Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**9th December 2014**
Subject:	**Better Care Fund Update**

Summary: Members of the Board will be familiar with the subject matter having received several previous reports detailing progress and national requirements in the previous 14 months. This paper provides an update to the Health and Wellbeing Board that covers three strands of work related to the Lincolnshire Better Care Fund (BCF): the first details work to produce a re-submission document that is required to be returned to NHS England on 9th January 2015. The second provides information on the development of a Section 75 legal agreement. This will incorporate all the pooled budgets ambition across Health and Care in 2015/16 that equates to £197m. The third details work to agree funding for schemes and the protection of Adult Care supported by the BCF in 2015/16.

Actions Required: Members of Health and Wellbeing Board are asked to:

1. Note the work to date and the timeline for re-submission of the BCF and production of the Section 75.
2. Agree the BCF re-submission as detailed in the accompanying papers, and delegate to the Chair of Health and Wellbeing Board final sign off subject to there being no material change to the BCF affecting performance or finances and subject to agreement by the four CCGs and the Director of Adult Social Services. (Appendix A).
3. Note the BCF Task Group Terms of Reference (attached Appendix B).
4. Agree the schemes as detailed in Appendix D.
5. Agree subsequent reports at each of the next four Health and Wellbeing Board formal meetings throughout 2015.

1. Background

The antecedents to the BCF are well known, and in Lincolnshire represent a growing source of funding that reflects national ambitions to secure improved performance across Health and Care and integration "at scale and pace". The value of the BCF in 2014/15 is £15.4M; in 2015/16 it will be £48.4M.

Members will recall that the first BCF submission due in spring 2014 was delayed by Ministers following representation within NHS England. A revised template and renewed focus on non-elective admission reductions to hospital were new features to be accommodated within the new BCF process and was submitted September 2014. Along with a number of other councils Lincolnshire's submission was "approved with conditions". As such we are expected to review and re-submit sections requiring further work at the latest by 9th January 2015. The primary areas of change are in Part 1 – the narrative. The attached 'Progress Tracker' details which sections are being reproduced and what stage of development they are at.

In parallel, the BCF Task Group continues to meet given the national prescriptions that will require ongoing work beyond approval of the re-submission. Specifically, a Section 75 agreement is required to be agreed across all the partners and the Health and Wellbeing Board which must include the minimum BCF allocation in 2015/16 of £48.4M. In Lincolnshire our pooled budget ambition has generated considerable national interest along with four other Health and Care systems in the country. It has allowed Ministers to say that the actual Better Care Fund is much bigger than the £3.8bn nationally and now stands at £5.3bn. The difference between the two figures is the top-up amount from local health and care communities. However, this level of ambition (£197m) represents a significant and profound step in Lincolnshire.
The BCF Task Group and the Joint Commissioning Board (JCB) have already discussed the production of a Section 75 and agreed a way forward. Two colleagues are leading on producing the draft: Paula Pilkington (from West CCG representing a financial perspective) and David Coleman (from LCC representing a legal perspective). A copy of the report to JCB at the end of November is attached (as Appendix C) detailing the project plan for production of the Section 75 and, the detail surrounding how the £197M is made up.

The third area of activity concerning the BCF is clarifying the details of the £20M allocated from the £48.4M in 2015/16 for the purposes of supporting existing schemes and, for 'protecting adult social care'. The attached spreadsheet (Appendix D) details the schemes. All schemes are expected to be reviewed by their respective Joint Delivery Board and recommendations made to the JCB that will meet on 15 December.

Further work will continue and be reported to Health and Wellbeing Board once a review of the remaining balance of the BCF fund equating to £28.4M has been completed by the JCB. This is funding proposed to be used by CCGs in Lincolnshire.

2. Conclusion

The BCF has grown in scale and resource requirement significantly since its inception in the Autumn of 2013. It can no longer be considered a short term exercise in securing the transfer of existing funds to the local health and care system. The local ambition to pool significantly more than the national allocation has generated a significant profile for the work being undertaken.

Notwithstanding the consequences of the national elections on the future of the BCF and any allocations for 2016/17 there is a significant workload to both secure an acceptable BCF submission, a Section 75 agreement and collective endorsement for the 2015/16 allocation. Throughout 2015/16 the Health and Wellbeing Board will be expected to oversee progress and address any issues that might arise.

3. Consultation

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	BCF Resubmission – Sections Updated and Action Tracker
Appendix B	BCF Task Group Terms of Reference
Appendix C	Report to JCB – Pooled Fund Update
Appendix D	List of Schemes Funded by BCF in 2015/16

5. Background Papers

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

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

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Better Care Fund planning template – Part 1

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	17/09/14

Signed on behalf of the Clinical Commissioning Group	Lincolnshire West
By	Sarah Newton
Position	Chief Officer
Date	18/09/2014

Signed on behalf of the Clinical Commissioning Group	Lincolnshire East
By	Gary James
Position	Chief Officer
Date	18/09/2014

Signed on behalf of the Clinical Commissioning Group	South Lincolnshire
By	Gary Thompson
Position	Chief Officer
Date	18/09/2014

Signed on behalf of the Council	Lincolnshire County Council
By	Tony McArdle
Position	Chief Executive
Date	18/09/2014

Signed on behalf of the Health and Wellbeing Board	Lincolnshire Health & Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Sue Woolley
Date	11/09/2014

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**
Written submission by Lincolnshire Independent Care Providers (Attachment 1)	This is a letter in support of the BCF resubmission from the Chair of the social care and housing providers' umbrella body in Lincolnshire.
Lincolnshire Health and Care Phase 2	Status report (please note this is not a

Status Report (Attachment 2)	public document at the moment)
Lincolnshire Health and Care Phase 1 Draft Blueprint (formerly Lincolnshire Sustainable Services Review) (Attachment 3)	This strategic document provides a comprehensive and detailed analysis of health and social care in Lincolnshire. It was produced in conjunction with PWC at the end of 2013 and precedes the design phase. The Lincolnshire Sustainable Services Review (LSSR) was the predecessor title before it became Lincolnshire Health and Care (LHAC).
Joint Health Wellbeing Strategy for Lincolnshire 2013 – 2018 (Attachment 4)	
Lincolnshire Joint Strategic Needs Assessment	http://www.research-lincs.org.uk/Joint-Strategic-Needs-Assessment.aspx
Lincolnshire BCF Summary Milestones Section 4a (Attachment 5)	
Terms of Reference – Proactive Care Board (Attachment 6)	The Proactive Care Board was set up early in 2014 as part of our new approach to Joint Commissioning. The Terms of Reference were formally agreed shortly afterwards.
Executive Portfolio Holder report – Dementia Family Support Service (Attachment 7)	This is the covering report and Business case for a new service to be agreed by the Portfolio Holder in October 2014 and referred to in Annex 1 – Carers.

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

Lincolnshire Health and Care Vision

Lincolnshire's Health and Wellbeing Board, in collaboration with its broader health and social care community, are committed to delivering the following vision:

Lincolnshire Health and Care Vision
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 or long term residential services. This will mean a shift in the balance towards delivering more care in the community.

Key Principles

The key principles to deliver 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
- Quality improvement wherever possible

Services in 2019/20

By 2019/20, our vision will have enabled Lincolnshire to:

- Be on 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.

Better Care Fund (BCF) Objectives

Lincolnshire's Health & Wellbeing Board recognises that the BCF will play a vital role in contributing to our wider heath and care vision. Our BCF has the following objectives:

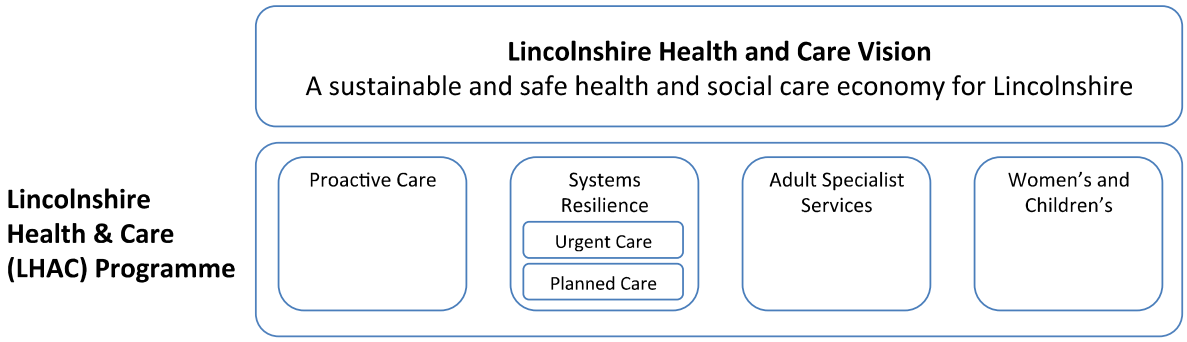
- A Reduce inappropriate admissions of older people into residential care
- B Keep older people at home longer after discharge from hospital into reablement
- C Reduce Delayed Transfers of Care (DTOC) from hospital
- D Reduce NEL Emergency Admissions through improved health and care collaboration
- E Increase in patients saying care and support services help them to have a better quality of life
- F Increase in proportion of people feeling supported in managing their Long Term Condition

Our BCF plan will deliver these objectives through 8 BCF themes:

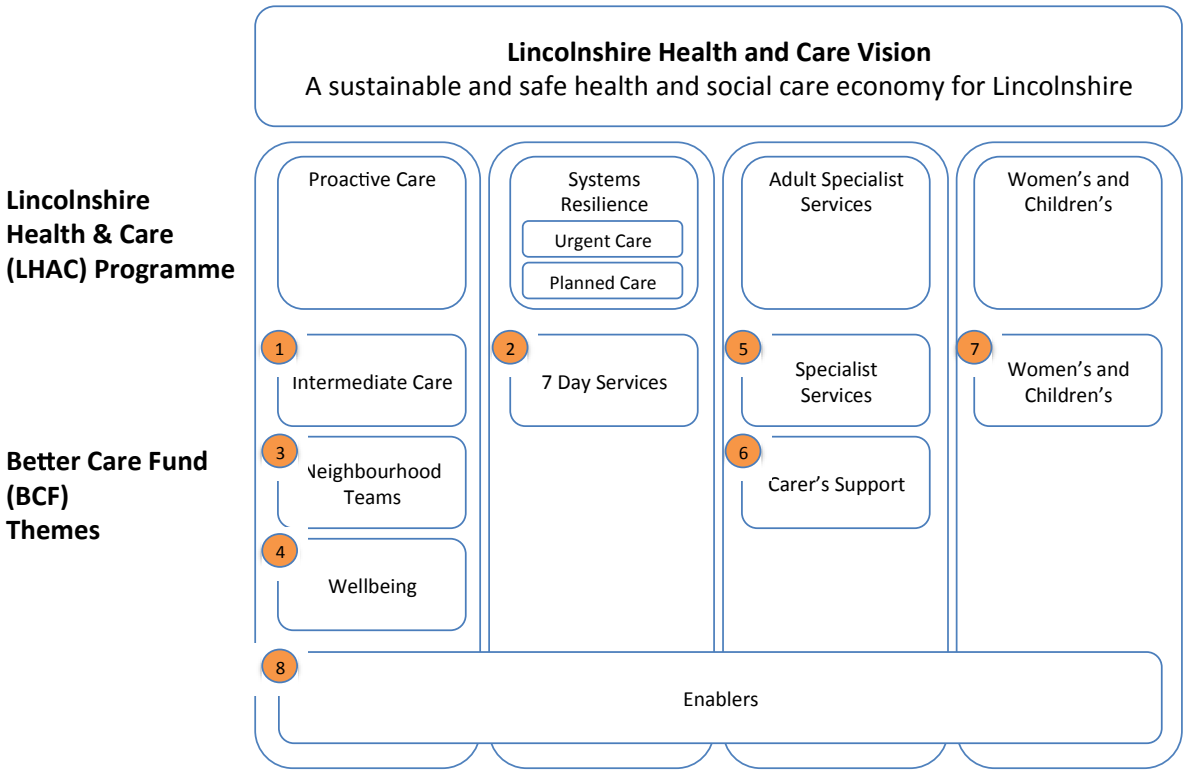
1. Intermediate Care
2. 7 Day Services
3. Neighbourhood Teams
4. Wellbeing
5. Specialist Services
6. Carer's Support
7. Women's and Children's
8. Enablers

How BCF Supports Our Health and Care Vision

Lincolnshire's vision for health and social care is being delivered by a whole health economy transformation programme called Lincolnshire Health and Care (LHAC). The LHAC programme has the following major component parts:



Lincolnshire's Better Care Fund will play a significant role in supporting our wider LHAC vision, and the BCF themes are aligned with the overall LHAC programme to maximise the combined impact of BCF and LHAC:



What Informs Our Vision

Our vision for health and social care has been informed by:

- Lincolnshire's 2013 JSNA
- Lincolnshire's Sustainable Services Review (LSSR) in November 2013
- Lincolnshire's 2013-18 JHWS
- Lincolnshire's on-going Health and Care Transformation Programme (LHAC)
- Extensive patient and service user feedback

The key findings that have informed our vision are summarised below:

Lincolnshire's JSNA and LSSR

All four Lincolnshire CCGs have above average disease prevalence for the majority of the disease categories investigated.

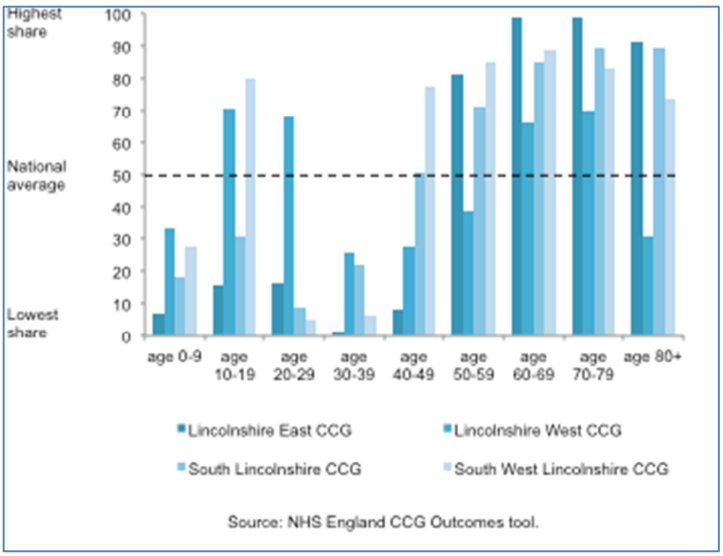
Disease prevalence relative to all CCGs

Disease	East CCG	South CCG	South West CCG	West CCG
Asthma	🟠	🟠	🟠	🟠
Atrial Fibrillation	🔴	🔴	🟠	🟠
Cancer	🔴	🔴	🔴	🟠
Cardiovascular Disease Primary Prevention	🟢	🔴	🔴	🟢
Chronic Kidney Disease (ages 18+)	🔴	🔴	🔴	🔴
Chronic Obstructive Pulmonary Disease	🔴	🟠	🟠	🟠
Coronary Heart Disease	🔴	🟠	🔴	🟠
Dementia	🟠	🔴	🟠	🔴
Depression (ages 18+)	🟠	🔴	🟠	🟠
Diabetes Mellitus (Diabetes) (ages 17+)	🔴	🔴	🟠	🟠
Epilepsy (ages 18+)	🔴	🟠	🟠	🟠
Heart Failure (2010)	🔴	🔴	🔴	🟠
Heart Failure Due to LVD	🔴	🟠	🔴	🟠
Hypertension	🔴	🔴	🔴	🟠
Hypothyroidism	🔴	🔴	🟠	🟠
Learning Disabilities (ages 18+)	🔴	🟠	🟠	🟠
Mental Health	🟢	🟢	🟢	🟠
Obesity (ages 16+)	🔴	🟠	🔴	🔴
Palliative Care	🔴	🟠	🟠	🔴
Stroke or Transient Ischaemic Attacks (TIA)	🔴	🟠	🟠	🟠

Source: NHS England CCG Outcomes Tool

In part, our high disease prevalence is due to the characteristics of the local population, which is significantly older than the England average, as illustrated in the diagram below:

Share of population by age group, compared to national average (percentiles related to all other CCGs)



This high disease prevalence creates a pressure on the health and social care economy. Although historically the population with the biggest health needs have been located in East Lincolnshire CCG, it appears that other CCG populations are ageing more rapidly. East and West Lincolnshire are still expected to have the greatest number of over 65s in 2018.

