County Offices
Newland
Lincoln
LN1 1YL

3 December 2018

Lincolnshire Health and Wellbeing Board

A meeting of the **Lincolnshire Health and Wellbeing Board** will be held on **Tuesday, 11 December 2018 at 2.00 pm in Committee Room One, County Offices, Newland, Lincoln LN1 1YL** for the transaction of the business set out on the attached Agenda.

Yours sincerely

Keith Ireland
Chief Executive

MEMBERS OF THE BOARD (*)

Lincolnshire County Council: Councillors: Mrs P A Bradwell OBE (Executive Councillor Adult Care, Health and Children's Services), Mrs S Woolley (Executive Councillor NHS Liaison and Community Engagement) (Chairman), C N Worth (Executive Councillor Culture and Emergency Services), Mrs W Bowkett, R L Foulkes, C E H Marfleet, C R Oxby and N H Pepper

Lincolnshire County Council Officers: Debbie Barnes OBE (Executive Director of Children's Services), Glen Garrod (Executive Director of Adult Social Services) and Professor Derek Ward (Director of Public Health)

District Council: Councillor Donald Nannestad

GP Commissioning Group: Dr Sunil Hindocha (Lincolnshire West CCG), Dr Kevin Hill (South Lincolnshire CCG) and Dr Stephen Baird (Lincolnshire East CCG)

Healthwatch Lincolnshire: Sarah Fletcher

NHS England: Jim Heys

Police and Crime Commissioner: Marc Jones

Lincolnshire Co-Ordinating Board: Elaine Baylis

LINCOLNSHIRE HEALTH AND WELLBEING BOARD AGENDA
TUESDAY, 11 DECEMBER 2018

7d **A memorandum of understanding to support joint action in Lincolnshire on improving health through housing** 75 - 94

(To receive a report from Sem Neal (Chief Commissioning officer) and Lisa Loy (Housing for Independence Programme Manager) on behalf of the Housing, Health and Care Delivery Group which asks the Board to support the Housing Memorandum of Understanding (MOU). The MOU articulates the benefits of collaborative working and considered the role housing has in supporting good health outcomes and sustaining independence)

7e **Better Care Fund Scheme Review** 95 - 106

(To receive a report from Steve Houchin (Head of Finance – Adult Care and Community Wellbeing) which updates the Board on Lincolnshire's BCF Plan for 2018/19 including proposed revisions to allocations made in the original plan and a description of the next steps required to implement the changes)

8 Information Items

8a **Better Care Fund** 107 - 152

(To receive an information report from Steve Houchin (Head of Finance – Adult Care and Community Wellbeing) providing the quarterly finance and performance update on Lincolnshire's BCF Plan 2017/19)

8b **An action log of previous decisions** 153 - 154

(For the Health and Wellbeing Board to note decisions taken since June 2018)

8c **Lincolnshire Health and Wellbeing Board Forward Plan** 155 - 156

(This item provides the Board with an opportunity to discuss items for the future meetings which will subsequently be included on the Forward Plan)

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Please note: for more information about any of the following please contact the Democratic Services Officer responsible for servicing this meeting

- Business of the meeting
- Any special arrangements
- Copies of reports

Contact details set out above.

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LINCOLNSHIRE HEALTH AND WELLBEING BOARD
25 SEPTEMBER 2018

PRESENT: COUNCILLOR MRS SUSAN WOOLLEY (CHAIRMAN)

Lincolnshire County Council: Councillors Mrs P A Bradwell OBE (Executive Councillor Adult Care, Health and Children's Services), Mrs W Bowkett, R L Foulkes, C E H Marfleet, C R Oxby and N H Pepper

Lincolnshire County Council Officers: Glen Garrod (Executive Director of Adult Social Services) and Professor Derek Ward (Director of Public Health)

District Councillor: Councillors Sunil Hindocha (Lincolnshire West CCG) (Vice-Chairman), Kevin Hill (South Lincolnshire CCG) and Stephen Baird (Lincolnshire East CCG)

GP Commissioning Group: Elaine Baylis (Lincolnshire Coordination Board)

Healthwatch Lincolnshire: Nicola Tallent (Partnership and Engagement Manager)

Officers In Attendance: Alison Christie (Programme Manager), Steve Houchin (Head of Finance, Adult Care and Community WEllbeing), Carolyn Nice (Assistant Director Long Term Conditions and Adult Frailty), Gina Thompson (Interim Commissioning Manager, Adult Frailty & Long Term Conditions) and Rachel Wilson (Democratic Services)

11 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillor C N Worth (Executive Councillor Culture and Emergency Services), Debbie Barnes OBE (Executive Director Children's Services) and Jim Heys (NHS England)

Apologies for absence Sarah Fletcher (Healthwatch) who was replaced by Nicola Tallent (Partnership and Engagement Manager) and Marc Jones (Police and Crime Commissioner) was replaced by Stuart Tweedale (Deputy Police and Crime Commissioner).

12 DECLARATIONS OF MEMBERS' INTEREST

There were no declarations of interest at this point in the meeting.

13 MINUTES OF THE MEETING OF THE LINCOLNSHIRE HEALTH AND WELLBEING BOARD HELD ON 5 JUNE 2018

RESOLVED

That the minutes of the meeting held on 5 June 2018 be signed by the Chairman and confirmed as a correct record.

14 ACTION UPDATES FROM THE PREVIOUS MEETING

RESOLVED

That the completed actions, as detailed in the report, be noted.

15 CHAIRMAN'S ANNOUNCEMENTS

In addition to the announcements, as circulated with the agenda pack, the Chairman provided an update on the Virgin Pulse Global Challenge of which County Council officers had taken part. It was highlighted that this was an international event with teams from many different organisations and countries throughout the world taking part. This event had now finished and the Board was informed that Lincolnshire County Council had received a special award for selling out of all the team slots in record time. It was noted that all slots had been filled within 30 minutes. However, more funding was found to be able to offer a further 6 or 7 team slots.

It was also commented that the City of Lincoln Council had taken part and had had 28 teams, which covered a high percentage of the workforce. This was a positive event to be involved in as it encourage people to go out and be more active.

It was queried whether the award had been publicised as it was a good news story and people should be made aware of it, particularly with the focus around health and wellbeing work which was taking place. The Board was advised that this event had been about promoting physical activity, and the next campaign in relation to health and wellbeing would be about staying healthy during the flu season.

Queries were raised regarding the tackling obesity programme, and what provision there was for those people who were successful but then had a problem of excess skin as a result of significant weight loss as this would require surgical intervention. Members were informed that this procedure could be commissioned through the CCG's, but it was noted that there were entry criteria and would need prior approval rather than being a routine procedure. However, it was highlighted that there was a bigger conversation needed about how all the different aspects of the obesity pathway fitted together so that surgical intervention was not required.

The Chairman also highlighted that the Chief Executive of LPFT Dr John Brewin, was due to leave to take up a position elsewhere in the country. On behalf of the Lincolnshire Health and Wellbeing Board, the Chairman wished him well in his new role, and added that she would be sorry to see him leave Lincolnshire.

RESOLVED

That the Chairman's announcements be noted.

16 DECISION/AUTHORISATION ITEMS

16a Better Care Fund

Consideration was given to a report which provided the Health and Wellbeing Board with an update on Lincolnshire's Better Care Fund plan for 2017 – 2019.

The Board was guided through the report, and members were provided with the opportunity to ask questions to the officers present in relation to the information contained within the report, and some of the points raised during discussion included the following:

- In relation to the table on page 26, it was highlighted that the percentages did not add up, and it was noted that this would be due to the figures being either rounded up or down.
- It was queried whether the hot summer had had an impact in terms of hospitals and care, similarly to how a cold winter could also have an impact. It was noted that the non-elected admissions had not hit the target, and it was suggested whether there was a need to start looking at what could be done better within the community. It was queried whether plans were addressing the pressures in the community system.
- It was noted that it was the acute sector that was highly dependent on the ability to support people in the community. Part of the NHS ambition was to enhance nursing provision in the community.
- It was noted that Lincolnshire's plan of preparedness had 5 or 6 years of experience behind it.
- It was acknowledged that the hot summer had had an impact on capacity within the NHS and the ability to cope with a bad winter may be impaired. There was a need to encourage things such as inoculations so people do not get sick, but also to ensure that there were sufficient staff available to work at key times. It was noted that a lot of effort had gone into ensuring that the health and care system was in a good place for the forthcoming winter, but it was emphasised, there were no guarantees.
- Concerns were raised regarding whether there would be a need to do things differently, if the plans were not different to the previous year. It was queried whether there was enough capacity in the system. Members were assured that officers learned from what had been done before and would replicate the good but not the bad.
- It was commented that according to a report by the ONS, life expectancy had dropped in the UK, as opposed to the rest of the world where things were improving.
- It was noted that the ability of health and social care, and housing to support the changing population was a challenge in this country as well as all other western countries. Members were advised that there were two critical

documents that the government were due to publish in November 2018, which were the NHS five year plan and the green paper for adult social care.

- It was noted that there were a number of new initiatives taking place in Lincolnshire, some of them had been done before and would be useful to repeat, for example in relation to workforce. It was suggested that it should be considered whether current pay rates were enough to secure the quality and volume of care that was needed.

RESOLVED

That the Lincolnshire Health and Wellbeing Board note the BCF report update.

16b Lincolnshire Joint Strategy for Dementia 2018 - 2021

It was reported that the Joint Strategy for Dementia 2018-2021 was a refresh of the existing Joint Strategy for Dementia Care 2014 – 2017 and had been developed and co-produced with the Council's strategic partners including CCG's, people who lived with Dementia, their families and carers to provide a strategic framework around Dementia for the next three years.

The Board was informed that the Strategy refresh set out the Council's vision and details the achievements since the implementation of the Lincolnshire Joint Strategy for Dementia 2014-2017. It was noted that an event was being planned for early in the new year to launch the refreshed Strategy. It was intended that this would be an interactive event for professionals, people living with Dementia, their families and carers.

It was also reported that this Strategy aligned with the Health and Wellbeing Board's priorities in relation to Dementia, and would be part of the action plan and would be governed by the Dementia Officer Group which it was hoped to reform into a sub-group of the Health and Wellbeing Board.

Officers advised that if the Strategy was signed off by the Board, it would then go to the Adults and Community Wellbeing Scrutiny Committee. It would then be developed into a final draft and a summary version in plain English would also be produced.

The Board was provided with the opportunity to ask questions to the officers present in relation to the information contained within the report and some of the points raised during discussion included the following:

- The importance of health checks for people with learning disabilities was highlighted as a factor in the prevention of vascular dementia.
- It was commented that if performance was to be progress towards government targets there would be a need for a more radical approach to how signs of dementia would be picked up.
- It was suggested whether when anyone approached social care services for support, a dementia check could be built in. It was noted that the adult frailty strategy was due for renewal in April 2019.

