Lincolnshire COUNTY COUNCIL
Working for a better future

Report on behalf of Lincolnshire Sustainability and Transformation Partnership

Report to:	**Adults and Community Wellbeing Scrutiny Committee**
Date:	**10 April 2019**
Subject:	**Integrated Community Care Portfolio**

Summary:

The Lincolnshire health and care community have all committed to working in partnership to realise the ambition that our default position is that care will be provided in the community unless there is a clinical need or value for money reason that care and treatment should be provided in an acute hospital setting.

Neighbourhood working is the foundation for making this happen. Across Lincolnshire we have identified twelve neighbourhoods. These neighbourhoods are used to define the area where colleagues from all agencies, statutory and voluntary, will come together to support the needs of the local population. We used the term Neighbourhood team to describe how professionals work together to support the needs of an individual. It is a way of working that is similar to the 'team around the child' framework, that is there is not a single team rather that teams of professionals come together to provide co-ordinated, person centred care to an adult with complex needs.

Whilst all twelve neighbourhoods are supported by a neighbourhood lead, the maturity of their service delivery arrangements varies as the leads came into post at different times.

From the work that has been completed to date there are great examples and good evidence that an integrated approach to care delivery not only improves patient experience and outcomes but supports best use of resource.

Our current focus is on pulling together the learning from the different areas in order to develop an understanding of the core elements that support the effective delivery of local services.

Alongside the development of Neighbourhood working colleagues there are other programmes of work that will support the shift of care and treatment from hospital settings into the community.

This report updates the Adult and Community Wellbeing Scrutiny Committee on the implementation of the Integrated Community Care portfolio and the progress that has been made in Neighbourhood Working; the Integrated Accelerator programme; and the KPMG and Optum commissioned work.

Actions Required:

To consider and comment on the information presented on the Lincolnshire Sustainability and Transformation Partnership's Integrated Community Care Portfolio.

1. Background

1.1 National Context

Where once the primary purpose of the health and care system was to provide episodic treatment for acute illness, it now needs to deliver joined-up support for growing numbers of older people and people living with long-term conditions. The recently published NHS Long Term Plan, framework for delivering universal personalised care and the new GP contract all describe:

- The changing needs of the population are putting pressure on the health and social care system in England.
- Ageing population – between 2017 and 2017 there will be 2 million more people aged over 75.
- Chronic conditions – increased focus on helping people manage long term conditions.
- New Treatments – steady expansion of new treatments gives rise to demand for an increasing range of services.

In addition they all reference the fact that:

- Service provision is fragmented in multiple different types of organisations.
- Too often these services do not communicate effectively with each other.
- The totality of patients' needs is not always understood by those serving them.
- Care is not always delivered in a person centred way.

Nationally and across Lincolnshire it is understood that to meet this challenge, the NHS and its partners must break down barriers between services and give greater priority to promoting population health and wellbeing.

Integrated care systems (ICSs) have been proposed as the future model for the health and care system. In England health and social care will work together to develop integrated service delivery that optimises the skills and expertise of key partners to support improved outcomes and best value.

These 'place-based' partnerships will be given more control over local funding and services in the hope that they can make better use of resources and improve the health and wellbeing of their populations.

Currently ICSs have no basis in legislation, and rest on the willingness and commitment of organisations and leaders to work collaboratively and there is no national blueprint to guide the way.

Supporting the development of an Integrated Care System remains one of the key areas of focus for Lincolnshire. The aim is that colleagues from across the whole system come together to ensure that the services that are delivered by all partners for people in Lincolnshire work together to promote health and wellbeing.

1.2 Lincolnshire Context

In seeking to establish an effective Integrated Care System it is necessary to raise the profile of services that are provided outside the acute hospital (including mental health in-patient settings).

Our ambition is that as a Lincolnshire system, our default position is that care will be provided in the community unless there is a clinical need or value for money reason that care and treatment should be provided in an acute hospital setting.

By focusing on our communities we can reserve our hospital services for those who really need it. Integrated Community Care brings together the ambitions of local people and professionals, encourages partnerships, innovation and use of technology to deliver accessible high quality health and care which is easier to access.

As such the development of care closer to home, Integrated Community Care (ICC), is a priority for the Lincolnshire system as it is the foundation of our ambition to improve the health and wellbeing of our population. The ICC programme will apply to all service areas and for all age groups. Our aim is to develop care and treatment arrangements that promote partnerships not only across General Practice and statutory bodies but with the third sector, independent agencies and specifically with the person themselves.

Care and treatment will be delivered to support the individual needs and promote quality of life. As such a key element of our work will be to work with individuals, communities and the wider population to raise awareness of how to reduce the risk of getting a condition, what changes an individual can make to their life-style to reverse or manage a long term condition, what support they can get from within their local communities and how to make best use of the care and treatment provided by their GP, other health and care professionals and partners in the third sector.

The core principles that will influence the design and development of Integrated Community Care (ICC) are:

- Home first & digital by default
- Truly integrated workforce
- Proactive population management
- Tackling the root cause of poor health
- Prevention and early intervention
- Resilient communities
- Personal responsibility and empowerment

The anticipated benefits of ICC include:

- Ensuring that people are treated and supported at the right time and in the most appropriate setting
- Ensuring an increased focus on prevention, encouraging individuals and mobilising the population to take personal responsibility for their own health and wellbeing
- Greater use of community assets to support wider individual wellbeing
- Focus on self-care / support for local people and their carers
- Embedding person centred care and shared decision making
- Providing more care close to home
- Better care planning / risk stratification across the health and social care system
- Reduced clinical variation
- More efficient services with less waste
- Positive patient experience

This will translate to:

- Reductions in attendance and use of hospitals, reducing unplanned admissions, length of stay and transfers across the system
- Reductions in the use of residential and nursing are, aiming to reduce admissions and overall length of stay
- Increase in people receiving rehabilitation and reablement at home to maximise independence
- Increased numbers of people being able to die in their own home rather than in hospital
- Increases in people being able to take control of their own health and care by use of expert patient programmes, digital access, telehealth and telecare
- Increased engagement of local organisations such as schools, employers, third sector groups in promoting health choices.

