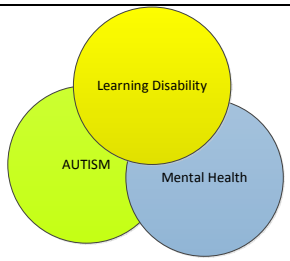
The strategic objective of this scheme is to improve the Wellbeing of Adults with Learning Disability, Autism and/or Mental Health needs within sustainable resources. There will be a number of building blocks which underpin the delivery of this strategic objective including:

- Achieving parity or esteem between Mental Health and Physical Health;
- Improving the quality of life and safeguarding of vulnerable adults;
- Joint commissioning arrangements and pooled budgets:
- Strong engagement and involvement of stakeholders;
- Integrated services and strategic partnerships:
- Effective prevention and early intervention strategies.

The objective and building blocks above will in turn make Specialist Adults Services contribution to the wider Lincolnshire vision of:

A sustainable and safe health ***and social care economy for Lincolnshire***
Lincolnshire residents will have access to safe and good quality services, which focus on keeping them as well as possible to reduce the need for unnecessary hospital care.

Traditionally services for people with Learning Disability, Autism or Mental Health problems have been commissioned in silo's and this has often led to services that are not joined up and are hard to access. Given there is often co-morbidity of these conditions a more integrated approach to the commissioning of the specialist services that support them (as well as a wider system based approach to the co-ordination of early intervention and prevention support) is most likely to reduce duplication and improve outcomes via a more person centred approach. Pooled budgets will reduce the discussions about who should pay for the support that is needed and focus attention on how to get the support that people need to them at the earliest opportunity and to minimise the risk of needs escalating. This in turn will help to underpin the sustainability.



PERSON CENTERED SUPPORT

Overview of the scheme
Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Background

There is a significant evidence base that Adults with Learning Disabilities, Autism and/or Mental Health needs are at risk of having poorer Health and Wellbeing Outcomes than the wider general Adult Population. These inequalities in Outcomes include but are not limited to lower rates of life expectancy, reduced quality of life, lower rates of employment, unstable accommodation arrangements; the potential for social exclusion and higher safeguarding related risks.

These inequalities in outcomes can in part be attributed to the relevant condition(s) for this vulnerable group of Adults but national policy (including Parity of Esteem and Closing the Gap) now recognises that problems in accessing good quality services and wider community support is also a contributing factor to poor outcomes for these people.

Recent high profile provider safeguarding and quality concerns including Winterbourne View have increased awareness of the need for commissioners to work in a more joined up way to improve patient safety and improve the quality of care and outcomes for people.

Pressures on existing service models and budgets (resulting from increases in demographics and the complexity of need coupled with the wider economic context) also pose a risk to the sustainability of services for Adults with Learning Disability, Autism and/or Mental Health problems if they continue to be commissioned and delivered in the same traditional ways.

Collectively the issues above drive the need for transformational change in the way outcomes are improved for these people. In 2012-13 a Lincolnshire review of local commissioning activity identified that the arrangements for commissioning and delivering Specialist Adult Services (Learning Disability, Autism and Mental Health) were fragmented and in some instances activity and associated costs were being duplicated, service budgets were overspending, performance in some areas was weak and projected demand was indicating that services were likely to become unsustainable.

The development of integrated commissioning and delivery arrangements (including

pooled budget arrangements) for Adults with Learning Disabilities, Autism and Mental Health needs has been identified as the best way to secure better outcomes, improve value for money and aid sustainability in relation to specialist adult services. The establishment of a Specialist Adult Services joint commissioning team provides for a clear focus on integrated assessment and care management, procurement, market and contract management for high cost packages of care. It also provides the opportunity for the joint commissioning team to develop wider strategic relationships and partnerships with other commissioners, providers and stakeholders in order to develop relevant early intervention and prevention strategies.

Early intervention and prevention strategies may be targeted at those vulnerable adults that are already eligible or in receipt of care but such strategies will also need to be targeted at people with Learning Disability, Autism or Mental Health needs that are not yet eligible for services (or may not need care at this point in time). Improving the wider wellbeing of these people through more targeted health promotion activity will be a key early intervention strategy as will improved transitions planning and support for carers. These strategies will utilise person centres approaches, that inform and engage stakeholders, help people to keep well and live independent lives in the community and where ever possible within their own home.

The collective joint commissioning arrangements for Specialist Adults Services will help to manage demand on high costs services including social care and secondary care in a more effective way, will lead to improved outcomes including improved wellbeing. The development of pooled budget arrangements for Specialist Adults Services is a key foundation stone for delivering these ambitions and is symbolic in terms of the wider integrated arrangements required at achieve local transformation.

Progress to Date

Good progress in establishing Joint Commissioning arrangements for Specialist Adult Services has already been made. There is a Joint Delivery Board for Specialist Adults Services (SAS) which forms part of the wider CCG and LCC joint Commissioning arrangements for Lincolnshire. This joint delivery board now has overview of all related commissioning and delivery activity related to Adults with Learning Disabilities, Autism and Mental Health needs.

The SAS Joint Delivery Board is supported by an integrated joint commissioning team lead by a Chief Commissioning Officer (CCO) appointed in September 2013. The CCO is a joint appointment by the four Lincolnshire Clinical Commissioning Groups and Lincolnshire County Council and is believed to be the first such joint appointment nationally since the formation of CCGs. The CCO who is hosted by LCC, line manages a small team of commissioning specialists hosted by South West CCG (as the lead commissioner of Mental Health Services in Lincolnshire) and Lincolnshire County Council (as Lead Commissioner for Learning Disability Services).

Learning Disability

A pooled budget has already been established for Learning Disability Services with

associated performance and risk sharing arrangements also agreed up to the 31 March 2015. The intention is to extend the pooled budget arrangements for a further period in line with the wider BCF pooled budget arrangements.

The Learning Disability pooled budget is managed by the CCO supported by a Head of Service for Learning Disability who manages an integrated Assessment and Care Management function also hosted by LCC. The pooled fund is used to finance personal budgets for service users with eligible needs including Continuing Health Care needs. Some service users may choose to take their personal budget as a Direct Payment and purchase the services they need to meet agreed outcomes. Alternatively the joint commissioning team will procure services on behalf of the service users directly from service providers. Predominately the services are provided by the Independent Sector (See also "The delivery chain" – below).

The new Joint Commissioning arrangements for Learning Disabilities (supported by the pooled budget) has delivered a step change in focus on the management of complex and high cost packages of care that was not achievable through the previously fragmented arrangements. The central management of Market Management activities and the provision of a County wide integrated Assessment and Care Management function (and associated Practice Enablement Group arrangements) have added an increased level of scrutiny in relation to outcomes and value for money of the cases funded via the pooled budget.

The Specialist Adult Services joint commissioning arrangements have also delivered a number of other benefits including improved assessment and care management performance, more robust transition arrangements of young people from Children's Services to Adult Care, strong unit cost performance, improved market management and the service is now living within available budget given 10 years of consecutive overspend on Learning Disability budgets prior to 2013-14. The integrated arrangements have received positive feedback in relation to the local Winterbourne action plan with all relevant discharges from inpatient care achieved within timescale. The overall quality rating for local learning disability service providers is also strong.

The robust centralised focus on the management of complex high cost packages of care will need to continue if outcomes, safeguarding and quality standards are to be met within the limits of the pooled budget arrangements. However "sustainability" of performance against the pooled budget arrangements is now also dependent upon the integrated commissioning team building stronger relationships and commissioning alliances with a wider set of stakeholders in order to manage a projected increase in the demand and complexity of cases expected to present to Specialist Adult Services in coming years.

The table below sets out the number of service users who were eligible for financial support and associated services from the Learning Disability Pooled budget during the 2013-14 financial year.

Required Activity Data	31-Mar-14 Learning Disabilities All Ages
Long term residential and nursing care throughout year	529
Short term residential and nursing care throughout year	48
Respite care in residential and nursing care throughout year	88
Homecare throughout year	597
Direct Payments throughout year	445
Daycare throughout year	385
Telecare throughout year	127
Equipment throughout year	177
Number of Clients (throughout the year)	1,761
Number of clients assessed	271
Number of clients reviewed	1,606
Number of reviews completed	1,872

NB. Eligibility for funding from the pooled budget relates only to people with Learning Disability with complex or substantial needs or Continuing Health Care needs. However some clients with Autism are also funded from the pooled budget.

Demand forecasting information collected by the integrated commissioning team suggests however that demand will increase year on year by a minimum of 1.5%.

Latest estimates suggest that there are over 13,000 Adults with Learning Disabilities who live in Lincolnshire and emerging figures from Children's Services suggests there are up to 330 young people aged 14+ who may be eligible for Transitions to Adult Care. There are also over 100 existing Learning Disability clients funded from the pooled budget where the primary carer is over 65 year of age. There is therefore expected to be an increased rate of placement breakdown of such placements even with additional levels of carers support. Managing down future need for services will therefore also depend on a much wider systems based approach. In particular strong relationships between the Specialist Adult Services integrated commissioning team and the following will be essential:

- Women and Children's Delivery Board (and Transitions Services);
- Proactive Care Delivery Board (in particular Carers Support and Neighbourhood teams);
- Public Health (in particular wellbeing services);
- Primary Care (in particular GP Annual Health checks and health plans);
- LPFT (in particular Learning Disability liaison service and Community Assertive Support Team).

Further improvements in outcomes and related performance metric will also be dependent on wider systems based approaches for early intervention and prevention.

Mental Health

Whilst the current arrangements for the joint commissioning of specialist mental health services does incorporate aligned budgets a formal pooled budget does not yet exist but is scheduled (subject to appropriate consultation) for the 1 April 2015. The level of scrutiny of high cost cases and of value for money is therefore at this

stage less advanced than with Learning Disability pooled budget arrangements.

However integrated working arrangements in terms of service delivery are significantly advanced with the South West CCG leading on the procurement of specialist Mental Health services on behalf of all 4 Lincolnshire CCGs through a single contract with Lincolnshire Partnership Foundation Trust (LPFT). Core services are therefore already integrated through one local Mental Health Trust service provider.

Over the last 24 Months LPFT, working in partnership with commissioners, have delivered significant service transformation. This includes but is not limited to a reduction in Inpatient Beds the development of more community based services including integrated Community Mental Health Teams (CMHTs) and the establishment of a Single Point of Access (SPA) for all mental health referrals to their trust.

Parallel to the above arrangements, Lincolnshire County Council has developed a Section 75 Agreement with LPFT who deliver a number of services on behalf of the local authority including Assessment and Care Management, Best Interest Assessors (BIA) and Adult Mental Health Professionals (AMHPS). These services again are delivered through integrated community teams and therefore this adds to the level of local service integration for Specialist Mental Health services in Lincolnshire.

Whilst the level of outcomes and value for money being achieved through the existing arrangements is seen to be relatively good in comparison to other areas it is considered that performance and value for money can be strengthened further through the development of a formal pooled budget and the further integration of contract management arrangements and associated market management activities relating to arrangements with LPFT. This centralised approach to the commissioning of high cost specialist mental health services, with greater scrutiny of high cost cases and value for money is anticipated to deliver benefits in line with those achieved for Learning Disability pooled budget.

Work has already commenced with the re-specification of the commercial agreements with LPFT held currently by both the CCGs and LCC. This work includes the re-specification of liaison services that work within the Lincolnshire Acute hospital sites managed by ULHT. The re-specified Adult Mental Health liaison services will play a key role in admission avoidance, improved training and support to ULHT employees and well as facilitating more speedy and effective discharge arrangements to the community. The intention following the re-specification of all of the contracts with LPFT is to develop a joint procurement strategy with the Specialist Adult Services joint commissioning team and South West CCG acting a lead commissioner via the pooled budget.

The pooled budget would incorporate the following budgets:

Area of Spend	Estimate 2014-15
CCG Core LPFT Contract	£61,977,300
CQUINN - CCG contract with LPFT	£1,549,400
LCC Section 75 with LPFT	£5,635,521
MH Section 256 Schemes	£1,200,000
MH CHC Cases	£17,100,000
MH other MHS contracts	£1,100,000
Total	£88,562,221

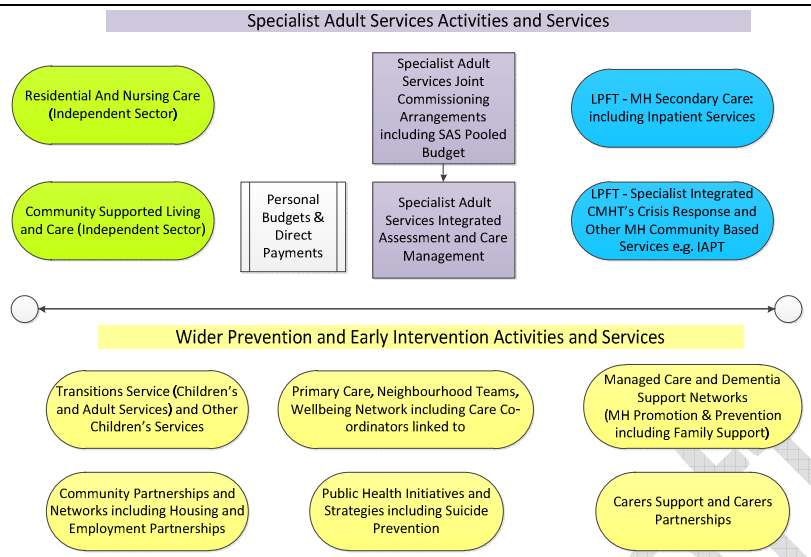
NB. Figures still to be subject to full validation

Whilst there are some areas of strong performance linked to the existing commercial agreements with LPFT for example IAPT penetration and recovery rates there are some areas where improved performance has been identified as necessary in particular:

- Mortality rates for people with Severe Mental Health problems;
- Assessment and Care Management (to be comparable with Lincs LD performance);
- Proportion of People with Severe Mental Health problems in Employment;
- Proportion of People with Severe Mental Health problems in Stable Accommodation;
- Dementia Diagnosis rates (contribution to CCG plan targets);
- Data Quality and reporting;
- Demand Management and waiting times for some services.

Whilst the new joint commissioning arrangements (including a pooled budget for Specialist Mental Health Services) will enhance the level of scrutiny applied to specialist Mental Health services and will hold providers to account through more robust contract management arrangements, performance improvement will also require LPFT and the integrated commissioning team to develop other strategic relationships and partnership arrangements and to develop system wide approaches to early intervention and prevention including mental health and wellbeing promotion.