- It was commented that early diagnosis of dementia would not resolve it, however, it could be an opportunity to encourage people to move home before the condition worsened and when it did, it was often not possible to adapt quick enough in that situation.
- The biggest issue to deal with in terms of dementia was the rurality of Lincolnshire, as those people who lived more rurally would have fewer opportunities to attend specialist groups without significant amounts of travel.
- Having back up for carers could be a key part of this.
- It was highlighted that not everyone would go to social services for help, some people were more likely to go their doctors for help.
- It was queried what the mechanism for district councils to feed into this would be, and it was confirmed that it was through this Health and Wellbeing Board, through neighbourhood teams and directly to the Assistant Director Adult Frailty and Long Term Conditions. It was highlighted that a district council representative on the dementia sub-group would be welcomed.
- It was noted that there was a need for respite care for carers, particularly as many carers were elderly and dealing with situations that were not within their experience. It was noted that there was a Carers Strategy in place, and the Council worked with Carers First. The Board was advised that there were a lot of programmes in place, but there was a need to join them up.
- It was commented that this was a really good strategy, and incorporated a lot of what had been spoken about during this meeting. the priorities within the Strategy were around raising awareness and prevention. Dementia was not inevitable, and research suggested that around 35% of dementia cases could be preventable. Stimulation of cognitive function, reducing blood pressure and increasing physical activity were all thought to have a positive impact. It was commented that being under the Health and Wellbeing Board was the right place for all the different aspects to be brought together.
- It was queried whether there was anything specific to alcohol consumption, and it was noted that this would be included under blood pressure management.
- In terms of cognitive function stimulation it was commented that attending adult education course may help, but the opportunity for evening classes seemed to have diminished.
- It was queried whether there was a need for more clinical pathways as there was variation across the country. It was suggested that a countywide pathway was needed as sometimes the diagnosis was not quick enough.
- In terms of blood pressure, it was highlighted that the number of people in Lincolnshire diagnosed with high blood pressure was higher than the national average. However, it was noted that Lincolnshire tended to 'import' an unhealthy population from elsewhere in the East Midlands, due to the desirability of the county as the retirement destination.
- It was noted that a high diagnosis rate was not necessarily a bad thing. The Director of Public Health advised that the real risk was the proportion of the population with undiagnosed with high blood pressure, as it was a risk factor across a whole range of conditions.
- It was queried whether there was any connection between dementia and the amount of water that someone drank. The Board was advised that there was

a need to ensure that people with dementia stayed hydrated in order to prevent hospital admissions. It was noted that this was something that could have a quick impact on avoidable admissions.

RESOLVED

1. That the Health and Wellbeing Board approve the draft Joint Strategy for Dementia as shown in Appendix A of the report.
2. That a summary document for the Strategy be developed.
3. That the Health and Wellbeing Board note that the Strategy will also be presented to the Adult Care and Community Wellbeing Scrutiny Committee.

17 DISCUSSION ITEMS

17a Multiagency Review of Mental Health Crisis Services

Consideration was given to a report by the Multiagency Review Steering Group in relation to the Multiagency Review of Mental Health Services in Lincolnshire which was completed in May 2018 and outlined ten key recommendations to be implemented in order to improve mental health and maximise the provision of mental health crisis services for the local population.

(NOTE: as this report and the next report were similar in subject it was agreed that the officers would introduce each report and the Board would then discuss both reports together)

17b Working Together to Create Safe, Well Communities - Policing and Mental Health Development Plan

Consideration was given to a report by the Office of the Police and Crime Commissioner which was commissioned to establish opportunities for collaboration between mental health and policing. It highlighted opportunities for effective use of system resources; collegiate decision making and sustainable effective actions to reduce the demand on policing from mental health as well as benefits for the entire health and social care system.

It was noted that all actions with the report had been considered against system impact, inclusive of public health and policing outcome measures. It was also noted that the report was produced prior to the crisis care concordat multi-agency review, and highlighted that they were mutually supportive.

The Health and Wellbeing Board was provided with the opportunity to ask questions to the officers present in relation to the information contained in the two reports and some of the points raised during discussion included the following:

- It was noted that it had not yet been agreed what funding was available to implement the recommendations.
- It was agreed that high level oversight was needed.

- It was commented that there was a need for a commitment from the CCG's on what they would be funding.
- It was noted that in Lincolnshire, health and policing were not currently considered at the same time.
- It was clarified that the report on the Multi-Agency Review had not yet been to the CCG's Board and so it had not been signed off yet. It was noted that a development session had been held two weeks previously where issues for alignment had been discussed. There was a need to link together the various strategies. In terms of support from commissioning, it would be queried where money was being spent, was it in the right place and was it helping the right people.
- In terms of the Crisis services team, it was noted that this was not for those people with severe mental health problems, but for those where something may trigger someone into a situation where their mental health was sub-optimal. It was highlighted that there was not a system that recognised when a person was in crisis. This was not about just giving a prescription for the right drug there was a need for a joint body between health and social care, employment, housing and training.
- It was noted that the Lincolnshire Safeguarding Adults Board was in the process of developing a prevent strategy which incorporated targeting scamming.
- It was noted a number of elements of mental health services were already integrated, but it was acknowledged that this could go further.
- In terms of governance, it was highlighted that there were clear groups already in existence, and there were two mental health priorities under the Health and Wellbeing Board. It would need to be considered how these aspects of governance could be dovetailed. It was suggested that some reporting mechanisms should be worked up.
- It was commented that it had been highlighted at the LPFT AGM that the amount of out of area treatment had reduced.
- In relation to scams, it was noted that anyone could be a victim of one, and it was suggested whether solicitors and banks should play more of a role in tackling scams. It was suggested whether when banks received a request for a large transaction, if the money could be held for a number of days before being released. The Board was advised that any money that was paid as part of a scam could be recovered if it was sent to a UK bank and the banks were notified within 48 hours.

Both reports were considered and discussed at the same time, however, each set of recommendations were considered separately as follows:

Multiagency Review of Mental Health Crisis Services in Lincolnshire:

RESOLVED

That the Health and Wellbeing Board note the recommendations of the review and oversee the implementation of those recommendations agreed by lead commissioners.

Working Together to Create Safe, Well Communities – Policing and mental Health Development Plan:

RESOLVED

That further work be carried out to identify how this would link with current strategies.

17c Consultation on the Contracting arrangements for Integrated Care Providers (ICPs)

The Lincolnshire Health and Wellbeing Board were advised that on 3 August 2018, NHS England launched a 12 week consultation on the contracting arrangements for Integrated Car Providers (ICPs). The consultation documentation detailed how the proposed ICP contract would underpin integration between services, how it differed from existing NHS contracts and how ICPs would fit into the broader commissioning system and which organisations would be able to hold an ICP contract. It was noted that the deadline for submitting responses to the consultation was 26 October 2018.

The report presented provided a brief overview of the key proposals and potential implications for Lincolnshire. Members were advised that this consultation gave a quite clear vision of what the health and social care system may look like in the future. It was noted that integration within the system had been discussed for a long time, and there were currently eight pilot areas which were already looking at how these services could bne integrated.

The Board was guided through the main points of the report and were provided with the opportunity to ask questions to the officers present in relation to the information contained within the report and some of the points raised included the following:

- It was confirmed that the principle was to provide all the care for the population through the one contract in order to prevent silo working and to remove transactional inefficiencies.
- It was noted that GP's could be employed through this contract, and it was highlighted that the West Midlands had employed 10 GP's.
- It was commented that 10 years was a long time for a contract, and during that time a population could increase or decrease as well as movement throughout the county, and it was queried whether there would be anything built into the contracts to protect against changes in population. The Board was advised that money would be able to move around the system as necessary. In relation to the contract length, it was noted that this was in order to provide motivation for those organisations to invest in preventative care and remove costs further down the line.
- There was support for the paper, but it was commented that it was important to not allow thinking to be fettered by the way the system was currently set up.
- It was commented that the consultation questions were not the interesting part, but everything that was in between, and it was suggested that the

questions should be answered in a way which gave a more strategic view and influence.

- It was suggested that Alison Christie and Derek Ward work up a response to the consultation on behalf of the Board, and it was also commented that it would be useful if this response could be circulated electronically for members of the Board to provide their views. It would be useful if points of view from different organisations could be provided.

RESOLVED

1. That the implications of the ICP consultation be noted;
2. That a response to the consultation be produced on behalf of the Board by the Director of Public Health and the Programme Manager and circulated to members for comment.

17d Social Housing Green Paper Consultation

The Board was advised that the government published its vision for social housing in the Social Housing Green Paper on 14 August 2018. The consultation outlined the government's proposals for addressing some of the issues raised by social housing tenants during a series of reviews after the Grenfell Tower tragedy.

The Board was advised that the report briefly set out the key consultation points, and sought to raise awareness of the Green paper and asked the Board to consider whether the Housing, Health and Care Delivery group (HHCDG) should be tasked with drafting a response to the consultation on behalf of the Board. It was reported that the next meeting of the HHCDG was on 16 October and the deadline for responses was 6 November 2018.

The Board was provided with the opportunity to ask questions to the officers present in relation to the information contained within the report and some of the points raised during discussion included the following:

- The District Housing Network was looking at how they could drive forward housing across Lincolnshire.
- It was noted that this group reported into the housing infrastructure group and was an officer group. There was a need to join up the economic infrastructure housing elements across the county, and the feedback reported to the district councils.
- It was reported that the green paper had been published the previous month, and had come out partly in response to the Grenfell Tower tragedy.
- It was noted that spending the housing budget was not just about increasing the social housing.
- As the HHCDG was a sub-group of the HWB, members could be assured that the health side of housing would be included in the response.
- It was commented that the green paper offered very little, and some of the contributions to date had been tempered as it was expected that the green paper for adult care would include what this one did not, for example those that required health and social care support.

- It was noted that the districts would be putting in their own responses, as they would see this from a different perspective with different issues being faced by district councils, as some had social housing, whilst others did not. However, it was acknowledged that health and housing were linked and it would be positive for a response to come from the HHCDG.
- It was queried whether the government was trying to ask where authorities would put any displaced families in an emergency. The Board was advised that there was a Lincolnshire Resilience Forum and networks within that which would be able to respond in these situations. The Board was assured that emergency plans were in place.
- It was highlighted that there was an impact to adult social care with badly built or inaccessible housing.

RESOLVED

It was agreed that a response on behalf of the Lincolnshire Health and Wellbeing Board would be drafted by the Housing Health and Care Delivery Group.

18 INFORMATION ITEMS

18a An Action Log of Previous Decisions

The Board received a report which noted the decisions taken since June 2018.

RESOLVED

That the report for information be received.

18b Lincolnshire Health and Wellbeing Board Forward Plan

The Board received and considered a copy of its Forward Plan.

RESOLVED

That the report for information be received.