Expected percentage increase in number of over 65s, 2013-2018

CCG	Projected increase in over 65s, 2013-18 (%)	Projected number of over 65s 2018
West Lincolnshire	12.59%	50,025
South West Lincolnshire	13.36%	29,391
South Lincolnshire	11.84%	35,611
East Lincolnshire	11.66%	65,909

Lincolnshire 2013-18 Joint Health and Wellbeing Strategy

Our 2013-2018 JHWS identified the following five themes:

1. Promoting healthier lifestyles
2. Improving the health and wellbeing of older people in Lincolnshire
3. Delivering high quality systematic care for major causes of ill health and disability

4. Improving health and social outcomes and reducing inequalities for children
5. Tackling the social determinants of health

The JHWS also identified three cross cutting issues:

1. **Mental Health** – mental health issues are a major cause for concern and need to be considered across all organisations.
2. **Inequalities** – inequalities in health are closely correlated with other inequalities and can arise because of gender, age, social circumstances, vulnerability, or pre-existing illness.
3. **Carers** – for many people with disabilities, long term conditions or frailty, relatives or friends who act as carers are critical to our care system. The strategy recognises this and it is expected that commissioning plans will reflect their needs.

Patient and Service User Feedback

We have drawn upon significant patient and service user feedback to develop our vision of a sustainable and safe health and social care economy in Lincolnshire.

The purpose of our on-going engagement is to:

- Develop emerging options that respond to and reflect views and feedback
- Provide an opportunity for questions, comments and input
- Prepare stakeholders for change

Our engagement principles are:

- Clear, accessible, inclusive and proactive
- Different channels for different audiences
- Open and honest communication, challenging misconceptions
- A coordinated approach across all LHAC partners
- Adherence to national guidance and best practice

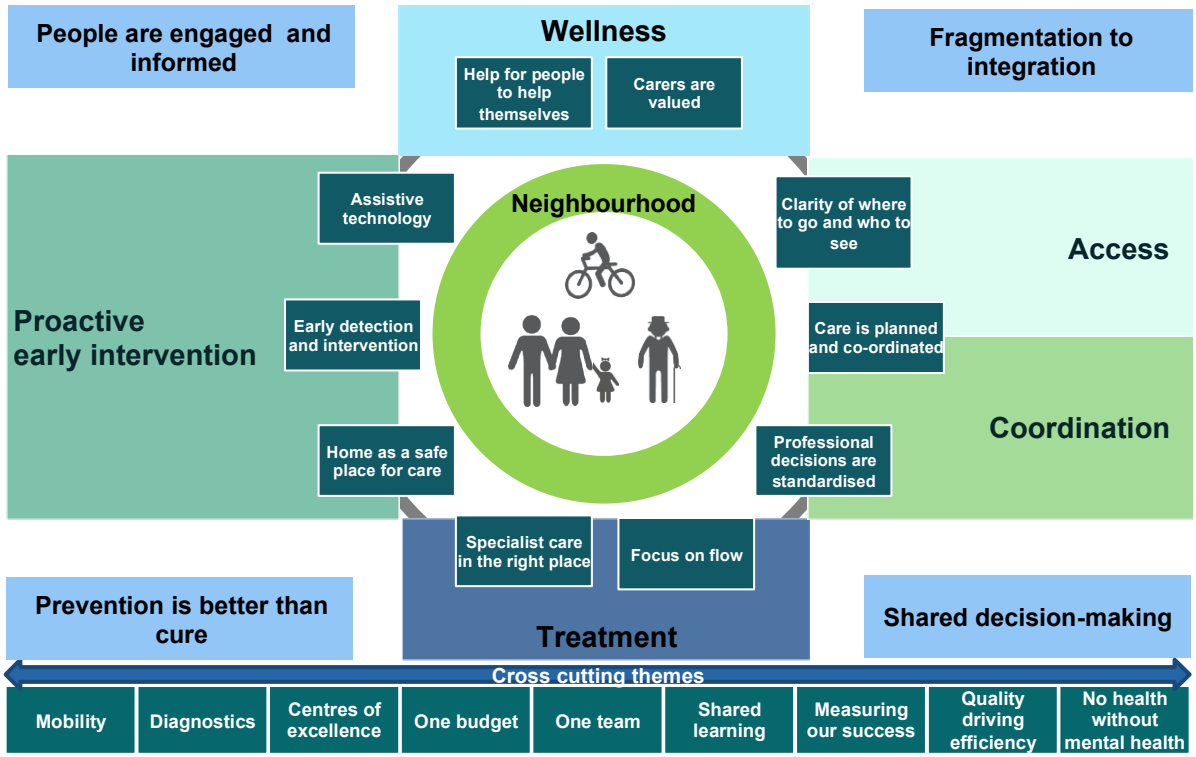
Sample feedback received from patients and services users to date is show below:

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

In delivering Lincolnshire's vision for health and social care services, we will make a significant positive impact on the outcomes of our patients, service users and their carers:

- **Improved patient safety** – Improved patient safety and patient outcomes
- **Joined up services** – Integrated teams (at neighbourhood and urgent care level), single assessments, better continuity of care, better information sharing, single point of access
- **7 day services** – Greater availability of appropriate services 7 days a week
- **Care closer to home** - Elements of planned care provided in settings closer to home, supported by Neighbourhood Teams
- **Signposting of services** – Improved clarity about where to go for support and who to see: to help more people help themselves
- **Shorter stays in hospital** – More people diverted from long hospital stays
- **Financial sustainability** – Services that are safe, high quality and affordable

The schematic below summarises the proposed future model of care, which will deliver these improved outcomes to Lincolnshire's patients and service users:



To facilitate these improvements there will need to be changes to both our arrangements for commissioning and the provider landscape in Lincolnshire and potential changes to the locations where services are provided.

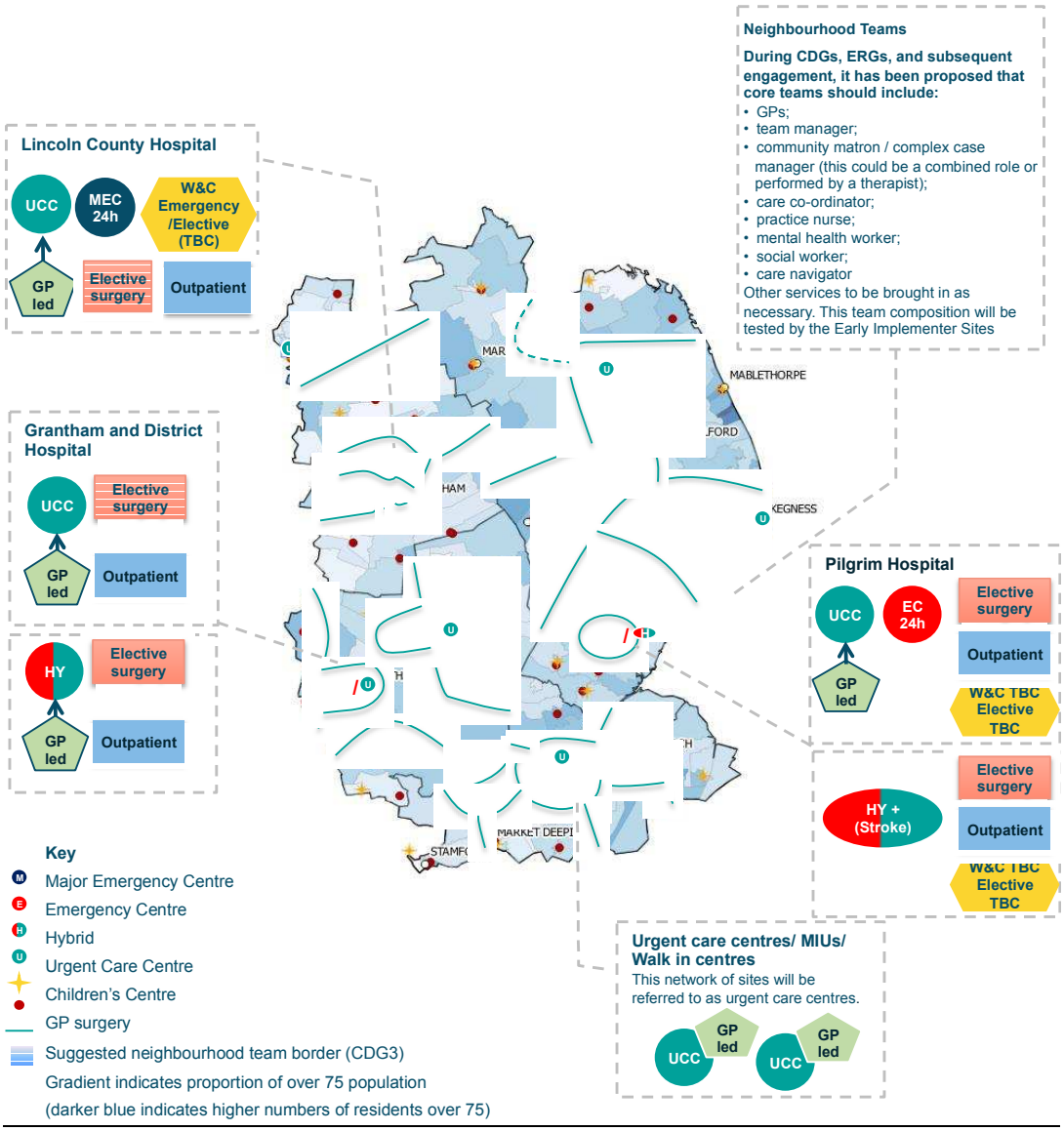
c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

Changes in the pattern and configuration of services over the next five years

Over the next five years, many of the services in Lincolnshire will look familiar, but will feel quite different, as services become better integrated and more care moves closer to communities. A map of services in Lincolnshire in the future would focus around teams rather than buildings, as people work in a more joined up way to provide care closer to home whenever it is appropriate.

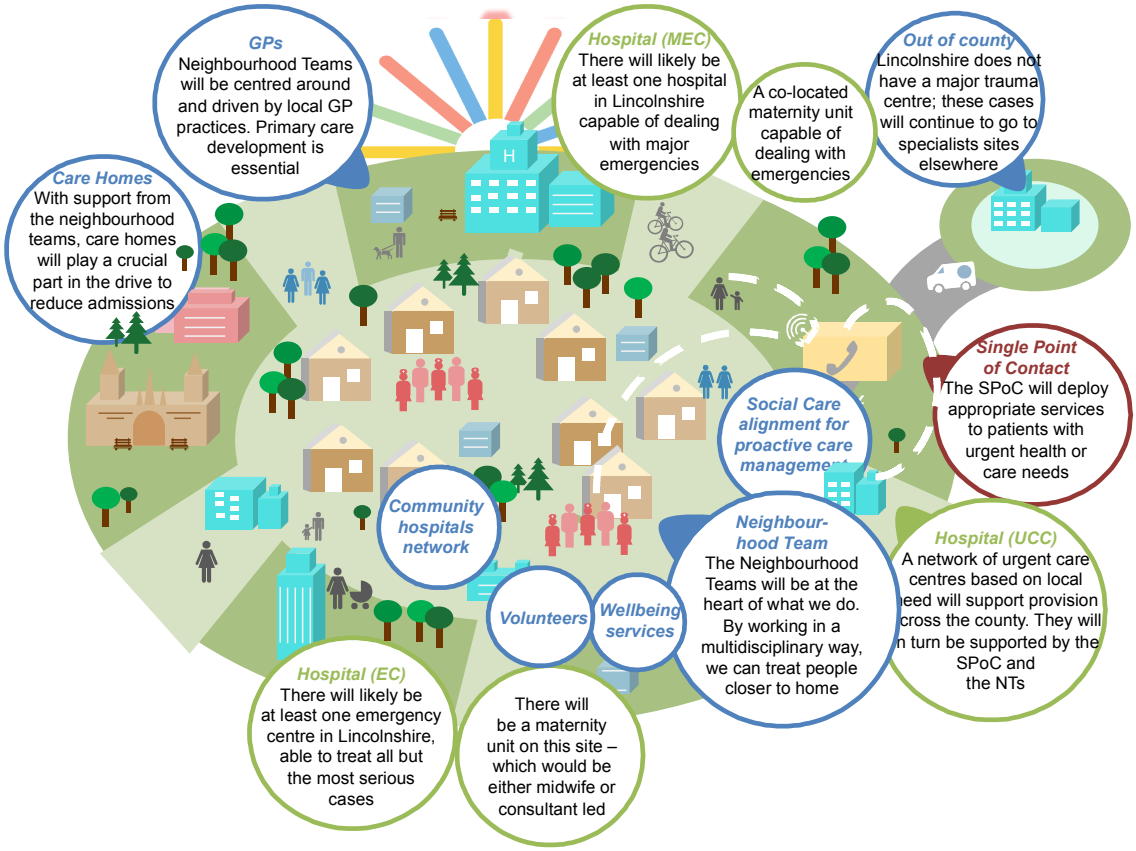
At the heart of this approach is the neighbourhood team model, which will work to facilitate care built around individuals within their communities. A network of urgent care services will support both the neighbourhood teams and the three main acute sites, with a team of professionals working together to avoid hospital stays wherever possible.

Possible scenarios have been plotted on the map below. These scenarios may be updated in later phases of work as discussions progress and in light of new guidance on Urgent Care.