The diagram below illustrates for Mental Health, Learning Disability and Autism services the services and activities which would be centrally managed via the Specialist Adult Services joint commissioning team (above the line) and examples of the wider Early Intervention and Prevention activities that would require a system wide approach to managing demand and performance improvement (below the line). The below the line activities will require the Specialist Adult Services joint commissioning team to commission through influence and to build strategic relationships and partnerships with key stakeholders to widen the asset base for improvement.



A good example of this wider system based approach is the recent development of the Lincolnshire Joint Dementia Strategy and associated action plan which has been developed and endorsed via the Specialist Adult Services Delivery Board, approved by the Health and Wellbeing Board and is now being implementing by the Pro-active Care Delivery Board.

Data for: Lincolnshire and districts
Table produced on 17/03/14 15:12 from www.pansi.org.uk version 7.0
People aged 18-64 predicted to have a mental health problem, by gender, projected to 2020

Disorder Type	2012	2014	2016	2018	2020
People aged 18-64 predicted to have a common mental disorder	69,001	69,597	70,316	71,158	71,770
People aged 18-64 predicted to have a borderline personality disorder	1,933	1,949	1,969	1,993	2,010
People aged 18-64 predicted to have an antisocial personality disorder	1,470	1,485	1,503	1,522	1,536
People aged 18-64 predicted to have psychotic disorder	1,715	1,730	1,748	1,769	1,784
People aged 18-64 predicted to have two or more psychiatric disorders	30,736	31,014	31,343	31,724	31,998

With a projected further increase in the number of Adults aged 18 to 64 with a mental health problem in future years aligned to a boom in the growth of 65+ population with related Mental Health needs these new "system wide" approaches to Early Intervention & Prevention and demand management will be essential to the delivery of sustainability in relation to Specialist Adult Services budgets as well as wider Acute Hospital services. Aligning integrated working within LPFT existing team, the assessment and care management team within Learning Disability with care co-ordinators in the neighbourhood teams will be a critical activity for over the next 12 months.

<u>Autism</u>

Commissioning services for people with Autism is arguably the most challenging area facing the Joint Commissioning team over the coming years. Currently there are no ring-fenced budgets for people with Autism in either Children's Services or Adults Services in Lincolnshire County Council or across Lincolnshire CCGs.

Information in relation to the number of people in Lincolnshire with Autism is also limited with diagnosis rates nationally being a key issue to be addressed. The best estimate currently available is that there are approximately 4,000 Adults with Autism in Lincolnshire.

Whilst there are some specific services funded for Adults with Autism from both the Learning Disability Pooled budget and provided via the Mental Health core contracts with LPFT the majority of support to people with Autism is provided via existing universal services such as Health and Education Services but supplemented by services funded via the voluntary sector and some generic targeted support through public health services.

For this reason a system based approach similar to that outlined in the Learning Disability and Mental Health Sections above is the approach to be adopted in Lincolnshire. Work is currently in progress to consult on a new joint All Age Autism strategy for people in Lincolnshire. The draft strategy has been developed with the support of the National Development Team for Inclusion and will promote the importance of the system based approach to provide improved support to people with Autism, greater awareness of Autism and better access to services. The commissioning strategy when agreed will be implemented with the support of the Lincolnshire Autism Partnership Board supported by a member of the Specialist Adult Services joint commissioning team. Key areas for action include:

- Increased diagnosis;
- Enhanced training for carers and professionals;
- Improved information and signposting;
- Better access to generic services;
- Improved targeting of prevention and early intervention support initiatives;
- Closer co-production;
- Greater awareness of Autism as a local priority.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners

Specialist Adults Services are jointly commissioned by:

- Lincolnshire West CCG
- Lincolnshire East CCG
- South West Lincolnshire CCG (Lead commissioner for Mental Health Services)
- South Lincolnshire CCG
- Lincolnshire County Council – Adult Care (Lead commissioner Learning Disability and Autism)

However individual service packages in some instances are commissioned directly by the service users through Direct Payments and there is also some sub-commissioning by LPFT for Adult Social Care Mental Health Services.

Wider system prevention and early intervention commissioning activity relies on partnership approaches and will incorporate a broad range of commissioners. Key commissioning relationships include other joint delivery boards (Pro-active Care and Women and Children), other parts of the County Council (Public Health and Economic Development), LPFT (Mental Health Promotion Network).

Specialist Adult Services Commissioning Strategies and activities are also shaped by co-production with the Learning Disability Partnership Board, Carers Partnerships, Shine, Autism Partnership Board and Lincolnshire Safeguarding Boards (Adults and Children's).

Mental Health Providers

The core Mental Health Specialist services are provided by Lincolnshire Partnership Foundation Trust. Lincolnshire County Council also procure services for Residential Providers from the Private and Voluntary Sector to supplement the services provided via LPFT in the community.

LPFT, through funding received from the Better Care Fund of £375,000 per annum and supplemented by Lincolnshire Public Health Team by approximately £100,000 per annum, also commission a number of Mental Health Promotion initiatives through grants to local community groups, community partnerships, local networks, clubs and other associations. This approach is part of the wider system based early intervention and prevention approach that is emerging.

Learning Disability Providers

Learning Disability Services are predominately provided by the Independent Sector (including Private and Third Sector providers). Currently there are over 100 Residential and Nursing Care providers as well as over 50 Community Supported Living providers of Learning Disability Adult Care.

In addition LPFT also provide some services for clients with a Learning Disability as part of the core contract with the CCGs and LCC. These include:

- Assessment and Treatment Longley's Court Lincoln
- CAST
- Green Light Service

Autism Providers

There are some residential and community based services commissioned by LCC via the Learning Disability pooled budget and access to Specialist Mental Health services via the Core contracts with LPFT but there are no other services directly commissioned by the Specialist Adult Services joint commissioning team. There are some services provided via the voluntary sector from other funding sources as well as local networks and community groups.

Wider generic universal services and targeted early intervention and prevention services are also available to people with Autism and a key priority is to improve

information and access to these services.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The development of integrated working and in particular integrated team working has been in train both nationally and internationally for some years. Increasing work has been done to evaluate the impact of integrated working resulting in an extensive library of research projects and evaluation reports on a range of different models for integration. As part of Phase 1 of the LHAC process significant trawling of evidence was undertaken, full details can be provided if required.

The benefits that have already been realised from the development of the joint commissioning team for Specialist Adult Services and the associated pooled budget for Learning Disabilities provides a foundation upon which to develop the joint commissioning model further.

There is a significant policy base supported by National and International Research supporting the development of integrated services that improve parity of esteem and will improve outcomes and value for money in relation to people with Learning Disability, Autism and or Mental Health problems. Relevant documents include but are not limited to:

- The National Service Framework for Mental Health;
- Health Lives: Healthy People;
- No Health without Mental Health;
- Closing the Gap: Priorities for Essential Change in Mental Health;
- Whole-Person Care: From Rhetoric to Reality (Parity of Esteem);
- 'A Call to Action: Commissioning for Prevention' and 'Transformative Ideas for the Future; NHS: A report of the NHS Futures Summit';
- Valuing People;
- Valuing People Now;
- Death by Indifference;
- Out of Site and associated reports in relation to Winterbourne View;
- Public enquiry Mid-Staffordshire NHS foundation trust;
- The Care Act;
- Think Autism, the new autism strategy for adults with autism in England;
- NHS Mandate;
- Preventing suicide in England - A cross-government outcomes strategy to save lives.

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

- £280,000 Maximising Independence
- £2,125,000 LD Demographic Growth
- £370,000 LPFT Mental Illness Prevention Fund

- £100,000 Programme Support Costs
- £4,400,000 Risk Sharing LD pooled budget
- £10,401,000 CCG Contribution to LD Section 75 Pooled Budget
- £646,000 Adult Mental Health
- £63,000,000 CCG Mental Health Contract Contribution
- £51,400,000 Mental Health Community

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The key feedback loop that will be used to measuring outcomes will be the Specialist Adult Services Delivery Board performance reports. These will incorporate relevant measures from the National Outcomes Frameworks, specific measures from Quality Schedules of contracts with key providers, feedback from stakeholders (e.g. friends and family) as well as other key metrics that allow an understanding of performance and value for money. Outlined below are priority areas that will also be incorporated into the performance reports:

- Improvements in Mortality Rates for people with Severe Mental Illness or Learning Disability;
- Improved Access to services for people with Autism, Learning Disability and /or Mental Health problems;
- Reduced Admissions of Specialist Adult Services service users to acute care hospitals;
- Improved discharge arrangements from Acute Care;
- Improved diagnosis of people with Autism;
- Improved diagnosis of Dementia;
- Maintained or improved Assessment and Review performance;
- An increase in relevant population on GP registers (specific read coded for Learning Disability, Autism and Mental Health);
- An increase in Health Checks and Health Plans for people with Learning Disability, Autism or Mental Health Problems;
- Maintained high rates of IAPT penetration;
- Increased proportion of Specialist Adult Services people in Employment;
- Increased proportion of Specialist Adult Services people in stable accommodation;
- An increase in the uptake of Direct Payments;
- Maintained or Improved Provider Quality ratings;
- Maintained or improved stakeholder feedback;
- Assessment and Review performance (Mental Health and Learning Disability);
- Spend maintained within 1% of annual budget;
- Annual Savings targets achieved;

- Maintain or improve Low units cost performance;
- Low levels of sickness absence and staff turnover.

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

- Core focus on safeguarding and quality;
- Effective Demand Management Strategies;
- Co-production with key stakeholders;
- Joint Commissioning of Specialist Adults Services across the Lincolnshire CCGs and County Council;
- Integrated working arrangements across lead commissioners and key providers;
- Retention, recruitment and development of key employees;
- Development of pooled budgets and operating effectively within them;
- Development of robust Commissioning Strategies and Plans;
- Strong relationships and commercial agreements with key providers (and commissioners);
- Effective Market Management;
- Further Development/evolution of system wide commissioning partnerships and alliances;
- Core focus on Outcomes but supported by robust metrics on value for money and productivity.

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ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Scheme name
Wellbeing and Prevention
What is the strategic objective of this scheme?
• A preventative service, designed to enhance wellbeing, and reduce or delay escalation to statutory support services • Improve accessibility to support services for individuals to access services more easily when they need them • Improve mobility throughout service provision, that will enable people to seamlessly get help where required • Deliver services that are fit for purpose and proactively identify need; adopting a principled approach to commissioning to ensure that services are fit for purpose and provision is balanced across the county
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Background and current position: The Wellbeing Service was developed following the end of the Supporting People programme and as a result of the prevention strategy within Lincolnshire County Council. This was influenced by priority themes, objectives and measures in Lincolnshire's Joint Health and Wellbeing Strategy (JHWS). In October 2011 The Executive of Lincolnshire County Council took the decision to change Adult Social Care's eligibility criteria threshold from moderate and above to substantial and critical only. The Health and Social Care Act 2013 seeks to increase integration and simplification of service 'journeys' for vulnerable people. Whilst this legislation pertains particularly to adults, similar directions of travel are clear in children's and young person's services. These legislative drivers are accompanied by unprecedented pressure on resources across all public sector organisations. Those pressures require innovation, targeting

of resources and rapid decision making on commissioning approaches to maintain sustainability.

The Wellbeing Service includes six elements:

- Trusted Assessment;
- Installation of Equipment, Minor Adaptations and TeleCare;
- A Short Term Intervention of Generic Support;
- Monitoring of TeleCare/community alarms;
- A Rapid Response Service;
- Home from Hospital (Home safe).

A key element of this service is having assessors who are skilled and trained to identify needs, establish how to meet those needs and either carry out the tasks themselves or organise others within the Wellbeing Service to do so. Under this model, the purchaser requires a timely assessment and where practical the immediate installation of small aids and Telecare, plus adaptations within 24 hours. The assessors will be used effectively so that they can carry out or arrange many tasks at the time of the assessment and record them in the support plan.

The assessment will also identify other needs outside of the Wellbeing Service and ensure the person is helped if required to access them. This will involve introducing people to new groups or activities to support their wellbeing and social inclusion.

The provider will deliver practical help where needed for a fixed term period; with up to six weeks being the average amount of time; to help people get back on their feet for example after a hospital admission, a family crisis or bereavement. This could include help with shopping, claiming benefits, making and keeping appointments and support to ensure that the person gets back to their optimum independence.

The installation of a range of community equipment that includes simple aids to daily living (SADLs) and TeleCare, plus minor adaptations is also integral to the service. Following an assessment of need and the consent of the service user and where applicable the landlord, the provider will install equipment as required. Where the person does not qualify or want Adult Care to fund these items the provider should offer options for purchase or rent of the items.

The Countywide Monitoring Centre monitors and initiates the appropriate response as agreed with the service user. Monitoring will be for service users in receipt of either TeleCare or community alarms and will include advising assessors or other professionals about trends and concerns from the service user use of the equipment eg if they are falling more frequently.

The Rapid response service is designed to respond to a non-critical emergency in a person's home. Promoting independence by enabling a person to be confident that when support is required that doesn't require an ambulance, a responder would be available to go to their home, this is available 24 hours 7 days a week

Home Safe is a transport and resettling service for individuals returning home from hospital. Drivers and support staff will take the individual home where they will be

met by a Home Safe Responder, who will ensure safe access and all facilities are switched on and working. They will also test equipment such as Lifeline units and inform the monitoring centre of their return, as well as informing care providers, family members or neighbours. They will ensure that the person is comfortable and has essentials such as medication, food and refreshments, additional shopping can be collected if required. This element of service operates seven days a week (including bank holidays) from 10am to 10 pm (last referral 9.30pm) to support admission avoidance and delayed discharge. Early evidence shows that WBS intervention at A&E is enabling people to return home and avoid admission.

Client Group:

This service is available to individuals aged 18 years and over who have assessed needs that can be met with the provision of a short term intervention, equipment and/or TeleCare/alarm service.