3. Neighbourhood Working

Neighbourhood working is the term used to describe the coming together of all services in a defined geographical area to support the needs of a local population. of It is an essential element of the Lincolnshire STP as it allows us to ensure that services are delivered to ensure both equity of access and the demographic needs of a local population. For example in Lincoln city there are a greater number of young people and families whilst on the East coast there are more older people living with a number of long term conditions.

The delivery of local services also enables us to recognise the important contribution of other agencies including but not limited to district councils, the third sector and local independent providers. The development of services for local residents and investment in local assets will encourage partnerships and innovation to address the challenges experienced, for example, investment in high

quality technology could enable patients to have access to consultations with clinicians in other areas without having to travel.

The vision for Neighbourhood working is simple:

> *It is the heart of our Integrated Community Care offer. The person and their support networks are our focus. Health, social care, the voluntary services and other local agencies will work in partnership to empower them to take an active role in their health and wellbeing with greater control and choice.*

Across Lincolnshire there are twelve Neighbourhood areas support by ten Neighbourhood leads. A map of these is attached at Appendix 1.

3.1 The Operating Framework for Neighbourhood Working

The five key functions of the operating framework are now clearly identified and defined and are being utilised to support the development of local services.

These are set out below :

i. Understanding the local population – through an **identification** process such as public health demographics and risk stratification of a local primary care population.

ii. A range of **local area coordination** is required to enable an individual to understand the level of support they require through self-navigation, aided navigation and supported coordination.

iii. The individual, core neighbourhood team and network identify a key worker if required and co-produce a **person centred care and support plan.**

iv. The core neighbourhood team and network deliver the plan supporting the individual to reach their agreed outcomes.

v. The individual care and support plan is regularly reviewed to manage any changing needs and requirements.

3.2 Primary Care Networks

The NHS Long Term Plan introduces Primary Care networks as the foundation for Integrated care Systems

The core principles of Primary Care Networks are consistent with those of Neighbourhood working. A National defintion of Primary Care Networks have been developed and funding has been made available to facilitate the develop of local structures that will enable the delivery of the intended outcome.

- Primary care networks enable the provision of **proactive, accessible, co-ordinated and more integrated primary and community care** improving outcomes for patients.

- They are likely to be formed around natural communities based on GP registered lists, often serving populations of around 30,000 to 50,000.

- Networks will be small enough to still provide the personal care valued by both patients and GPs but large enough to have impact through deeper **collaboration between practices and others in the local health (community and primary care) and social care system.**

- They will provide a platform for providers of care being sustainable into the longer term.

It is anticipated that across Lincolnshire there will be more PCNs than Neighbourhoods but that PCNs will be developed so that they align with the current Neighbourhood areas and support local communities.

3.3 Neighbourhood Working Progress

Outlined below are some case studies describing how neighbourhood working has supported individuals.

Starting in early October an initial pilot was ran with one GP practice to review a number of patients who frequently attended A & E and had a high frailty score when using a nationally recognised assessment tool.

One patient who was identified through this review had attended A & E on 31 occasions during the last twelve months for treatment of problems associated to a catheter.

Working together the local teams completed a review to understand the nature of the catheter issues. An advanced care plan was developed with the patient and the care home team so that they knew what to do if they notice changes thus avoiding a problem developing. The team have remained in regular contact with the care home team and after 20 days the patient had not had any further problems that had required attendance at A & E.

This simple intervention provided a much better experience for the individual concerned and meant that the ambulance that would have been called was available for someone else and that there was one less person attending A & E.

Introduction of Primary Care Coordination.

Primary Care Coordinators are working across the South and South West of Lincolnshire as the link between Primary Care and the neighbourhood. They proactively support individuals who have a high level of frailty, offering clinical expertise but also linking up and coordinating support with colleagues from across the locality.

"I just wanted to drop you an e mail to inform you that recent changes within the Deepings practice are having a positive impact here at Rose lodge.

"The primary care co-ordinator has been working closely with resident RM and the GP. This has resulted in his falls reducing from 10 per month to zero; this is just one example of many. The weekly visit by the GP is working exceptionally well; improving patient care and reducing crisis situations and our work load so that we can spend more time with our clients."

James was living with diabetes and working as a graphic designer when he permanently lost his sight. James is 30 and the loss of his sight has had a profound effect on his physical and emotional wellbeing. Partners from across health, care and the third sector working together have supported James to:

- Receive the physical care he needed
- Understand and manage his mental health needs
- Access housing support through his local authority
- Join local support groups with other people living with a disability
- Complete a training course to maintain his independence
- Adapt and manage his disability, including using technology he is passionate about
- Seek support for his father, who is his full time carer

One 91 year old gentleman, who lives alone, went to his GP after a number of falls in his own home. He asked the GP to support him to get a place in a residential setting. After discussion the gentleman agreed to a referral to the MDT. He was seen by a member of the team who completed a personal assessment. This highlighted that the gentleman was isolated, had a visual impairment and was very lonely. The team referred the gentleman to the visual impairment team. They arranged for the gentleman to receive large print newspapers and other aids. In addition they found out that there was a local history group. The gentleman now attends this having bought himself a new mobility scooter with lights so that he could go out in the early evening.

The Living With and Beyond Cancer team have worked with the local neighbourhood teams to support proactive referral to services in the community for a patient with lung cancer. They compared the time taken by the MDT to review the case and make all the referrals to various agencies required to support this patient with the time taken by the Clinical Nurse Specialists in the hospital.

The results were as follows:

- A referral to the MDT took the CNS five minutes. The MDT reviewed the case – 2 hours and took 40 minutes to make all the referrals. Total 2 hours 45 mins
- The CNS took 4 hours to make the referrals to the various agencies. Because of other responsibilities these referrals were made over a period of 13 days. Total time 13 days 4 hours.
- Impact the patient had all care and support they required in the hospital and the probability of a crisis occurring was significantly reduced.