The meeting closed at 4.03 pm

Meeting Date	Minute No	Agenda Item & Action Required	Update and Action Taken
05.06.18	**8a**	**TERMS OF REFERENCE AND PROCEDURE RULES, ROLES AND RESPONSIBILITIES OF CORE BOARD MEMBERS** Key roles and responsibilities of individual core members, as listed on pages 46 and 47 of the agenda pack, should also include the Office of the Police and Crime Commissioner and the Chairman of the Lincolnshire Coordination Board of the STP	The key roles and responsibilities have been updated to include the Office of the Police and Crime Commissioner and the Chairman of the Lincolnshire Coordination Board of the STP.
	8b	**JOINT HEALTH AND WELLBEING STRATEGY FOR LINCOLNSHIRE 2018** • That the publication of the Joint Health and Wellbeing Strategy document be agreed; • That the basis for progressing the delivery of the Joint Health and Wellbeing Strategy for Lincolnshire by way of Delivery Plans be agreed; • That the adoption of the proposed Governance Accountability Framework by the Lincolnshire Health and Wellbeing Board be agreed;	The Joint Health and Wellbeing Strategy, along with the delivery plans and supporting documentation, have been published on the council's website. Communications have been sent to key partners and stakeholders to promote the strategy and an article has appeared in June's HWB newsletter. In addition, over the summer the Chairman, Director of Public Health and the Programme Managers have attended a number of events and meetings around the county to promote the strategy. Ongoing engagement will be built into the JHWS programme over the life span of the strategy. A Joint Health and Wellbeing Strategy – Joint Delivery Group Workshop, to help promote joint working across the JHWS priorities was held on 26 November 2018.
25.09.18	**16b**	**LINCOLNSHIRE JOINT STRATEGY FOR DEMENTIA 2018-2021** • That the Health and Wellbeing Board approve the draft Joint Strategy for Dementia as shown in Appendix A of the report. • That a summary document for the Strategy be developed. • That the Health and Wellbeing Board note that the Strategy will also be presented to the Adult Care and Community Wellbeing Scrutiny Committee.	The Joint Strategy for Dementia 2018 -2021 was presented to the Adults and Community Wellbeing Scrutiny Committee on 10 October 2018. The summary document is to be developed taking account of best practice guidance, and with the involvement of people who live with dementia, their families and carers. The Dementia Conference, to launch the new Strategy, has been rescheduled for February 2019.

	17a	**MULTIAGENCY REVIEW OF MENTAL HEALTH CRISIS SERVICES** • That the Health and Wellbeing Board note the recommendations of the review and oversee the implementation of those recommendations agreed by lead commissioners.	Following the HWB meeting, a meeting was held with representatives from the STP Mental Health Group to look at developing an overarching plan covering all the strands of work relating to mental health. The intention is for this plan to become the JHWS Mental Health Priority Delivery Plan. A workshop with wider partners is planned for early December to follow up this work and finalise the plan.
	17b	**WORKING TOGETHER TO CREATE SAFE, WELL COMMUNITIES – POLICING AND MENTAL HEALTH DEVELOPMENT PLAN** • That further work be carried out to identify how this would link with current strategies.	
	17c	**CONSULTATION ON THE CONTRACTING ARRANGEMENTS FOR INTEGRATED CARE PROVIDERS (ICPS)** • That the implications of the ICP consultation be noted; • That a response to the consultation be produced on behalf of the Board by the Director of Public Health and the Programme Manager and circulated to members for comment.	Draft response prepared by the Director of Public Health and the Programme Manager, and circulated to Board Members for comment. The final response was signed off by the HWB Chairman and submitted via the online consultation on 22 October 2018. A copy of the final response was included in the Chairman's Announcements for the December 2018 meeting.
	17d	**SOCIAL HOUSING GREEN PAPER CONSULTATION** • That a response on behalf on behalf of the Lincolnshire Health and Wellbeing Board would be drafted by the Housing Health and Care Delivery Group.	Draft response prepared by the Housing Health and Care Delivery Group on behalf of the Health and Wellbeing Board. The final response was signed off by the Chairman of the HHCDG and the HWB, and submitted via the online consultation on 5 November 2018. A copy of the final response was included in the Chairman's Announcements for the December 2018 meeting.

Lincolnshire Health and Wellbeing Board – 11 December 2018

Chairman's Announcements

Joint Health and Wellbeing Strategy – Obesity Delivery Group

I am very pleased to say that in October I chaired the inaugural meeting of the delivery group which will lead on the work to tackle obesity as set out in the Joint Health and Wellbeing Strategy. Alongside officers from children's services, public health, environment and economy there were also representatives invited from West Lincolnshire Clinical Commissioning Group, Boston Borough Council and the University of Lincoln. At the meeting the group agreed to take forward the work through developing a whole system approach as this has been tested around the country (including in North Kesteven).

The group also agreed the importance of focusing the work on assets in communities, understanding what good practice there is (both in Lincolnshire and beyond) and how this learning can be shared and scaled up to achieve outcomes across Lincolnshire. To this end the delivery group will be developing a wider network of interested individuals, organisations and community groups to do some essential work in identifying examples of good practice as well as support a wider understanding of needs related to obesity within our communities and actions that will be taken to tackle the issue.

District Council Engagement

Following the publication of the Joint Health and Wellbeing Strategy in June 2018, I wrote to all the district councils offering to attend an appropriate committee or board meeting in order to share the new strategy and explore ways in which district councils might be able to work with the Health and Wellbeing Board to improve the health and wellbeing in Lincolnshire. I am pleased to report that I, along with Derek Ward and officers from Public Health, have attended meetings at South Kesteven, West Lindsey and East Lindsey, with the further meetings planned with the remaining districts in the new year. The strategy has been well received and I am encouraged by the level of interest being shown by our district colleagues to support its delivery. District councils provide a number of key local services and they are therefore keen to play a greater role in preventing ill health and supporting people to maintain their independence.

Sharing Good Practice

Through my work with the Local Government Association, I was asked to facilitate a workshop with West Sussex Health and Wellbeing Board as part of the process to refresh their Joint Health and Wellbeing Strategy. I think it is a testament to the work that we have undertaken over the past 18 months that other Health and Wellbeing Boards are looking to Lincolnshire for ideas and support. It provided an opportunity for me to not only share the learning and experiences, but also to promote the work being undertaken in Lincolnshire.

In addition, Nottinghamshire and Oxfordshire have contact officers in Public Health to learn more about the process Lincolnshire followed to refresh the Joint Strategic Needs Assessment in 2017, as well as the on-going approach Lincolnshire is taking to maintain the JSNA as a comprehensive evidence base.

National Award Nominations

I am delighted to say that two submissions to the national Local Government Chronicle Awards in relation to our work to support carers have been shortlisted in the categories of Health and Social Care, and Public/Private Partnerships. The next stage involves Panel Interviews in January with outcomes announced in March 2019.

In addition, representatives from the Lincolnshire Carers Services attended the Health Service Journal Awards in London on 21 November 2018. The Lincolnshire Carers Service was shortlisted in the 'System Led Support for Carers' category. Unfortunately the nomination was not successful but the nomination has raised the profile of the work that is being done in Lincolnshire to support carers.

Community Maternity Hubs

Public Health and Children's Services, in partnership with NHS Better Births Lincolnshire Team, have established four community maternity hubs in four Children's Centres in Lincolnshire. The pilot hub sites are in Skegness, Lincoln Birchwood, Grantham Swingbridge and Boston Norfolk Lodge. A further hub is being developed in Spalding. The hubs provide a one stop shop, enabling pregnant women and their families to access a range of services under one roof.

United Lincolnshire Hospitals NHS Trust (ULHT) – Senior Management Retirements

On 25 October 2018, Jan Sobieraj, Chief Executive of ULHT, announced that he would be retiring in 2019. Jan, who became Chief Executive December 2015, has worked for the NHS for over forty years. To ensure a smooth transition for his successor, an exact date has not yet been set for his departure, but it is expected to be in spring 2019. On behalf of the Board, I would like to thank Jan for his drive and contribution to the health and care system in Lincolnshire during this period of unprecedented demand on health services.

Karen Brown, ULHT's Director of Finance also announced her retirement at the beginning of September 2018.

National Centre for Rural Health and Care

The National Centre for Rural Health and Care (NCRHC), based in Lincoln, was formally launched at an event at the House of Commons on 16 October 2018. The NCRHC, the brainchild of health and education professionals from Lincolnshire and the East Midlands, aims to improve health and care in rural areas across the UK through research, better use of data, workforce developments and improved technology.

Ambulance Summit

On 7 November 2018, Cllr Martin Hill, Leader of Lincolnshire County Council hosted an ambulance summit with chief officers from health and emergency services to look at ways of improving ambulance services in Lincolnshire. All the organisations made a commitment to work together to identify opportunities for greater collaboration. Additional

funding for East Midlands Ambulance Service EMAS will be used to take forward a number of new and existing projects to help people access the right services, in the right place, at the right time to reduce the demand on hospital services.

In addition, the county council has pledged £300,000 from the funding allocated to local councils to help deal with winter pressures to develop a model of response for people who have fallen, allowing EMAS to prioritise the most life threatening calls. This pilot project is planned to be up and running before Christmas, with impacts being monitored and any improvements being made in spring 2019.

Advice Lincolnshire ASAP

The Lincolnshire NHS launched a new health app and website last September. The Advice Lincolnshire ASAP app and website provide basic information about conditions and some self-care advice where appropriate. It can also use the user's GPS tracking on their phone to provide a list of the specific treatment services as well as a map showing their location. If necessary, it can also call 999 or 111 for the user.

The ultimate goal is to help alleviate some of the pressure on our emergency departments, especially over winter, but also to ensure that patients are getting the most appropriate treatment for their needs in the fastest possible time.

Contracting arrangements for Integrated Care Providers – consultation response

Following the agreement at our last meeting, a response to the ICP consultation was prepared by Derek Ward and Alison Christie, and shared with Board Members for comment prior to approval by the Chairman. A copy of the final response, submitted on 22 October 2018, is provided in Appendix A.

Social Housing Green Paper – consultation response

Housing has been identified as a key priority area in the Joint Health and Wellbeing Strategy, in light of this, the Board agreed that a response should be submitted on behalf of the Health and Wellbeing Board. The response, drafted by the Housing Health and Care Delivery Group, was approved by the Chairman and submitted on 5 November 2018. A copy of the final response is provided in Appendix B.

Appendix A

Response from the Lincolnshire Health and Wellbeing Board to the draft ICP Contract Consultation (submitted online 22 October 2018)

The Lincolnshire Health and Wellbeing Board is broadly supportive of the proposals set out in the draft ICP Contract consultation document. However, to avoid perverse incentives an ICP needs to focus on whole population health management within a given geographical area, rather than dealing with individual conditions, age bands or pathways of care. Any further drive for closer integration needs to result in whole scale system change which improves the overall health and wellbeing of the local population and reduces health inequalities.

Q1: Should local commissioners and providers have the option of a contract that promotes the integration of the full range of health, and where appropriate, care services?

Yes, having the option of a contract that promotes the integration of the full range of health, and where appropriate, care services would deliver better care and outcomes, as well as breaking down silo working and reducing perverse incentives.

Q2: The draft ICP Contract contains new content aimed to promoting integration, including:

- **Incorporation of proposed features of a whole population care model, as services, included in a streamlined way with the draft ICP contract**
- **Descriptions of important feature of a whole population care model, as summarised in paragraph 30**

a) Should these specific elements be amended and if so how exactly?

No, the specific elements look appropriate. Being too prescriptive should be avoided as there needs to be flexibility in the approach to driven local improvements which are outcomes focused.

However, the Lincolnshire Health and Wellbeing Board would like clarification on how the proposals set out in paragraph 30 will align with the existing statutory powers of the Health and Wellbeing Boards to produce a Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy, as well as having a duty to promote integration and joint working.

b) Are there any additional requirements which should be included in the national content of the draft ICP Contract to promote integration of services?