Lincolnshire whole system of health and social care

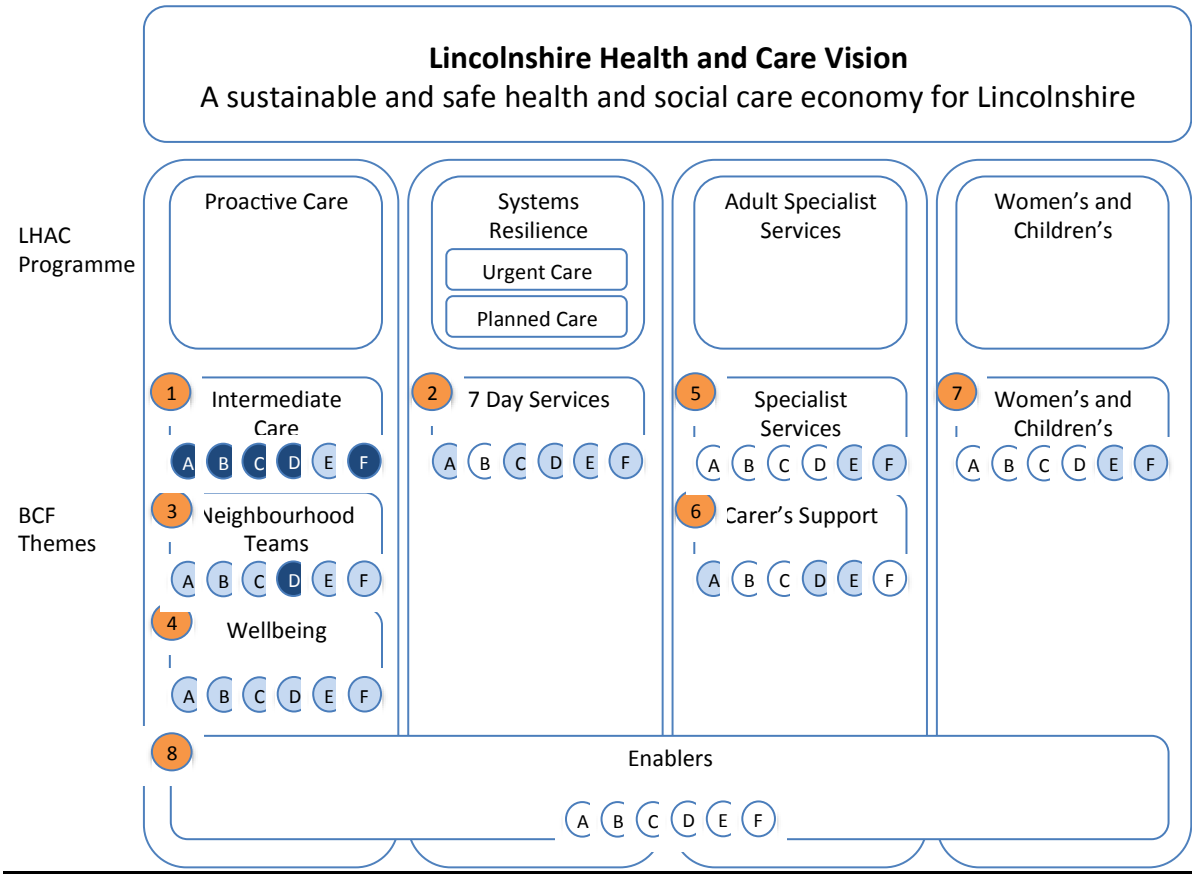
The future provision of health and social care will be centred around individuals and communities, as illustrated below:



How BCF funded work will contribute to the future service configuration

Lincolnshire's BCF work will play a pivotal role contributing towards our health and social care vision. The BCF themes will enable us to deliver integrated, personalised care through integrated teams, with a focus on outcomes, safety, quality and patient experience.

The diagram below shows how BCF themes will contribute to each of the BCF outcomes.



Key to BCF Outcome Metrics

- A Reducing inappropriate admissions of older people (65+) in to residential care
- B Increase in effectiveness of these services whilst ensuring that those offered service does not decrease
- C Delayed transfers of care from hospital per 100,000 population
- D Reduce emergency admissions which can be influenced by effective collaboration across the health and care system
- E Increase in patients saying care and support services help them to have a better quality of life
- F Increase in proportion of people feeling supported in managing their LTC

- Significant contribution
- Moderate contribution
- Low contribution

Lincolnshire's BCF schemes are structured into eight overarching themes as explained below:

BCF Theme 1 - Intermediate Care

Intermediate Care will improve pathways of care and outcomes in the community for people who have an escalating health or social care need, by helping them avoid going into hospital unnecessarily. This will help people to be as independent as possible after a stay in hospital, preventing people from having to move into a residential home until they really need to, and facilitating a transfer from hospital to avoid any unnecessary delays

BCF Theme 2 - 7 Day Services:

7 Day Services will ensure that the patient / service user has a seamless pathway of care when accessing services no matter what day of the week. We will support patients being discharged from hospital and prevent hospital admissions at weekends. By ensuring weekends are treated no different to weekdays, we will reduce weekend mortality rates, increase system efficiency, and ensure service users/patients receive the same standard and quality of care regardless of the day of the week.

BCF Theme 3 - Neighbourhood Teams

Neighbourhood Teams will 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 the end of their lives.

BCF Theme 4 - Wellbeing

Wellbeing is a preventative service, which is 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

BCF Theme 5 - Specialist Services

Specialist Services will improve the wellbeing of adults with Learning Disability, Autism and/or Mental Health needs within sustainable resources by:

- Achieving parity of esteem between mental health and physical health
- Improving the quality of life and safeguarding of vulnerable adults
- Delivering joint commissioning arrangements and pooled budgets
- Engaging and involving stakeholders
- Delivering integrated services and strategic partnerships
- Delivering effective prevention and early intervention strategies.

BCF Theme 6 - Carer's Support

Carer's Support will alleviate or delay breakdowns in informal caring relationships by targeting proactive preventative support at older carers of people with a learning disability and carers of people with dementia (who are particularly at risk of breakdown). The work will:

- 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
- Meet the statutory outcomes for Health & Wellbeing Boards
- Support delivery against the requirements of the Care Act from April 2015

BCF Theme 7 - Women's and Children's (CAMHS)

Child and Adolescent Mental Health Services (CAMHS) will 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
- Reducing the dependency levels of young people with mental health needs moving though transition to adult care

BCF Theme 8 – Enablers

The BCF will be enabled by two schemes:

- Care Act implementation
- LHAC programme

The Care Act implementation scheme will support the implementation of the Care Act and Dilnot recommendations.

The LHAC programme will provide:

- Consultancy support from Pricewaterhouse Coopers
- Other specialist support such as external legal, public relations and financial input
- Programme Management Office
- Communications and engagement including provision for formal public consultation support

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.

This section is currently being redrafted.

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

This section is currently being redrafted.

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

This section is currently being redrafted.

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

This section is currently being redrafted.

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.

Lincolnshire's BCF schemes are delivered through 8 overarching themes as outlined below.

Theme ID	Theme	Scheme ID	Scheme	Scheme Description
1	Intermediate Care	IC1	Reablement	Development of individualised care plans for patients with increased risk of deteriorating health (identified through predictive risk planning), and, if admission to hospital is required, integrated discharge planning is commenced on day one of admission.
		IC2	Community Response and Reablement (CR&R)	Supporting integration of reablement teams across the county. To provide assessments to allow timely hospital discharge, emergency responses and enabling people to return home sooner and maintain their independence longer.
		IC3	Lead Provider Model	Retendering of Intermediate Care to be a Lead Provider Model with a range of subcontracted services, which will eliminate duplication and improve efficiencies. Includes ULHT step down provision, Community Hospital step up provision & further development of the Single Point of Contact (SPoC)
2	7 Day Service	SDS1	Independent Living Team	Increasing the capacity of the Independent Living Team at weekends.
3	Neighbour-hood Teams	NT1	Community Based Neighbourhood Teams	Community Based Neighbourhood Teams
		NT2	Community Integrated Reablement Service	Integrated reablement teams across the county. To provide assessments to allow timely hospital discharge, emergency responses and enabling people to return home sooner and maintain their independence longer.
		NT3	Co-responders	Provision of a 24/365 day availability for emergency responses.This scheme is a collaboration with Lincs Fire and rescue, East Midlands Ambulance service and Lincolnshire integrated Voluntary Emergency services.
		NT4	Programme Support	To support,develop,maintain and evaluate all of the proactive care workstreams. The cost incorporates the Proactive care Programme Director, the Adult Care Assistant Director & Demographic growth.
		NT5	Protecting Adult Social Care	Provision of additional capacity for Neighnourhood Teams to meet additional demand from demographic growth.
4	Wellbeing	W1	Installation of Equipment, Minor Adaptations and TeleCare	The installation of a range of community equipment that includes simple aids to daily living (SADLs) and TeleCare, plus minor adaptations.
		W2	Monitoring of TeleCare / Community Alarms	Provision of a Countywide Monitoring Centre that monitors Telecare and Community Alarms and initiates the appropriate response as agreed with the service user.
		W3	Prevention - Integrated Community Equipment Services (ICES)	This is S(75) hosted by LCC (includes health and social spend) for community equipment and is an essential service to support all aspects of the integrated health and social care model.
		W4	Prevention - Disabled Facilities Grant (DFG)	Utilisation of the Disabled Facilities Grant to provide adaptations in people's homes.
5	Specialist Services	SS1	Learning Disability Services	Learning Disability pooled budgets and future risk sharing.
		SS2	Mental Health Services	Mental Health Contract, Mental Health community support schemes & mental health prevention.
				Mental Illness Prevention - Payment to LPFT to support the ongoing development of a preventative network of projects that offer support to people with Mental Health needs to help enable them to remain living independently.
		SS3	Maximising Independence	Builds on work done by Fit for the Future team. Analysing individual care packages and to provide short term period of intensive care to increase peoples independence and reduce intervention.
		SS4	Programme Support	To support,develop,maintain and evaluate all of the Specialists care workstreams. The cost incorporates the Joint Health, the Adult care cost of an Assistant Director & demographic growth.
		SS5	Protecting Adult Social Care	Provision of additional capacity in Specialist Services to meet additional demand from demographic growth.

Theme ID	Theme	Scheme ID	Scheme	Scheme Description
6	Carers Support	CS1	Older Carers of People with a Learning Disability	Support to older carers of people with Learning Disabilities including preparing for unforeseen circumstances, providing information & advice.
		CS2	Carers of People with Dementia	Support to carers of people with Dementia including providing access to short breaks to help them sustain their role as a carer.
7	Women's and Children's	WAC1	Promoting Independence	Supporting people through the transition from Education to adult life. Focus is on Employment, independent living, community inclusion and good health and wellbeing.
		WAC2	Refreshed Child and Adolescent Mental Health Service (CAMHS)	Refreshing the CAMHS - improving the model of care and outcomes for children and adolescents with mental health needs.
		WAC3	Short Breaks & Children Act Register	Established S(256) agreement for St. Bernard's School supporting short breaks for children & Children Act Register.
		WAC4	Programme Support	To support,develop,maintain and evaluate all of the Women's and Children's Board workstreams. The cost incorporates the Health and Adult care cost of an Assistant Director.
8	Enablers	E1	Care Act	To support the implementation of the Care Act and Dilnot recommendations.
		E2	Lincolnshire Health and Care Transformation Programme	To develop and promote the integration of health and social care services through a coordinated transformation programme.

Our BCF schemes are explained in greater detail in the Annexes.

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.

A summary of the risk log is shown below. The detailed risk log is provided as an additional appendix.

Ref	Risk	Impact	Primary Risk Type	Financial Impact score	Non financial Impact	Non financial Impact score	Likelihood	Likelihood Score	Total Impact	Financial risk score	Non financial impact score	Total risk score	Controls and mitigations	Responsibility
BCF01	Failure to deliver reduction in non-elective admissions	Failure to deliver on BCF target leads to retention of performance payments with financial and reputational impact	Financial	3	High	5	Low	1	8	3	5	8	Strong and effective governance and accountability including management of contributing risks, good communication, focus on performance supported by clear responsibility and accountability.	JCB Chair
BCF02	Clinical risk is inadvertently increased during transition to new model of care	Potential for issues to occur during transition to new model of care, leading to safety issues, reputation loss and delay in implementation	Quality	0	High	5	Low	1	5	0	5	5	Sensitivity to leading indicators and accountability through performance management as set out in BCF governance	JCB Chair
BCF03	People's experience of health and social care is temporarily reduced during transition to new model of care	Potential for issues to occur during transition to new model of care, leading to safety issues, reputation loss and delay in implementation	Quality	0	High	5	Low	1	5	0	5	5	Sensitivity to leading indicators and accountability through performance management as set out in BCF governance	JCB Chair
BCF04	Unexpected growth in activity increases demand on acute provision	Spikes in activity due to weather, epidemic etc. will lead to increased admissions	Financial	3	Medium	3	Medium	3	6	9	9	18	Limited ability to control. Requires sensitivity to the situation and mitigating actions if the risk is likely to materialise.	JCB Chair
BCF05	Re-baselining of emergency admissions leads to unrealistic targets	Lincs has addressed many 'low hanging fruit' and targets in CCG plans already take account of performance trajectory so re-baselining may create unrealistic target and increase	Financial	1	High	5	High	5	6	5	25	30	Rebaselining is outside control of Lincs. Be prepared to escalate concerns if likely that risk will materialise.	DASS (as BCF lead)
BCF06	Stakeholders resistance to change	Stakeholder resistance to change could frustrate or delay plans for new model of care and reducing acute admissions	Financial	3	High	5	Medium	3	8	9	15	24	Effective stakeholder analysis that focuses stakeholder engagement	LHAC Engagement Lead
BCF07	Patient behaviour does not change	Failure to change patient behaviour to take advantage of new model of care would mean that they still seek to access acute provision rather than e.g. Neighbourhood Teams	Financial	3	High	5	High	5	8	15	25	40	Effective communication and engagement with patients, carers and public.	LHAC Engagement Lead
BCF08	Culture does not change within health and social care organisations and workforce	Failure to achieve cultural and behavioural change will frustrate or delay plans for reducing acute admissions	Operational	0	High	5	Medium	3	5	0	15	15	Focus on change management. Cross organisational workforce group and engagement with HE East Midlands.	Workforce Board Chair
BCF09	No agreement on risk/ gain share between commissioners and with providers	Failure to agree risk / gain share leads to parochialism between organisations and sub-optimised system performance	Financial	3	Medium	3	Low	1	6	3	3	6	Principles of risk and gain share agreed between commissioners and further dialogue with providers.	JCB Chair
BCF10	Lack of system wide engagement on reducing emergency admissions	Current ULHT plans and TDA requirements are for increasing revenue which could frustrate achievement of BCF target	Financial	3	High	5	Medium	3	8	9	15	24	ULHT have responded positively to BCF targets	LHAC SRO
BCF11	ULHT special measures and financial deficit diverting attention from BCF	Focus of acute provider could be on other priorities	Financial	3	Medium	3	High	5	6	15	15	30	Ongoing dialogue with ULHT. TDA membership of LHAC Board.	ULHT Deputy CX
BCF12	Reduction in emergency admissions does not realise financial savings in acute cost base	Admissions reduce but provider does not reduce cost base leading to financial instability and pressure on commissioners to provide support	Financial	3	High	5	High		8	0	0	0	Extension of risk share agreement to providers.	Lead Commissioner for Hospital