The following key pieces of work have been progressed and compliment neighbourhood working :

Library of Information and Services – has been developed in partnership with Lincolnshire County Council and the STP, and will offer the public and staff a central repository of services and functions across the county. The service will also offer both 'live webchat' and telephone contact for advice and guidance.

Local Area Coordination – Care Navigation and Social Prescribing is now being piloted across the County – with partnership working between the Lincolnshire Voluntary Sector infrastructure, primary care and the voluntary and third sector organisations, including a connection into the Wellbeing service.

Individuals who have been offered a non–medical solution have had a different and alternative experience and in one case the individual has built up enough confidence to start volunteering at a local group, having not been able to leave their property due to anxiety.

Personalised Care and Support Planning – now forms part of the Integrated Accelerator programme being led by NHS England. This has given the Neighbourhood working project the impetus and momentum to really start to drive this forward.

3.4 Information and Technology

IM&T and the use of digital technology to support local care delivery is vitally important to delivery of integrated care and treament.

The roll out of the Care Portal into the Neighbourhoods and into GP practices across Lincolnshire is starting to have a positive impact, for example being able to see appropriate information regarding an individual's stay in hospital.

- There are currently 1,300 active users on the Lincolnshire Care portal
- Providers with access enabled are United Lincolnshire Hospitals NHS Trust (ULHT), Lincolnshire Community Health Services NHS Trust, Lincolnshire Partnership NHS Foundation Trust and 25 GP Practices across Lincolnshire
- ULHT information available on the portal includes the patient administration system, radiology reports, lab results, estimated dates of deliveries and outpatient letters.
- Also available from the spine is the patient's summary care record, patient demographic service and child protection information sharing
- Next phases of roll out are: Lincolnshire County Council Adult Social Care Q1 in 2019/20, ULHT Maternity Services Q1 2019/20, East Midlands Ambulance Service Q3 2019/20
- Timescales for roll out to St Barnabas, care homes and other secondary care NHS trusts are yet to be identified
- Feedback from portal users has been very positive, particularly in relation to ULHT - to understand progress of referrals, the patient journey in secondary care, radiology results and electronic discharge summary.

Digital technology is now high on the agenda for the system and is starting to be tested at Neighbourhood Level. For example, Stamford are currently running a pilot with a small number of individuals who have been identified as having a moderate level of frailty and using Apps on their phones and iPads tracking how they are on a day to day basis.

4. Integrated Accelerator Programme

On 20 March 2018, the Secretary of State for Health and Social Care announced three pilots integrating health and social care assessments, to take place over two years in Gloucestershire, Nottinghamshire and Lincolnshire.

4.1 Purpose and scope

NHS England will support the sites to implement a pro-active and joined-up approach to needs assessment, personalised care and support planning, and (where beneficial) integrated personal budgets. This builds on the work already underway as part of the Integrated Personal Commissioning and the personalised care demonstrator programmes.

The objectives of the pilots are:

- better health and wellbeing outcomes
- reduced demand on health and care services
- better experience for people and their families.

The scope of the pilots includes anyone who receives a needs assessment under the Care Act 2014 from the local authority, including carers and regardless of financial circumstances. The initial focus will be decided with each site based on local priorities.

In Lincolnshire this programme is being embedded into Neighbourhood Working and is building on the progress that has already been made.

NHS England is specifically working in three Neighbourhoods;

- Grantham (South West)
- Boston
- Gainsborough

The initial phase of the project commenced in October, and will focus on using the skills and expertise learnt through the Helen Sanderson and Associates project and test out a co-produced and designed care and support plan template.

The next steps will be to develop an electronic solution to enable individuals and workforce the appropriate visibility of their plans, including emergency services.

5. Building the Infrastructure to Support ICC

The Lincolnshire Health and Care system is working with two nationally renowned organisations (KPMG & Optum) to develop a model of an Integrated Care System, through using data analytics, designing an operating model and building on the work of neighbourhood programme.

This programme consists of a number of separate but related initiatives:

a. **Modelling and data analytics** – looking at data across the STP including adult care to understand where best to put resources, and how many and which services will be needed in the near future

b. **Whole system engagement** – leaders from all organisations in the STP including Lincolnshire County Council are working together to develop a shared vision and model for integrated care in Lincolnshire. The current system is no longer fit for purpose and a radical redesign is needed that focuses on prevention, self-care and ensuring care is closer to home.

c. **Locality activities** – neighbourhood working is a step in the right direction. Now, the focus is to ensure that it is working well and focusing their efforts and prioritising as well as they can.

A Case for change which will bring together the feedback and outcomes of the data modelling will be published shortly. For the first time this will bring together the whole picture for the Lincolnshire system.

The case for change will create the opportunity for the Lincolnshire system to come together to support co-design and development of the delivery plan.

7. Conclusion

This report outlines the background to the evolution of the Integrated Community Care portfolio, its links to both national and local priorities and the outline with regards future building a shared strategic delivery plan.

It is presented to inform the Adults and Community Wellbeing Scrutiny Committee of the current progress in development of the Integrated Community Care Portfolio for Lincolnshire.