The introduction of a shared electronic patient record system, with the appropriate safeguards, is essential to the future effectiveness of the health and care system. Fully utilising new digital technologies will enable greater efficiency and help to reduce some of the burden which is being placed on staff to work in a more joined up way. It will also improve integration by joining up services so that they are focused on improving the outcomes for individuals.

However, the development of a shared record system will need clear national guidance and specification as this is not something that can be implemented locally in isolation. Without this, the risk is that a myriad of different systems will be developed which then don't interact with each other.

The Lincolnshire Health and Wellbeing Board would also caution against only using the term 'patient'. The potential inclusion of care and public health services, where appropriate, means that from a local government perspective, 'clients' or 'service users' is more appropriate terminology to use.

Q3: The draft ICP Contract is designed to be used as a national framework, incorporating core requirements and processes. It is for local commissioners to determine matters such as:

- **The services with scope for the ICP**
- **The funding they choose to make available through the contract, within their overall budgets**
- **Local health and care priorities which they wish to incentivise, either through the locally determined elements of the financial incentive scheme or through additional reporting requirements set out in the contract**

Have we struck the right balance in the draft ICP Contract between the national content setting out requirements for providers, and the content about providers' obligations to be determined by local commissioners?

Yes, broadly the Lincolnshire Health and Wellbeing Board is in agreement. There is a national role to have sight of the local priorities that will be incentivised as these can either drive improvements or operate as perverse incentives.

Q4: Does the bringing together of different funding streams into a single budget provide a useful flexibility for providers?

Yes, this is a fundamental tenet for an ICP or integrated care system. To drive improvements across the health and care system funding needs to be pooled into a single budget.

Q5: We have set out how the ICP Contract contains provisions to:

- **Guarantee service quality and continuity**
- **Safeguard existing patient rights to choice**
- **Ensure transparency**
- **Ensure good financial management by the ICP of its resources.**

a) Do you agree or disagree with our proposal that these specific safeguards should be included?

No comment

b) Do you have any specific suggestions for additional requirements, consistent with the current legal framework, and if so what are they?

No, already covered under current legislation.

Q6:

a) Should we create a means for GPs to integrate their services with ICPs, whilst continuing to operate under their existing primary care contracts?

Yes, GPs must be able to be integrated within the ICP. The proposal to allow ICPs to hold GMS or PMS is sensible and there should also be the opportunity for ICPs to employ clinicians as appropriate.

b) If yes, how exactly do you think we should create this?

Secondary care consultant contracts may be a suitable model for input into the ICP.

c) Are there any specific features of the proposed options for GP participation in ICPs that could be improved?

No comment

Q7: Do you think that the draft ICP Contract adequately provides for the inclusion of local authority services (public health services and social care) within a broader set of integrated health and care services?

Unsure, the draft proposals are heavily focused on 'health' and do not adequately reflect an integrated approach which recognises the equal importance of wider partners within a complex health and care system. Local authorities, specifically social care, provide services to support local people and communities, as well as acting as advocates for the local area. The ICP proposals do not necessarily recognise and support the role of local authorities within an integrated system.

Currently, the Health and Wellbeing Board is the only statutory forum which has the democratic mandate to discuss and agree system integration, as well as holding the authority to recommend integration of public health and social care services. Therefore meaningful engagement of Health and Wellbeing Board in the development and sign off of ICPs is essential.

Q8: The draft ICP Contract includes safeguards designed to help contracting parties to ensure commissioners' statutory duties are not unlawfully delegated to an ICP:

- **It provides a framework within which decisions can be taken by the ICP, based on a defined scope of services which the commissioners require the ICP to deliver**
- **It includes a number of specific protections, outlined in paragraph 83, which together prohibit the provider from carrying out any activity which may place commissioners in breach of their statutory duties.**

Are there any other specific safeguards we should include to help the parties to ensure commissioners' statutory duties are not unlawfully delegated to an ICP?

No comment

Q9: The draft ICP Contract includes specific provisions, replicating those contained in the generic NHS Standard Contract, aimed at ensuring public accountability, including:

- **Requirements for the involvement of the public as explained in paragraph 89-93**
- **Requirement to operate an appropriate complaints procedure**
- **Complying with the 'duty of candour' obligation**

a) Should we include much the same obligations in the ICP Contract on these matters as under the generic NHS Standard Contract?

Yes

b) Do you have any additional, specific suggestions to ensure current public accountability arrangements are maintained and enhanced through the ICP Contract?

Yes, as stated in the response to Question 7, engagement of and sign off by the statutory Health and Wellbeing Board provides an existing vehicle for public accountability at a system level and also provides local democratic accountability that the NHS can't provide.

Q10: It is our intention to hold ICPs to a higher standard of transparency on value, quality and effectiveness, and to reduce inappropriate clinical variation. In order to achieve this the draft ICP Contract builds on existing NHS standards by incorporating additional provisions describing the core features of a whole population model of care and new requirements relating to financial control and transparency:

a) Do you think that the draft ICP Contract allows ICPs to be held to a higher standard of value, quality and effectiveness and to reduce inappropriate clinical variation?

Unsure, the model is unproven at this stage.

b) Do you have any additional, specific suggestions to secure improved value, quality and effectiveness, and reduce inappropriate clinical variation?

Yes, open book accounting, with local scrutiny through the local authority's Health Scrutiny function.

Q11: In addition to the areas covered above, do you have any other suggestions for specific changes to the draft ICP Contract, or for avoiding, reducing or compensating for any impacts that introducing this Contract may have?

Yes, changes need to happen at pace. The concept needs to be tested and a best practice approach then implemented. To start with the requirements for the ICP need to be quite prescriptive, once locally the ICP can demonstrate improvements then there needs to be the opportunity to request additional freedoms and flexibilities.

Q12: Are there any specific equality and health inequalities impacts not covered by our assessment that arise from the national provisions within the draft ICP Contract?

Yes, the ICP Contract needs to include an explicit understanding that there will be appropriate clinical variation but that this should only be to address health inequalities.

Additional comments:
In order to realise the ambition and opportunities offered by the ICP Contract consultation it needs to take account of the national policy context for health and social care. Therefore these proposals need to be considered and developed within context with the new NHS Five Year Forward View and the Social Care Green Paper.

There is also an opportunity to look wider than just social care and public health; consideration should be given to the role of other statutory agencies that provide services aimed at helping people to maintain their independence and remaining living in their own home. Specifically in two tier areas, District Councils have an important role to play in the wider prevention agenda through for example; their statutory housing role, adaptations and disability facility grants (DFGs).

Appendix B

Lincolnshire Health and Wellbeing Board Response to "A New Deal for Housing" Consultation (submitted online 5 November 2018)

Chapter 1: Ensuring homes are safe and decent	
1. How can residents best be supported in this important role of working with landlords to ensure homes are safe?	Local authorities have a history of effective engagement and the application of this process to Registered Providers is to be welcomed. Tenants need to be informed of safety measures their landlord should be complying with and be provided with guidance on issues that could make a home unsafe. Tenants need to know the responsibilities landlords have in regard to rectifying issues. The tenant needs to be made aware of what they can do if the landlord is failing to keep the property in a safe condition. This could include speaking to the landlord or agent in the first instance and then to contact the local authority Housing Standards team if advice and support is required. Guidance also needs to include information about their rights if the landlord subsequently serves a notice to quit and whether they can withhold rent until the issues are rectified It is important to recognise that not all residents will have a strong enough voice on their own to raise concerns about safety, particularly in supported housing. Arrangements locally need to ensure that any contract with the landlord includes clear lines of communication, and who in the locality can support if required.
2. Should new safety measures in the private rented sector also apply to social housing?	The same measures should apply across all rented housing to provide consistency. The private sector standards for smoke, CO2 and electrical testing are already best practice within local authorities. Extending these to Registered Providers is welcome, although more clarity is needed on some standards such as wired linked alarms.
3. Are there any changes to what constitutes a Decent Home that we should consider?	A significant issue is around proposals on energy efficiency and whether social housing should be upgraded to Energy Performance Certificate Band C by 2030. This is a good aspiration, but is likely to be extremely costly and potentially unachievable in the short term. Bringing all levels of housing stock up to Band C Energy Performance will require significant capital investment. Councils would either need additional capital grant for this, more flexibility on setting appropriate rent levels or the ability to use right to buy receipts without restriction (e.g. no time limit on when it can be spent or longer time to spend and/or the ability to use receipts to fund 100% of the scheme value and not just 30%). Even with these measures, some properties, which are very popular with their tenants, would be uneconomic to improve. There is currently no enforcement of letting lower EPC performance housing. If Registered Providers do not advertise the EPC rating or if they let properties without formally advertising these, such enforcement would need action by Trading Standards teams which are not likely to have enough capacity to deliver this given the funding pressures and reductions to Trading Standards services.
4. Do we need additional measures to make sure social homes are safe and decent?	No comments.
Chapter 2: Effective resolution of complaints	
5. Are there ways of strengthening the mediation opportunities available for landlords and residents to resolve	Providing a resolution and mediation service may help resolve some complaints, but it feels some complainants' goal is to get a complaint to the Ombudsman and cannot be reasoned with during the complaints process. A link in supported housing mediation could be to make sure mental health patients and their landlords have a local appropriate contact for housing support from

disputes locally?	someone skilled in mental health. This would be very beneficial.
6. Should we reduce the eight week waiting period to four weeks, or should we remove the requirement for the "democratic filter" stage altogether?	The democratic filter should either be removed or timescales reduced. For some complaints such as severe disrepair or anti-social behaviour a quick resolution is required. Therefore, the complaints process needs to be simplified with a quicker response provided.
7. What can we do to ensure that the "designated persons" are better able to promote local resolutions?	Designated persons need to know the process the landlord should have followed, and what standards they should be working to. Where the designated person considers this is not being achieved, they should know who to escalate the issue to within the registered provider / local authority for the situation to be reviewed. A link is needed in supported housing mediation to make sure mental health patients and their landlords have a local appropriate contact for housing support from someone skilled in mental health.
8. How can we ensure that residents understand how best to escalate a complaint and seek redress?	Residents need to be aware of how to make a complaint and be confident that doing so is worthwhile. Some residents may think it is not worthwhile to make a complaint because nothing will change. Some residents may not make a complaint because they consider this will result in negative treatment. This is a myth and needs to be overcome. If residents could make the initial complaint to an independent Government organisation possibly via Gov.uk they might be more confident of achieving a positive outcome, but this could be resource intensive. We are occasionally told by housing applicants who have been provisionally offered a property that they won't make a complaint about the condition of the property because they believe they will be refused the property and be put to the bottom of the waiting list.
9. How can we ensure that residents can access the right advice and support when making a complaint?	Ensuring a consistent standard for Local Authorities and Registered Providers in dealing with complaints would be welcome. Tenants should be given details of the complaints process and their rights by the landlord upon taking up the tenancy. Awareness will then increase amongst tenants, and landlords will feel more inclined to deal with matters more quickly, as they know the tenant has access to the complaints process. More in-depth information could be provided on Gov.uk than is currently provided. There needs to be an independent advocacy service for tenants who need support to make a complaint, for example via Citizens Advice Bureau or Shelter.
10. How can we best ensure that landlords' processes for dealing with complaints are fast and effective?	National guidance could be produced that all landlords have to follow, with compensation for the tenants if the landlords do not adhere to the procedure/timeframe.
11. How can we best ensure safety concerns are handled swiftly and effectively within the existing redress framework?	Social housing landlords need to be provided with timescales to respond, with shorter timescales for urgent matters such as health and safety concerns. We suggest the government advises social housing landlords and the Ombudsman of appropriate timescales. The Ombudsman could then take these timescales into account when dealing with a complaint.
Chapter 3: Empowering residents and strengthening the Regulator	
12. Do the proposed key performance indicators cover the right areas? Are there any other areas that should be	The proposed indicators cover the right areas but could be expanded as set out below. The current regulatory standards also cover most areas but are too brief and offer little guidance to residents about the standards they can expect from their landlord.