Ref	Risk	Impact	Primary Risk Type	Financial Impact score	Non financial Impact	Non financial Impact score	Likelihood	Likelihood Score	Total Impact	Financial risk score	Non financial impact score	Total risk score	Controls and mitigations	Responsibility
BCF13	Delays in implementing primary care strategy due to co-commissioning and area team mergers	Delays put further stress on primary care in Lincs	Financial	3	High	5	Medium	3	8	9	15	24	Little ability of Lincs to influence this. Maintain vigilance to take mitigating actions if likely to materialise.	NHS Area Team rep on LHAC Board
BCF14	Delays in implementation increase double running costs	Delays from other risks will increase costs due to extended periods of double running.	Financial	5	High	5	Medium	3	10	15	15	30	Effective costing that takes account of double running realistically. Effective programme controls and behaviours to compel progress at right pace.	LHAC Finance Lead
BCF15	Slippage in procurement timescales for intermediate care delay implementation	Intermediate care procurement set for autumn 2015 so impact will be later on within BCF. Any delay will impact on reduced admissions profile.	Financial	3	High	5	Medium	3	8	9	15	24	Appropriate capacity in place for procurement.	Joint Commissioning Proactive Programme Director
BCF16	Failure to achieve reduction in permanent admissions to residential care, leading to higher costs for the local authority	BCF reductions in acute admissions could increase costs for county council if they are unable to implement other cost reductions.	Financial	3	High	5	Medium	3	8	9	15	24	Clear priority in County Council. BCF schemes focus on upstream and local support to minimise permanent residential placements	DASS
BCF17	Inability to secure appropriately skilled workforce	Need to secure shift in workforce into community settings. Historical difficulties in recruiting to Lincolnshire. Increasing age profile of GPs.	Operational	0	High	5	Medium	3	5	0	15	15	Cross organisational workforce group and engagement with HE East Midlands. Focus on change management and development.	Workforce Board Chair
BCF18	Not achieving 7 day working and extended hours	Inability to deploy workforce in this way frustrates operating new model of care and / or increases costs	Operational	0	High	5	Medium	3	5	0	15	15	Cross organisational workforce group and engagement with HE East Midlands. Focus on change management and development.	Joint Commissioning Proactive Programme Director
BCF19	Unable to modify IMT systems and Information Governance to support new model of care especially neighbourhood teams	IMT enablers are critical to effective medium / long term working of NTs	Operational	0	High	5	Medium	3	5	0	15	15	Cross organisational IMT group engaged.	JCB IMT Lead
BCF19	Transport infrastructure and provision in rural Lincs does not support new model of care	Transport provision will need to support new model of care. Failure to do so will increase risk that public behaviours will not change.	Operational	0	High	5	Medium	3	5	0	15	15	Cross organisational Transport group engaged.	JCB Transport Lead
BCF20	Estates management does not support new model of care	NTs will require co-location. Inability of Estates management to support that will frustrate plans	Operational	0	Medium	3	Medium	3	3	0	9	9	Cross organisational Estates group engaged.	JCB Estates Lead
BCF21	Whilst some detailed plans are in place, other plans are in early stages of development	Inability to achieve outcomes; inefficiency if dependencies are not managed.	Operational	0	Medium	3	Medium	4	3	0	12	12	Sensitivity to leading indicators and accountability through performance management as set out in BCF governance	JCB leads
BCF22	Disinvestment by partners as result of pressures on their individual organisations or other reasons	Limits capacity to implement BCF depending on extent of disinvestment with resulting reductions in benefits .	Financial	5	High	5	Low	1	10	5	5	10	Engagement of all partners. Commissioner led approach through JCB and system wide engagement through Stakeholder Board. Sharing budget pressures between partners through those forums with particular emphasis on budget setting cycle.	JCB Chair

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 BCF plan assumes delivery of a 3.5% reduction in emergency admissions. This figure has been agreed following detailed analysis of past and current performance in this area, and the key drivers impacting on the likely success of the plan. We believe the range of BCF investments will be significant contributors to delivering the plans. In addition the development of the Neighbourhood Team approach, building as it will throughout 2015, should be a key element in achieving this target in the short-term and further improving performance in this and related activities in the medium and longer terms. Total non-elective savings are as follows:

Financial Value of Non Elective Saving/ Performance Fund (as per Lincolnshire Plan)	**£3,747,350**
Combined total of Performance and Ring-fenced Funds (as per allocation)	**£13,988,150**

The plans for each investment and overall scheme allocations have been developed jointly between the County Council and the 4 CCGs, and with full transparency and agreement of the HWBB. Regular informal discussions also take place with the Chairman of the HWB who is kept updated and appraised of all key issues. The schemes are allocated to the individual Delivery Boards who will be held accountable for investment decisions, performance delivery and financial monitoring. Reporting from these Boards will be to the Joint Commissioning Board who will have the responsibility of reporting on a regular basis to the HWBB.

The BCF Governance arrangements have created a forum for discussing overall risk management and specifically risk sharing and 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 being 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. The Joint Commissioning Board has held regular discussions on the subject and work is ongoing to finalise plans. These are being developed by the BCF Task and Finish Group and by the NHS/LCC Senior Finance Group. The Joint Commissioning Board is committed to considering the risk agenda at each of its coming meetings and will ensure alignment with the ambitions of LHAC.

Through discussions between the council and the 4 CCGs the amount assessed as 'at risk' is the £3,747,350 shown above, which derives from the detailed information and metrics included in Part 2 of the BCF submission. The Joint Commissioning Board has already formally agreed to the creation of a contingency reserve equal to the £3,747,350, with the sum created from work undertaken to achieve underspendings and slippage within the overall BCF programme and its predecessor ITF. It is envisaged that elements of this sum will be released for further investment during the year as the actions taken to deliver the 'pay for performance' elements of the BCF are delivered and in particular that the 3.5% emergency admissions target is successfully achieved. The contingency reserve will be

reviewed on a regular basis by both the Task and Finish Group and the NHS/LCC Senior Finance Group, and will be reviewed quarterly by the JCB and HWB and adjusted based on the level of residual or emerging risk.

The health and social care community already has a sound understanding of risk sharing having had in place for many years S75 agreements around the major services of Learning Disabilities, Mental Health, CAMHS, and ICES, and also have a wide range of S256 agreements. In each of these areas the subject of risk management and risk sharing has been a recurring topic. In particular the ICES pooled budget has been subject to considerable recent (2014) discussions on risk sharing and successful discussions/negotiations have taken place across health and social care commissioners and also with key health providers. 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 £6m will be needed in total 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 £2m though the BCF (in line with national requirements) and £4m coming through the formula grant mechanism as additional resources to underwrite Care Act costs at least in 2015/16.

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. We have developed a 'Lincolnshire model' to exemplify Care Act costs and are confident that this nationally used model gives us firm indications of the extent of Care Act funding requirements.

6) ALIGNMENT

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

This section is currently being redrafted.

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

This section is currently being redrafted.

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.

This section is currently being redrafted.

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)

This section is currently being redrafted.

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

This section is currently being redrafted.

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.)

This section is currently being redrafted.

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

This section is currently being redrafted.

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

This section is currently being redrafted.

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

This section is currently being redrafted.

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

This section is currently being redrafted.

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

This section is currently being redrafted.

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))

This section is currently being redrafted.

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.

This section is currently being redrafted.

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

This section is currently being redrafted.

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

This section is currently being redrafted.

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

This section is currently being redrafted.

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

There has been extensive engagement on the BCF schemes and the wider LHAC programme over the last two years. Patients, service users and the public have been consulted in a wide variety of fora in many different locations and through quantitative survey. NHS Trusts, including the mental health Trust, and primary care providers are actively engaged with the developing BCF schemes, as are the Local Council and voluntary and community groups.

A summary of the engagement activities pertaining to each BCF scheme is shown in the table below. It is estimated there have been over 13,500 individual engagements including responses to the survey.

Theme	Scheme ID	Scheme	Who was Engaged? (Groups/ Organisations etc.)	How were they Engaged?	Name of Fora/Event	Date(s)	Engagement Groups			
							a) Patients Service Users and Public	b.i) NHS Foundation Trusts and NHS Trusts	b.ii) Primary Care Providers	b.iii) Social Care, Voluntary and Community
Intermediate Care	IC1	Reablement	Independent living team/ Community health services staff. Staff across all the partner organisations: LPFT, ULHT,LCHS,LCC,EMAS, 4XCCGs and voluntary sector service users/ patients and their careras who have had a heart attack/stroke Residential care home providers (LinCa network)	Drop in information sessions and staff workshops. Presentation, Q&A and tabletop discussions LinCa Provider event	Staff South West Care Network event Staff events across county HOPE support group	01/04/2014 Daily 9-10th June 2014 and 22nd, 24th and 25th July. 03/04/2014	✓	✓	✓	✓
	IC2	Community Response and Reablement (CR&R)								
	IC3	Lead Provider Model								
7 Day Service	SDS1	Independent Living Team	All About Me' programme board members (programme looking at personal care records to support with care needs in	Discussion at meeting	AAM board meeting	25/03/2014	✓	✓	✓	✓
Neighbourhood Teams	NT1	Community Based Neighbourhood Teams	Urgent and elective care clinicians, patient representatives and provider organisational staff	Workshop sessions	Urgent and elective care design groups	08/04/2014	✓	✓	✓	✓
	NT2	Community Integrated Reablement Service								
	NT3	Co-responders								
	NT4	Programme Support								
	NT5	Protecting Adult Social Care								
Wellbeing	W1	Installation of Equipment, Minor Adaptations and TeleCare	South west network provider members Boston Mayflower Housing association residents Minster Court housing residents Finance group meetings	Presentation and Q&A Residents meeting	SW care network Residents meeting	01/04/2014 10/04/2014	✓			✓
	W2	Monitoring of TeleCare / Community Alarms								
	W3	Prevention - Integrated Community Equipment Services (ICES)								
	W4	Prevention - Disabled Facilities Grant (DFG)								

Theme	Scheme ID	Scheme	Who was Engaged? (Groups/ Organisations etc.)	How were they Engaged?	Name of Fora/Event	Date(s)	Engagement Groups			
							a) Patients Service Users and Public	b.i) NHS Foundation Trusts and NHS Trusts	b.ii) Primary Care Providers	b.iii) Social Care, Voluntary and Community
Specialist Services	SS1	Learning Disability Services	Members of the public with an interest in LD services and LPFT staff Finance Group Meetings LD S75 board Dementia sufferers and their carers Provider contract meetings	Presentation and Q&A 1:2:1 discussions	LPFT public event Dementia support group	10/06/2014 17/04/2014	✓	✓	✓	✓
	SS2	Mental Health Services								
	SS3	Maximising Independence								
	SS4	Programme Support								
	SS5	Protecting Adult Social Care								
Carers Support	CS1	Older Carers of People with a Learning Disability	Dementia sufferers and their carer	1:2:1 discussions	Dementia support group	17/04/2014	✓			
	CS2	Carers of People with Dementia								
Women's and Children's	WAC1	Promoting Independence	Young persons football event Dementia sufferers and their carers Children centre staff and families on attendance CAMHs S(75) board Women and childrens services clinicians, patient representatives and provider organisational staff	Video interviews 1:2:1 conversations Workshop session Presentation Q&A	Sleaford football event Welton Childrens centre Womens and childrens care design group	09/04/2014 09/04/2014	✓	✓	✓	✓
	WAC2	Refreshed Child and Adolescent Mental Health Service (CAMHS)								
	WAC3	Short Breaks & Children Act Register								
	WAC4	Programme Support								
Enablers	E1	Care Act	LinCa providers event South west care network providers Members of the public in town centres etc. Colleagues from across the partner organisations, councillors, patient reps. Experts in health and social care	Group discussions/workshop Presentation Q&A 1:2:1 conversations Presentation and questions	LinCa Provider event South West Care Network Public locations across county Care Summit	01/04/2014 04/04/2014 28/03/2014 02/05/2014 08/05/2014	✓	✓	✓	✓
	E2	Lincolnshire Health and Care Transformation Programme								

Patients, service users and the public have been and continue to be engaged throughout the LHAC and BCF programmes based on a clear 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 – these included development of options for the BCF schemes described in the Annex 1 templates
- provide opportunities for questions, comments and other input and
- 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 level of involvement of Healthwatch is that they have recently decided to modify how they operate in order for them to facilitate more effective engagement with the BCF schemes and LHAC programmes.

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 including hard to reach groups and mental health groups such as Dementia and Sheltered Housing groups, Age UK, parents with young children and local grass roots

organisations. Focussed discussion of the proposals has also taken place at county wide events. For example there have been two Care Summits, one in November 2013 and one in May 2014 each with significant attendance from all sectors and special interests. Articles have been published in county-wide publications which go to every household, and a dedicated website was has been set up with live updates on the programme. This has had over 8,000 unique hits since going live. See www.lincolnshirehealthandcare.org and follow the link to 'Have Your Say'. Regular staff bulletins are issued to staff across all 13 partner organisations covering development of the LHAC and BCF scheme proposals.

There has been a large number of separate events logged including street interviews, group events, survey, web hits and twitter contacts, engaging with over 13,500 people demonstrating robust patient and public engagement. An interactive map on the website shows the locations of these events. http://www.lincolnshire.gov.uk/lincolnshire-health-and-care/have-your-say

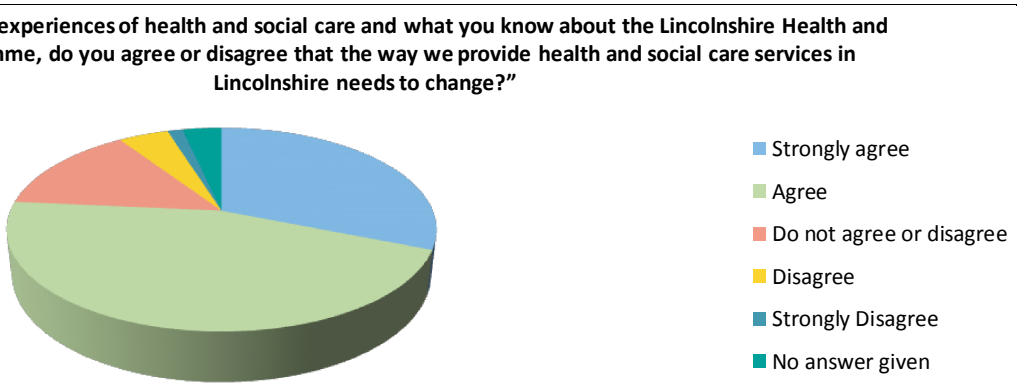
The first phase of engagement focused on asking a wide range of questions to get feedback and comment on the current health and social care system as well as hearing views on where improvements could be made. The material gathered through engagement was fed back at a number of key points into the design work to inform the Care Design Groups and the Expert Reference Groups which prepared the plans for the proposed BCF Schemes. Engagement with the public was a feature of each Care Design Group and of the Care Summit where the top themes from public engagement were fed back to the audience.