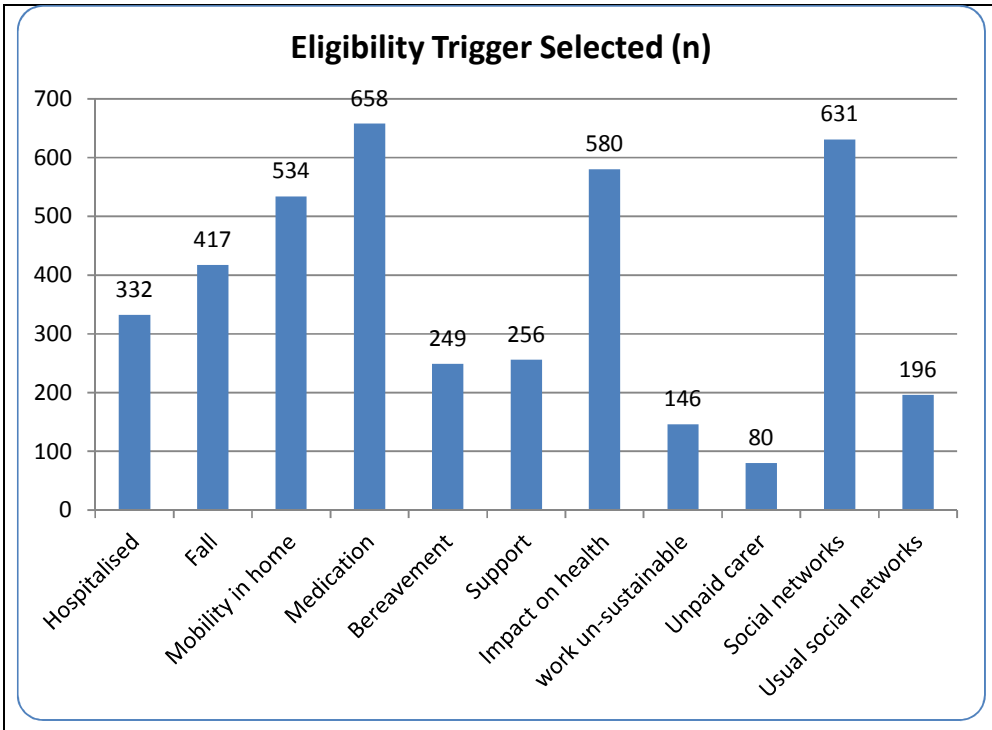
Headline Performance Issues:

- From 1 April 2014 up until 13 July 2014 there have been 891 eligibility checks, 844 (95%) have been referred through to the Wellbeing Service to undertake a face to face assessment and the remaining 47 were signposted either directly to the Wellbeing Service Partners for the self-funding route, or to a more appropriate agency.

- Prior to the WBS 60% of people who called up for Adult Care Service were sign posted to other agencies. With the Wellbeing Service in place there is now an opportunity to support these people earlier through easier access to low level support and equipment services.

- Previously these 891 would have likely been sign posted, as these people would generally fall under the Low/Moderate criteria for Adult Care service, as such they would not have received a service.

The four leading eligibility triggers which have been the most hit are with medication, social network (isolation), impact on heath and mobility at home being.



The table above shows the 11 eligibility triggers for the WBS and which ones are most commonly identified.

Emerging Outline Strategy:

The Wellbeing Service is a key driver within a number of programmes within Lincolnshire and fundamental to the emerging Wellbeing Strategy. This commissioning strategy aims to assist improvements in the health and wellbeing of the population as a whole; it covers advice, information and preventative services.

The Wellbeing service will identify gaps in provision, services and customer need as the service delivers and progresses. This will inform and influence commissioners as part of the commissioning cycle. The WBS is delivered by four providers across the county – one being the countywide monitoring service. With the non-monitoring elements of the WBS being delivered across the county by three providers, including two District Council emerging service delivery solutions will be identified, tested and integrated where appropriate.

The service will be independently evaluated along with ongoing internal review, assessment against objectives.

Anticipated benefits and outcomes:

The overarching service outcomes are:

- People have easy access to a wide range of information that will enable them to make informed decisions about their own wellbeing, in good time to plan ahead

- People receive targeted preventative services or assistance at an early stage that will help them remain independent in their own homes and communities
- People, particularly those who are frail and vulnerable, feel secure, cared for, have a good quality of life and feel part of a supportive, enabling community

The Wellbeing Service is designed to help local people achieve multiple outcomes for as long as possible. The support provided should contribute to all of the following National outcomes:

- NHS Outcomes Framework 2.3.i Reduced unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
- NHS Outcomes Framework 2.6ii Effective post-diagnosis care in sustaining independence and improving quality of life
- NHS Outcomes Framework 2 Enhanced quality of life for people with long term conditions
- NHS Outcomes Framework 3.6.i Increased proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into enablement/rehabilitation services
- Adult Social Care Outcomes Framework 1G Increased proportion of adults with a learning disability who live in their own home
- Adult Social Care Outcomes Framework 2A Reduced admissions to residential and nursing care homes
- Adult Social Care Outcomes Framework 1B Increased proportion of people who use services have control of their daily life
- Adult Social Care Outcomes Framework 2A Reduced/delayed permanent admissions to residential care homes
- Public Health Outcomes Framework 4.11 Reduced emergency readmissions within 30 days of discharge from hospital
- Public Health Outcomes Framework 4.16 Dementia and its impacts (placeholder)
- Public Health Outcomes Framework 1.6 Increased number of people with a mental illness and/or disability in settled accommodation.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The service described above is jointly commissioned by:

- Public Health
- Adult Social Care
- Health (in relation to the Home safe element)

The service is provided by:

- North Kesteven District Council
- East Lindsey District Council
- Lincolnshire Independent Living Partnership
- Mears 24/7

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Joint Strategic Needs Assessment (p16) highlights the need for Wellbeing and Older People in particular in relation to falls prevention, income maximisation and support.

http://www.research-lincs.org.uk/Joint-Strategic-Needs-Assessment.aspx

Public Health Market Position Statement (p7-10) evidences the current supply and demand of clients and services. (p13) states what is needed to meet this demand, including prevention, telecare, partnership working and improved access to information.

http://www.lincolnshire.gov.uk/residents/adult-social-care/for-providers/key-documents/market-position-statement-2013/116472.article

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

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Benefits:
- All elements within Wellbeing will be preventative, designed to enhance well-being, and reduce or delay escalation to higher level services.
- Better self-management of health issues leading to an increased level of independent living and less demand on emergency services.
- Improved accessibility to services by introducing a signposting service, removing entry criteria, and boundaries; vulnerable people will be able to access services more easily when they need them.
- Improved mobility throughout service provision - the service will be a joined up matrix of personalised support services that will enable people to seamlessly get help when required. Services offered will be part of an integrated pathway with social care and NHS community services.
- The model will offer an exit route for those clients whose Adult Social Care services have been reduced.
- Fit for purpose services - the new service model will enable Public Health to redesign its commissioning strategy within Lincolnshire. By proactively identifying need early and adopting a principled approach to commissioning; commissioners

can ensure that services are fit for purpose and provision is balanced across the county.

- Will enable the potential for a consortia approach to commissioning which will encourage partnership working.
- Developed specifications will demonstrate increased capacity, demand management and added value.

Volumes expected to be supported:

District	Total number of current users	Estimated percentage of growth need	Projected total number of users
Boston	1,051	16%	1,219
East Lindsey	1,562	14%	1,781
City of Lincoln	1,244	17%	1,455
North Kesteven	1,660	12%	1,859
South Holland	1,256	14%	1,432
South Kesteven	1,578	13%	1,783
West Lindsey	1,058	13.50%	1,201
County Wide Services	182	14%	207
Total In Scope	6,369		7,298

The current level of service provision is **estimated at 6369** service users; we expect this to increase during the life of the contract. The growth percentage is derived from the Market Position Statement.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

At a strategic level the Wellbeing Service is overseen by Public Health Directorate Management Team, and overseen by the Proactive Care Working Group feeding directly in to the Proactive Care Board and the Health and Wellbeing Board.

At an operational level, success will be measured utilising the Public Health Quality Assessment Framework and performance data.

The key elements looked at are:

- Assessment and Support Planning
- Security, Health and Safety
- Safeguarding and Protection from Abuse
- Fair Access, Diversity and Inclusion
- Client Involvement and Empowerment

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

- Improve wellbeing and independence of vulnerable adults.

- Delay escalation of vulnerable adults into higher level health and social care interventions
- Greater personalisation of services
- Greater focus on outcomes not activities
- More effective partnership working and co-production
- Greater focus on reablement and support that maximises independence
- Service users and carers have more choice and control over how their needs are met
- Ensuring value for money by improving efficiency and performance against Government targets for service delivery
- Safeguarding of vulnerable people

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.

Scheme name

Seven day services – Increasing the capacity of the Independent Living Team particularly focused at the weekends.

What is the strategic objective of this scheme?

Seven day service provision is about equitable access, care and treatment, regardless of the day of the week. The overall strategic objective for seven day services is to ensure that the patient / service user has a seamless pathway of care when accessing services no matter what day of the week.

The strategic objective of this scheme is to support patients being discharged from hospital and prevent hospital admissions at weekends, with four main drivers:

- Reducing mortality which is generally worse at weekends
- Increasing efficiency in the system
- Moving with the times, weekends should be no different to a week day
- The compassionate argument, service users/patients should be entitled to receive the same standard and quality of care regardless of the day of the week.

The case for need for this service is that discharges from acute care are low at weekends. Whilst A&E attendances and emergency admissions do not vary significantly by day of the week, this is not the case for discharges. There appears to be little difference between the mean number of discharges and the 85th centile on Monday to Thursday when compared with Friday at Pilgrim Hospital; however for Lincoln County Hospital, the mean is 32 more on Fridays, with 13 more at Grantham Hospital and 8 more at Peterborough Hospital. In summary, there are raised numbers of discharges on Friday and very few on Sunday. It is well known that the lack of availability of in-patient beds increases waiting times and breaches in A&E. By increasing discharges at the weekend, not only does this improve patient experience and reduce unnecessary hospital stays, it will also improve the flow of patients through acute care. This scheme will “pull” patients into the community.

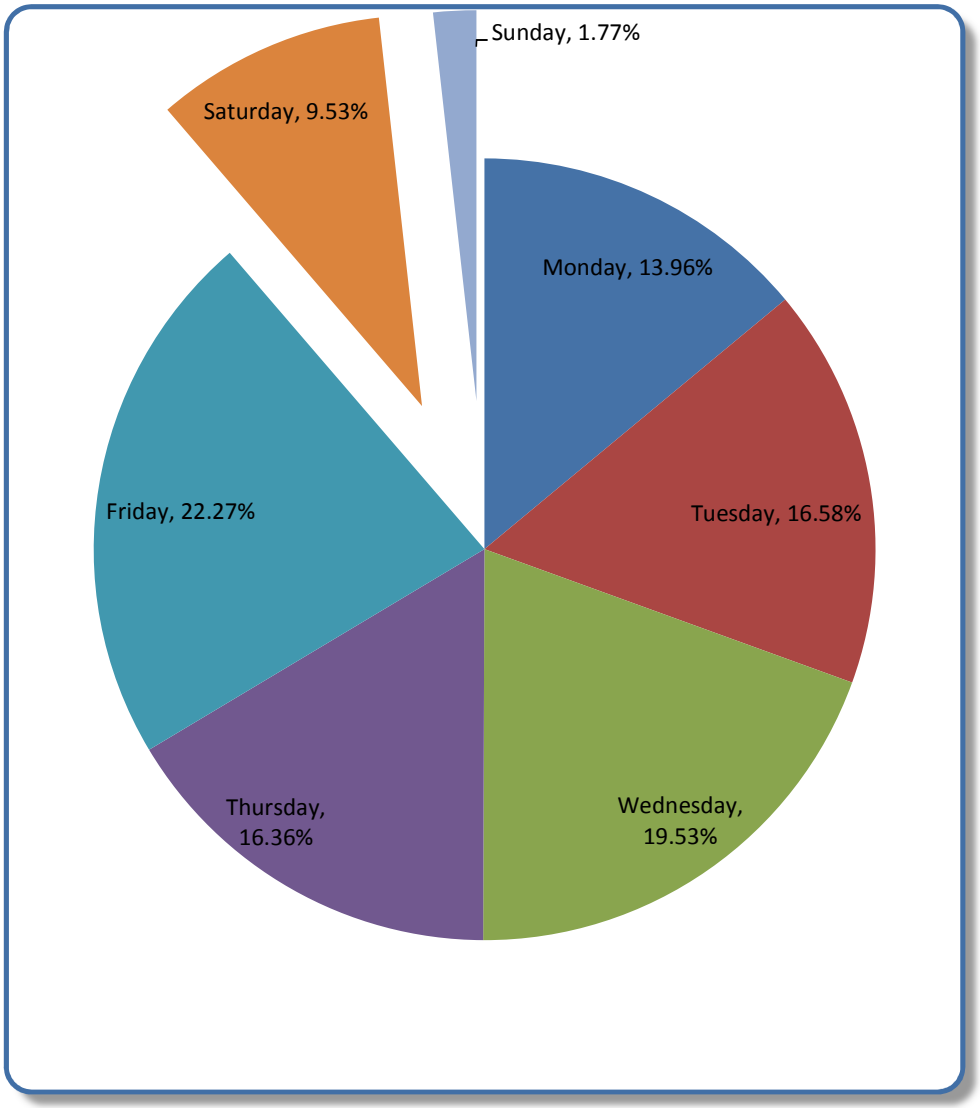
Under the current grant agreement, Lincolnshire County Council has set the following activity targets for the service over the lifespan of the agreement.

- 2014/15: 174,759 face to face contact hours
  5,823 unique service user episodes
- 2015/16: 192,133 face to face contact hours
  6,405 unique service user episodes
- 2016/17: 192,133 face to face contact hours
  6,405 unique face to face episodes

The aim is for LPFT to deliver these targets based upon a whole service redesign,

although the current service provision provides for a seven day service, the bulk of the weekend working is focussed upon follow up interventions to aid re-ablement. The service can and does take new referrals at weekends but this impacts on the delivery schedule; the consequence of it being difficult to take on new referrals at weekends is discharges from hospitals are significantly reduced.

The following pie chart provides a breakdown of the days when re-ablement services commence the chart clearly demonstrates a significant reduction in commencement of re-ablement at weekends. The Data covers the period of April to July 2014.



	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Grand Total
Grand Total	**331**	**393**	**463**	**388**	**528**	**226**	**42**	**2371**

Percentage	13.96%	16.58%	19.53%	16.36%	22.27%	9.53%	1.77%	100.00%

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Context of seven day services in Lincolnshire

Before describing the scheme, below are details of other schemes that are targeted at seven day service provision. This has been provided so the whole system is described and the context / rationale for this scheme is explicit. All these schemes will be required to improve access, care and treatment, regardless of the day of the week.