covered?	The Tenancy Standard needs to include measures to ensure the best use of stock is made including identifying tenants who are under-occupying or overcrowded and what should be offered to resolve both situations. The following standards are also required: • Allocation of accommodation – most Social Landlords now expect housing applicants to pay rent in advance. This is not always possible, and may result in applicants missing out on an offer or taking out a loan they may not be able to afford. Guidance is required to ensure consistency across the country, including how much the advance should be and circumstances when it should be reduced or removed. • Supporting tenants – due to the digital era some residents will no longer have the level of interaction they once had with their landlord. Housing Officers are less visible and Rent Collection rounds probably no longer exist meaning issues can go unnoticed and can escalate. Measures should be put in place to ensure landlords do estate walkabouts and speak to their residents. This could be included in the indicator "respectful and helpful engagement with residents". • Preventing homelessness – separate guidance is required to ensure social landlords try to prevent their tenants from becoming homeless. This should include measures they can take, plus when to make a referral such as to Social Care, Citizens Advice Bureau or to the local housing authority for assistance, and where assistance is not forthcoming from such organisations, how to escalate this.
13. Should landlords report performance against these key performance indicators every year?	Yes.
14. Should landlords report performance against these key performance indicators to the Regulator?	Yes.
15. What more can be done to encourage landlords to be more transparent with their residents?	Most, if not all, landlords will have some information on their websites, but it is inconsistent and often lacking in detail and doesn't comply with current regulations. Provide guidance to landlords outlining what is expected of them in regard to transparency and how to inform their tenants. All landlords could be asked to have a webpage showing the required national service standards, previous performance against these standards, how to make a complaint, how to obtain support in making a complaint. This information could also be provided annually with the rent statement. The Ombudsman should check the website when dealing with a complaint and if it is below standard, the Ombudsman should set a timescale for it to be rectified.
16. Do you think that there should be a better way of reporting the outcomes of landlords' complaint handling? How can this be made as clear and accessible as possible for residents?	Provide guidance to landlords outlining what is expected of them in regard to transparency and how to inform their tenants. All landlords could be asked to have a webpage showing the required national service standards, previous performance against these standards, how to make a complaint, how to obtain support in making a complaint. This information could also be provided annually with the rent statement. The Ombudsman should check the website when dealing with a complaint and if it is below standard, the Ombudsman should set a timescale for it to be rectified.
17. Is the Regulator best placed to prepare key performance indicators	Yes. A single regulator would ease tenants' concerns over who to approach. However, there are different considerations and obligations for Local Authorities and Registered Providers, and a regulator would need to take this into account.

in consultation with residents and landlords?	
18. What would be the best approach to publishing key performance indicators that would allow residents to make the most effective comparison of performance?	Each landlord could provide their performance annually as part of one of their current returns and this data be published on Gov.uk. The use of league tables needs further clarity. All local authorities have priorities that are set in their locality. Not all housing organisations are set up or operate in the same way so a blanket ranking may not inform relative performance. That said, it would be helpful to have a set of core performance indicators (preferably 5-10, not 20-30) and for these to be monitored by a regulator. The contact details for the regulator need to be well publicised and clear to promote access and use.
19. Should we introduce a new criterion to the Affordable Homes Programme that reflects residents' experience of their landlord? What other ways could we incentivise best practice and deter the worst, including for those providers that do not use Government funding to build?	Yes. Landlords who do not look after their tenants or properties to an acceptable standard should receive less Affordable Homes Programme funding. Funding could be linked into tenant satisfaction levels which would incentivise Housing Associations to achieve a higher level of satisfaction.
20. Are current resident engagement and scrutiny measures effective? What more can be done to make residents aware of existing ways to engage with landlords and influence how services are delivered?	This is largely unknown. We suggest they are possibly not, particularly with social housing providers who cover a very large geographical area. How do they ensure the views of all residents are heard when, for example, the local office could be a 100 miles away from where the tenant lives and face to face contact is very minimal? Information and surveys can be posted, but response rates are traditionally low.
21. Is there a need for a stronger representation for residents at a national level? If so, how should this best be achieved?	No comments.
22. Would there be interest in a programme to promote the transfer of local authority housing, particularly to community-based housing associations? What would it need to make it work?	No comments.
23. Could a programme of trailblazers help to develop and promote	Yes, but there is a need to ensure urban, rural and deprived areas are included as well as including people of varying backgrounds and vulnerabilities.

options for greater resident-leadership within the sector?	
24. Are Tenant Management Organisations delivering positive outcomes for residents and landlords? Are current processes for setting up and disbanding Tenant Management Organisations suitable? Do they achieve the right balance between residents' control and local accountability?	No comments.
25. Are there any other innovative ways of giving social housing resident's greater choice and control over the services they receive from landlords?	No comments.
26. Do you think there are benefits to models that support residents to take on some of their own services? If so, what is needed to make this work?	No. Managing this would be too complex and time consuming and not achieve value for money.
27. How can landlords ensure residents have more choice over contractor services, while retaining oversight of quality and value for money?	We suggest it is more important to make sure a single, cost effective service is provided. Introducing competition can potentially lead to additional on-costs for the residents.
28. What more could we do to help leaseholders of a social housing landlord?	No comments.
29. Does the Regulator have the right objective on consumer regulation? Should any of the consumer standards change to ensure that landlords provide a better service for residents in line with the new key performance indicators	The current regulatory standards cover most areas, but are too brief and offer little guidance to residents about the standards they can expect from their landlord. They also allow housing providers too much scope for interpretation. Tenants should also be asked whether they are aware of these standards. We expect the majority are not aware because their landlord has not told them. The Tenancy Standard needs to include measures ensuring the best use of stock is made, including identifying tenants who are under-occupying or overcrowded and what should be offered to resolve both situations. The following standards are also required: - Allocation of accommodation – most Social Landlords now expect housing

proposed, and if so how?	applicants to pay rent in advance. This is not always possible, and may result in applicants missing out on an offer or taking out a loan they may not be able to afford. Guidance is required to ensure consistency across the country, including how much the advance should be and circumstances when it should be reduced or removed. - Supporting tenants – due to the digital era some residents will no longer have the level of interaction they once had with their landlord. Housing Officers are less visible and Rent Collection rounds probably no longer exist meaning issues can go unnoticed and can escalate. Measures should be put in place to ensure landlords do estate walkabouts and speak to their residents. This could be included in the indicator "respectful and helpful engagement with residents". - Preventing homelessness – separate guidance is required to ensure social landlords try to prevent their tenants from becoming homeless. This should include measures they can take, plus when to make a referral such as to Social Care, Citizens Advice Bureau or to the local housing authority for assistance, and where assistance is not forthcoming from such organisations, how to escalate this.
30. Should the Regulator be given powers to produce other documents, such as a Code of Practice, to provide further clarity about what is expected from the consumer standards?	Either the current standards need to include examples of what "good" means in regard to a type of service or standard of accommodation, or additional guidance should be provided.
31. Is "serious detriment" the appropriate threshold for intervention by the Regulator for a breach of consumer standards? If not, what would be an appropriate threshold for intervention?	A landlord could continually provide a poor service to its tenants but never meet the serious detriment threshold. We understand that only a very small percentage of complaints currently meet the threshold which would suggest it needs to be reviewed. A lower threshold could be included which would call upon the regulator to inspect the landlord concerned once a set number of complaints had been reached. This would encourage landlords to provide a good service.
32. Should the Regulator adopt a more proactive approach to regulation of consumer standards? Should the Regulator use key performance indicators and phased interventions as a means to identify and tackle poor performance against these consumer standards? How should this be targeted?	Yes. There is a consensus that we do not know whether landlords are meeting the current standards, which indicates there is not enough publicity of the landlord's performance. Responsive repairs appear to be the biggest area of complaint that the Housing Ombudsman receives from tenants. Therefore, there needs to be performance indicators for this area of work. The regulator could set timescales landlords should meet, and monitor performance against these timescales. However, tenants need to feel empowered to make a complaint and this be registered in some way so the regulator is aware of the complaint. Could there be a national system where tenants could log the complaint and the landlord be informed and given a set period of time to respond. The regulator would then have access to all complaints and obtain statistical information helping inform the landlords to be targeted.
33. Should the Regulator have greater ability to	Yes. The same performance indicators and scrutiny process should apply to housing associations and local authorities who manage properties.

scrutinise the performance and arrangements of local authority landlords? If so, what measures would be appropriate?	
34. Are the existing enforcement measures set out in Box 3 adequate? If not, what additional enforcement powers should be considered?	Yes.
35. Is the current framework for local authorities to hold management organisations such as Tenant Management Organisations and Arm's Length Management Organisations to account sufficiently robust? If not, what more is needed to provide effective oversight of these organisations?	No comments.
36. What further steps, if any, should Government take to make the Regulator more accountable to Parliament?	No comments.
Chapter 4: Tackling stigma and celebrating thriving communities	
37. How could we support or deliver a best neighbourhood competition?	No comments.
38. In addition to sharing positive stories of social housing residents and their neighbourhoods, what more could be done to tackle stigma?	Traditional council homes tend to have a specific look, whereas new build social housing often looks the same as owner occupied properties which might help to reduce some of the stigma from now on. We assume social housing contains more vulnerable people per head than any other sector and without sufficient support services including adult social care and mental health which are being cut year on year the issues will increase and so will the stigma. There are opportunities to link with local initiatives through existing public sector work streams to develop communities. Tackling stigma associated with mental health for is a national driver for mental health organisations. How do programmes associated with this link with social housing development?
39. What is needed to further encourage the professionalisation of housing management	This should be managed by managers within each organisation and not require any external intervention, unless the issues are not being dealt with. Providing a good and polite service to tenants should be common practice. This could be monitored by the regulator, if a national complaints system was put in place as per question