8. Consultation

a) Have risks and Impact analysis been carried out?

b) Risks and Impact and Analysis

9. Background Papers

The following background papers were used in the preparation of this report: -

Document title	Where the document can be viewed
NHS Long Term Plan 2019	https://www.england.nhs.uk/long-term-plan/
Universal Personalised 2019	https://www.england.nhs.uk/personalisedcare/
GP Forward View 2016	https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf
GP contract 2019	https://www.england.nhs.uk/wp-content/uploads/2019/01/gp-contract-2019.pdf

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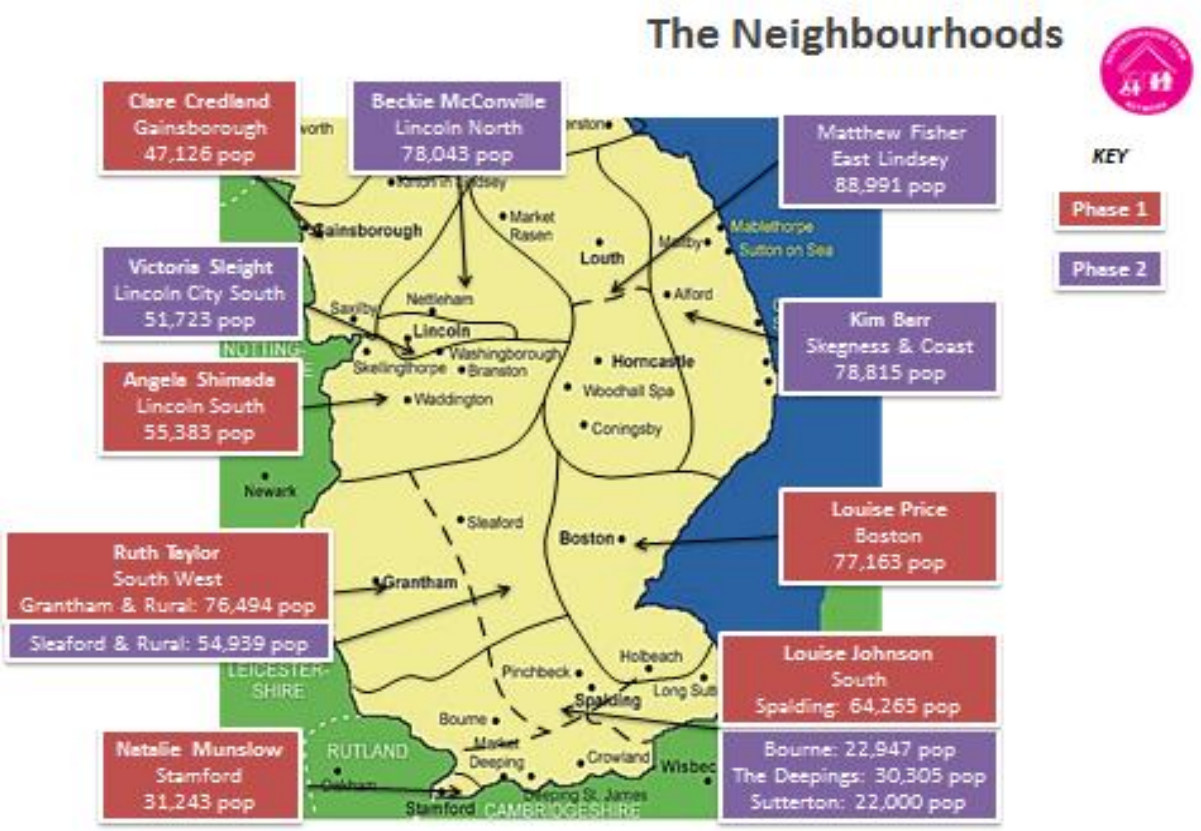
The Neighbourhoods
Clare Credland
Gainsborough
47,126 pop
Beckie McConville
Lincoln North
78,043 pop
Matthew Fisher
East Lindsey
88,991 pop
KEY
Phase 1
Phase 2
Victoria Sleight
Lincoln City South
51,723 pop
Kim Barr
Skegness & Coast
78,815 pop
Angela Shimada
Lincoln South
55,383 pop
Louise Price
Boston
77,163 pop
Ruth Taylor
South West
Grantham & Rural: 76,494 pop
Sleaford & Rural: 54,939 pop
Louise Johnson
South
Spalding: 64,265 pop
Netelie Munslow
Stamford
31,243 pop
Bourne: 22,947 pop
The Deepings: 30,305 pop
Sutterton: 22,000 pop
Gainsborough
Market Rasen
Louth
Mablethorpe
Sutton on Sea
Alford
Nettleham
Lincoln
Skellingthorpe
Washingborough
Branston
Horncastle
Woodhall Spa
Coningsby
Waddington
Newark
Sleaford
Boston
Grantham
Holbeach
Pinchbeck
Spalding
Bourne
Market Deeping
Crowland
RUTLAND
Stamford
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CAMBRIDGESHIRE
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Lincolnshire COUNTY COUNCIL
Working for a better future

Open Report on behalf of Glen Garrod, Executive Director, Adult Care and Community Wellbeing

Report to:	**Adults and Community Wellbeing Scrutiny Committee**
Date:	**10 April 2019**
Subject:	**A Memorandum of Understanding to Support Joint Action in Lincolnshire on Improving Health and Wellbeing through the Home**

Summary:

The role of housing in achieving and maintaining good health, and the need to connect Housing services with Health and Social Care is well recognised nationally and locally. Lincolnshire's Health and Wellbeing Board has included housing as one of seven priorities in its Joint Health and Wellbeing Strategy (JHWS) and established the Housing, Health and Care Delivery Group (HHCDG) to oversee the Housing Delivery Plan.

The HHCDG identified the need to agree a strategic vision with principles and core values for a Lincolnshire approach to working across the Housing, Health and Care sectors. This Memorandum of Understanding (MoU) articulates the benefits of collaborative working and creates an opportunity for better understanding of the preventive role that housing can play in achieving good health outcomes and sustaining independence. The Delivery Plan for the Housing Priority of the Joint Health and Wellbeing Strategy is included in the MoU.

The MoU was presented to and well received by the Health and Wellbeing Board on 11 December 2018. A number of partners have already formally signed up to this and others are following due process in order to do so.

Actions Required:

Adults and Community Wellbeing Scrutiny Committee is asked to:

- Review the Memorandum of Understanding in its current format and provide any further comments to support the annual review, which will take place in June.
- Note and comment on the actions within the Delivery Plan which is currently being refreshed by the Housing, Health and Care Delivery Group
- Note and refer to the Memorandum of Understanding when scrutinising other topics to ensure that its principles are embedded within Lincolnshire County Council's activities.