The themes identified by the public 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

Focussed discussions since the Care Summit have allowed us to test out some key areas of work with members of the public and care professionals.

In addition to this qualitative work, Greater East Midlands Commissioning Support Unit (GEM CSU) conducted a quantitative survey using several channels including on-line access and hard copies. The survey asked individuals to rank a pre-defined set of priorities that included; quality, safety, cost, choice and distance. Results from 1,024 responses have recently been widely publicised through local media and online and distributed to stakeholder groups with the headline being that 76% (783) of respondents either agreed or strongly agreed that the way we provide health and social care in Lincolnshire needs to change**.** 6% (60) disagreed or strongly disagreed that the way we provide health and social care needs to change.



Future involvement will include continuing engagement on similar lines. The current emphasis is on awareness of Neighbourhood Teams. This is very important, as public behaviour will need to change to take advantage of improved models of care.

There will be formal Public Consultation at an appropriate time and following NHS assurance of the BCF Plan.

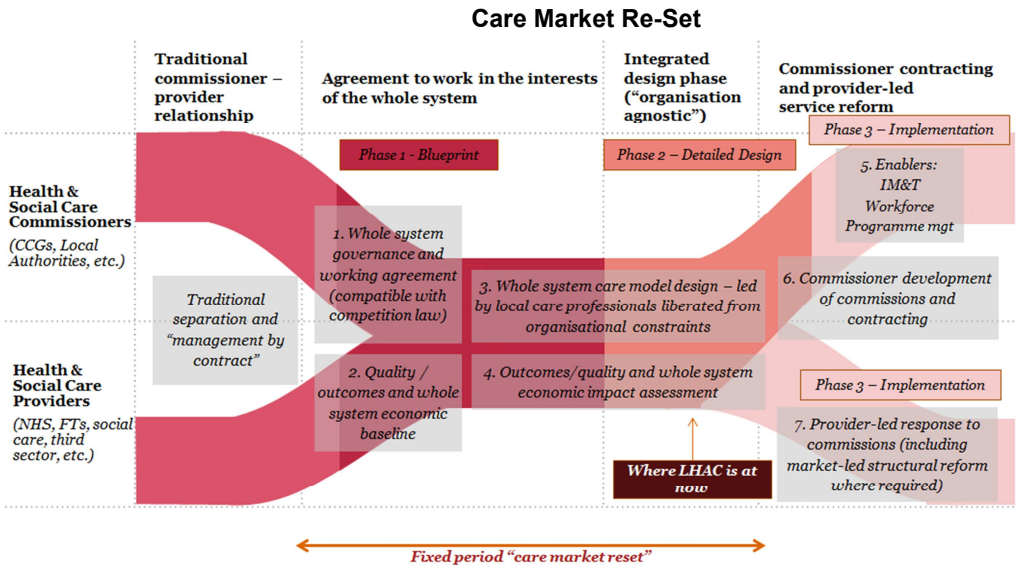
b) Service provider engagement

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 reconfiguration and BCF 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 is signed up to, underwrites working together in this way.

The diagram below summarises the transition under this Market Re-Set, from provider/commissioner split to integrated contracting and provider led reform.



Each of the local providers: United Lincolnshire Hospitals NHS Trust, Lincolnshire Community Health Services and Lincolnshire Partners NHS Foundation Trust (mental health services) together with East Midlands Ambulance Service has two seats on the programme Board and is represented on the Operations Board. Each of NHS Trusts' Boards approved the Phase 1 draft blueprint. Annex 2 Provider Commentary demonstrates their commitment to the proposed reconfiguration.
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 BCF schemes 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 being organised within provider workplaces. A summary of events since July is shown in the table below.

Date	Name of event	Location	Stakeholders present (staff/public etc.)
14/07/2014	Cleveland GP practice	LWCCG	Practice staff
03/09/2014	Swineshead PPG	Fairfax medical practice, Swineshead	Practice staff/public
04/09/2014	PPG	Newmarket medical practice, Louth	Practice staff/public
15/09/2014		District Council CX	All DC CX
15/09/2014	McMillan steering group	Lincoln	Staff/public/councillors
16/09/2014		LCC -Leaders	MH, TM, SW
16/09/2014		Alford and Spilsby area committee	District/parish councillors
17/09/2014		LWCCCG AGM/stakeholder event	Staff/public
18/09/2014		Moorland Community Board	Public/staff/district councillors
19/09/2014	Councillor briefing	SHDC	Councillors
19/09/2014	Stamford GP meeting	Stamford	GPs/practice managers/staff
29/09/2014	Boultham GP practice visit	LWCCG	Practice staff
30/09/2014	CAB staff meeting	Grantham CAB	Volunteers/staff
01/10/2014	Mablethorpe are committee	ELDC - Mablethorpe	Councillors/staff
01/10/2014	Kings Fund Event		
10/10/2014	Age Uk Staff	Lincoln	Age UK staff
10/10/2014	Birchwood GP practice visit	LWCCG	Practice staff
13/10/2014	City Medical GP practice visit	LWCCG	Practice staff
15/10/2014	PPG Cluster meeting	South CCG	CCG staff/public representatives
16/10/2014	Staff event	Skegness	Staff from across east CCG
20/10/2014	Ingham GP practice visit (Lincoln North)	LWCCG	Practice staff
21/10/2014	Leader briefing	Lincoln	Leader of LCC
21/10/2014	Informal exec CMB	Lincoln	Councillors/senior managers
21/10/2014	Practice Nurse session	LWCCG	Practice nurses
22/10/2014	Bereavement event	Boston	STAFF/PUBLIC
27/10/2014	Richmond GP practice	LWCCG	Practice staff
28/10/2014	Involving Lincs network event		Voluntary sector/public
29/10/2014	Lincoln City South staff event	Lincoln	Staff
29/10/2014	Skegness PPG	Skegness	Public/practice manager
03/11/2014	ASC roadshow	Hemswell	staff
06/11/2014	Skeg. NT event	Skegness	Staff
07/11/2014	ASC roadshow	Lincoln	staff
10/11/2014	Welton GP practice visit	LWCCG	Practice staff
11/11/2014	Presentation to Peterborough Hosp.	Peterborough	CX/board members
12/11/2014	HW provider event	Stamford	Local Providers
13/11/2014	Healthwatch provider event	Sleaford	Local Providers
17/11/2014	Woodland GP practice	LWCCG	Practice staff
17/11/2014	North Lincs joint scruitny	Grimsby	Councillors/clinicians
18/11/2014	ASC roadshow	Louth	staff
18/11/2014	Health and wellbeing network meeting	Lincoln	Providers/staff/councillors/public
19/11/2014	ASC roadshow	Boston	Staff
19/11/2014	Healthwatch provider event	Lincoln	Providers
20/11/2014	Healthwatch provider event	Horncastle	Providers
21/11/2014	ASC roadshow	Spalding	Staff
28/11/2014	Alford PPG	Alford	public/staff
24/11/2014	LinCa conference	Lincoln	providers

ii) Primary care providers

CCGs are one of the driving forces behind the reconfiguration programme and members of the programme Board that approved the BCF Plan have been briefing their members. Briefings have been held for practice managers across the area. There is a regular reconfiguration focussed newsletter issued to all members of staff and the general public. Primary Care providers have been part of CDGS, ERGs, Care Summits, workforce and drop-in sessions etc. in the same way as other providers.

The May 2014 Care Summit invited the Lincolnshire Medical Committee to join the BCF and LHAC programmes. This has been very successful and adds significant value. A special countywide interactive session for GPs was held in July 2014 and more are planned.

Primary care providers have been involved with the Specialist Services Pooled Budget BCF Scheme, the joint Finance Committees, the St Bernard's School project supporting short breaks for children, the Dilnot reforms to support implementation of the Care Act and the wider LHAC programme.

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

The County Council's Director of Children's Services and the Director of Adult Social Services are members of the LHAC Board, which is chaired by the Director of Public Health and participate in the BCF Plans. Social care and public health are 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 who is, herself, another Portfolio Holder within the County Council. There is formal and informal engagement with the Health Scrutiny Committee and Health and Wellbeing Board. 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. (See also earlier related documentation section: Letter from the Chairman of LinCA). These sectors have participated in One to One discussions, Group Workshops, the Care Summits and locality meetings and presentations.

Investment in engagement summarised in this section will continue but with a shifting emphasis towards implementation of the BCF schemes.

In the Greater East Manchester Clinical Support Unit qualitative survey:

- When asked to prioritise, most people chose 'having a range of services' as their top priority closely followed by 'having consistent quality and safety'.
- The majority chose 'having financially sustainable services' as their lowest priority.

Through their engagement with the LHAC and BCF scheme planning, all service providers are incorporating the implications of the BCF in their operational plans.

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?

Lincolnshire's vision for service reconfiguration includes 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. All

local providers are incorporating the impact of the BCF Plan within their own plans to ensure consistent alignment. Lincolnshire's objectives are consistent with the national requirement to reduce emergency admissions by 3.5% in 2015. 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 the LHAC and BCF schemes will result in a significant financial gap across Lincolnshire Health and Social Care Services as identified in LHAC Phase 1. This gap is estimated at approximately £282 million gross before efficiency savings (£68 million net) in the financial year 2018/19.

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 System Resilience Group 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 to progress a reduction of 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, BCF schemes 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.

Modelling exercises indicate that if this reduction is achieved, the impact on acute providers will be as follows:

- Planned non elective admissions prevented in 2015/2016 - 2,492
- Planned reduction of in outturn between 2013/14 and 2015/16 - £3,628,000

(Taken from the Provider Commentary shown at Annex 2). Through their engagement with the process, local providers are incorporating the impact of the BCF schemes in their plans.

The modelling work was moderated to ensure there is no duplication of QIPP planning. We fully expect that the consequences of LHAC including the BCF schemes 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.

The Specialist Services Pooled Budget theme and the BCF schemes within that are specifically designed to enhance mental health services by providing a co-ordinated approach to commissioning. The BCF schemes will not negatively impact the parity of esteem for mental health.

Lincolnshire's early modelling work for the impact on acute providers was cited as a case study of good practice in NHS England's "Better Care Fund (BCF) Support and Resources Pack for Integrated Care" issued to CCGs in December 2013.

Workforce Considerations

The workforce is central to shaping and achieving the future vision of integrated care across Lincolnshire. The design of an effective integrated care system will focus on ensuring there are staff with the right skills, in the right settings, at the right time with the right values and behaviours to deliver high quality care. This will be achieved through a workforce model comprising of multi-disciplinary primary and secondary care professionals working within integrated health and social care teams.

The workforce modelling has been driven by optimising capacity, capability and flexibility, in order to deliver a productive, efficient and sustainable workforce. In practice, this is reflected in a shift of resources from acute to community settings. Therefore the approach is not simply based on headcount reductions or savings on staff costs – where changes in FTEs are indicated throughout this section, it must be remembered that these are not outright reductions. As such, modelling has identified staff (in FTEs) who will be affected by this change, which includes changes in roles and/or working practices, rather than simply a reduction in headcount or savings on staff costs.

The new workforce will require staff with an evolved skill-set to adapt to different ways of working and proactively care for people at home or in the community through multi-disciplinary teams and extended operating hours of some services.

The scale and scope of workforce change required to deliver integrated health and social care is significant and the challenges in achieving this are complex, yet achievable through a robust strategic Workforce and Organisational Development plan.

The key challenges and recommendations for the local health economy of Lincolnshire are:

Challenges	Recommendations for a strategic workforce plan
1. The 'big supply challenge' reflecting the inability to recruit talented and skilled clinical staff including A&E consultants, paediatric nurses, GPs, nurse practitioners and allied health professionals.	• 'Core' training and rotational programmes across both acute and community settings to increase overall workforce adaptability. • Define career pathways within and across professions to retain and incentivise the workforce through career advancement.
2. Developing strong leadership to empower staff when delivering new models of care and driving quality improvement through new working practices	• Partnership working to effectively coordinate health and social care staff. • Effectively resource a leadership and OD programme to support Neighbourhood Teams (NTs) and whole-system transition.
3. Optimising workforce capacity through the effective deployment and utilisation of staff across staff groups to increase workforce productivity and efficiency.	• Enhance the core skills and competencies of staff across professions to achieve a more flexible and agile workforce, through a combination of on-the-job and off-the-job training. • Minimise redundancies by exploring all available options for upskilling and redeployment.
4. Introducing integrated health and social care roles and implementing new ways of working to deliver whole-system	• Engage staff in the design and implementation of new roles and

transformation	ways of working. • Build on existing workforce initiatives that have worked well e.g. independent living teams.
5. Establishing truly integrated education and training provision to ensure the workforce is fit for the future.	• Consider training provision offered across primary care, community, mental health and acute setting, and plan how to best align resources. • Redesigning of core skills training for professions across organisational boundaries e.g. nursing, therapies.
6. Breaking down organisational boundaries and developing shared values and culture.	• Engage staff to understand where communication barriers and silo-working exist within and across organisations and develop realistic solutions.

The total workforce spend across health and social care organisations is £347.2million and the aim of workforce modelling is to achieve a clinically and operationally sound model that incorporates a 20% reduction in workforce costs (as per Phase One assumptions). As highlighted previously, this reduction is likely to be achieved by a change in what, where and who undertakes various roles, rather than a net reduction or saving in staff costs through redundancies.

The Expert Reference Groups considered the workforce implications associated with changing the models of care for their workstream areas and considered how resources could be deployed differently across design areas. Outputs from ERGs were fed into the Workforce Programme Board for further review by HR and OD experts.

Outputs have been used alongside current staff in post lists to define the workforce required to deliver the planned service changes in each of the seven BCF Themes. Workforce modelling has followed an iterative approach with key stakeholders in each group working collaboratively across organisations to develop, test and define the optimum workforce requirements for the delivery of integrated care across Lincolnshire.

Future state workforce modelling for each theme has progressed at different rates, with focus on identifying the increased resource required for community teams following the activity shift from the acute setting. The detailed development was also dependent on ease of design implementation and the level of complexity required for workforce change.

The modelling approach includes the following key steps:

- Agree current workforce baseline across each organisation.
- Consider patient pathways, key activities and working practices for each design area
- Model the workforce impact of activity shifts from the acute to community setting.
- Explore the competencies and skills required for each design area and how that translates to roles (new and existing) and working practices.
- Review current capacity versus future requirement (including local variance)
- Establish training and development requirements across the system
- Model indicative cost implications and subsequent investment to deliver change.
- Develop a workforce and Organisational Development plan for managing the transition

Workforce modelling work is continuing under the Workforce and Organisational Development Board.