to ensure all staff deliver good quality of services?	32 above.
40. What key performance indicator should be used to measure whether landlords are providing good neighbourhood management?	Does the performance sit with the landlord alone? Good neighbourhoods are about more than premises management. How do local authorities and wider partners support the measure of safe, well communities and allocate resource to respond to need?
41. What evidence is there of the impact of the important role that many landlords are playing beyond their key responsibilities? Should landlords report on the social value they deliver?	No comments.
42. How are landlords working with local partners to tackle anti-social behaviour? What key performance indicator could be used to measure this work?	Some landlords are slow to react to complaints of antisocial behaviour and take minimal action if the complainant does not follow up the complaint with evidence, such as diary sheets. Sometimes antisocial behaviour is linked to ill health, addictions and vulnerability for which landlords need additional and sometimes expert support to manage the issue. Access to support is continually being reduced and can result in landlords having to evict the tenant as the only means to resolve the problem. Where support is required and not provided, this should be recorded. The number of complaints and percentage of positive / negative outcomes should be monitored including how the antisocial behaviour was resolved. Any learning can then be shared through good practice guidance. The data should be by Social Landlord and not be broken down to estate level, as this could increase stigma.
43. What other ways can planning guidance support good design in the social sector?	Greater importance should be given through the planning process to ensure that affordable properties are integrated into developments and to ensure that the properties are of an appropriate size and design to meet the housing needs. If a developer refuses to meet these requirements, it should be grounds for a planning refusal. Local Authorities can be reluctant to use these reasons as the sole ground for a planning refusal when in reality it has a significant impact on the scheme. Higher grant rates could also be made available to improve the quality of design on fully affordable sites. When cost to value is marginal, it is difficult to provide a higher standard of accommodation as it is likely to mean that a site is unviable. Many Registered Providers do build well, but as they have been required to be more commercial and to build more new properties, there is a concern that they may in future build to a lower standard and potentially invest less in maintaining the quality of their existing stock. We absolutely agree with the need to tackle stigma. This needs a well thought-through approach from national government outwards. In particular the language needs to change: 'social housing', 'benefits', as this supports existing stereotypes and attitudes. This is also a much wider 'place' issue' which requires effort from a very wide range of organisations. The same level of care needs to be required of all agencies including utility companies, railways, etc. in undertaking repairs and maintenance in

	all locations. The quality of finish is sometimes noticeably poorer in areas of high social housing. This is a collective responsibility. Even where old social housing is cleared or renovated, the area retains its stigma. All of our towns have an area known as 'council housing' or 'sink estate'. We are concerned that stigma for residents will continue in any system where the preferred option / aspiration from government are that home ownership is always the best option. This creates a wider culture that rented accommodation is second class, and that social rented housing is beneath that. Housing management is a key component of tackling stigma. Many Registered Providers have been required to be commercial in their approach, moving more to being developers and rent-collectors than good landlords engaging with their tenants, supporting community activity, etc.
44. How can we encourage social housing residents to be involved in the planning and design of new developments?	This could potentially be achieved through liaison with the Housing Associations Tenant Participation Officers for existing tenants. As part of new affordable housing developments it could be beneficial to hold community consultation events which would enable local residents and potential new social housing tenants to have an involvement in the planning process. The focus on community events / community pride is welcome but this needs funding and support / facilitation. Many Council and Registered Provider funds for such activities and support have been lost in recent times due to budget pressures.
Chapter 5: Expanding supply and supporting home ownership	
45. Recognising the need for fiscal responsibility, this Green Paper seeks views on whether the Government's current arrangements strike the right balance between providing grant funding for housing associations and Housing Revenue Account borrowing for local authorities.	Stock transfer authorities have for some years been unable to borrow through the Housing Revenue Account. Councils considering new development would like as much flexibility as possible to be able to do this. We very much welcome the recent announcement that the government's position may change and look forward to further information on this. Councils are also not currently eligible to apply for grant funding which is also restricting new development. The recent announcement to scrap plans to require Councils to sell their most valuable homes as they become vacant, in order to fund the extension of the right to buy to all housing association tenants is a very welcome move for local authorities. The separate consultation on giving Councils new flexibilities to spend the money raised from right to buy sales on new homes is helpful. Such flexibilities would be very welcome move for local authorities. We welcome the move to ensure that where an existing secure/assured tenant needs to move as a result of domestic abuse, they are always able to retain their lifetime tenancy.
46. How we can boost community-led housing and overcome the barriers communities experience to developing new community owned homes?	Community Led Housing is very positive but is difficult to achieve without the community having the right skill set and long term commitment. It is also very difficult to achieve a consensus of opinion within a community which can lead to schemes not progressing. Overcoming this is sometimes possible but time consuming. The new NPPF definition for affordable housing is too restrictive for Community Led Housing because communities are unlikely to register to become a Registered Provider for the small number of houses that they wish to deliver. This is likely to prevent schemes progressing. In Lincolnshire, there have been a few successful community-led housing schemes but others are not working. Making these work requires significant support from the

	Council. The main benefit is the lack of opposition for development proposals. This could be achieved with good community engagement outside community-led models. Community-led models require considerable time and expertise from local community members. This exists in some areas, but less so in sparse rural areas and/or where people are already involved in volunteering activity, have work or childcare commitments, are unwell, or have no experience or skills to undertake the longer term management tasks required.
47. What level of additional affordable housing, over existing investment plans, could be delivered by social housing providers if they were given longer term certainty over funding?	The level of housing that could be delivered is not known however longer term funding is likely to be beneficial to Providers as it would enable them to plan for the longer term and look at future pipeline schemes with more confidence that the scheme can be funded.
48. How can we best support providers to develop new shared ownership products that enable people to build up more equity in their homes?	The Government could create a savings scheme to work alongside the rental element of the Shared Ownership property. This way every time a tenant makes their monthly payment, part of the money could be set aside to increase the equity in the property. It is important to enable residents to increase the equity in their home but it is also important to ensure that the overall stock of affordable housing does not decrease as a result of this. Registered Providers should be made to ensure that a replacement dwelling is provided in the same settlement as often units are being provided within a much wider area and often not even in the original district. Whilst this is welcome and better shared ownership options may help to reduce stigma, this also still implies that people are and should be working towards the preferred option / aspiration that home ownership is always best.

Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Lincolnshire Physical Activity Taskforce

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**11 December 2018**
Subject:	**Developing a Blueprint for a More Active Lincolnshire**

Summary:

This paper provides an update on developments to establish a Lincolnshire Physical Activity Taskforce (L-PAT) and an approach to producing a *Blueprint for a More Active Lincolnshire* (the Blueprint).

An L-PAT was established in summer 2018 and has begun to engage partners to develop Lincolnshire into a more active and healthy county. Key developments to date include:

- Governance and management structures for L-PAT agreed
- Establishment of an Executive Group
- Vision, purpose, goals, and high level objectives for 'A Blueprint for a More Active Lincolnshire' agreed
- Employment of L-PAT Strategic Programme Manager
- Public launch of L-PAT – 18 October 2018
- Engagement with local authorities and partner agencies
- Agreement to have a district-based approach

Actions Required:

The Health and Wellbeing Board is asked to note progress with establishing a Lincolnshire Physical Activity Taskforce and developments to produce a *Blueprint for a More Active Lincolnshire*

1. Background

Physical inactivity is a Public Health issue. The Joint Chief Medical Officer's report `Start Active, Stay Active` presents a compelling case for the benefits of physical activity and the damage associated with a sedentary lifestyle (Department of Health, 2011). A narrative on physical activity and the policy context is contained in Appendix A.

Physical inactivity is a contributing factor in heart disease, strokes, diabetes, certain cancers and poor mental wellbeing. The culture of sedentary lives is also contributing to an increasingly obese population.

The levels of physical activity and inactivity are recorded by the Active Lives Survey from Sport England. The latest survey places Lincolnshire in an undesirable position as the most inactive shire county in England. The Active Lives results (published Oct 2018) presents a worrying trend towards greater physical inactivity within the county (Appendix B).

The Lincolnshire Health and Wellbeing Board (HWB) has requested that Active Lincolnshire establish and coordinate a 'Lincolnshire Physical Activity Taskforce' (L-PAT). The aim of the L-PAT is to develop and deliver a *'Blueprint for a More Active Lincolnshire'* (the Blueprint). The Blueprint will set out a scheme for integrating and embedding physical activity into Lincolnshire's key public, private and voluntary sector decision-making, planning and delivery services that impact on physical and mental wellbeing.

The developing Joint Health and Wellbeing Strategy (JWHS) theme for Physical Activity contains a series of objectives proposed for the Taskforce:

- To develop and drive the countywide 'Blueprint' for physical activity.
- Develop an action plan for physical activity (March 2018) to inform the development stages of the 'Blueprint' for the county
- Undertake robust local insight analysis to target actions more equitably and effectively
- Embed physical activity across clinical pathways
- Develop and cement the relationship with Integrated Neighbourhood Working and Greater Lincolnshire Local Enterprise Partnership (GLLEP)
- Engage districts with a portfolio of activity interventions
- Enhance workforce wellbeing – Wellbeing Charter (Public Health England, 2018).

This paper provides an update on developments to establish an approach to produce a *Blueprint for a More Active Lincolnshire* that meets the objectives of the JHWS theme for Physical Activity and the wider benefits of embedding physical activity into services and behaviours that impact on physical and mental wellbeing.

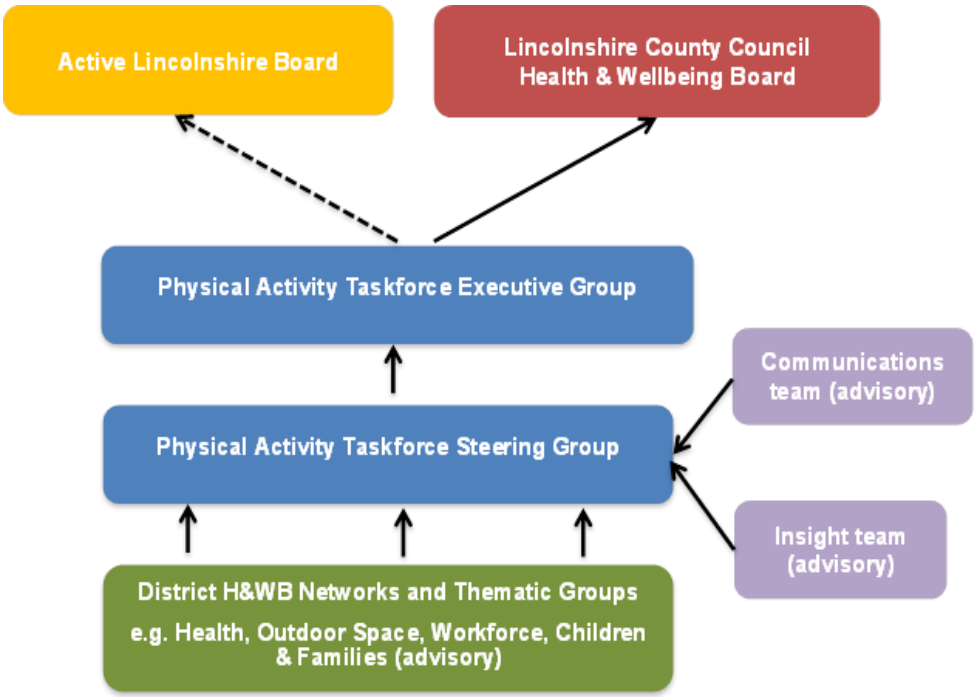
Governance and Project Management

L-PAT was formed over the summer and has held two Executive Group meetings to-date. The Executive Group (membership and terms of reference in Appendix C), at their October meeting, has agreed the following (illustrated below):

- the L-PAT governance and relationship to the HWB and Active Lincolnshire Board
- management structures for strategic oversight and operational planning for the development and delivery of the Blueprint with

- seven district activity partnerships and thematic working groups

Figure: L-PAT Outline Governance Structure



For each layer of governance a set of terms of reference have been produced

Active Lincolnshire and Lincolnshire County Council have agreed to co-fund a Strategic Programme Manager post (SPM) for up to two years, to guide the development of the Blueprint. A secondment agreement between the Council, Active Lincolnshire and the post holder has been completed, with the L-PAT SPM formally engaged from the 1 October 2018.