- **Acute Care**
  Through the operational resilience plan for 2014/15, the following schemes will be funded;
  - Integrated Discharge team working within acute care with hospital, community and adult social care staff that work seven days a week. Staffing includes social workers and brokerage staff to support weekend discharges with the identification of care packages at the weekend. Investment is £411,595 PYE.
  - Therapy services in acute care at weekend to support weekend discharges and a reduction in acute length of stay. Investment is £217,589 PYE.
  - Therapy services in the community rapid response team (new service seven days per week) and the A&E departments (extension of current service into weekends) to prevent hospital admissions. Investment is £367,795 PYE.
  - MRI diagnostics on a Saturday and Sunday to reduce hospital admissions for a diagnostic test only and reduce waiting times for patients. Investment is £155,100 PYE.
  - Pharmacy working at the weekend to increase level discharge by 5% every day over 7 days, reduce missed and omitted medications with associated improved patient outcomes and reduction in acute length of stay. Investment is £602,155 PYE.
  - Ambulatory Emergency Care Services are being expanded to open at Pilgrim Hospital and Grantham Hospital at the weekend and an additional 3 hours in the week at Pilgrim. The objective being to reduce the number of admissions and reduce acute length of stay. Investment is £785,843 PYE.

- **Community Care**
  The impact of the Neighbourhood teams and the Intermediate Care Service will need to be fully understood in order for further investment to be decided from 2016/17 onwards in terms of seven day services.

- **Primary Care**
  Through the operational resilience plan for 2014/15, the following schemes will be funded:
  - Minor Injuries Unit in Sleaford is being expanded to operate at the weekend to reduce A&E attendances and admissions. Investment is £195,262 PYE.
  - Lower acuity pathway is being developed at Lincoln and Pilgrim Hospitals which will provide GPs in A&E seven days per week to reduce paediatric

admissions and admissions for the frail elderly. Investment is £446,659 PYE.

Collectively these schemes will either prevent hospital admissions or increase discharges at the weekend from acute care with impact starting September 2014 and continuing to the end of March 2015. Impact will be measured through the Lincolnshire System Resilience Group. The projected impact is currently being modelled into trajectories and will be available by the time this BCF is submitted. Depending on impact, each service will either have an exit strategy to stop the service or a plan to sustain the service from April 2015.

The above schemes will mean that people will be rapidly assessed and will either receive their care in the community or experience a rapid discharge from hospital when they are medically fit for discharge. Therefore additional resource is required in the community to support these people and promote their independence. Hence the scheme below.

Increasing the capacity of the Independent Living Team
Lincolnshire Partnership NHS Foundation Trust is currently conducting a whole systems service redesign for the ILT support service. The objective being to shape the service and structure to exert the greatest amount of efficiencies as possible, this will include creating capacity with the introduction of new shift patterns, reducing the amount of downtime, and allowing home support workers to work across a number of different patches which will provide the critical mass required to meet the demands for the service.

With the introduction of new technology, this will release the home support workers' time to concentrate on service delivery. The creation of a countywide roster, underpinned by clear criteria, will ensure that the right level of re-ablement can be delivered to the right person, and also provide an administrative function to the whole service. The Service User will continue to receive an assessment and subsequent reablement at home and onward signposting to the brokerage service. The ILT support service will continue to work in a fully integrated way with the ILT health service and the contact centre. The service provision will continue to be provided at the service user's home and will be fully focused on short term interventions/support which allows the individual to remain at home or be discharged from hospital.

The additional funding will allow the service to increase the number of home support workers available at weekends which will allow and support increased discharges or admission avoidance from ULHT beds. The increased capacity will allow the ILT support service to deliver the following projected volumes. An assessment will be conducted by the Home co-ordinator within 48 hours of the referral being received, with subsequent reviews completed during the reablement period.

The projected increase of staffing establishment would be approximately 12 whole time equivalents creating 22,000 additional hours offering services to a further 800-1000 service users. The focus will be primarily on the older adult population.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

For the scheme, Lincolnshire County Council will commission Lincolnshire Partnership Foundation Trust (LPFT) to deliver the service through the current contract.
In addition, the Independent Living Team works closely as an integrated service with Lincolnshire Community Health NHS Services. This relationship will need to be taken into account not only in terms of care delivery but also in terms of the Contact Centre (24/7 single point of contact) which will receive the referral to the scheme from acute care and the community and deploy the resource as they do currently.

The Contact Centre will continue to be the gateway for all referrals into the ILT support service; the Contact Centre will undertake an initial screening and then warm transfer the referral onto the LPFT's central roster team who will then deploy the resources required in conjunction with the service user.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

In September 2013 LCC published an evaluation report on the Independent Living team
The results of the evaluation are attached:

Independent Living Team Appendix A.pdf

As part of the service redesign process LPFT held a number of staff engagement workshop events across the county to determine how the service should look going forward. The outputs from the engagement events have been included within the proposed service redesigned model and subsequently LPFT has formally commenced staff consultation on the proposed new service model, on the whole staff are broadly in favour of the proposed changes.

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

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Headline metrics – the service will contribute to:
- Increasing the number of discharges from acute care
- Reducing Delayed Transfers of Care
- Reducing re-admissions to acute hospital with 30 days
- Reducing permanent admissions of older people to residential and nursing care homes
- Increase the proportion of older people who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services

- Reduction in unnecessary A&E attendances/readmissions, at weekends

Service outcomes will be:

- Quality
  - Enabling patients to feel better supported in the management of their own health
  - Improving independence – Health and Wellbeing Strategy

- Productivity
  - Reduction in the number of frequent fallers
  - Levelling discharges across the week by increasing discharges at weekends from acute care ULHT would have smoother patient flows, in particular avoiding some of the current pressures on Mondays
  - Reducing length of stay in acute care

- Prevention
  - Improvements in outcomes for patients with long term conditions through better case management and prevention of deterioration of their condition
  - Reduction in the number of falls through regular assessment
  - Increased number of patients who are re-abled to full independence, thus reducing reliance on long term packages of health and/or support care

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

LPFT already collects KPI performance data for LCC, this performance matrix can be added to, to reflect weekend working and include key deliverables that meets the objectives of the service. The Trust already collect service user feedback on the current service provision, again this can be broadened out to include service user views on the weekend provision.

The opportunity to use new technology in collecting data will enable LPFT to generate KPI data electronically through the development of dynamic window and uploaded to the Trusts clinical system.

The National Audit for Intermediate Care 2013 has used PREMS outcome measures for the first time, with some interesting results. Given our participation during 2014 LPFT can ensure that this is built into their planning and auditing of their own services, but in the meantime there are proxy measures which can be used as additional measures of success (or otherwise). Some of the measures used as part of the urgent care /winter pressures evaluation (of which there is a high level of cross over into intermediate / transitional /out of hospital based services, due to the nature of the patient journey).

Key outcome measures, which are whole system and representative of the entire patient pathway, are already being used after being drawn from other major programmes of work – e.g. the evaluation of the ILT.

These are lifted from the various outcome frameworks – e.g. ASCOF, NHSOF and PHOF – and cross mapped to ensure that we are consistently measuring the benefits from

service change.

LPFT intend to use The Better Care programme which plans to use a range of simple output measures which have been fixed nationally to monitor relative success in developing integrated care type services, and these are:

- Admissions to residential care
- Effectiveness of reablement
- Delayed Transfers of Care
- Avoiding emergency admissions
- Patient and Service User Experience

Additional benefits may be described through the "QIPP" (Quality, Innovation, Productivity and Prevention) Framework used extensively in NHS planning, and provides a means of segregating outputs for means of benchmarking against best practice. In addition to those outcomes detailed in the section above, other measures could include:

Quality:

- Improving clinical and social care outcomes – as per measures detailed in NHS OF, ASCOF, PHOF – by offering a greater range of services and interventions targeted at individual patients.
- Enabling patients to feel better supported in the management of their own health
- Improving independence – Health and Wellbeing Strategy Innovation:
- Through the introduction of new technology – e.g. telehealth/telemedicine, risk stratification
- By means of integrated commissioning and new shared contractual mechanisms

Productivity:

- Improvements in primary care productivity
- Reduction in length of stay of those patients requiring support type interventions
- Reduce duplication in provision through a range of fully integrated services by means of multiple providers using a single point of access and common pathways of care
- Reduction in the number of patients admitted to long term residential care

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

Key success factors include:

- Completing the staff consultation and implementing changes with full support of current staff and without a loss of the workforce
- If there is an attrition rate in the current workforce, to be able to recruit and retain new members of the workforce
- There is an interdependency with both the Integrated Discharge Team (and the other acute care seven day services) to identify patients ready for discharge at the weekends and an interdependency with the Contact Centre who will manage the referrals into this service.
- There is a huge support across the health and care system to expand this service so no issues identified with implementing this new resource.

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ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Scheme name
Development of Community Based Neighbourhood Teams
What is the strategic objective of this scheme?
Neighbourhood teams are being developed to enable people to be: - Supported to remain well, independent and safely at home - Maintained as close to home as possible during a crisis - Supported to return home quickly and safely following a stay in hospital - Supported to experience a good death when at end of life. By working together these teams will aim to: Work in a multi-disciplinary way to provide more joined up care. People will be treated and cared for closer to home where possible and will only be admitted to hospital when necessary. The Lincolnshire Health and Care community aspires to a population based model of health and care where wellbeing is maximised through communities, voluntary and statutory services working together.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Developing Neighbourhood Teams The concept of delivering integrated community care has been a strategic driver for the Lincolnshire Health and Care community for some considerable time and some work has taken place to see this happen. However, during 2013, Lincolnshire initiated the Lincolnshire Health and Care (LHAC) Review designed to ensure sustainable services into the future and to agree a radical, transformational change plan to be delivered over the next 5 years.

The Proactive Care Programme has a number of projects designed to deliver preventative and pro-active services aimed at reducing the demand on acute care and long term care for Adult Social Care and to support people to remain well and independent for longer.

During Phase 2 of the LHAC process the Pro-active care work stream developed the following design principles for the proactive care model:

- Co-ordinated and delivered in a multi-disciplinary team focussed around primary care.
- Multi skilled team members who are empowered to act and be accountable.
- Locality/neighbourhood/geographical delivery
- Enabled by technology
- Interfaces with specialist and acute services

Using these principles work commenced to design the Neighbourhood Team model. The teams are also following a developing set of operational principles to guide their work, these include:

- Prevention – first and foremost
- Think Home First
- Discharge to Assess
- Comprehensive Geriatric Assessment
- Taking responsibility and being accountable

At present there is a comprehensive project plan to develop and deliver a Neighbourhood Team model across all parts of the County by April 2015. Currently work is taking place to establish 4 early implementer sites, with rapid roll-out anticipated over the winter – See Figure 1 at end of section.

The design of the teams is based on both national and international evidence of where this approach has already been adopted and has shown some evidence of impact. Within Lincolnshire itself some areas have already done work to establish integrated working eg Mobile Outreach Team in Lincolnshire Southwest and Integrated Community Teams in Lincolnshire West.

Over time it is expected that Neighbourhood Teams will work together to deliver a range of functions on a basis of need to its local population, for example:

- Risk Stratification – linking with the National GP DES for Unplanned Admissions.
- Supportive Self Care – both Primary and Secondary prevention
- Pro-active care planning
- Carer Support – linking to the Carers Partnership
- Care co-ordination/navigation
- Crisis response
- Chronic Disease Management
- Falls Management
- Nursing Care

- Effective Discharge Planning & Support
- Mental health and wellbeing
- Dementia Support and care
- Recovery and rehabilitation
- End of life care.

Whilst initially the focus for the Neighbourhood Teams will be the support and management of older people, over time this model will incorporate children and younger people as this is very much seen as a 'whole population' model.

The Neighbourhood Teams will comprise of a range of multi-professional staff with the core team including:

- Primary Health Care – GPs and their team
- Community nursing
- Therapy and re-ablement
- Community Mental Health teams
- Adult Social Care – named social workers
- Clinical and non-clinical care co-ordinators

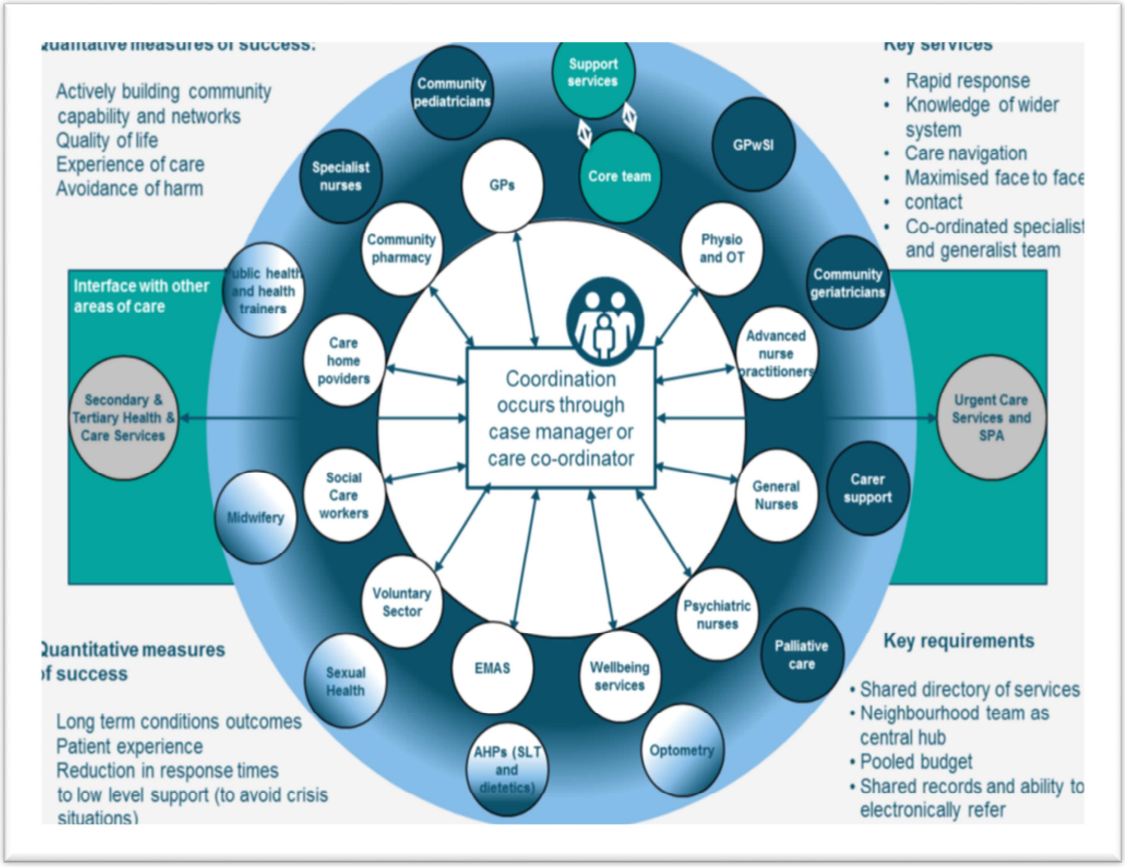
This core team will then be able to rapidly access a range of services and support, for example:

- Third Sector Services – Wellbeing Service
- Lifestyle services
- Carer support
- Specialist medical services eg Specialist nurses, Community Geriatrician
- Transitional Care support (step up/step down) – See Intermediate Care Section.
- Housing services

As mentioned the emphasis of the work for the Neighbourhood Teams will be to develop systems and processes to work together to identify increasing frailty, including patients at increasing risk of a hospital admission and from this deliver a more pro-active response in line with individual patient and carer needs.