It is worth noting that over the last few months there has been considerable national interest in the Lincolnshire programme. A press release was issued following Simon Stevens announcements on the NHS calling for more health and care services to be delivered closer to patients' homes and through expanded community services making best use of community hospitals. This echoes the overall LHAC's blueprint and the BCF schemes and emerging model for health and care. The local media picked up the close alignment with positive coverage of the programme.

Sir John Oldham who spoke at the Care Summit on 8th May said "The current health system is still trying to deal with the separate parts of the person rather than care for them as a whole. The world is changing. Whether we like it or not, no change is not an option. I have to commend the work you have done in Lincolnshire. I am amazed. It would give me a great deal of confidence if I lived in the county that you are going to tackle these problems."

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.

Health and Wellbeing Board Details

ROCR approval applied for
Version 3

Please select Health and Wellbeing Board:

Lincolnshire

Please provide:

Glen Garrod
glen.garrod@lincolnshire.gov.uk

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

Health and Wellbeing Funding Sources

Lincolnshire

Please complete white cells

	Gross Contribution (£000)	
	2014/15	**2015/16**
Local Authority Social Services		
Lincolnshire	59,221	85,850
<Please select Local Authority>		
<Please select Local Authority>		
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<Please select Local Authority>		
Total Local Authority Contribution	**59,221**	**85,850**
CCG Minimum Contribution		
NHS South West Lincolnshire CCG		7,905
NHS South Lincolnshire CCG		9,810
NHS Lincolnshire West CCG		14,497
NHS Lincolnshire East CCG		16,187
-		-
-		-
-		-
Total Minimum CCG Contribution	**-**	**48,399**
Additional CCG Contribution		
NHS South West Lincolnshire CCG	**1,913**	**10,360**
NHS South Lincolnshire CCG	**2,294**	**12,490**
NHS Lincolnshire West CCG	**3,352**	**18,260**
NHS Lincolnshire East CCG	**4,020**	**21,890**
<Please Select CCG>		
<Please Select CCG>		
<Please Select CCG>		
Total Additional CCG Contribution	**11,579**	**63,000**
Total Contribution	**70,800**	**197,249**

Summary of Health and Wellbeing Board Schemes

Lincolnshire

Please complete white cells

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	being pooled to support joint development of neighbourhood teams, as
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	(286)	(249)	
Reduction in non-elective (general + acute only)	(952)	(3,747)	3,747
Other	-	(763)	
Total	**(1,656)**	**(5,800)**	**3,747**

<Please explain discrepancy between D44 and E44 if applicable>

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)**
1.1. Intermediate Care - Reablement	Community Health		CCG			NHS Mental Health	CCG Minimum Contribution	2,000	2,000
1.2. Intermediate Care - Community Response & Reablement	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution	2,100	
1.3. Intermediate Care - Health Funds	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution		3,600
1.4. Intermediate Care - 30 Day Post Discharge	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution		2,800
1.5. Intermediate Care - LCC funds	Social Care		Local Authority			Private Sector	Local Authority Social Services		1,800
2.1. 7 Day Service - Provider of Last Resort	Social Care		CCG			Private Sector	CCG Minimum Contribution	500	500
2.2. 7 Day Service - Assessments and Care	Social Care		CCG			Local Authority	CCG Minimum Contribution		300
3.1. Neighbourhood Teams - Community Integrated Reablement Service and Agency Staff	Social Care		CCG			Local Authority	CCG Minimum Contribution	1,400	1,400
3.2. Neighbourhood Teams - Monitoring Centres	Social Care		CCG			Private Sector	CCG Minimum Contribution	180	180
3.3. Neighbourhood Teams - Demographic Growth	Social Care		CCG			Private Sector	CCG Minimum Contribution		2,125
3.4. Neighbourhood Teams - Co-responders	Social Care		CCG			Local Authority	CCG Minimum Contribution	150	150
3.5. Neighbourhood Teams - Programme Support Costs	Social Care		CCG			Local Authority	CCG Minimum Contribution	150	100
3.6. Neighbourhood Teams - Health Funds	Community Health		CCG			NHS Community Provider	CCG Minimum Contribution		7,600
3.7. Neighbourhood Teams - Social Care Funds	Social Care		Local Authority			Private Sector	Local Authority Social Services		20,000
4.1 Wellbeing - Prevention & Wellbeing - Community Equipment Minor Adaptations and Assisted Technology (CEEMAT)	Social Care		CCG			Private Sector	CCG Minimum Contribution	1,000	1,000
4.2. Prevention - Prevention - Integrated Community Equipment Services (ICES)	Community Health		Joint	54%	46%	Private Sector	Local Authority Social Services	600	5,800
4.3. Prevention - DFG	Community Health		Local Authority			Private Sector	Local Authority Social Services		4,900
5.1. Specialist Services - Maximising Independence	Social Care		CCG			Local Authority	CCG Minimum Contribution	280	280
5.2. Specialist Services - Demographic Growth	Social Care		CCG			Private Sector	CCG Minimum Contribution		2,125
5.3. Specialist Services - Mental Illness Prevention	Mental Health		CCG			NHS Mental Health Provider	CCG Minimum Contribution	375	370
5.4. Specialist Services - Programme Support Costs	Social Care		CCG			Local Authority	CCG Minimum Contribution		100
5.5. Specialist Services - Future Risk Sharing	Social Care		CCG			Local Authority	CCG Minimum Contribution	4,400	4,400
5.6. Specialist Services - Learning Disabilities S(75) Health Funds	Other	Learning Disabilities	CCG			Private Sector	CCG Minimum Contribution	10,401	10,401
5.7. Specialist Services - Adult MH Support Schemes	Mental Health		CCG			Charity/Voluntary Sector	CCG Minimum Contribution	647	646
5.8. Specialist Services - MH Contract (Health Funds)	Mental Health		CCG			NHS Mental Health Provider	Additional CCG Contribution		63,000
5.9. Specialist Services - MH and LD Community	Mental Health		Local Authority			NHS Mental Health Provider	Local Authority Social Services	43,800	51,400
6.1. Carers Support	Social Care		CCG			Private Sector	CCG Minimum Contribution	200	200
7.1. Women and Childrens - Promoting Independence	Social Care		CCG			Local Authority	CCG Minimum Contribution	500	370
7.2. Women and Childrens - Promoting Independence CAMHS	Social Care		CCG			NHS Mental Health Provider	CCG Minimum Contribution	350	350
7.3. Women and Childrens - Programme Support Costs	Social Care		CCG			Local Authority	CCG Minimum Contribution	31	100
7.4. Women and Childrens - CAMHS S75	Mental Health		CCG			NHS Mental Health Provider	CCG Minimum Contribution		4,844
7.5. Women and Childrens - S256 Childrens	Continuing Care		CCG			Charity/Voluntary Sector	CCG Minimum Contribution	521	521
8.1. Enablers - Care Act	Social Care		Local Authority			Local Authority	Local Authority Social Services		2,000
8.2. Enablers - LHAC	Social Care		CCG			Private Sector	CCG Minimum Contribution	1,220	1,937
Total								**70,805**	**197,299**

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	(818)	350	(286,300)	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						(1,656,360)		

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)	350	(249,200)	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	(2,240)	1,490	(3,337,600)	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						**(5,799,980)**		

Lincolnshire

Red triangles indicate comments

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

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

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.

Lincolnshire

Red triangles indicate comments

Planned deterioration on baseline (or validity issue)

Planned improvement on baseline

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

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 2013/14	Planned 14/15 (if available)	Planned 15/16
Do care and support services help you to have a better quality of life (% ASC survey). Source: Annual Adult Social Care Survey as part of ASCOF–data provided by Adult Care Performance Team. (Note Planned 14/15 figures are	*Metric Value*	90.0	91.0	92.0
	Numerator	378	382	386
	Denominator	420	420	420
Improvement indicated by:	Increase			

Local Metric

Metric		Baseline 2013/14	Planned 14/15 (if available)	Planned 15/16
Proportion of people feeling supported to manage their (long term) condition. Source: Annual GP Patient Survey provided by Greater East Midlands CSU. (Note Planned 14/15 figures are indicative)	*Metric Value*	63.0	63.5	64.0
	Numerator	9,418	9,504	9,600
	Denominator	14,933	14,967	15,000
Improvement indicated by:	Increase			

References/notes

Population projections are based on Subnational Population Projections, Interim 2012-based (published May 2014)

1. Based on "Personal Social Services: Expenditure and Unit Costs, England2012-13" (HSCIC) http://www.hscic.gov.uk/catalogue/PUB13085/pss-exp-eng-12-13-fin-rpt.pdf
2. There is no robust national source for the average annual saving due to being at home 91 days after discharge from hospital in to reablement / rehabilitation services. Therefore HWBs should provide the estimate that underpins their planned financial savings, which it is assumed will include the impact of reduction admissions to hospital and to residential car
3. Based on 12-13 Reference Costs: average cost of an excess bed day. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/261154/nhs_reference_costs_2012-13_acc.pdf

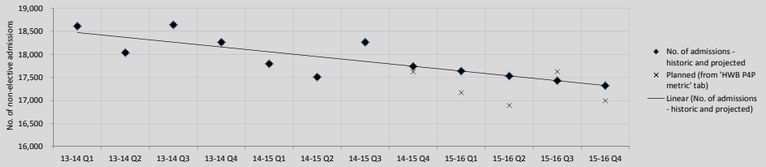
Lincolnshire

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

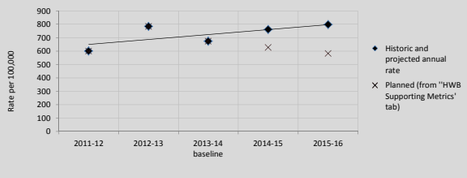


Metric		Projected				
		2014 -2015 Q4	2015-16 Q1	2015-16 Q2	2015-16 Q3	2015-16 Q4
Total non-elective admissions (general & acute), all-age	*Quarterly rate*	*2,436.1*	*2,405.4*	*2,391.2*	*2,376.9*	*2,346.0*
	Numerator	*17,742*	*17,637*	*17,532*	*17,428*	*17,323*
	Denominator	*728,288*	*733,220*	*733,220*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

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

Residential admissions

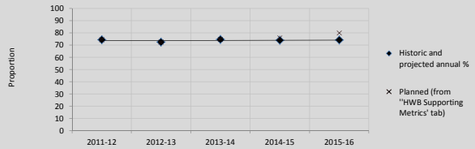
Metric		2011-12 Historic	2012-13 historic	2013-14 baseline	2014-15 Projected	2015-16 Projected
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Historic and projected annual rate*	600	785	674	*761*	*798*
	Numerator	895	1,215	1,045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

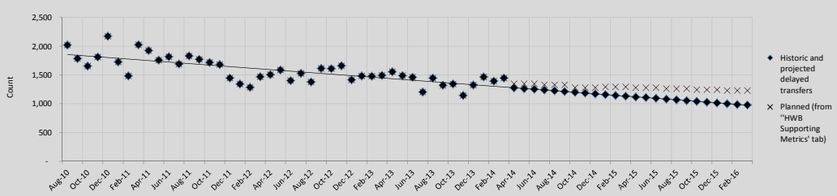
Metric		2011-12 Historic	2012-13 Historic	2013-14 Baseline	2014-15 Projected	2015-16 Projected
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Historic and projected annual %*	74.4	72.4	74.6	*74.0*	*74.1*
	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																												Baseline											
		Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14
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	1,830	1,775	1,720	1,683	1,449	1,342	1,285	1,472	1,507	1,587	1,401	1,531	1,382	1,615	1,610	1,658	1,414	1,485	1,477	1,491	1,557	1,489	1,463	1,203	1,448	1,321	1,345	1,143	1,324	1,467	1,394



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

	Linear projection* (set so cannot fall below zero)																					
Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
1,449	*1,278*	*1,264*	*1,251*	*1,238*	*1,225*	*1,212*	*1,199*	*1,186*	*1,173*	*1,159*	*1,146*	*1,133*	*1,120*	*1,107*	*1,094*	*1,081*	*1,068*	*1,054*	*1,041*	*1,028*	*1,015*	*1,002*	*989*	*976*

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

Section Title / Scheme Name / Worksheet	Status	First Significant Re-draft	Internal Reviewer	Notes
Summary information	Final			
Vision	Helen Dabbs Reviewed	Jay Rebbeck	Glen Garrod, David Laws, David O'Connor	
Case for change	In progress	Jay Rebbeck	Glen Garrod, David Laws	
Key milestones	Minor amendments required	David O'Connor / Jay Rebbeck	Glen Garrod, David Laws	Minor changes to GANNT needed
Overarching governance	Minor amendments required	David O'Connor / Jay Rebbeck	Glen Garrod, David Laws	Minor changes to Governance chart needed
Management and oversight	Minor amendments required	David O'Connor / Jay Rebbeck	Glen Garrod, David Laws	
Planned BCF Schemes	Minor amendments required	Jay Rebbeck		Ready pending any revisions to scheme list from Annex reviews
Risk log	In progress	David O'Connor / David Laws / David Boyd	David O'Connor / David Laws	Risk section needs more on mitigation & financial risks.
Contingency plan and risk sharing	Internal BCF Team Reviewed	David Boyd	David Laws / David O'Connor	
Alignment	In progress	Jay Rebbeck	Glen Garrod, David Laws & David O'Connor	
National Conditions	In progress	David Boyd	Glen Garrod, David Lawsaws	
Engagement	Minor amendments required	David Boyd	David O'Connor	David Boyd has made David O'Connor's amends & workforce related comments from KPMG.
Annex 2 : Provider commentary	Minor amendments required			
Intermediate Care	Minor amendments required	Jay Rebbeck	Yee Cho	
Seven day service provision	In progress	Jay Rebbeck	Lynne Bucknell	
Neighbourhood Teams	Minor amendments required	Jay Rebbeck Rebbeck	Yee Cho	
Wellbeing	In progress	Jay Rebbeck	Yee Cho	
Specialist Services Pooled Budget	Minor amendments required	Jay Rebbeck	Justin Hackney	
Carers Support	Minor amendments required	Jay Rebbeck	Justin Hackney	
Women's and Children's - CAMHS	In progress	Jay Rebbeck	Sally Savage	
Enablers	Minor amendments required	Pete Sidgwick / David O'Connor		
HWB Funding Sources	Internal BCF Team Reviewed	Jay Rebbeck	Paula Pilkington	Helen Dabbs reviewing on Thurs
Summary	Internal BCF Team Reviewed	Jay Rebbeck	Paula Pilkington	Helen Dabbs reviewing on Thurs
HWB Expenditure Plan	Internal BCF Team Reviewed	Jay Rebbeck	Paula Pilkington	Helen Dabbs reviewing on Thurs
HWB Benefits Plan	Internal BCF Team Reviewed	Jay Rebbeck	Paula Pilkington	Helen Dabbs reviewing on Thurs
HWB P4P Metric	Internal BCF Team Reviewed	Jay Rebbeck	Paula Pilkington	Helen Dabbs reviewing on Thurs
HWB Supporting Metrics	Internal BCF Team Reviewed	Jay Rebbeck	Paula Pilkington	Helen Dabbs reviewing on Thurs
Metric trends	Internal BCF Team Reviewed	Jay Rebbeck	Paula Pilkington	Helen Dabbs reviewing on Thurs