The L-PAT Executive Group has agreed the geographies for the L-PAT developments; these being based on local authority boundaries and their respective communities, where many of the regulatory powers and responsibilities for health improvement, including many areas relating to physical activity reside (see Appendix D).

The Strategic Programme Manager is currently recruiting partners to form the L-PAT Steering Group with the associated links with district council partners and thematic working groups across the NHS, voluntary sector, leisure industry and communities.

The Strategic Programme Manager is also in the process of establishing an ‘Insight Team’ to advise the steering group. Once established, the Insight Team will work to ‘research insight, interpretation, modelling, evaluation and impact’ that will be used to inform the development of the Blueprint and ‘measures of success’.

A L-PAT communications and engagement strategy is in development and is being led by Active Lincolnshire’s Director for Strategy and Insight. Specialist advice will be provided, as required, to the Steering Group by a separate ‘Communications Team’, once established.

Developing the Blueprint

The L-PAT Executive Group has scoped and agreed:

a. the vision, goals, and high level objectives for 'A Blueprint for a More Active Lincolnshire'
b. An approach to developing and monitoring the Blueprint
c. an outline project plan,
d. a joint executive risk register between L-PAT and Active Lincolnshire,
e. an initial communications and stakeholder engagement strategy.

The L-PAT Executive Group has developed the following, as a draft:

A Vision: To improve people's lives through habitual physical activity

Mission: Everyone in Lincolnshire has the opportunity, environment and means to lead an active and healthy life

Intended Outcome: Lincolnshire will be the most active county in England, where physical activity is a part of everyday life

Goals and Objectives (based a WHO framework). The Goals are:

- Goal 1 – Active Society
- Goal 2 – Active Place
- Goal 3 – Active People
- Goal 4 – Active Systems

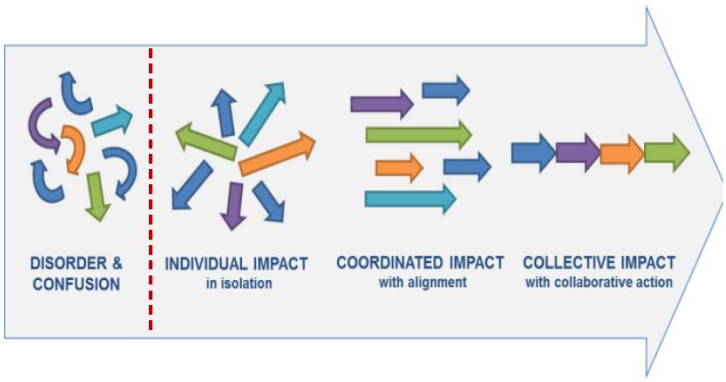
Appendix E provides information on the objectives which sit under each of the Goals. The goals and objectives will be discussed and further refined as appropriate, in discussion with partners and stakeholders to the Blueprint.

Stakeholder Engagement

The range and scope of partners and stakeholders contributing to the Blueprint goals is considerable and runs across the community and voluntary sectors, the private sector and the public sector. Early engagement has been most productive with agencies and authorities in committing to the process, including building the local picture.

An important component to the Blueprint development will be representation of the actions of others within the Blueprint when working towards a mutual agenda. Another physical activity strategy (Sheffield) utilised an insightful visual image representing the current status and the future mutual approach. The dotted red line represents a position for Lincolnshire where partners and stakeholders recognise their own contributions as valuable, but not sufficient for substantial change:

Image: Where in Terms of a Whole System Approach is the Current State



Source: R Copeland. Move More: Sheffield

To-date, five of seven local authorities, the voluntary sector infrastructure (CVS/VCS), Greater Lincolnshire Enterprise Partnership, Lincolnshire Police, leisure providers, the One Network and Public Health England are committed to engaging with a whole systems approach. Enquiries with the remaining councils (City of Lincoln, South Kesteven) and NHS partners are continuing in order to secure the respective representation across CCGs, trusts, clinicians and neighbourhood teams.

The Active Lincolnshire Annual General Meeting and the launch of L-PAT (18 October 2018) raised the profile of the L-PAT and re-enforced the importance of the Blueprint with partners, particularly in light of the challenging Active Lives physical activity statistics recently published (appendix). The chair of L-PAT was interviewed by Look North and Radio Lincolnshire in relation to the L-PAT launch and the Blueprint.

A Whole Systems Approach methodology to develop the Blueprint

L-PAT has agreed to utilise the Whole System Approach methodology (Leeds Beckett University model), derived from the obesity agenda to develop the Blueprint and move from a state of `individual impact` to collective impact`, as outlined below:

Phase 1: Set Up (July-Sept 2018)
Secure senior level support and establish the necessary governance structure to effectively implement the 'whole system' approach.

Phase 2: Building the Local Picture (October 2018-January 2019)
Build a compelling narrative explaining why physical activity matters locally & create a shared understanding of how physical activity is currently addressed at a local level

Phase 3: Mapping the Local Reality (January–March 2019)
Bring stakeholders together to create a comprehensive map of the local ecosystem system which is understood to contribute to inactivity and sedentary behaviour.

Launch of the Blueprint – 5 April 2019

Phase 4: Action (from April 2019)
Brings stakeholders together to prioritise areas to intervene in the local ecosystem and propose collaborative and aligned actions.

Phase 5: Creating a dynamic local system (from April 2019)
Bring stakeholders together to agree process for accountability, monitoring and evaluation of actions, agreeing new actions and maintaining momentum of change and structure to effectively implement the 'whole system' approach.

Phase 6: Reflection (from April 2019)
Critically reflect on the process of undertaking a whole systems approach and consider opportunities for strengthening the process.

The outline project plan for the Blueprint production contains the following actions and timeframes:

- District partner engagement and commitment– November 2018 to January 2019
- Draft 1 of the Blueprint – 21 December 2018
- L-PAT Executive Group development of the draft Blueprint – 29 January 2019
- Engagement and feedback from partners on draft 1 – during February 2019
- Draft 2 approval through L-PAT and HWB – 26 March 2019
- Blueprint launch – 5 April 2019

It is intended that the Blueprint will describe future actions in the form of district activity plans alongside themes reflecting health-related opportunities, the use of the urban and rural outdoor spaces, active travel, workforce development, workplace health, building on community assets and challenging social norms.

2. Conclusion

The L-PAT developments to gain a consensus and strategic direction for physical activity and health gain in Lincolnshire through the production of a Blueprint for a More Active Lincolnshire are underway with activities focusing on the preliminary phases of Set Up and Building the Local Picture with authorities and partners.

Through the coming weeks district health and wellbeing partnerships and themed based working groups will map the local reality of why physical activity matters locally and determine plans to embed physical activity into policies, plans and actions that will contribute to the Blueprint and meet the goals and high level objectives agreed by the L-PAT Executive Group.

The progress being made is an excellent starting point to-date. The garnering of the collective ambitions, shared goals and outcomes will be made, along with the building of relationships with a wide range of partners to realise this ambition.

3. Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy

The Council and Clinical Commissioning Groups must have regard to the Joint Strategic Needs Assessment (JSNA) and Joint Health and Wellbeing Strategy.

Physical Activity is a theme of the refreshed JHWS and there is a JSNA: physical activity topic. L-PAT has the responsibility of updating and maintaining this topic in the future.

4. Consultation

None required.

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Physical Activity and A Whole Systems Approach
Appendix B	Active People & Active Lives Surveys' Statistics (date)
Appendix C	L-PAT Executive Group Membership and Terms of Reference
Appendix D	Regulatory Powers and Responsibilities for Local Authorities regarding Health Improvement
Appendix E	Goals and Objectives

6. Background Papers

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

This report was written by Philip Garner, LPAT Strategic Programme Manager, who can be contacted on 01552 552292 or philip.garner@lincolnshire.gov.uk

Physical Activity and a Whole Systems Approach **Appendix A**

Physical activity can include components of active living, active travel, recreation, exercise and sport:

Active Living	**Active Travel**	**Recreation**	**Sport**
Housework	Walking	Exercise	Informal sport
Gardening	Cycling	Dance	Organised sport
Walking	Running	Swimming	Structured competition
Play		Play	Elite & professional sport

The determinants of physical activity and exercise can be categorised as demographic, social, environmental, cognitive and emotional:

- Demographics – age, gender, disability, socioeconomic status, economy
- Social – culture, education, health status, inequalities
- Environmental – design, travel, safety, pollution, access
- Cognitive – self efficacy, value, past behaviours, future behaviours, defaults
- Emotional - attitudes, experiences, costs, benefits, motivation.

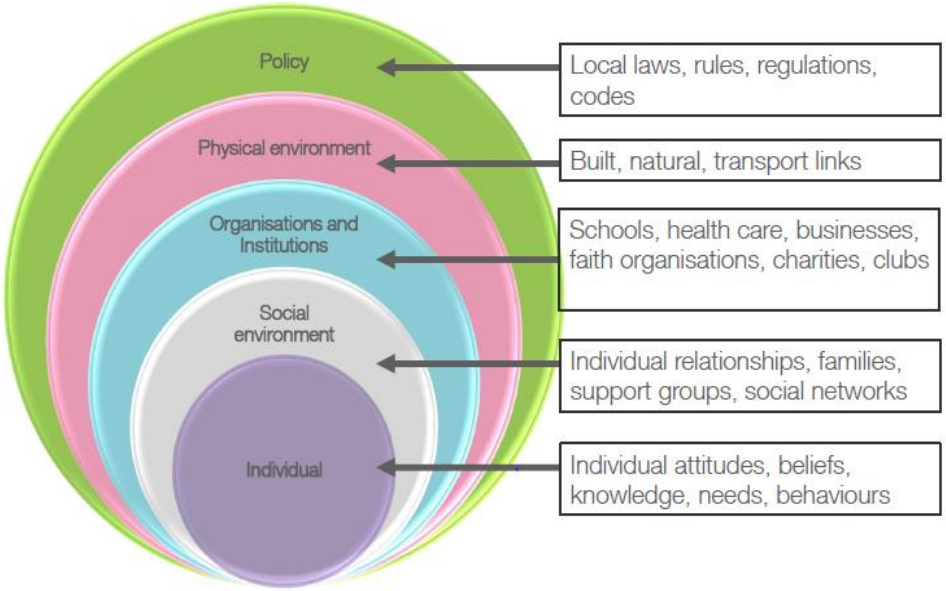
Understanding which determinants the Blueprint seeks to influence will need to be assessed as to the strength of the relationship between the determinants and physical activity / inactivity varies and may or may not be amenable to change.