These teams form part of a wider set of system developments which are inextricably linked, e.g. Intermediate Care, Contact Centre and Rapid Response, Integrated Discharge Teams, all of which are essential to deliver an effective, safe, integrated pathway of care for older people.

The diagram below shows the proposed model for the Neighbourhood Teams:



The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The elements that currently make up Neighbourhood Teams are commissioned by the four CCGs in Lincolnshire and the County Council:

- Lincolnshire West CCG
- Lincolnshire East CCG
- South West Lincolnshire CCG
- South Lincolnshire CCG
- Lincolnshire County Council
- 7 x District Councils for Housing and some Wellbeing Services

The core services for Neighbourhood Teams are provided by:

- Lincolnshire Community Health Services
- Lincolnshire Partnership Foundation Trust
- United Lincolnshire Hospitals Trust
- Lincolnshire County Council – Adult Social Care
- 102 Primary Care Providers
- A range of Third Sector Providers
- Carers Partnership

As part of the development of the Neighbourhood Teams a Memorandum of Understanding is being developed and signed off by the four main provider organisations. This document provides confirmation of each organisation's commitment to be fully engaged in this development and the expectations for each of the organisations.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The development of integrated working and in particular integrated team working has been in train both nationally and internationally for some years. Increasing work has been done to evaluate the impact of integrated working resulting in an extensive library of research projects and evaluation reports on a range of different models for integration. As part of Phase 1 of the LHAC process significant trawling of evidence was undertaken, full details can be provided if required.

The evidence from sites such as Torbay, North West London, Gwent, New Zealand and Valencia would suggest delivering co-ordinated and integrated services for people with increasing frailty and long term conditions have potential to deliver better and more cost-effective care if they are well designed, involve professionally trained case managers and care teams and are embedded in a wider system that supports co-ordinated care (Ross et al 2011). Evidence suggests that a significant proportion of admissions could be avoided if alternative forms of care were available (Health Foundation 2013).

Key components to achieve the above would include:

- a focus on early action and prevention, targeted at particular communities to mobilise local people
- community based multi-professional teams based around general practices or groups of practices that promote close working and communication between staff in different organisations.
- A single point of access, single assessment and shared clinical records.
- Targeting individuals who are at high risk of future emergency admission to hospital, before they deteriorate – risk stratification.
- The individual and their case manager co-producing a personal care plan, which brings together an individual's personal circumstances with their health and social care needs.
- Systems to enable all those involved in a patient's care to access up-to-date patient records.
- Continuity of care, including effective communication processes where all information is streamed though the case manager.
- Case managers having the necessary skills for the role, as well as clear boundaries and accountabilities.

(Ross et al 2011)

With the evidence becoming stronger to support the development of pro-active, integrated modes of care and the very clear national steer towards integrated care, Lincolnshire's decision to implement the Neighbourhood Team concept fits well with this.

Evidence locally that this approach can impact on Emergency Admissions for older people has been produced by the Lincolnshire West CCG, who have for a number of years been developing an end to end frailty pathway.

Part of this Programme of work has been the development of 5, locality based, Integrated Community Teams, which, are essentially a Neighbourhood Team with the same 'core' membership and working towards the same outcomes.

Over the past two years a systematic development and roll-out programme has been taking place with all 5 teams now up and running. As at 31st March 2014, the CCG saw the following impact on emergency admissions when compared to the same period 2013.

- Overall reduction in all ages/all cause emergency admissions of 6.8%
- All age emergency admissions for ACS conditions reduced by 7.5%
- Emergency Admissions for patients over 65 was 5%
- Emergency Admissions for patients over 75 was 8%

As well as the qualitative data the CCG recently commissioned a qualitative evaluation of the impact on the staff members within each team, the key findings being:

- Everyone felt the concept of Integrated Teams to be a good thing.
- Professionals involved have identified clear benefits for themselves and patients.
- The teams members believed the concept could (and should) be expanded.

Benefits for the team members:

- Communication between professionals from different services had improved – better relationships.
- Knowledge transfer between the different professional groups was seen as particularly beneficial.
- More mutual understanding of roles.
- Much better access to specific colleagues from different services.
- Have greater and quicker access to other service professionals between MDT meetings.
- Now doing more joint visits – different services attending together.
- Now starting to identify those patients who may have a need in the future rather than just working reactively.

Benefits for Patients:

- Patients were being identified earlier and offered different support and care.
- Patients were only having one visit by the appropriate team members working jointly.
- Patients were being assessed and managed more holistically.
- All services needed to support patients were involved from the beginning.
- Some patients had definitely avoided a hospital admission.

The 5 teams are now taking the learning from this evaluation and the LHAC support to further strengthen their performance and since April a Community Geriatrician has been in post, which from evidence elsewhere is a key post to ensure specialist medical oversight is provided to the teams.

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

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

These outcomes detailed above will work together to support achievement of:

- Reduction in emergency admissions – at least 3.5%
- Reduction in emergency readmissions
- Reduced length of stay in hospital
- Reduction in delayed transfers of care
- Fewer people attending A&E
- Fewer people conveyed to an acute hospital
- More people supported to remain safely at home after a hospital stay – people over 65 still at home after 91 days post discharge
- Ensuring all patients with one or more long term condition will have a personalised care plan
- Fewer people needing long term care
- More people dying in their preferred place of death

Linking to the GP Unplanned Admission DES it is expected that through risk stratification that all of the 2% of patients identified on the Practice risk register, as well as any other patient referred to the Neighbourhood Team, will all have:

- A jointly agreed, integrated care plan that is shared with the Neighbourhood Teams.
- A named care co-ordinator either their own GP or an appropriate member of the Neighbourhood Team.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The development of Neighbourhood Teams is being done as part of a wider, whole system, programme of work to transform the way services are delivered across the County.

As part of this there is an extensive joint governance structure developing which will ensure that the various programmes and projects are effectively monitored and managed. This structure is articulated within the main body of the submission.

Specifically for Neighbourhood Teams the project sits under the remit of the Proactive Care Commissioning Board and this will provide the Project governance and infrastructure.

There is a range of both system and project KPIs that will align to other interdependent programmes, particularly the Urgent Care Programme. Work is taking place with our Business Intelligence colleagues both within health and social care to ensure that the reporting requirements to monitor impact of the various BCF projects can be reported automatically.

At a tactical and operational level each CCG is likely to review the progress of their local Neighbourhood Teams. For example in Lincolnshire West the CCG has produced a Frailty Performance Report for over 3 years which is now able to demonstrate a real impact against the original KPIs agreed.

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

The development of Neighbourhood Teams across such a rural and diverse geography brings a number of factors that can potentially impact upon successful delivery of this project.

A key one, given the integrated working required, is the need to ensure that all stakeholders involved are signed up to this approach and ensure that their organisation facilitates the integrated working required. This is being tackled via two routes:

- Strategically the Lincolnshire Health and Care Programme Board
- Operationally by the development and signing of the Memorandum of Understanding in relation to Neighbourhood Teams.

Other factors include:

- GPs and their practices are key members of the Neighbourhood teams and there is a challenge ensuring that they are fully involved and engaged in their development. However, the Unplanned Admission DES and the £5 per head included in CCGs' Operating Plans to support frail older people, helps mitigate the risk of lack of GP engagement.

At this stage CCGs are looking to implement the following additional support via the £5 per head:

Care Navigator roles

GPs with Extended Role in Elderly Care

Increase in community nurses – particularly Case Managers

Supporting the Neighbourhood Team development

Specialist Nurses in Elderly Care

Closer working with the Third Sector to deliver lower level support to patients/carers.

- The Neighbourhood Teams effectiveness will depend on the multi-disciplinary team being empowered to:
    - Take responsibility for the development of the team and how it works within the agreed operational framework.
    - Have access to first class Organisational Development to support the required cultural change and ensure they are equipped to make the changes necessary.
    - That the teams are fully staffed and that the staff have the right skills and competencies to deliver increasingly more complex care to patients within a home environment.

  A key 'enabler' work stream within the LHAC Programme is that of OD and Workforce Development, which is aimed at addressing the issues above, with an expectation that expert OD resource will be available to each of the teams as they develop.
- Ensuring the 'right' workforce is one of the biggest risk to the community as Lincolnshire's ability to attract and retain high quality workforce can be difficult and the existing workforce is ageing. The County is working as part of a joint Workforce Planning process to work collaboratively to ensure a robust and sustainable workforce can be established over the next 5 years.
- The need to resolve some of the IT and information governance issues are essential to the effective working of the teams. It is essential that over time the team can all have access to a single patient record and that patients and carers have the confidence that their information will be shared appropriately and safely.

  Again, this is an 'enabling' work area for the LHAC Programme with a team already engaged in identifying solutions to support better, more integrated use of IT.
- Estates – there has been some discussion regarding the benefit of co-locating teams, wherever possible, although it is accepted that in some areas this may be difficult. Therefore all methods of communicating will be explored with an increasing utilisation of the interactive communication solutions now available. However, where it is possible to co-locate this will be exploited.
- It will be essential for the Neighbourhood Teams to integrate effectively into both the wider community service provision and into the local acute hospital sites. As each of the early implementer sites are becoming established part of the process is to gain an understanding of other local services available to them and most importantly how they can be quickly accessed.

- The relationship with each of the local Acute Hospital sites will be essential as it is expected that, over time, the Neighbourhood Teams will be utilised to support 'admission avoidance' and also early supported discharge, particularly as the principle of 'Discharge to Assess' is developed and adopted.

Figure 1. Early Adopter Neighbourhood Team Sites

Lincolnshire West CCG: Lincoln City South

Pop: 51,636; GP surgeries: 6; Geography: Urban
Clinical Lead: Dr Nick Smith
Operational Lead: Carol Cottingham

- Integrated community teams operate in this locality including Adult social care, LCHS community nursing, ULHT community geriatrician, LPFT mental health team but have not been fully operationally linked with GPs.
- The community team identify vulnerable patients weekly using the frailty score
- GPs also use the Devon tool for risk stratification
- LWCCG has recently demonstrated a 6.84% fall in all age emergency admissions (all Lincs CCGs 3.19%) and 8.11% reduction in over 75yrs emergency admissions for our CCG, (all Lincs CCGs 0.01%.)

Lincolnshire East CCG: Skegness

Pop: 51,500; GP surgeries: 4; Geography: Coastal
Clinical Lead: Dr. Dr Jose Quevedo
Operational Leads: Duncan Richardson: Martin Jego

- Significant work underway
- Team mobilised includes GPs, practice managers, LCHS matron for integrated care, LPFT mental health team, ELDC housing and community support, Adult care social workers, EMAS, LCHS case manager, St Barnabus & Age UK
- Agreed vision and will commence development of operating model and OD with support from LHAC PMO
- Risk stratification in progress
- Keen to commence OD development as support is confirmed

South West Lincolnshire CCG: Sleaford

Pop: 54,660; GP surgeries: 6; Geography: Rural/Market Town
Clinical Leads: Dr. Da Silva & Dr. Robinson
Operational Leads: Val Blankley, Joanne Hart & Lynne Young

- Successful engagement event attended by 40+ people (GPs/ teams; LPFT, LCHS, St. Barnabas Hospice, ULHT
- Developed a governance framework for oversight of NT development
- Work underway to review specific roles e.g. care coordinators
- MDT meetings already happening within practices but will be more coordinated through the NT development process with attendance secured by core team members

South Lincolnshire CCG: Stamford

Pop: 30,967; GP surgeries: 3; Geography: Market town (with cross border considerations)
Clinical Lead: Dr Steve Reiss
Operational Lead: Simon Jessop/ Sally Clipson

- Good local team engagement with GPs, LCHS complex case manager, LPFT mental health team, Adult Care social worker, Wellbeing service partner
- Further engagement with adult social care in development
- MDT meetings already happening within practices
- Further support required to mobilise from LHAC PMO

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Scheme name
Carers Support The two separate projects in this workstream represent an aligned and coherent approach to providing targeted support for two high risk groups of informal carers: • Older carers of people with a learning disability • Carers of people with dementia
What is the strategic objective of this scheme?
Without additional support we know through engagement, co-production and experience that carer and family support arrangements are at risk of breaking down over time as the needs of the carer and cared for person increase. These pressures often ultimately lead to increases in maintenance costs through unplanned and unwanted residential care and hospital admissions. The shared objectives of these projects are, therefore, to alleviate or delay a break down in informal caring relationships by targeting proactive preventative support at two groups of carers who are particularly at risk of breakdown and specifically to: • Improve the mental and physical health and wellbeing of older carers. • Enable carers to continue in their caring role. • Ensure peace of mind for families by putting emergency plans in place • Reduce and/or delay the cost to social care services required in an emergency or in the form of permanent packages of care. • To meet the following statutory outcomes for Health & Wellbeing Boards; Adult Social Care Framework 2012/13; • Ensuring that people have a positive experience of care and support 1. Overall satisfaction of people who use services with their care and support 2. Overall satisfaction of carers with social services 3. The proportion of people who use services and carers who find it easy to find information about support • Enhancing quality of life for people with care and support needs – carer reported quality of life Public Health Outcomes Framework 2013 – 16 • Health Improvement - self-reported well being • Healthcare, public health and preventing premature mortality -dementia and its impacts

The NHS outcomes framework 2012/13 Domain 2:

- Enhancing quality of life for people with long term conditions
- Enhancing quality of life for carers
- Enhancing quality of life for people with dementia

The Carers Trust, citing evidence from randomised controlled trials in 2011 found that, in addition to reducing unwanted residential care admissions and length of stays, increasing support for carers can also reduce unwanted admissions, readmissions and delayed discharges in hospital settings. A whole systems study which tracked a sample of people over 75 years old who had entered the health and social care system, found that 20% of those needing care were admitted to hospital because of the breakdown of a single carer on whom the person was mainly dependent[1].

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

1. For older carers of people with a learning disability these outcomes are most effectively met by providing support which:
   - Identifies ways in which carers can be assisted in preparing for unforeseen circumstances and plan for emergencies.
   - Provides a range of information, advice, emotional support and advocacy to enable carers to continue their caring role and plan for the future, including housing and support options, wills and trusts.
   - Enables carers to continue their caring role by increasing the take up of Carers Assessments.
   - Provides a choice of short breaks that complement the future housing plan, including overnight breaks in a setting which may become a longer term home for the person they care for, such as a Shared Lives arrangement.
   - Recognises carers as expert care partners and enables them to establish positive relationships with individuals and services likely to have a role supporting their son or daughter in the future.
   - Provides support for the role of other family members, particularly siblings, who are taking on an increased role as the carer ages.