KEY
Wider Lincs Review Complete
Helen Dabbs Reviewed
Internal BCF Team Reviewed
Final
Minor amendments required
In progress
Not started

Lincolnshire Better Care Fund Action Plan Tracker

ACTION PLAN REF	FEEDBACK DESCRIPTION	ACTION	OWNER	ACTION STATUS	OVERALL STATUS
1	A4-P4P: the overall level of ambition is not consistent with the quantified impact of the schemes contributing to a reduction in non-elective admissions	Confirm best approach to responding to request to reconcile two sets of numbers in PFP Metrics tab and HWB Benefits Plan - Note I propose just using the PFP period in the benefits tab.	Jay Rebbeck	Complete	Complete
		Jay & Paula to agree how best to update the benefits numbers for NEL admissions to reflect three quarters rather than four quarters.	Jay Rebbeck / Paula Pilkington	Complete	
2	A10-Supporting Metrics: information provided on Patient Experience Metric is not valid	Jay Rebbeck has already updated. Paula Pilkington/Emma Scarth to review and add in Planned 14/15 targets for metric.	Jay Rebbeck/Paula Pilkington/Emma Scarth	Complete	
3	A11-Supporting Metrics: information provided on Local Metric is not valid	Jay Rebbeck has already updated. Paula Pilkington/Emma Scarth to review and add in Planned 14/15 targets for metric.	Jay Rebbeck/Paula Pilkington/Emma Scarth	Complete	Complete
4	F4-BCF financial risks are not fully identified, inadequate contingencies, lack ownership	David Laws updating the financial risks as part of risk/benefits paper	David Laws/David Boyd	In Progress	Moderate rework
5	F5-Full budgets are not identified to meet the additional costs resulting from the new Care Act duties	Template 2 to be updated to explain discrepency between £39m and £20m Figure (with explanation agreed by Paula and David).	Jay Rebbeck / Paula Pilkington / David Laws	Complete	Complete
		Template 1 to be updated with £2.8m changed to actual figure of £2m	Paula Pilkington/Jay Rebbeck	Complete	
6	F9- Unrealistic savings	Draft the matrix aligning schemes to metrics.	Jay Rebbeck	Complete	Complete
		First cut at scheme level of high/medium/low impact / PP to review	Jay Rebbeck	Complete	
		High level one line summary of schemes descriptions have been completed by Paula	Paula Pilkington	Complete	
		Align schemes to link to section 2 benefits tab	Jay Rebbeck / Paula Pilkington	In Progress	In Progress
7	F9- Unrealistic savings	No action required as no quantitative benefits for the local metric and the patient experience metric	N/A	Complete	Complete
8	N3-The plan does not describe a clear overarching vision for the future of health and social care in the local area	Redrafting key / prioritised sections – Jay Rebbeck / David B to draft and circulate to Glen Garrod/AK/David Laws/Paula Pilkington for first line review and comment.	Jay Rebbeck	Complete	Complete
9	N3-The plan does not describe a clear overarching vision for the future of health and social care in the local area	Redrafting key / prioritised sections – Jay Rebbeck / David B to draft and circulate to Glen Garrod/AK/David Laws/Paula Pilkington for first line review and comment.	Jay Rebbeck	Complete	Complete
10	N3-The plan does not describe a clear overarching vision for the future of health and social care in the local area	Update the impact section of all Annexes as per the info. in the metric model - and send to Programme Directors for review.	Jay Rebbeck / Programme Directors	In Progress	Moderate rework
		Revise existing GANTT chart (high level key milestones of projects) so it is aligned with the agreed list of BCF theme and schemes	David O' Connor	In Progress	
11	N4-The plan does not sufficiently explain how the overarching vision will be achieved	Governance – noted further work underway including paper to JCB November – suggested high level points of decision making plus reference to over arching S(75) with draft intent re hosting etc arrangements and be explicit that this will evolve as part of Q4 14/15 project plan. Paula Pilkington/David Laws meet with David Coleman on	Paula Pilkington / David O'Connor (liaising with David Laws/Glen Garrod)	In Progress	Moderate rework
12	N4-The plan does not sufficiently explain how the overarching vision will be achieved	Aligning with work in section 8/9/10	Jay Rebbeck	In Progress	Moderate rework
13	N7-There is insufficient detail as to how the schemes will be delivered	Jay Rebbeck to liaise with Programme Directors re giving clarity at scheme level (and ensuring consistent format for all annexes)	Jay Rebbeck / Programme Directors	In Progress	Moderate rework
		Paula Pilkington to email PD's plus Jay Rebbeck to make intros	Paula Pilkington	Complete	
		Write new Annex for 8. Enablers - Jay has pre-populated. David to complete the next draft.	David Laws	In Progress	
14	N8-Insufficient documentation of the risks	Review Risk Log – David L and Sandra as part of risk paper	David Boyd/David Laws/Sandra Williamson	In Progress	Moderate rework

KEY
Wider Lincs Review Complete
SW Lincs Review Complete
Complete
Moderate rework
Significant rework

15	N5-The plan is not aligned	Revised explanation of how the BCF Plan aligns with CCG Plans and Provider Plans - Ref GANT chart above	Jay Rebbeck / Paula Pilkington	In Progress	Moderate rework
16	N1-The National Conditions have not been met	Respond to David Boyd's information request so David can redraft the narrative.	Glen Garrod/David Laws	In Progress	Moderate rework
		Paula Pilkington has forwarded the make-up of the £20m - and this will be included in the redraft of the section.	Paula Pilkington	Complete	
17	N9-Insufficient evidence of engagement	David Boyd has developed a first draft engagement section, structuring the document around the What Good Looks Like Criteria.This includes a table explaining what BCF engagement has taken place for each scheme.	David Boyd	Complete	Moderate rework
	N9-Insufficient evidence of engagement	Paula Pilkington is working with Programme Directors to complete a table describing what BCF specific engagement has taken place - and what/when/who this occured. Once received David will amend the section with the revised information.	David Boyd / Glen Garrod / Paula Pilkington	Complete	
	N9-Insufficient evidence of engagement	Review and comment on first draft of engagement section.	Glen Garrod	In Progress	

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BCF TASK AND FINISH GROUP

TERMS OF REFERENCE

1. OVERALL PURPOSE

A Time limited group (as yet undetermined) to support:

- Co-ordination of BCF related activity on behalf of the Joint Commissioning Board
- Compilation of the BCF Agreement Documentation – notably the required Section 75 agreement
- Response to any subsequent national requirements and issues identified by JCB/JDBs or the Health & Wellbeing Board

2. Governance

The BCF Task Group is accountable to the Joint Commissioning Board and beyond that to the Health and Wellbeing Board.

3. MEMBERSHIP

BCF Programme Director	Glen Garrod	Director of Adult Social Services, LCC
BCF Vice Programme Director	Allan Kitt	Chief Officer SWLCCG
JDB Programme Directors	Yee Cho Sarah Furley Justin Hackney Sally Savage Pete Sidgwick	PD Proactive Care JDB PD Operational Resilience JDB PD Specialist Adult Services JDB PD Women & Children's JDB Chief Commissioning Officer - LCC
Project Manager for 15/16 S(75) compilation	Paula Pilkington	Deputy CFO SWLCCG
BCF Finance Representation	Rob Croot David Laws Sandra Williamson	CFO LWCCG Strategy Financial Advisor LCC CFO LECCG
BCF Information Lead	Emma Scarth	Commissioning Manager LCC

4. KEY ROLES AND FUNCTIONS

The BCF Task and Finish Group is responsible for the following functions:

a. Supporting a co-ordinated approach on behalf of the Joint Commissioning Board utilising Joint Delivery Boards by:-

- Revision of BCF submission as required by December subject to grading at national level.

- Reviewing Projects Funded from BCF for 14/15 and 15/16 to assess delivery against the BCF key performance indicators and pooled budget ambition.

- Review delivery of the collective JDB planned financial savings against the Lincolnshire agreed savings plan

- Establishing a monthly BCF performance reporting process to JCB and maintain an overview of delivery to ensure a co-ordinated approach is taken.

- Ongoing reporting of budget position against pooled budget ambition and spend against BCF combined fund

- Production and oversight of required Section 75.

b. Support Compilation of BCF S(75) documentation by:-

- Satisfying national pre-conditions
- Maintaining a firm link with the aspirations of LHAC
- Keeping focus on the high level principles
- Ensuring appropriate an action plans are produced and supporting delivery through JDBs

c. Supporting timely response to National Requirements and issues identified by JCB/JDBs by:-

- Discussing highlighted issues to reach a common understanding and agreement of solution or to make recommendations where appropriate

- Being the conduit for responses to national and regional requirements and ensuring a co-ordinated and targeted response to BCF related activity on behalf of the JCB.

5. REPORTING ARRANGEMENTS

The BCF Task and Finish Group is a working group for the Joint Commissioning Board

6. FREQUENCY OF MEETINGS

The meeting will be monthly (or more frequently as required)

7. CESSATION OF GROUP

It is anticipated that this group will cease once the policy direction of the new Government is made clear with respect to the BCF and subject to decision by JCB. The group will be reviewed at the February meeting and a recommendation for any iterations made to the JCB.

Lincolnshire COUNTY COUNCIL
Working for a better future

REPORT TO JOINT COMMISSIONING BOARD

REPORT	
Report Title:	**Better Care Fund S(75) Pooled Fund Update**
Appendices	Appendix A – BCF Task Group Terms of Reference Appendix B – Project Plan
Senior Responsible Officer	Glen Garrod, Director of Adult Social Services (LCC)
Author:	Paula Pilkington, Deputy Chief Finance Officer (SWLCCG)
Date of meeting:	25 November 2014

Background:

Nationally there are 5 Health and Social Care groups whose financial level of ambition for pooling of resources is significantly higher than the national minimum contribution of which Lincolnshire is one. There is therefore considerable national interest and focus upon Lincolnshire's S(75) arrangements and the signing of the agreement prior to the end of March 2015 under pinned by robust governance approval arrangements is now an imperative.

With best endeavours there may be some components which may not be fully agreed by February which will need to be clearly identified and logged with an agreed timeframe for resolution, to support the overall agreement being signed.

Summary Recommendations

The Joint Commissioning Board is asked to :-

1. Note the national profile of Lincolnshire BCF S(75) arrangements and fully commit to ensuring a signed agreement by March 2015, noting a log for areas which require further resolution with a clearly agreed timeframe.

2. Ratify the project plan and the lead areas of responsibility

3. Ratify the BCF Task Group Terms of Reference

4. Consider the intended approach to pooled fund flexibilities for the key areas and advise on any changes required.

5. Decide on the "Host" organisation which will be responsible for appointing one of its officers as the Pooled Fund Manager noting that the roles will largely be discharged through the governance arrangements to the JCB, JDBs and individual organisations.

6. Consider adopting a Performance Manager function as part of the S(75) arrangement

Key Issues – S(75) Project Management – progress update

At the October meeting, the JCB approved the high level project plan and timeline for the compilation of the S(75) agreement. Since then the BCF Task Group have met and are giving focus on timely resubmission of the BCF documentation and also co-ordination of the S75 documentation.

The JCB are requested to ratify the BCF Task Groups terms of reference attached in Appendix A.

The project plan for the compilation of the S(75) documentation has been updated with work stream leads identified and includes the timeline for the approval process. It is extremely tight and will require a penultimate draft of the agreement by end of January to enable formal consultation February and March. A degree of pragmatism will be required. In particular this means that the S(75) documentation will reflect the BCF resubmission

In this spirit of pragmatism it is proposed that the BCF Pooled Fund section 75 Agreement will be structured as a framework. This framework will operate at three levels.

At the highest level the Agreement will record the principles for the establishment and management of the pooled fund itself to include the amount of the Fund, the contributions, the host, The pooled fund manager, the governance arrangements, the risk arrangements (including overspends and risk on reduction to non-elective activity) and the general terms and conditions including duration and termination.

At the next level the Agreement will establish the rules governing the use of the Pooled Fund. To a large extent this will be done by incorporating existing contractual arrangements (including existing section 75 Agreements into the Pooled Fund arrangements. In this way the rules for spending the Pooled Fund will be the rules by which this money is already spent. This limits the amount of new bespoke drafting that will be necessary.

Although it is understood that a number of the existing section 75 arrangements are under review and subject to some degree of renegotiation the need for pragmatism dictates that there will come a point at which further amendment before 1 April cannot be accommodated within the Pooled Fund section 75 project. Further change will need to be made after 1 April 2015 on the basis of change control provisions.

The final level will deal with how changes are made to the arrangements that will exist from the commencement. This will be dependent on the governance arrangements and being clear how business case generation, change management and decision-making sign off will be dealt with. Change provisions at the level of the Pooled Fund section 75 Agreement will need to join up with change provisions in individual contract arrangements

There are three critical factors which require particular focus and impetus to conclude:

decision making scheme of delegation and governance arrangements	This is being closely linked to the work which David O'Connor is leading in conjunction with the JCB and delivery boards to codify future governance arrangements. The documentation also needs to reflect the legal responsibility for making changes to the S(75) as at 1st April which will largely rest at organisational level via signing a change control provision to the S75, albeit in practice the recommendations will have been agreed in principle at JDB and ratified at JCB.
financial performance and risk management issues	In October the JCB agreed in principle to a one-off contingency reserve of £3.75m to manage the financial risk associated with payment for performance target on reduction to non-elective activity. David Laws and Sandra Williamson are leading the wider financial risk management framework which will give clarity on the risks which should sit at organisational level, the risk management framework at JDB level and the framework at JCB level with clear parameters as to the apportioned share of the risk. More generally risk will also be managed at the level of individual contract and section 75 arrangements. These different level of risk have to be aligned. Further the financial governance needed to be determined and in particular how the pooled fund will be managed and how pooled fund management relates to management of individual streams through existing contractual and section 75 arrangements
clarity on provider contractual arrangements on 1st April 2015.	As set out above much of this will be covered by existing arrangements which will be brought under the pooled fund section 75 framework. However, where there are not such already available mechanisms for determining how pooled fund expenditure will be governed, the S(75) framework will need to define where the legal responsibility and authority sits to contractually commit resources recognising that much of the expenditure is baseline and many of these contracts will need to be agreed prior to 1st April 2014. The legal responsibility will need to sit at individual organisational level.

The JCB are requested to ratify the Project Plan attached in Appendix B and to note that a further paper will be brought to the next JCB for discussion and approval which will give clarity on the approach to the above within the S(75) documentation.

Pooled Fund Flexibilities – intended approach.