1. Background

The right home environment is essential to good health and wellbeing, throughout life. Our homes are the cornerstones of our lives. We need warm, safe and secure homes to help us to lead healthy, independent lives and to recover from illness. Poor housing increases the risk of ill-health and disease, potentially increasing demand on health and care services.

In 2014 a national Memorandum of Understanding (MoU) called "Joint Action to Improving Health Through the Home" was agreed between a number of government bodies and other key national stakeholders. It shows a shared commitment to action, principles for joint working and a shared action plan. This was updated in 2018, with commitments to:

- Better strategic planning;
- Better understanding of the preventive role of housing;
- Greater collaborative care;
- Better use of resources;
- Improved signposting;
- More shared learning;
- Wider sector engagement.

In March 2017, Lincolnshire's Health and Wellbeing Board (HWB) recognised the need for a Strategic Housing Group, establishing the Housing, Health and Care Delivery Group (HHCDG) to bring together a large group of stakeholders from across a range of public sector organisations.

Lincolnshire is one of only 14 (out of 151) Health and Wellbeing Board areas across the country to have a Housing and Health Joint Strategic Needs Assessment (JSNA) topic. The JSNA information led to housing being included as a Joint Health and Wellbeing Strategy (JHWS) priority.

This MoU brings a focus to housing, health and care through an agreed set of joint principles and aims. It is based on the national MoU, with slight alterations to make sure it is relevant to Lincolnshire. The Lincolnshire MoU sets out:

- A shared commitment to joint action across local government, health, social care and housing organisations;
- Principles for joint working for better health and wellbeing outcomes, and reducing health inequalities;
- A framework for local organisations and cross-sector partnerships to provide healthy homes, communities and neighbourhoods;
- Conditions for developing integrated and effective services to meet the needs of individuals, carers and families with a range of local stakeholders;
- What shared success might look like.

Whilst it is still early days, nevertheless, since the development of the MoU and the Delivery Plan:

- Attendance at the HHCDG meetings has been very good including a stronger commitment and presence from health colleagues;
- The MoU has provided a framework for driving positive action across partners;
- The MoU and its development has allowed an opportunity to capture progress of the HHCDG during 2018/19 and will enable a yearly report to be created for the HWB;
- 5 members of the HHCDG attended a London conference which resulted in Lincolnshire being asked to speak at a Kings Fund Event on "Progress in a Two Tier Area".

Please see Appendix A – "A memorandum of understanding to support joint action in Lincolnshire on improving health and wellbeing through the home".

2. Consultation

a) Policy Proofing Actions Required

n/a

3. Appendices - These are listed below and attached to the report

Appendix A	A Memorandum of Understanding to Support Joint Action in Lincolnshire on Improving Health and Wellbeing through the Home

4. 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 Lisa Loy, who can be contacted on 01522 554697 or lisa.loy@lincolnshire.gov.uk

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A Memorandum of Understanding (MoU) to support joint action in Lincolnshire on improving health and wellbeing through the home

Housing, Health and Care – A practical partnership

Why a Memorandum of Understanding (MoU)?

1. The right home environment is essential to health and wellbeing, throughout life. Timely and appropriate support services enable people to live at home safely and independently.

2. We in Lincolnshire will work together, across local government, housing, health, care, and voluntary and community sectors to understand and respond to current and future needs.

3. This Memorandum of Understanding sets out:

    - Our shared commitment to joint action across local government, housing, health and care sectors, in Lincolnshire;
    - Principles for joint-working to deliver better housing, health and wellbeing outcomes and reduce health inequalities;
    - The context and framework for local cross-sector partnerships to design and deliver:
        - Appropriate levels and types of housing, to meet a range of needs;
        - Healthy homes, communities and neighbourhoods which promote health and wellbeing;
        - Integrated and effective services that meet individuals', their carer's/carers' and their family's needs;
    - A shared action plan, with specific actions agreed by individual partners in accordance with their own policies, to help deliver these aims.

4. Working together, we will:

    - Establish ways to secure, interpret and share evidence to support local dialogue and decision-making across local government, health, social care and housing sectors;
    - Enable improved collaboration and integration between housing, health and care agencies in planning, commissioning and delivering homes and services;
    - Promote the housing sector's contribution to:
        - Addressing the wider determinants of health and health equity.
        - Improving the patient experience and outcomes.
        - 'Making Every Contact Count' (MECC).
        - Safeguarding.
    - Promote the contribution of health and care services, whether directly delivered or commissioned from others to:
        - Enable people to secure and remain in their homes.
        - Reduce homelessness.
        - Maintain access to education, employment and their wider community.
    - Develop the workforce across all sectors so they are confident and skilled in understanding the relationship between where people live and their health and wellbeing and are able to identify suitable solutions to improve outcomes.

Context

5. The Health and Social Care Act 2012 introduced a number of provisions intended to improve the quality of care received by patients and patient outcomes, efficiency, and to reduce inequalities of access and outcomes. Provisions require co-operation between the NHS and local government at all levels. The Health and Wellbeing Board (a partnership of all those working to advance the health and wellbeing of the people in Lincolnshire), also have a duty to encourage commissioners to work together.

6. The Children and Social Work Act 2017 outlines that Local Authorities and Partners must consider the needs of looked after children, care leavers and young people. Through this group we are able to ensure that service planning and designs meet the needs of young people and reduce the need for intervention and support in later life. We should afford all children the same care, nurture, health and well-being opportunities, and ensure Looked After Children and Care Leavers have the same life chances as any other child or young person. The corporate parenting principles outline that good, responsible parenting involves, but is not limited to:

   - Making sure that children and young people have a strong sense of belonging, and that they are cared about as well as cared for.
   - Supporting children and young people through school, college or work, being ambitious for them and helping them develop a sense of aspiration and self-belief.
   - Making sure children and young people are safe.
   - Making sure children and young people are healthy, and health-aware, and are offered the very best parenting.
   - Making sure children and young people have the best start in life and opportunities to thrive and grow.
   - Making sure children and young people are actively listened to, respected and valued, encouraging them to develop and participate as citizens now, not simply as 'citizens in waiting'.
   - Encouraging and supporting children and young people to form and sustain a range of healthy relationships, developing how they manage their feelings and behaviours, and understanding those of others.