2. In the case of carers of people with dementia, the scheme aims to provide support for the following issues:
   - To increase take up of short breaks to help carers for people with dementia sustain their caring role
   - To improve information of short breaks for dementia carers who care for people with dementia at home
   - To increase awareness of short breaks provision to all key stakeholders
   - To increase carer uptake of assessment to improve carer quality of life and access to funding for short breaks
   - To prepare for an increase of carers supporting dementia sufferers as per future projections

This targeted approach enables carers to do the things they tell us are important to

[1] Supporting Carers, the Case for Change, Carers Trust 2013

maintain their own wellbeing; maintain friendships and networks; carry out everyday activities, such as shopping; take care of their own health by being able to get to doctor or hospital appointments, as well as have valuable time away in order to recharge their batteries.

The following table identifies the current and projected estimates of eligible carers:

Dementia Carers	**Apr 13 – Sept 13**	**Per Month**	**Full Year Estimate**
Number assessed	261	44	522
Number eligible for a Personal Budget	170	28	340
% eligible for a Personal Budget	62%	8%	66%
Number eligible for Short Break funding[2]	71	12	142

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

1. The proposed delivery chain for the older carers element of the project replicates national best practice by establishing a small team of family support workers, employed by a third sector organisation and therefore avoiding any negative associations for carers with statutory services. Addressing an accumulation of known cases where carers are at risk, rather than referral-into the service, the project will involve:

- Family Contact Workers visiting older family carers referred to the service by LCC in order to:
  - Establish emergency plans, futures plans and carer breaks
  - Facilitate meetings with appropriate professionals in respect of future arrangements:
  - Work at a distance from LCC's locality teams, but to have regular contact with a lead Principal Practitioner in LCC.
  - Identify older carers not known to LCC, and as a second phase of the project, using Better Care funding for 2015/16, to address the needs of carers aged 60-70 years.
  - Help to build and develop the capacity and skill of locality teams to take over long term planning role when project ends.
- The management by County Carers of a self-employed Circles of Support Project Worker for older carers.
- The facilitation by County Carers of four workshops with follow up sessions to inform carers about powers of attorney, trusts, wills and housing options.
- The provision of short breaks for people who have never previously spent time away from the family home, to enable them and their carers to gradually become accustomed to separation and greater independence.

Detailed version of the draft Older Carers delivery plan:

Support for Older Carers

[2] Scoring higher than the average RAS score of 64

2. The delivery arrangements for the Dementia Carers Short Breaks scheme has been developed in partnership with the following groups:

- Adult Care Commissioning Team
- Adult Care Performance Team
- Carers Team
- Lincolnshire Carers and Young Carers Partnership
- Direct Payments Team
- Adult Care Older People/Physical Disabilities Operational Staff
- Carers Trusted Assessors

Any carer is eligible for a Carer's Assessment and this is a pre-requisite for applying for short break funding. Eligibility is determined by meeting a threshold within the Resource Allocation Scheme (RAS), which identifies needs as substantial or critical. Eligible carers can apply for funding for a short break via a simple application form, which is evaluated at a monthly panel. They can apply for any amount between £100 and a maximum of £1,300 dependent on the support needs they have identified. This figure is based upon the average cost of up to two weeks privately funded respite care, including transport for their chosen option.

An application pack, including a Lincolnshire Dementia Carer's Handbook, which details a full range of short break services they may wish to procure, including traditional options, such as sitting services, respite care, supported holidays and social groups has been developed with feedback from carers throughout Lincolnshire, the Carers Team and the Carers Partnership.

Briefings were also delivered at LCC facilitated Provider Forums in February 2014 and, as a result of provider feedback, invitations to all known local short break providers (over 400) were extended to attend an information session on 12 March 2014.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

1. Older Carers of People with a Learning Disability

More than 100 carers aged 70 and over, who are caring for a son or daughter with a learning disability at home, are known to LCC Adult Services. The average age of carers in this group is 78 years. (Figures for 1st Quarter 2013 - LCC). A literature review undertaken by Lincoln University in 2013 on behalf of the project uncovered a number of characteristics common to this group of carers:

- A majority (65% aged 60-94) have chronic health problems or a disability
- These health problems are exacerbated by a lack of appropriate respite care and/or reluctance on the part of the carer to access respite where it is available.
- Carers and their families are often socially isolated because of the constraints imposed by the caring role.
- Carers are often unwilling to consider future care options; having had negative experiences of statutory services when their child was younger, and are now resistant to the attempts of professionals to intercede.
- Aside from the trauma the need for unplanned interventions can bring to the family, the breakdown in informal care and support often has significant cost

implications for Health and Social Care services. Carer related reasons for admissions to nursing or residential care are common, with carer stress the reason for admission in 38% of cases.

2. Dementia Carers Short Breaks

The prevalence of dementia, its severity and impact on the family increase with age. Estimates show there were approximately 10,460 people with dementia in Lincolnshire in 2012. This number is predicted to grow to over 13,589 by 2020, meaning more carers than ever will need support.

As part of the consultation for the Dementia Strategy Refresh in 2013, 58.6% of carers stated that they had not had a Carers Assessment and could be eligible to additional support to help them continue in their role. The consultation also confirmed a number of widely supported conclusions:

- Carers feel their needs are not adequately recognised and that services are not always available when needed or delivered in the most acceptable way
- Access to respite care suitable for people with dementia is difficult in many localities. Carers also say there is no suitable brokerage service to determine what options are available
- Carers' feel they need more support and do not have enough control over their lives, and would like more social contact. In particular, information about support still needs to be easier to find

Investment requirements

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

The two carer support projects were each allocated £100k in 2014/5.

The development of a second phase of the older carers' project, using the same level of Better Care Funding for 2015/16, will address the needs of carers remaining from the initial cohort, carers aged 60-70 years known to LCC, and identify as a preventative measure older carers in crisis who are not currently known to LCC (a quarter of all people with learning disabilities who live at home with older family carers are not known to Adult Care).

A further allocation of Better Care funding to resource a second phase of the Dementia Carers Breaks project will give more carers greater choice and control in organising a break to suit their particular needs thereby maintaining their wellbeing and sustain their caring role.

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Unplanned and emergency referrals to Adult Care, often by necessity, result in short term residential placements which then become permanent; denying people the greater choice and independence offered by supported living. The efficacy of the approach proposed in these projects rests on the assumption that the costs of providing additional, targeted support for older carers will be more than offset by reductions in emergency admissions to short breaks and the scale and cost of unplanned, permanent packages of care.

In practical terms, the impact of the Older Carers project will include:

- Equipping carers to deal with the practicalities of planning ahead, of broaching the sensitive issues of change and loss with other family members, taking steps to set up trusts or seek powers of attorney and discussing future care options with Care Services.
- Supporting carers to enhance the skills they need to help improve the independence of the person they care for in preparation for independent living.
- Using the opportunities of short breaks to show people how to take care of their own safety, advise on independent living, personal care, nutrition and health, to improve communication skills and begin to manage their financial affairs.
- Care knowledge benefits – training and staff development
- Improved practitioner problem solving and casework.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The outcomes of the Older Carers component will be measured by Lincoln University from a baseline assessment of how carers view their general wellbeing prior to contact with the project and their actual outcomes twelve months later. These findings are expected to show whether the carer has greater confidence in their role and the support offered by LCC, and has emergency plans and longer term plans in place.

In terms of the Dementia Carers Short Breaks project, it has been agreed that the Carers Partnership will conduct an evaluation survey with each carer who has successfully been awarded funding to ascertain benefits of the scheme to them and actual use of funding. This information will be fed into an evaluation report, which will review a number of aspects of the scheme, including the following:

- Total number of applicants/amount awarded
- Location of carer (by District)
- Type of Short Break requested
- Outcomes (Good Health, Quality of Life, Feel in Control and Supported, Confident about the Future, Respected and Involved)
- Overall satisfaction with the service
- Did having a break help avoid you needing to access other services?
- Number of admissions to respite
- Assumption based savings
- Number of people with dementia able to live at home for longer

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

The success of a targeted approach to the issues faced by older carers include:

- The need for a very sensitive assessment of a particular family's needs. Older carers find it beneficial, although initially daunting, to talk with practitioners at length about all relevant aspects of their situation, but this requires time and expertise.
- Regular contact with family support workers in acknowledgment of the fact that the situation of carers and those they support may change dramatically between one review and another.
- An accord between the carers' and professionals' views of the family's coping abilities and their respite needs, and a recognition that offering short breaks,

without commitment to approaches which recognise carer resilience and expertise, can lead to families continuing to feel isolated and unappreciated.

A critical success factor of the Dementia Carers project will be measuring the benefits and outcomes for carers of receiving a short break. It offers the opportunity of collecting future commissioning intelligence and to obtain further feedback from carers to secure continued funding. This will include monitoring what category of short break carers have identified in their Carers Assessment as being of most benefit, and whether funding from this project has helped them to meet this identified need and continue and feel supported in their caring role.

Other factors that are key to ensuring that the implementation of this scheme is seen as successful include the following:

- Development of the market with Providers to offer a diverse range of bookable respite and short breaks and promote the different categories of break that are available
- Production of information and advice material to support people with dementia and their families
- Co-production and engagement with all key stakeholders to promote awareness and uptake of dementia short breaks
  Increased take up of short breaks by carers to avoid carer breakdown

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ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Scheme name
Women and Children's – Child and Adolescent Mental Health Services (CAMHS)
What is the strategic objective of this scheme?
To improve the pathways of care and outcomes for children and young people with mental health needs by: • Providing more early intervention services that identify young people with emotional and psychological difficulties before they become more serious problems • Integrating these services with other early help services making sure we have a holistic response that meets needs • Specifically improving our response to the growing incidence of self-harm and avoiding a hospital admission for these young people where clinically appropriate • Improving our response to young people in crisis to provide a safe alternative to hospital admission • To reduce the dependency levels of young people with mental health needs moving though transition to adult care Thereby contributing to a 3.5% reduction in hospital admissions across Lincolnshire.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
A review of CAMHS services is currently underway which will inform the re-commissioning of a service which will deliver the following improvements to our current model of care: - Is integrated across tier 2 and 3 services ensuring that children and young people get the help they need in multiple settings and at a time convenient to them - Access via a single point of referral - Delivering care bundles that are outcome focussed - Has specific pathways for self-harm and behaviour - Has defined step down processes - Has a "tier 3+" service that can provide intensive community based support

The cohorts that are specifically being targeted are:

- Young people who access A&E after harming themselves – we have invested additional funding to ensure that A&E sites in Lincoln and Boston have access to a self-harm nurse Monday to Friday from 8am to 8pm
- Children and young people who are inappropriately referred to CAMHS by providing greater support to schools and other universal setting to manage behaviour issues – we have invested in additional Primary Mental Health Workers
- Young people in crisis by providing a better immediate response via our Mental Health Concordat and by the planned commissioning of a community based rapid response service
- Those young people who require in-patient mental health services by providing more intensive community based support
- Those young people who will need continuing support from adult services and so need an effective transition

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The commissioning of CAMHS is via a section 75 agreement delegating the commissioning responsibility of the four CCGs to Lincolnshire County Council.

The services are currently provided by Lincolnshire Partnership Foundation Trust and the Voluntary Sector.

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

A local needs assessment and review to include the views of all stakeholders, including children, young people and their families has provided evidence of need.

We have drawn on the experience of other areas who are currently reviewing their CAMHS services with the aim of re-procurement for example Birmingham and Nottingham.

We have used relevant NICE guidance and recent national reviews of CAMHS.

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

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The impact of the scheme will be measured via specific indicators within a broader quality assurance framework and the monitoring of key performance indicators, including:

- Number of professionals in universal services who are engaged in consultation and support sessions provided by CAMHS practitioners
- Number of early help assessments contributed to by CAMHS
- Number of urgent and emergency referrals
- Average and maximum waiting times for triage
- Number of referrals accepted
- Number of young people moving into adult services with a person centred transition plan
- Number of young people enabled to return to a community setting from inpatient care
- Number of admissions avoided by the provision of assessment in A&E (self-harm)

Patient experience will be at the heart of service delivery through the implementation of "You're Welcome" standards and through individual care via the use of Strengths and difficulties questionnaires, Goal based Outcome measures, and the Child Outcome rating Scale – all nationally validated tools.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The Women and Children's Delivery Board is the owner of this scheme and reporting of progress takes place at every meeting. This Board is also the owner of our work to deliver integrated services so appropriate links are made at this level. This Board reports to the Joint Commissioning Board so any cross over issues with adult and/or urgent care services are made via this route.

Any issues are raised via contract monitoring meetings held regularly with providers with an escalation route via the lead CCG commissioners if required.

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

The success factors are:

Reduction in inappropriate referrals to:

- Specialist CAMHS with more young people supported via early help services
- In patient CAMHS and where this happens shorter lengths of stay
- Paediatric wards due to specialist assessment and discharge with community support

A reduction of those young people needing intensive support from adult services and for those that do a person centred transition plan.

Integrated community based services delivered through neighbourhood teams.