The Head of Legal Services (LCC) is providing expert advice and support to ensure these issues are clarified within the S75 documentation in line with agreements reached by JCB. The framework provides sufficient flexibility for the S(75) agreement to reflect the agreed position.

For example resources may be aligned which would enable parties to independently contract for services (under the direction of the delivery board), or to follow a lead commissioner model which transfers statutory functions to one organisation who then contractually commits the resources on behalf of all parties. There can also be differential timelines across different projects to ensure the balance between stability, continuity and progression is achieved. The importance is to ensure the legal framework represents the contractual position as at 1st April 2015 and provide the mechanism to make changes through a signed change control provision.

The BCF task and finish group meeting in December aims to conclude the intended approach to the pooled fund flexibilities for most areas. There may be some more complex aspects such as ICES which require further debate. A recommendation will be forwarded to the JCB meeting in December.

The current intended approach is summarised below for the key areas within each Joint Delivery Board:

Women and Childrens Joint Delivery Board

Collectively this contributes £6.2m to the £197.3m – the LCC contribution to CAMHs S(75) is over and above the £197m and will become part of the unified S(75) agreement

CAMHs	This is a well-established agreement and current governance framework is working well. The intention is to bring CAMHs into the unified S(75) under a lead commissioner arrangement with LCC as lead organisation and to discharge the responsibility to the Women and Children's JDB. The service is being re-commissioned and we need to ensure S(75) framework has 3 year duration to underpin the new contractual framework.
Current children service spend under S(256) arrangements	The children's services under current S(256) arrangement which are part of the health minimum contribution within the £197m BCF will also be part of the unified S(75) framework with LCC as lead organisation and responsibility discharged to Women and Children's JDB.
Projects within £20m	For those projects linked to Women and Children's funded from the £20m stream will also be part of the unified S(75) framework with LCC as lead organisation and responsibility discharge to the Women and Children's JDB (*noting the context of the contingency reserve*)
Potential Expansion post 1st April	The Women & Childrens JDB is currently considering additional opportunities for the pooling of health and social care funds for children's services to support more integrated care in line with SEND and promote more efficient use of joint funds. An initial area of focus will be joint spend on complex cases of care. A future paper will be brought to the JCB for consideration and any agreed changes to the pooled fund will be incorporated through a change control provision signed by all parties

Adult Specialised Services Joint Delivery Board

Collectively this contributes £132.7m to the £197.3m

Learning Disabilities	This is a well-established agreement and current governance framework is working well. The intention is to bring LD into the unified S(75) under a lead commissioner arrangement with LCC as lead organisation and to discharge the responsibility to the Adult Specialised JDB
Mental Health Baseline spend	As at 1st April 2015 the resources will be aligned across health and social care within the unified S(75) whereby CCGs will have a contract with the MH provider and LCC will continue with current contract arrangements for the provision of social care MH services. During 15/16 the ground work will be undertaken to develop a single integrated contract for health and social care with the effective date April 2016 and this responsibility will be discharged to the Adult Specialised JDB.
S(256)	The adult MH services under current S(256) arrangement which are part of the health minimum contribution within the £197m BCF will also be part of the unified S(75) framework with LCC as lead organisation and responsibility discharged to Adult Specialised JDB.
Projects part of £20m	For those projects linked to Adult Specialised Services JDB funded from the £20m stream will also be part of the unified S(75) framework with LCC as lead organisation and responsibility discharge to the Adult Specialised Services JDB (*noting the context of the contingency reserve*)
Expansion post 1st April	The Adult Specialised JDB has considered and approved in principle (subject to individual organisational agreement) to bring into the pooled fund arrangement other spend aligned to MH and LD services post 1st April to support the effective use of resources and planned savings targets plus support more streamlined services across health and social care. This includes MH/LD complex cases, social care funded packages of care and Joint funded packages of care for MH, other MH contracts and LD Responsible Commissioner out of county placements. Although this will not be part of the S(75) agreement from 1st April 2015, it is the aspiration to align these resources during 15/16 which will meant that virtually all Mental Health and LD services across health and social care will be under the unified S(75) arrangement

Proactive Care Joint Delivery Board

Collectively this contributes £54.5m to the £197.3m

Intermediate Care Baseline funds	As at 1st April 2015 the CCGs will largely have the current contractual commitments for intermediate care as will LCC and therefore at the start of the year the resources will be aligned across health and social care within the unified S(75). During the year this arrangement will need to be amended through the Section 75 change provisions to a lead commissioner model to underpin the re-procurement exercise and to confirm the exact financial contribution of all parties at that stage.

30 day post discharge from hospital	As at 1st April 2015 the CCGs are likely to have financial commitments for patients placed in 30 day care home beds post discharge from hospital as new pathways will not be established at the start of the year. It is envisaged that the resources will be re-utilised in a more effective way thereby releasing savings and once the pathway changes have been agreed these can be incorporated through a change to provisions of the S75. However until such time and as at 1st April the resources will be aligned across health and social care within the unified S(75).
Neighbourhood Teams	Different localities may be wanting to adopt a different approach. However it is anticipated that as at 1st April 2015, the CCGs will largely have the current contractual commitments for intermediate care as will LCC and therefore at the start of the year the resources will be aligned across health and social care within the unified S(75) and decision making is likely to be at organisational level albeit co-ordinated via the Proactive Care JDB. It is likely that 15/16 will lay the ground work for developing service and contractual model and any changes will be made through the change to provisions the S(75) agreement
Projects part of £20m	Those projects linked to Proactive Care JDB funded from the £20m stream will also be part of the unified S(75) framework with LCC as lead organisation and responsibility discharge to the Proactive Care JDB (*noting the context of the contingency reserve*)

Joint Commissioning Board – Enablers

Collectively this contributes £3.9m to the £197m

Dilnot – Care Act – part of £20m	The identified sum is £2m and forms part of the unified S(75) framework with LCC as lead organisation and responsibility discharge to LCC.
LHAC, enablers – part of £20m	part of the unified S(75) framework with LCC as lead organisation and responsibility discharge to JCB

The JCB are asked to consider the intended approach to pooled fund flexibilities for the key areas above and advise on any changes required to support discussions at the BCF task and finish group in December.

Key Issues – Host Organisation, Host Pooled Fund Manager, Performance Manager

There is a legal requirement to have a host organisation for the S(75). The host must be one of the parties to the section 75 Agreement. The host has the responsibility for the accounts and audit of the pooled fund arrangements. The host partner is then required to appoint one of its officers as the pooled fund manager responsible for:

- Managing the pooled fund on the host partners behalf and
- Submitting to the partners quarterly reports and an annual return about the income of and expenditure from the pooled fund and other information by which the partners can monitor the effectiveness of the pooled fund arrangements.

These assurance functions will largely be discharged via the Joint Commissioning Board or to Joint Delivery Boards at the level of the individual arrangements (almost at a sub-host level). The requirement for a Pooled Fund Manager is to ensure that the pooled funds are being deployed in line with the agreement and for having an overarching assurance responsibility. Again this role will largely be discharged to each of the Joint Delivery Boards and to individual organisations. The pooled fund section 75 Agreement will have to have robust financial and performance reporting mechanisms to enable the pooled fund manager to get the assurance they need that funds at the individual agreement level are being spent in accordance with the relevant terms and to monitor and respond to impacts on the pooled fund itself.

There are two issues for determination about the management of the pooled fund.

- The first is the degree to which the pooled fund can be a virtual pooled fund – i.e no transfers of money take place into a fund managed by a single host but instead funds held by different organisations are treated in accounting terms and managed as a single fund.

- The second issue is who should be the host and pooled fund manager.

To support the debate it is proposed that LCC is host organisation (this is balanced by JCB Chair being health). If LCC is the host then it must appoint one of its officers as the pooled fund manager. This would on the face of it prevent a pooled fund manager from being a representative from a CCG with deputy pooled fund manager role from LCC. However, under section 113(1A) of the Local Government Act 1972 LCC can enter into an agreement with a CCG under which the CCG makes available one of its officers to LCC.. An officer made available in that way is to be treated as an officer of LCC. This would potentially enable a CCG officer (albeit seconded to LCC) to be the pooled fund manager.

Furthermore for each JDB there will be identified finance lead(s) to provide the link to the Pooled Fund Manager.

Ultimately this will need to be co-ordinated via a finance leads group which should meet on a monthly basis.

A critical role will be delivery of key targets. Although not a mandated post under S(75) requirements, it is suggested that a Performance Manager role is also identified which LCC would be ideally placed to host. This role would be supported by a lead representative for each delivery board and also a sub group supported by CCG CSU CI and performance teams.

The JCB are requested to consider the above suggestion and decide on the Host Organisation, and Pooled Fund Manager.

The JCB is also asked to consider approving the Performance Manager Role so this can be woven into the S(75) documentation.

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Lincolnshire BCF Themes & Schemes

Theme ID	Theme	Scheme ID	Scheme	Scheme Description (mainly from Annex)	Finance ID	Finance Item	FY15/16 (£k)
1	Intermediate Care	IC1	Reablement	Development of individualised care plans for patients with increased risk of deteriorating health (identified through predictive risk planning), and, if admission to hospital is required, integrated discharge planning is commenced on day one of admission.	1.1	Reablement (Social Care)	**2,000**
		IC2	Community Response and Reablement (CR&R)	Supporting integration of reablement teams across the county. To provide assessments to allow timely hospital discharge, emergency responses and enabling people to return home sooner and maintain their independence longer.	1.2	Community Response and Reablement (CR&R) Health	-
		IC3	Lead Provider Model	Retendering of Intermediate Care to be a Lead Provider Model with a range of subcontracted services, which will eliminate duplication and improve efficiencies. Includes ULHT step down provision, Community Hospital step up provision & further development of the Single Point of Contact (SPoC)	1.3	Intermediate Care (Health Funds)	**3,600**
					1.4	30 Day Post Discharge	**2,800**
					1.5	Intermediate Care (LCC Funds)	1,800
2	7 Day Service	SDS1	Independent Living Team	Increasing the capacity of the Independent Living Team at weekends.	2.1	Provider of Last Resort	**1,500**
					2.2	Assessments and Care	**300**
3	Neighbourhood Teams	NT1	Community Based Neighbourhood Teams	Community Based Neighbourhood Teams	3.6	Neighbourhood Team Funds (Health Funds)	**7,600**
					3.7	Neighbourhood Team Funds (Social Care Funds)	20,000
		NT2	Community Integrated Reablement Service	Integrated reablement teams across the county. To provide assessments to allow timely hospital discharge, emergency responses and enabling people to return home sooner and maintain their independence longer.	3.1	Community Integrated Reablement Service and Agency Staff	**1,400**
		NT3	Co-responders	Provision of a 24/365 day availability for emergency responses.This scheme is a collaboration with Lincs Fire and rescue, East Midlands Ambulance service and Lincolnshire integrated Voluntary Emergency services.	3.4	Co-responders	**150**
		NT4	Programme Support	To support,develop,maintain and evaluate all of the proactive care workstreams. The cost incorporates the Proactive care Programme Director, the Adult Care Assistant Director & Demographic growth.	3.5	Programme Support Costs	**100**
		NT5	Protecting Adult Social Care	Provision of additional capacity for Neighnourhood Teams to meet additional demand from demographic growth.	3.3	Demographic Growth	**2,125**
4	Wellbeing	W1	Installation of Equipment, Minor Adaptations and TeleCare	The installation of a range of community equipment that includes simple aids to daily living (SADLs) and TeleCare, plus minor adaptations.	4.1	Prevention & Wellbeing - Community Equipment Minor Adaptations and Assisted Technology (CEEMAT)	-
		W2	Monitoring of TeleCare / Community Alarms	Provision of a Countywide Monitoring Centre that monitors Telecare and Community Alarms and initiates the appropriate response as agreed with the service user.	3.2	Monitoring Centres	**180**
		W3	Prevention - Integrated Community Equipment Services (ICES)	This is S(75) hosted by LCC (includes health and social spend) for community equipment and is an essential service to support all aspects of the integrated health and social care model.	4.2	Prevention - Integrated Community Equipment Services (ICES)	5,800
		W4	Prevention - Disabled Facilities Grant (DFG)	Utilisation of the Disabled Facilities Grant to provide adaptations in people's homes.	4.3	Prevention - DFG	4,900

5	Specialist Services	SS1	Learning Disability Services	Learning Disability pooled budgets and future risk sharing.	5.6	Learning Disabilities S(75) Health Funds	**10,401**
					5.5	Future Risk Sharing	**4,400**
					5.9	MH and LD Community	51,400
		SS2	Mental Health Services	Mental Health Contract, Mental Health community support schemes & mental health prevention.	5.7	Adult MH Support Schemes	**646**
					5.8	MH Contract (Health Funds)	63,000
				Mental Illness Prevention - Payment to LPFT to support the ongoing development of a preventative network of projects that offer support to people with Mental Health needs to help enable them to remain living independently.	5.3	Mental Illness Prevention	**370**
		SS3	Maximising Independence	Builds on work done by Fit for the Future team. Analysing individual care packages and to provide short term period of intensive care to increase peoples independence and reduce intervention.	5.1	Maximising Independence	**280**
		SS4	Programme Support	To support,develop,maintain and evaluate all of the Specialists care workstreams. The cost incorporates the Joint Health, the Adult care cost of an Assistant Director & demographic growth.	5.4	Programme Support Costs	**100**
		SS5	Protecting Adult Social Care	Provision of additional capacity in Specialist Services to meet additional demand from demographic growth.	5.2	Demographic Growth	**2,125**
6	Carers Support	CS1	Older Carers of People with a Learning Disability	Support to older carers of people with Learning Disabilities including preparing for unforeseen circumstances, providing information & advice.	6.1	Carers Support	**200**
		CS2	Carers of People with Dementia	Support to carers of people with Dementia including providing access to short breaks to help them sustain their role as a carer.	6.1	Carers Support	
7	Women's and Children's	WAC1	Promoting Independence	Supporting people through the transition from Education to adult life. Focus is on Employment, independent living, community inclusion and good health and wellbeing.	7.1	Promoting Independence	370
		WAC2	Refreshed Child and Adolescent Mental Health Service (CAMHS)	Refreshing the CAMHS - improving the model of care and outcomes for children and adolescents with mental health needs.	7.4	CAMHS S75	**4,844**
					7.2	Promoting Independence CAMHS	**350**
		WAC3	Short Breaks & Children Act Register	Established S(256) agreement for St. Bernard's School supporting short breaks for children & Children Act Register.	7.5	S256 Children's	**521**
		WAC4	Programme Support	To support,develop,maintain and evaluate all of the Women's and Children's Board workstreams. The cost incorporates the Health and Adult care cost of an Assistant Director.	7.3	Programme Support Costs	**100**
8	Enablers	E1	Care Act	To support the implementation of the Care Act and Dilnot recommendations.	8.1	Care Act	**2,000**
		E2	Lincolnshire Health and Care Transformation Programme	To develop and promote the integration of health and social care services through a coordinated transformation programme.	8.2	Lincolnshire Health & Care (LHAC)	**1,937**