   Safe and secure accommodation is fundamental to ensuring all of the above and ensuring the wellbeing of young people and those transitioning into adulthood at 18 years old. By working together we can reduce the need for local authority and health intervention in later life by offering young people stability and suitable accommodation earlier.

7. The Care Act 2014 aims to improve people's quality of life, delay and reduce the need for care, ensure positive care experiences and safeguard adults from harm[1]. Local authorities in Lincolnshire are required to consider the physical, mental and emotional wellbeing of the

[1] The Care Act relates primarily to people aged 18 and over but young people approaching adulthood and those caring for an adult or in families of someone receiving care should also benefit. The Children and Families Act 2014 is also relevant to young people with care and support needs.

individual needing care, and assess the needs of carers. They must ensure the provision of preventative services and carry out their care and support functions with the aim of integrating services with those provided by the NHS or other health-related services.

8. The Care Act calls for:

    - A shared vision and culture of cooperation and coordination across health, public health, social care and local authority roles, e.g. as housing commissioners, working closely with public, voluntary and private sector providers to improve services.

    - A whole system, outcomes based approach to meeting the needs of individuals, their carer(s) and family, which is based on a robust understanding of the needs of individuals, their carer(s) and families now and in the future.

    - Consideration to the health and wellbeing of the workforce and carers.

    - Solutions to meet local needs based on evidence of 'what works'.

    - Services that will address the wider determinants of health, e.g. housing, employment. Integrated health, care and support, and housing solutions could make best use of the budgets across the NHS, local authorities and their partners to achieve improved outcomes for less; for example, drawing on the Better Care Fund to support service transformation.

9. The Homelessness Reduction Act (2018) requires a stronger focus on preventing homelessness, extending the statutory duties of local housing authorities and places a duty to refer on a wide range of agencies to support prevention and early intervention.

10. Lincolnshire's Health and Wellbeing Board has legal duties to undertake Joint Strategic Needs Assessment (JSNA). Lincolnshire's JSNA includes a topic on Housing. The Board must also produce a Health and Wellbeing Strategy. Lincolnshire's Strategy includes a Housing Priority. This recognises that:

    - Poor housing, unsuitable housing and precarious housing circumstances affect our physical and mental health. Generally speaking, the health of older people, children, disabled people and people with long-term illnesses is at greater risk from poor housing conditions. The home is a driver of health inequalities, and those living in poverty are more likely to live in poorer housing, precarious housing circumstances or lack accommodation altogether.

    - Key features of the right home environment (both permanent and temporary) are:
        - It is warm and affordable to heat.
        - It is free from hazards, safe from harm and promotes a sense of security.
        - It enables movement around the home and is accessible, including to visitors.
        - There is support from others if needed.

    - The right home environment can:
        - Protect and improve health and wellbeing and prevent physical and mental ill-health.
        - Enable people to manage their health and care needs, including long-term conditions, and ensure positive care experiences by integrating services in the home.

- Allow people to remain in their own home for as long as they choose.

- In doing so it can:
  - Delay and reduce the need for primary care and social care interventions, including admission to long-term care settings.
  - Prevent hospital admissions.
  - Enable timely discharge from hospital and prevent re-admissions to hospital.
  - Enable rapid recovery from periods of ill-health or planned admissions.

11. In Lincolnshire the right home environment is enabled by a range of stakeholders (not exhaustive):
    - The Health and Wellbeing Board has a duty to understand the health and wellbeing of their communities, the wider factors that impact on this and local assets that can help to improve outcomes and reduce inequalities. The inclusion of housing and housing circumstances, e.g. homelessness in Joint Strategic Needs Assessments and the Board's Strategy supports this MoU and steers local commissioning.
    - Local housing and planning authorities[2] commission the right range of housing to meet the needs of people living in Lincolnshire, and intervene to protect and improve health in the private sector, to prevent homelessness and enable people to remain living in their own home should their needs change.
    - Housing providers' knowledge of their tenants and communities, and expertise in engagement, informs their plans to develop new homes and manage their existing homes to best meet needs. This can include working with NHS providers to re-design care pathways and develop new preventative support services in the community;
    - Housing, care and support providers provide specialist housing and a wide range of services to enable people to re-establish their lives after a crisis, e.g. homelessness, or time in hospital, and to remain in their own home as their health and care needs change. Home improvement agencies and handyperson services deliver adaptations and a wide range of other home improvements to enable people to remain safe and warm in their own home.
    - The voluntary and community sector offers a wide range of services, from day centres for homeless people to information and advice to housing support services.

12. All stakeholders understand the needs of their customers and communities; their knowledge and insight can enable health and wellbeing partners to identify and target those who are most in need.

[2] Local housing and planning authorities in two-tier areas are the district councils.

Oversight

13. We aim to act and work together to ensure momentum continues in the coming years.

14. The key signatories to this MoU will be represented at the Housing, Health and Care Delivery Group. The group will review progress annually and agree if changes are required to the MoU or the action plan.

15. The Joint Health and Wellbeing Strategy (JHWS) identifies housing as a priority. A delivery plan is in place and puts the responsibility on a range of people across housing, health and care. We will use JHWS delivery plan for housing as the basis for our actions, but it will not be limited to this.

16. All relevant agencies are invited to adopt this MoU, contributing to the local evidence base, needs analysis, commissioning and service delivery, and agree to work towards and meet the aims and delivery plan of this document.