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	Lincolnshire Health and Wellbeing Board
Name of Provider organisation	United Lincolnshire Hospital Trust (ULHT)
Name of Provider CEO	Ms Jane Lewington
Signature (electronic or typed)	

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	73,548
	2014/15 Plan	71,314
	2015/16 Plan	69,920
	14/15 Change compared to 13/14 outturn	2,234
	15/16 Change compared to planned 14/15 outturn	1,394
	How many non-elective admissions is the BCF planned to prevent in 14-15?	639
	How many non-elective admissions is the BCF planned to prevent in 15-16?	2,492

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	
3.	**Can you confirm that you have considered the resultant implications on services provided by your organisation?**	

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Health and Wellbeing Board Details

ROCR approval applied for
Version 3

Please select Health and Wellbeing Board:

Lincolnshire

Please provide:

<Contact Name>
<Contact Email>

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Health and Wellbeing Board Payment for Performance

There is no need to enter any data on this sheet. All values will be populated from entries elsewhere in the template

Lincolnshire

1. Reduction in non elective activity

Baseline of Non Elective Activity (Q4 13/14 - Q3 14/15)	71,834
Change in Non Elective Activity	-2,515
% Change in Non Elective Activity	-3.5%

2. Calculation of Performance and NHS Commissioned Ringfenced Funds

Figures in £

Financial Value of Non Elective Saving/ Performance Fund	3,747,350
Combined total of Performance and Ringfenced Funds	13,988,150
Ringfenced Fund	10,240,800
Value of NHS Commissioned Services	48,399,000
Shortfall of Contribution to NHS Commissioned Services	0

2015/16 Quarterly Breakdown of P4P

	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Cumulative Quarterly Baseline of Non Elective Activity	18,262	36,058	53,568	71,834
Cumulative Change in Non Elective Activity	-639	-1,262	-1,875	-2,515
Cumulative % Change in Non Elective Activity	-0.9%	-1.8%	-2.6%	-3.5%
Financial Value of Non Elective Saving/ Performance Fund (£)	952,110	928,270	913,370	953,600

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Health and Wellbeing Funding Sources

Lincolnshire

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	Gross Contri
	2014/15
Local Authority Social Services	
Lincolnshire	59,221
<Please select Local Authority>	
<Please select Local Authority>	
<Please select Local Authority>	
<Please select Local Authority>	
<Please select Local Authority>	
<Please select Local Authority>	
Total Local Authority Contribution	**59,221**
CCG Minimum Contribution	
NHS South West Lincolnshire CCG	
NHS South Lincolnshire CCG	
NHS Lincolnshire West CCG	
NHS Lincolnshire East CCG	
-	
-	
-	
Total Minimum CCG Contribution	**-**
Additional CCG Contribution	
NHS South West Lincolnshire CCG	**1,913**
NHS South Lincolnshire CCG	**2,294**
NHS Lincolnshire West CCG	**3,352**
NHS Lincolnshire East CCG	**4,020**
<Please Select CCG>	
<Please Select CCG>	
<Please Select CCG>	
Total Additional CCG Contribution	**11,579**
Total Contribution	**70,800**

bution (£000)
2015/16
85,850
85,850
7,905
9,810
14,497
16,187
-
-
-
48,399
10,360
12,490
18,260
21,890
63,000
197,249

Summary of Health and Wellbeing Board Schemes

Lincolnshire

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Summary of Total BCF Expenditure

Figures in £000

	From 3. HWB Expenditure Plan		Please confirm the amount allocated for the protection of adult social care		If different to the figure in cell D18, please indicate the total amount from the BCF that has been allocated for the protection of adult social care services
	2014/15	2015/16	2014/15	2015/16	
Acute	-	-			
Mental Health	44,822	120,260			
Community Health	4,700	26,700			
Continuing Care	521	521			
Primary Care	-	-			
Social Care	10,361	39,417	9,989	20,000	
Other	10,401	10,401			
Total	**70,805**	**197,299**		**20,000**	

Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool

Figures in £000

	From 3. HWB Expenditure
	2015/16
Mental Health	5,860
Community Health	16,000
Continuing Care	521
Primary Care	-
Social Care	15,617
Other	10,401
Total	**48,399**

Summary of Benefits

Figures in £000

	From 4. HWB Benefits		From 5.HWB P4P metric
	2014/15	2015/16	2015/16
Reduction in permanent residential admissions	(113)	(360)	
Increased effectiveness of reablement	(305)	(681)	
Reduction in delayed transfers of care	(174)	(147)	
Reduction in non-elective (general + acute only)	(952)	(3,713)	3,747
Other	-	(763)	
Total	**(1,544)**	**(5,664)**	**3,747**

D44 is calculated on a financial year and E44 on a calendar year

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Health and Wellbeing Board Expenditure Plan

Lincolnshire

Please complete white cells (for as many rows as required):

	Expenditure								
Scheme Name	**Area of Spend**	**Please specify if Other**	**Commissioner**	**if Joint % NHS**	**if Joint % LA**	**Provider**	**Source of Funding**	**2014/15 (£000)**	**2015/16 (£000)**
Intermediate Care - Reablement	Community Health		CCG			NHS Mental Health Provider	CCG Minimum Contribution	2,000	2,000
Intermediate Care - C R & R	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	2,100	
Intermediate Care	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution		3,600
Intermediate Care - 30 day post discharge	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution		2,800
Intermediate Care	Social Care		Local Authority			Private Sector	Local Authority Social Services		1,800
Neighbourhood Teams - Community intergrated reablement service and agency staff	Social Care		CCG			Local Authority	CCG Minimum Contribution	1,400	1,400
Prevention - Cemaat/ Wellbeing	Social Care		CCG			Private Sector	CCG Minimum Contribution	1,000	1,000
Neighbourhood Teams - Monitoring Centres	Social Care		CCG			Private Sector	CCG Minimum Contribution	180	180
Neighbourhood Teams - Demographic growth	Social Care		CCG			Private Sector	CCG Minimum Contribution		2,125
Neighbourhood Teams - Co-responders	Social Care		CCG			Local Authority	CCG Minimum Contribution	150	150
Neighbourhood Teams - Programme Support Costs	Social Care		CCG			Local Authority	CCG Minimum Contribution	150	100
Neighbourhood Teams - CCG	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution		7,600
Neighbourhood Teams - Social Care	Social Care		Local Authority			Private Sector	Local Authority Social Services		22,000
Carers	Social Care		CCG			Private Sector	CCG Minimum Contribution	200	200
7 day working - provider of last resort	Social Care		CCG			Private Sector	CCG Minimum Contribution	500	500
7 day working - assessments and care	Social Care		CCG			Local Authority	CCG Minimum Contribution		300
Women and Childrens - Promoting Independence	Social Care		CCG			Local Authority	CCG Minimum Contribution	500	370
Women and Childrens - CAMHS	Social Care		CCG			NHS Mental Health Provider	CCG Minimum Contribution	350	350
Women and Childrens - Programme Support Costs	Social Care		CCG			Local Authority	CCG Minimum Contribution	31	100
Women and Childrens - CAMHS S75	Mental Health		CCG			NHS Mental Health Provider	CCG Minimum Contribution		4,844
Women and Childrens - S256	Continuing Care		CCG			Charity/Voluntary Sector	CCG Minimum Contribution	521	521
Specialist Services - Maximising Independence	Social Care		CCG			Local Authority	CCG Minimum Contribution	280	280
Specialist Services - Demographic Growth	Social Care		CCG			Private Sector	CCG Minimum Contribution		2,125
Specialist Services - Mental Illness Prevention	Mental Health		CCG			NHS Mental Health Provider	CCG Minimum Contribution	375	370
Specialist Services - Programme Support Costs	Social Care		CCG			Local Authority	CCG Minimum Contribution		100
Specialist Services - Future Risk Sharing	Social Care		CCG			Local Authority	CCG Minimum Contribution	4,400	4,400
Specialist Services - LD S75	Other	Learning Disabilities	CCG			Private Sector	CCG Minimum Contribution	10,401	10,401
Specialist Services - Adult MH	Mental Health		CCG			Charity/Voluntary Sector	CCG Minimum Contribution	647	646
Specialist Services - MH Contract	Mental Health		CCG			NHS Mental Health Provider	Additional CCG Contribution		63,000
Prevention - ICES	Community Health		Joint	54%	46%	Private Sector	Local Authority Social Services	600	5,800
Prevention - DFG	Community Health		Local Authority			Private Sector	Local Authority Social Services		4,900
Enablers - LHAC	Social Care		CCG			Private Sector	CCG Minimum Contribution	1,220	1,937
Specialist Services - MH and LD Community	Mental Health		Local Authority			NHS Mental Health Provider	Local Authority Social Services	43,800	51,400
Total								**70,805**	**197,299**

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Health and Wellbeing Board Financial Benefits Plan

Lincolnshire

If you would prefer to provide aggregated figures for the savings (columns F-J), for a group of schemes related to one benefit type (e.g. delayed transfers of care), rather than filling in figures against each of your individual schemes, then you may do so.

If so, please do this as a separate row entitled "Aggregated benefit of schemes for X", completing columns D, F, G, I and J for that row. But please make sure you do not enter values against both the individual schemes you have listed, and the "aggregated benefit" line. This is to avoid double counting the benefits.

However, if the aggregated benefits fall to different organisations (e.g. some to the CCG and some to the local authority) then you will need to provide one row for the aggregated benefits to each type of organisation (identifying the type of organisation in column D) with values entered in columns F-J.

2014/15

Please complete white cells (for as many rows as required):

			2014/15					
Benefit achieved from	**If other please specifiy**	**Scheme Name**	**Organisation to Benefit**	**Change in activity measure**	**Unit Price (£)**	**Total (Saving) (£)**	**How was the saving value calculated?**	**How will the savings against plan be monitored?**
Reduction in permanent residential admissions		Intermediate Care/ Prevention	Local Authority	(15)	7,500	(112,500)	The unit price is calculated based on the cost of older persons residential care provision less client contribution less the average cost of reprovsion in the community	By Proactive Care Joint Delivery Board with oversight by Joint Commissioning Board
Increased effectiveness of reablement		Intermediate Care	NHS Commissioner	(205)	1,490	(305,450)	Using national determined value	By Proactive Care Joint Delivery Board with oversight by Joint Commissioning Board
Reduction in delayed transfers of care		Intermediate Care/ Prevention/ Neighbourhood Teams	NHS Commissioner	(841)	207	(174,087)	Average cost of bed per above trim point	By Proactive Care Joint Delivery Board with oversight by Joint Commissioning Board
Reduction in non-elective (general + acute only)		Intermediate Care	NHS Commissioner	(600)	1,490	(894,000)	Using national determined value	By Proactive Care Joint Delivery Board with oversight by Joint Commissioning Board
Reduction in non-elective (general + acute only)		Women and Childrens	NHS Commissioner	(39)	1,490	(58,110)	Using national determined value	By Women and Children's Joint Delivery Board with oversight by Joint Commissioning Board
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Total						**(1,544,147)**		

2015/16

			2015/16					
Benefit achieved from		**Scheme Name**	**Organisation to Benefit**	**Change in activity measure**	**Unit Price (£)**	**Total (Saving) (£)**	**How was the saving value calculated?**	**How will the savings against plan be monitored?**
Reduction in permanent residential admissions		Intermediate Care/ Prevention	Local Authority	(48)	7,500	(360,000)	The unit price is calculated based on the cost of older persons residential care provision less client contribution less the average cost of reprovsion in the community	By Proactive Care Joint Delivery Board with oversight by Joint Commissioning Board
Increased effectiveness of reablement		Intermediate Care	NHS Commissioner	(457)	1,490	(680,930)	Using national determined value	By Proactive Care Joint Delivery Board with oversight by Joint Commissioning Board
Reduction in delayed transfers of care		Intermediate Care/ Prevention/ Neighbourhood Teams	NHS Commissioner	(712)	207	(147,384)	Average cost of bed per above trim point	By Proactive Care Joint Delivery Board with oversight by Joint Commissioning Board
Reduction in non-elective (general + acute only)		Intermediate Care/ Prevention/ Neighbourhood Teams	NHS Commissioner	(2,217)	1,490	(3,303,330)	Using national determined value	By Proactive Care Joint Delivery Board with oversight by Joint Commissioning Board
						-		
Reduction in non-elective (general + acute only)		Women and Childrens	NHS Commissioner	(125)	1,490	(186,250)	Using national determined value	By Women and Children's Joint Delivery Board with oversight by Joint Commissioning Board
						-		
Reduction in non-elective (general + acute only)		7 Day Working	NHS Commissioner	(125)	1,490	(186,250)	Using national determined value	By System Resilience Board with oversight by Joint Commissioning Board
Reduction in non-elective (general + acute only)		Specialist Services	NHS Commissioner	(25)	1,490	(37,250)	Using national determined value	By Specialist Service Joint Delivery Board with oversight by Joint Commissioning Board
						-		
						-		
Other	Pooled Resources	Specialist Services	Local Authority	(1)	314,150	(314,150)	Anticipated saving of reprovision and effective resource utilisation of mental health contracts	By Specialist Service Joint Delivery Board with oversight by Joint Commissioning Board
Other	Pooled Resources	Specialist Services	NHS Commissioner	(1)	448,350	(448,350)	Anticipated saving of reprovision and effective resource utilisation of mental health contracts	By Specialist Service Joint Delivery Board with oversight by Joint Commissioning Board
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Total						**(5,663,894)**		

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Lincolnshire

Red triangles indicate comments

Please complete the five white cells in the Non-Elective admissions table. Other white cells can be completed/revised as appropriate.

Planned deterioration on baseline (or validity issue)
Planned improvement on baseline of less than 3.5%
Planned improvement on baseline of 3.5% or more

Non - Elective admissions (general and acute)

Metric		Baseline (14-15 figures are CCG plans)				Pay for performance period				
		Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population	*Quarterly rate*	**2,508**	**2,444**	**2,404**	**2,508**	**2,404**	**2,342**	**2,304**	**2,404**	**2,302**
	Numerator	18,262	17,796	17,510	18,266	17,623	17,173	16,897	17,626	16,998
	Denominator	728,288	728,288	728,288	728,288	733,220	733,220	733,220	733,220	738,418

Rationale for red/amber ratings

P4P annual change in admissions -2515
P4P annual change in admissions (%) -3.5%
P4P annual saving £3,747,350

Please enter the average cost of a non-elective admission[1] **£1,490**

Rationale for change from £1,490

The figures above are mapped from the following CCG operational plans. If any CCG plans are updated then the white cells can be revised:

Contributing CCGs	CCG baseline activity (14-15 figures are CCG plans)				% CCG registered population that has resident population in Lincolnshire	% Lincolnshire resident population that is in CCG registered population	Contributing CCG activity			
	Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)			Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)
NHS Cambridgeshire and Peterborough CCG	18,317	17,237	17,554	18,496	0.2%	0.2%	36	34	35	37
NHS East Leicestershire and Rutland CCG	7,028	6,017	6,384	6,326	0.2%	0.0%	13	11	12	12
NHS Lincolnshire East CCG	6,600	6,291	6,229	6,536	99.2%	32.3%	6,547	6,240	6,179	6,483
NHS Lincolnshire West CCG	5,446	5,427	5,382	5,585	98.5%	30.2%	5,367	5,348	5,304	5,504
NHS Newark & Sherwood CCG	3,126	3,120	3,057	3,172	2.4%	0.4%	75	75	74	76
NHS North East Lincolnshire CCG	3,784	3,562	3,624	3,593	2.6%	0.6%	100	94	95	95
NHS North Lincolnshire CCG	4,664	4,143	4,189	4,189	2.7%	0.6%	124	110	111	111
NHS South Lincolnshire CCG	3,700	3,434	3,239	3,468	90.6%	19.4%	3,352	3,111	2,935	3,142
NHS South West Lincolnshire CCG	2,844	2,977	2,970	3,013	93.1%	16.3%	2,649	2,773	2,766	2,806
Total						100%	18,262	17,796	17,510	18,266

References

[1] The default figure of £1,490 in the template is based on the average reported cost of a non-elective inpatient episode (excluding excess bed days), taken from the latest (2012/13) Reference Costs. Alternatively the average reported spell cost of a non-elective inpatient admission (including excess bed days) from the same source is £2,118. To note, these average figures do not account for the 30% marginal rate rule and may not reflect costs variations to a locality such as MFF or cohort pricing. In recognition of these variations the average cost can be revised in the template although a rationale for any change should be provided.