Indicators of Success

1. Better strategic planning:

Include housing and homelessness in key strategy and planning processes for health, social care and local government at a local level. The planning processes should be responsive to the needs and input of local communities. They should deliver good quality housing options for all, meeting both current health needs across the lifespan and be responsive to future changes.

2. Better understanding of the preventative role of housing:

Place greater recognition the role a stable and secure housing situation plays in keeping people healthy, independent and preventing ill health or injury. There is a strong case for investment in improving poor housing, as well as providing new and specialised housing.

3. Greater collaborative care:

Greater joint action on the contribution housing can make in different care pathways, including prevention, transfer of care or discharge planning.

4. Better use of resources:

Use our resources more effectively to improve health through the home, prevent illness, manage demand and deliver service improvements across local housing, health and social care sectors.

5. Improved signposting:

Frontline housing, homelessness, health and social care professionals should know which services and interventions are available locally across other sectors, and how to refer people into these. There should be greater awareness among the general public about the services they can access to improve their home environment where this is affecting their health and wellbeing outcomes.

6. More shared learning:

Housing, homelessness health and social care professionals to have the appropriate training to better prevent ill health and promote good health and wellbeing through the home, and deliver integrated care and support across the sectors.

7. Wider sector engagement:

Increase the number of signatories to the MoU, including organisations representing frontline professionals and experts by experience.

Declaration Statement for Lincolnshire

We, the organisations listed below, support this Memorandum of Understanding.

Boston Borough Council	The right home environment is essential to health and wellbeing, throughout life. Timely and appropriate support services enable people to live at home safely and independently. We are committed to working together, across local government, housing, health, care, and voluntary and community sectors to understand and respond to current and future needs in Lincolnshire.	**We support the aims of the Memorandum of Understanding**
East Lindsey District Council	The right home environment is essential to health and wellbeing, throughout life. Timely and appropriate support services enable people to live at home safely and independently. We are committed to working together, across local government, housing, health, care, and voluntary and community sectors to understand and respond to current and future needs in Lincolnshire.	**We support the aims of the Memorandum of Understanding**
City of Lincoln Council	The right home environment is essential to health and wellbeing, throughout life. Timely and appropriate support services enable people to live at home safely and independently. We are committed to working together, across local government, housing, health, care, and voluntary and community sectors to understand and respond to current and future needs in Lincolnshire.	**We support the aims of the Memorandum of Understanding**
LACE Housing Association	The right home environment is essential to health and wellbeing, throughout life. Timely and appropriate support services enable people to live at home safely and independently. We are committed to working together, across local government, housing, health, care, and voluntary and community sectors to understand and respond to current and future needs in Lincolnshire.	**We support the aims of the Memorandum of Understanding**
Lincolnshire Community Healthcare Services NHS Trust	The right home environment is essential to health and wellbeing, throughout life. Timely and appropriate support services enable people to live at home safely and independently. We are committed to working together, across local government, housing, health, care, and voluntary and community sectors to understand and respond to current and future needs in Lincolnshire.	**We support the aims of the Memorandum of Understanding**

Lincolnshire County Council	The right home environment is essential to health and wellbeing, throughout life. Timely and appropriate support services enable people to live at home safely and independently. We are committed to working together, across local government, housing, health, care, and voluntary and community sectors to understand and respond to current and future needs in Lincolnshire.	**We support the aims of the Memorandum of Understanding**
Lincolnshire Partnership NHS Foundation Trust	The right home environment is essential to health and wellbeing, throughout life. Timely and appropriate support services enable people to live at home safely and independently. We are committed to working together, across local government, housing, health, care, and voluntary and community sectors to understand and respond to current and future needs in Lincolnshire.	**We support the aims of the Memorandum of Understanding**
North Kesteven District Council	The right home environment is essential to health and wellbeing, throughout life. Timely and appropriate support services enable people to live at home safely and independently. We are committed to working together, across local government, housing, health, care, and voluntary and community sectors to understand and respond to current and future needs in Lincolnshire.	**We support the aims of the Memorandum of Understanding**
South Holland District Council	The right home environment is essential to health and wellbeing, throughout life. Timely and appropriate support services enable people to live at home safely and independently. We are committed to working together, across local government, housing, health, care, and voluntary and community sectors to understand and respond to current and future needs in Lincolnshire.	**We support the aims of the Memorandum of Understanding**
South Kesteven District Council	The right home environment is essential to health and wellbeing, throughout life. Timely and appropriate support services enable people to live at home safely and independently. We are committed to working together, across local government, housing, health, care, and voluntary and community sectors to understand and respond to current and future needs in Lincolnshire.	**We support the aims of the Memorandum of Understanding**
United Lincolnshire Hospitals NHS Trust	The right home environment is essential to health and wellbeing, throughout life. Timely and appropriate support services enable people to live at home safely and independently. We are committed to working together, across local government, housing, health, care, and voluntary and community sectors to understand and respond to current and future needs in Lincolnshire.	**We support the aims of the Memorandum of Understanding**

West Lindsey District Council	The right home environment is essential to health and wellbeing, throughout life. Timely and appropriate support services enable people to live at home safely and independently. We are committed to working together, across local government, housing, health, care, and voluntary and community sectors to understand and respond to current and future needs in Lincolnshire.	**We support the aims of the Memorandum of Understanding**

Joint Health and Wellbeing Strategy | **Delivery Plan**

Priority | **Housing and Health**

Objective	**Key Deliverables/Actions**	**Linked Theme**	**Outcome**	**Lead Responsibility**	**Timescale**
Our shared commitment to joint action across local government, health, social care and housing sectors, in Lincolnshire through an agreed Memorandum of Understanding.	Host a targeted workshop to jointly develop and create a MoU with all members of the HHCDG (invite representative member of the HWB). Agree an action plan with measurable outcomes. Ensure the HWB signs off the MoU. Agree and appoint champions members of the HHCDG to act as the voice for Lincolnshire ensuring that we are committed to be the collective voice to seek appropriate support to help the housing market, especially for specialist housing for disabled people. Ensure information sharing arrangements	1, 2 & 5	A formal signed MoU in place. Measurable outcomes such as tasks that will: Review the effectiveness and positive impact the HHCDG has made. Adopt a positive culture regarding	Cllr Bowkett Derek Ward	July/Sept 2018 Agree yearly dates for annual effectiveness review.

Objective	Key Deliverables/Actions	Linked Theme	Outcome	Lead Responsibility	Timescale
	are in place to support closer working, problem solving and escalation processes. Ensure the MoU covers key areas of legislation such as the Homelessness Reduction Act 2017		funding and budget savings "we are in it together". Capture areas of improved practise due to the HHCDG for example development work identifying invisible young carers. Evaluate core areas of work which require housing health and care colleagues to joint work such as DFG. Clear objectives and understanding of a shared responsibility of housing.		

Objective	Key Deliverables/Actions	Linked Theme	Outcome	Lead Responsibility	Timescale
Adopt a whole family approach to tackling housing needs.	Embrace opportunities such as the New Wellbeing service to embed a whole house approach. Develop and influence a whole house approach with-in the neighbourhood teams Work with MECC to develop a Whole Housing Approach Toolkit and awareness training package which includes an area of safeguarding training. Work with the young Carer's Service to plan how to identify the hidden young carers who are invisible to the housing process. Proactively work towards a county wide consistent approach to working with under 25's looked after children, example all DC helping their housing issues i.e.: council tax.	1, 3 & 5	Create housing champions in neighbourhood teams and wellbeing service. Deliver MECC training to a targeted number of people. Number of young people identified as a YC. Develop and create New pathways for dealing with YC, amending polices as required.		2019
Concerted action across partners to tackling homelessness	Developing strategic relationships and partnerships through the Homelessness Strategic Partnership to deliver concerted action across partners to tackle homelessness	1, 3 & 5	Established cross sector senior group with a clear delivery plan and oversight of	Alison Timmins	2018/19

Objective	Key Deliverables/Actions	Linked Theme	Outcome	Lead Responsibility	Timescale
	Explore the opportunity for a standalone topic for JSNA for homelessness. A clear action plan to respond to the increase in rough sleeping. Deliver the social impact bond project ACTion Lincs working with entrenched rough sleepers with complex needs. Improve access to health and treatment services to reduce or prevent homelessness.		the county wide homelessness strategy. Improved evidence and understanding of rough sleeping and an agreed plan of action to respond including informing commissioning decisions. ACTion Lincs project delivering long term life changing support for 120 entrenched and complex need rough sleepers across the county. Improved evidence and understanding regarding the health needs of homeless		

Objective	Key Deliverables/Actions	Linked Theme	Outcome	Lead Responsibility	Timescale
			people in Lincolnshire and how this can inform health service provision.		
Ensure people have the knowledge and capability to access and maintain appropriate housing	Develop and Embed a Sustainable Housing Plan for vulnerable people (including those with mental health needs) and young people which would see the introduction of multi- agency meetings before evictions especially for those who are known to adult social care and would have safeguarding concerns. Connect to the Financial Inclusion Partnership Board (FIP) for joint working and collaboration. Explore support and advice to private sector landlords to reduce evictions Work with DWP to ensure vulnerable people are supported through the implementation of Universal Credit	1, 3 & 5			2018/19
Review supported housing arrangements across partners to support vulnerable people with complex presenting needs,	All stakeholders and partners to contribute and agree with a proactive programme to deliver much needed extra care beds.	1, 2, 3 & 5			

Objective	Key Deliverables/Actions	Linked Theme	Outcome	Lead Responsibility	Timescale
(including extra care and DFG)	Improve and deliver quicker adaptions: • Agree a county wide schedule of rates for Lincolnshire to drive improvements • Work with the Moving forward DFG group to identify top 5 actions and recommendations as published by Foundations. • Action plan phase two of Mosaic to improve pathways and intelligence supporting DFG • Embrace and adopt a culture change which is dissolved and extended to other staff regarding the "we are in it together". • Celebrate success and promote good practise. • On a local level for Lincolnshire, address the current inequalities on who is eligible for DFG e.g. those in council property (some of the poorest people in our communities) through their landlord HRAs pay for adaptions but tenants in the RP sector receive adaptations out of general taxation.		Improved time scales and process Improved joint working for BCF outcomes Improved evidence of data to drive improvements	Moving Forward DFG Group	Sept 2018
Understand and address housing related delayed transfers of care	Develop a hoarding protocol and policy to understand and address the demand hoarding presents to DTOC Review and evaluate learning from the	1 & 2		Lisa Loy Rachel Redgrave	2018/19

Objective	Key Deliverables/Actions	Linked Theme	Outcome	Lead Responsibility	Timescale
	Hospital housing Link worker Develop Key contacts list for staff to use and help navigate the Housing Health and Care arena. Influence the Public health intelligence team to 'deep dive' into the data and intelligence presented by DTOC targeted work with LPFT to created new Housing pathways			Sem Neal	
Addressing poor standards of housing and the level of appropriate housing required	1. Influence investment and consideration to using funding opportunities to address poor houses. 2. Use the research and evaluation from Healthwatch to demonstrate how poor housing impacts on your health. 3. Develop and Embed a Sustainable Housing Plan for vulnerable people, this will identify each vulnerable person and capture the barriers presented. The plan would be based on the same principles of the homelessness housing plan 4. Poverty and poor housing standards are prevalent in all districts, often and notably in the private rented sector (not always). As a newly established group we	1, 2, 3 & 5		Housing, Health and Care Delivery Group	2019

Objective	Key Deliverables/Actions	Linked Theme	Outcome	Lead Responsibility	Timescale
	should work towards and encourage a collective approach to this. An action should be to influence and embed suitable initiatives about tackling rogue landlords, promoting good landlord schemes				

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