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Lincolnshire

Please complete all white cells in tables. Other white cells should be completed/revised as appropriate.

Red triangles indicate comments

Planned deterioration on baseline (or validity issue)

Planned improvement on baseline

Residential admissions

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Annual rate*	674.3	626.8	582.9
	Numerator	1,045	1,030	982
	Denominator	155,115	164,314	168,468
	Annual change in admissions		-15	-48
	Annual change in admissions %		-1.4%	-4.7%

Rationale for red rating

Reablement

Metric		Baseline (2013/14)	Planned 14/15	Planned 15/16
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Annual %*	74.6	76.0	80.0
	Numerator	870	1,075	1,532
	Denominator	1,165	1,415	1,915
	Annual change in proportion		1.4	4.0
	Annual change in proportion %		1.8%	5.3%

Rationale for red rating

Delayed transfers of care

Metric		13-14 Baseline				14/15 plans				15-16 plans			
		Q1 (Apr 13 - Jun 13)	Q2 (Jul 13 - Sep 13)	Q3 (Oct 13 - Dec 13)	Q4 (Jan 14 - Mar 14)	Q1 (Apr 14 - Jun 14)	Q2 (Jul 14 - Sep 14)	Q3 (Oct 14 - Dec 14)	Q4 (Jan 15 - Mar 15)	Q1 (Apr 15 - Jun 15)	Q2 (Jul 15 - Sep 15)	Q3 (Oct 15 - Dec 15)	Q4 (Jan 16 - Mar 16)
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	772.4	680.5	653.0	733.5	688.4	679.4	653.0	656.9	648.3	639.9	631.4	618.8
	Numerator	4,509	3,972	3,812	4,310	4,045	3,992	3,837	3,888	3,837	3,787	3,737	3,689
	Denominator	583,728	583,728	583,728	587,562	587,562	587,562	587,562	591,829	591,829	591,829	591,829	596,120
								Annual change in admissions	-841			*Annual change in admissions*	-712
								Annual change in admissions %	-5.1%			*Annual change in admissions %*	-4.5%

Rationale for red ratings

Patient / Service User Experience Metric

Metric		Baseline Apr 13 to Mar 14	Planned 14/15 (if available)	Planned 15/16
Do care and support services help you to have a better quality of life (ASC survey)	*Metric Value*	90.0		92.0
	Numerator	378		386
	Denominator	420		420
Improvement indicated by:	<Please select>			

Local Metric

Metric		Baseline Apr-13 to Mar 14	Planned 14/15 (if available)	Planned 15/16
Proportion of people feeling supported to manage their (long term) condition	*Metric Value*	63.0		64.0
	Numerator	9,418		9,600
	Denominator	14,933		15,000
Improvement indicated by:	<Please select>			

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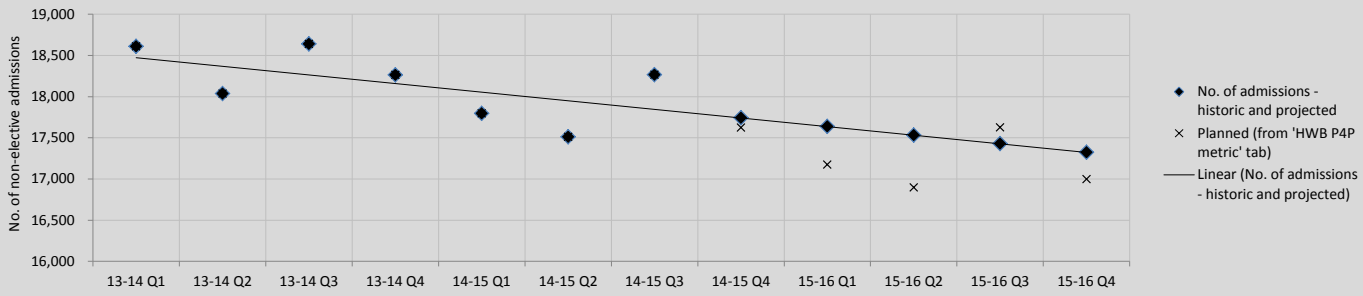
Lincolnshire

To support finalisation of plans, we have provided *estimates* of future performance, based on a simple 'straight line' projection of historic data for each metric. We recognise that these are crude methodologies, but it may be useful to consider when setting your plans for each of the national metrics in 2014/15 and 2015/16. As part of the assurance process centrally we will be looking at plans compared to the counterfactual (what the performance might have been if there was no BCF).

No cells need to be completed in this tab. However, 2014-15 and 2015-16 projected counts for each metric can be overwritten (white cells) if areas wish to set their own projections.

Non-elective admissions (general and acute)

Metric		Historic			Baseline				Projection				
		13-14 Q1	13-14 Q2	13-14 Q3	13-14 Q4	14-15 Q1	14-15 Q2	14-15 Q3	14-15 Q4	15-16 Q1	15-16 Q2	15-16 Q3	15-16 Q4
Total non-elective admissions (general & acute), all-age	*No. of admissions - historic and projected*	18,610	18,036	18,640	18,262	17,796	17,510	18,266	17,742	17,637	17,532	17,428	17,323

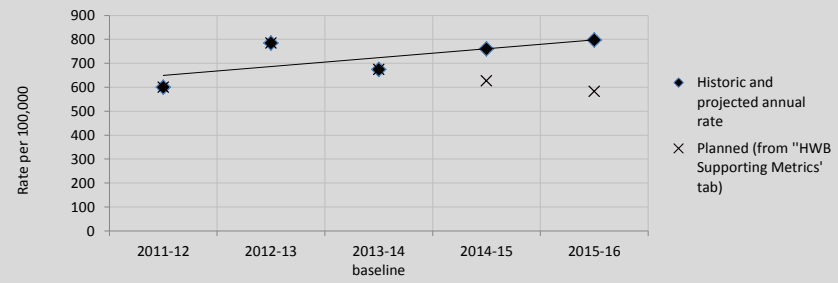


Metric		Projected				
		2014 -2015 Q4	2015-16 Q1	2015-16 Q2	2015-16 Q3	2015-16 Q4
Total non-elective admissions (general & acute), all-age	*Quarterly rate*	*2,436.1*	*2,405.4*	*2,391.2*	*2,376.9*	*2,346.0*
	Numerator	*17,742*	*17,637*	*17,532*	*17,428*	*17,323*
	Denominator	*728,288*	*733,220*	*733,220*	*733,220*	*738,418*

* The projected rates are based on annual population projections and therefore will not change linearly

Residential admissions

Metric		2011-12 Historic	2012-13 historic	2013-14 baseline	2014-15 Projected	2015-16 Projected
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Historic and projected annual rate*	600	785	674	*761*	*798*
	Numerator	895	1,215	1,045	*1,250*	*1,344*
	Denominator	149,150	155,115	155,115	*164,314*	*168,468*



This is based on a simple projection of the metric proportion.

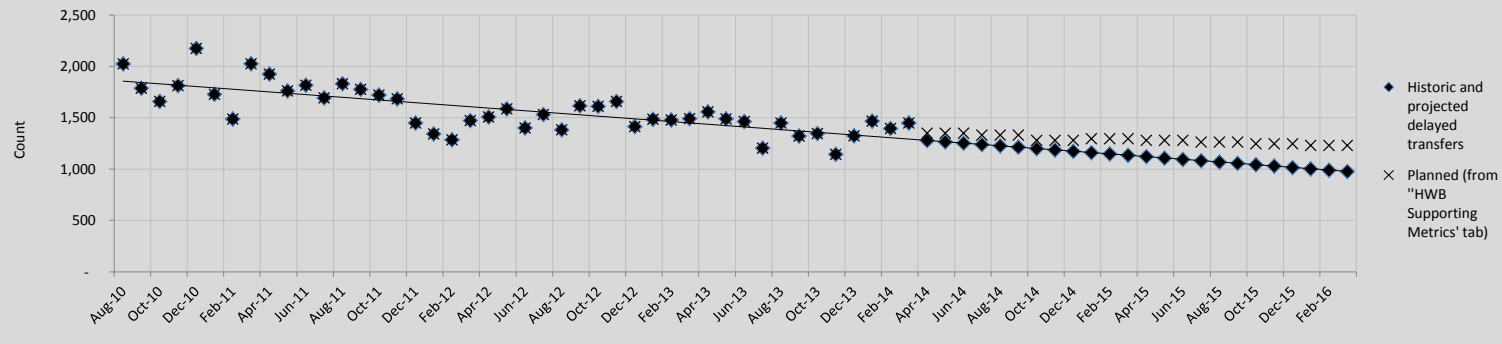
Reablement

Metric		2011-12 Historic	2012-13 Historic	2013-14 Baseline	2014-15 Projected	2015-16 Projected
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Historic and projected annual %*	74.4	72.4	74.6	*74.0*	*74.1*
	Numerator	430	655	870	*862*	*863*
	Denominator	580	900	1165	*1165*	*1165*

This is based on a simple projection of the metric proportion, and an unchanging denominator (number of people offered reablement)

Delayed transfers

Metric		Historic											
		Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11
Delayed transfers of care (delayed days) from hospital	*Historic and projected delayed transfers*	2,023	1,786	1,657	1,813	2,175	1,728	1,486	2,025	1,925	1,760	1,816	1,692



Metric		Projected rates*							
		2014-15 Q1	Q2	Q3	Q4	2015-16 Q1	Q2	Q3	Q4
Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).	*Quarterly rate*	*645.6*	*625.5*	*605.4*	*581.1*	*561.1*	*541.2*	*521.2*	*497.6*
	Numerator	*3,793*	*3,675*	*3,557*	*3,439*	*3,321*	*3,203*	*3,085*	*2,967*
	Denominator	*587,562*	*587,562*	*587,562*	*591,829*	*591,829*	*591,829*	*591,829*	*596,120*

* The projected rates are based on annual population projections and therefore will not change linearly

HWB Financial Plan

Date	Sheet	Cells	Description
28/07/14	Payment for Performance	B23	formula modified to *=IF(B21-B19<0,0,B21-B19)*
28/07/14	1. HWB Funding Sources	C27	formula modified to *=SUM(C20:C26)*
28/07/14	HWB ID	J2	Changed to Version 2
28/07/14	a	Various	Data mapped correctly for Bournemouth & Poole
29/07/14	a	AP1:AP348	Allocation updated for changes
28/07/14	All sheets	Columns	Allowed to modify column width if required
30/07/14	8. Non elective admissions - CCG		Updated CCG plans for Wolverhampton, Ashford and Canterbury CCGs
30/07/14	6. HWB supporting metrics	D18	Updated conditional formatting to not show green if baseline is 0
30/07/14	6. HWB supporting metrics	D19	Comment added
30/07/14	7. Metric trends	K11:O11, G43:H43,G66:H66	Updated forecast formulas
30/07/14	Data	Various	Changed a couple of 'dashes' to zeros
30/07/14	5. HWB P4P metric	H14	Removed rounding
31/07/14	1. HWB Funding Sources	A48:C54	Unprotect cells and allow entry
01/08/14	5. HWB P4P metric	G10:K10	Updated conditional formatting
01/08/14	5. HWB P4P metric	H13	formula modified to *=IF(OR(G10<0,H10<0,I10<0,J10<0),"",IF(OR(ISTEXT(G10),ISTEXT(H10),ISTEXT(I10),ISTEXT(J10)),"",IF(SUM(G10:J10)=0,"",(SUM(G10:J10)/SUM(C10:F10))-1)))*
01/08/14	5. HWB P4P metric	H13	Apply conditional formatting
01/08/14	5. HWB P4P metric	H14	formula modified to *=if(H13="","",-H12*J14)*
01/08/14	4. HWB Benefits Plan	J69:J118	Remove formula
01/08/14	4. HWB Benefits Plan	B11:B60, B69:B118	Texted modified
Version 2			
13/08/14	4. HWB Benefits Plan	I61, I119, J61, J119	Delete formula
13/08/14	4. HWB Benefits Plan	rows 119:168	Additional 50 rows added to 14-15 table for orgaanisations that need it. Please unhide to use
13/08/14	4. HWB Benefits Plan	rows 59:108	Additional 50 rows added to 15-16 table for orgaanisations that need it. Please unhide to use
13/08/14	3. HWB Expenditure Plan	rows 59:108	Additional 50 rows added to table for orgaanisations that need it. Please unhide to use
13/08/14	a	M8	Add Primary Care to drop down list in column I on sheet '*3. HWB Expenditure Plan*'
13/08/14	HWB ID	J2	Changed to Version 3
13/08/14	6. HWB supporting metrics	C11, I32, M32	Change text to *'Annual change in admissions '*
13/08/14	6. HWB supporting metrics	C12, I33, M33	Change text to *'Annual change in admissions %'*
13/08/14	6. HWB supporting metrics	C21	Change text to *'Annual change in proportion '*
13/08/14	6. HWB supporting metrics	C22	Change text to *'Annual change in proportion %'*
13/08/14	6. HWB supporting metrics	D21	Change formula to *=if(D19=0,0,D 18 -C 18)*
13/08/14	6. HWB supporting metrics	D21	Change format to 1.dec. place
13/08/14	6. HWB supporting metrics	E21	Change formula to *= if(E19=0,0,E 18 -D 18)*
13/08/14	6. HWB supporting metrics	E21	Change format to 1.dec. place
13/08/14	6. HWB supporting metrics	D22	Change formula to *=if(D19=0,0,D 18 /C 18 -1)*
13/08/14	6. HWB supporting metrics	E22	Change formula to *=if(E19=0,0,E 18 /D 18 -1)*
13/08/14	5. HWB P4P metric	J14	Cell can now be modified - £1,490 in as a placeholder
13/08/14	5. HWB P4P metric	N9:AL9	Test box for an explanation of why different to £1,490 if it is.
13/08/14	4. HWB Benefits Plan	H11:H110, H119:H218	Change formula to eg. *=H11*G11*
13/08/14	2. Summary	G44:M44	Test box for an explanation for the difference between the calculated NEL saving on the metrics tab and the benefits tab

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