Policies, Strategies and Plans for a Whole Systems Approach

A range of international and national publications support a strong case for the promotion of active daily living through integrated approaches across health, education, sports, leisure, transport, planning and employment (International Society for Physical Activity and Health,2010; Public Health England, 2014; Sport England, 2016; World Health Organisation, 2018). The potential contributions from local agencies could include:

- Planning and Design - creation and maintenance of environments that promote and enable access to safe places and spaces for daily activity
- Leisure – culture & heritage, recreation, exercise, sports development and participation, access to parks, allotments and outdoor spaces
- Education –physical education, sports and physical activity through the curriculum, extra-curricular activities, play and the community use of facilities
- Health – commissioning health improvement programmes (prevention), activity provision for people with specific conditions through clinical pathways (therapy and rehabilitation) and actions for a healthy workforce
- Voluntary and Community – community engagement, social prescribing, activity programmes, sports clubs and associations
- Commercial and Private Sector– access to facilities, outdoor spaces, sponsorship, employment and actions for a healthy workforce
- Media – promotion, publicity, celebration of success.

Many strategies recognise the value of tackling this challenge as a whole systems approach:



The ‘whole system approach’ provides a framework within which key stakeholders that influence and shape policy, the physical and socio-economic environment, organisations, communities and individuals and the provision of services can come together, share the reality of the challenge, consider how the ‘whole system’ is interacting and operating and where it might be feasible to intervene, agree actions and how, as a network, stakeholders can move forward together to bring about a sustainable shift in physical activity that will impact positively on the wider determinants of health as well as physical and mental wellbeing.

Active Lives Survey Results (2018) **Appendix B**

Figure: Active Lives Survey: Counties (May 2017/18 - Updated October 2018)

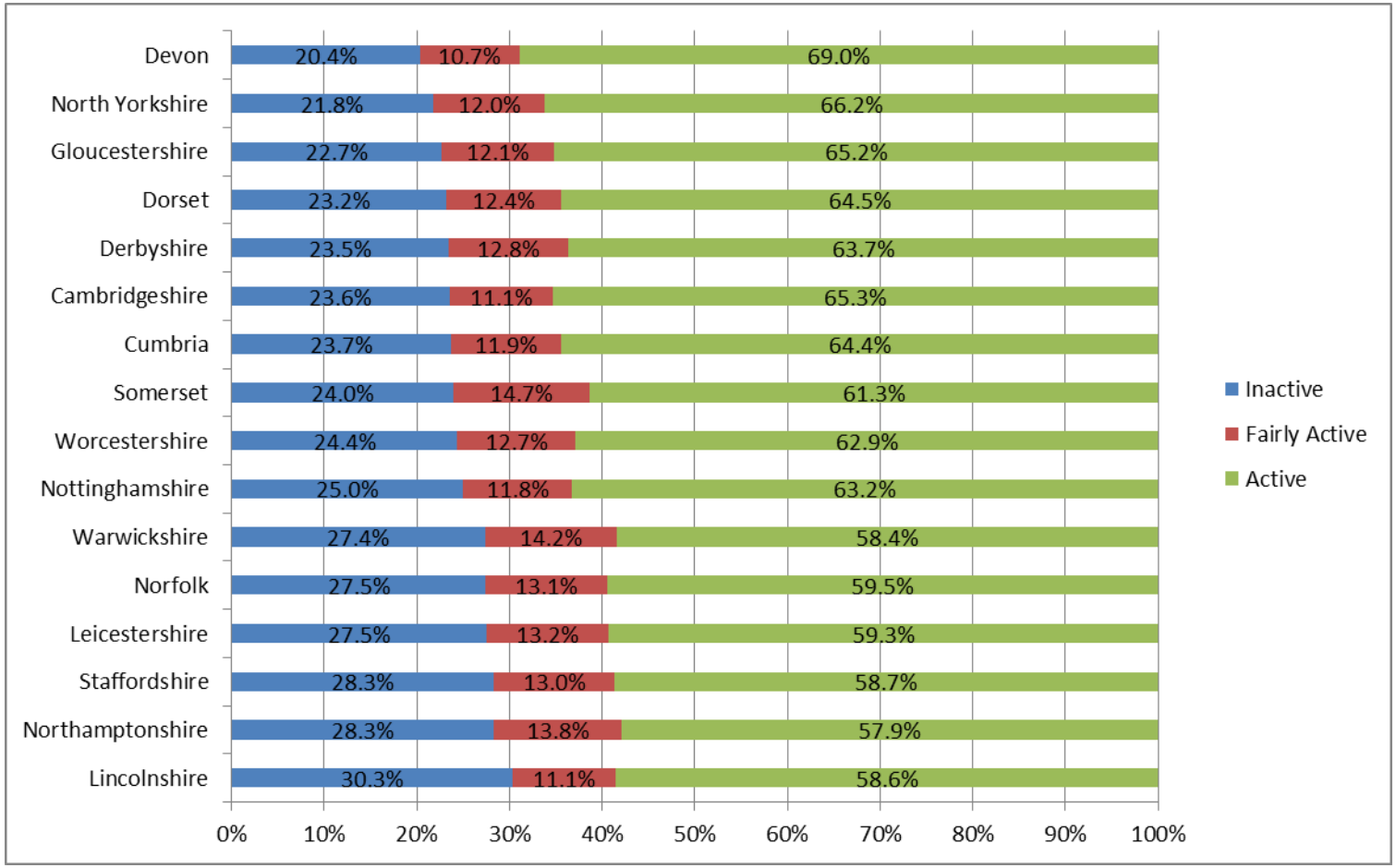


Figure: Active Lives Survey: Lincolnshire and Districts (May 2017/18)

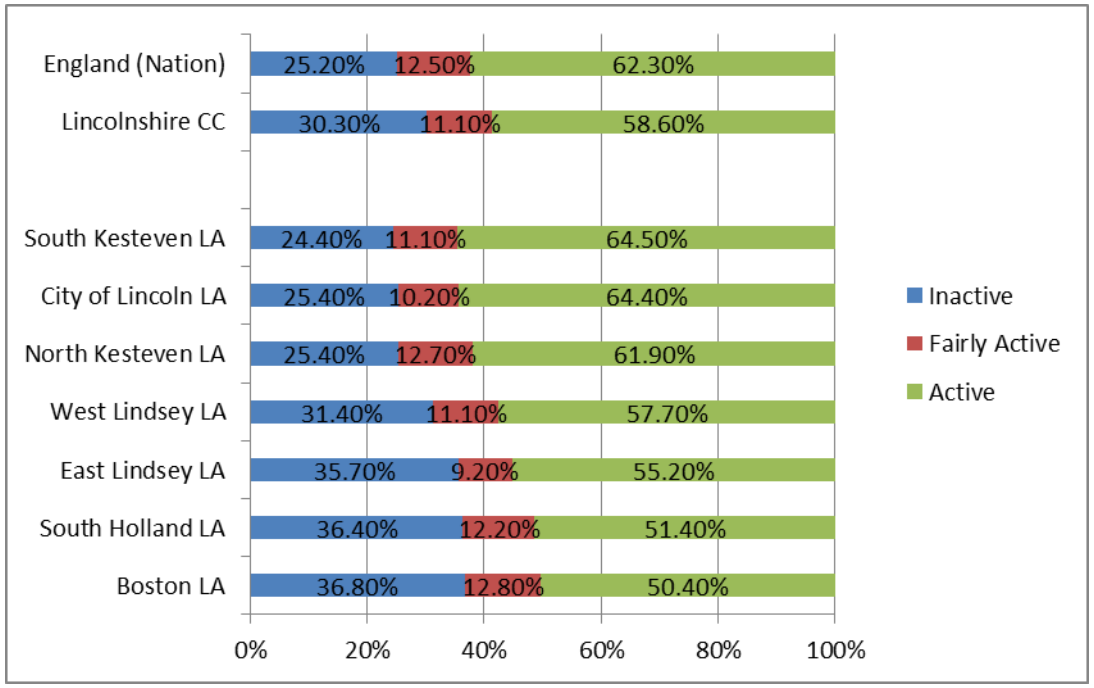


Figure: Activity Status by Local Authorities: 2012-2018

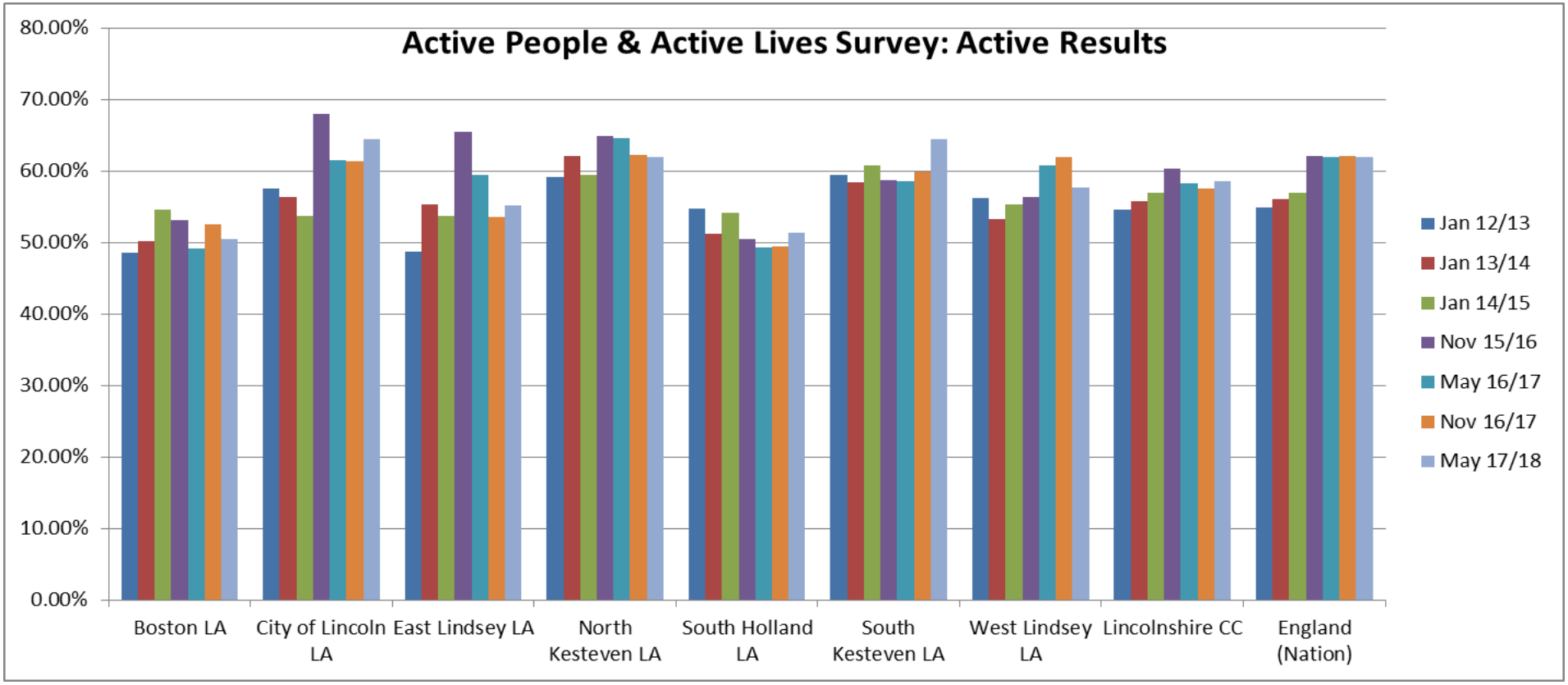
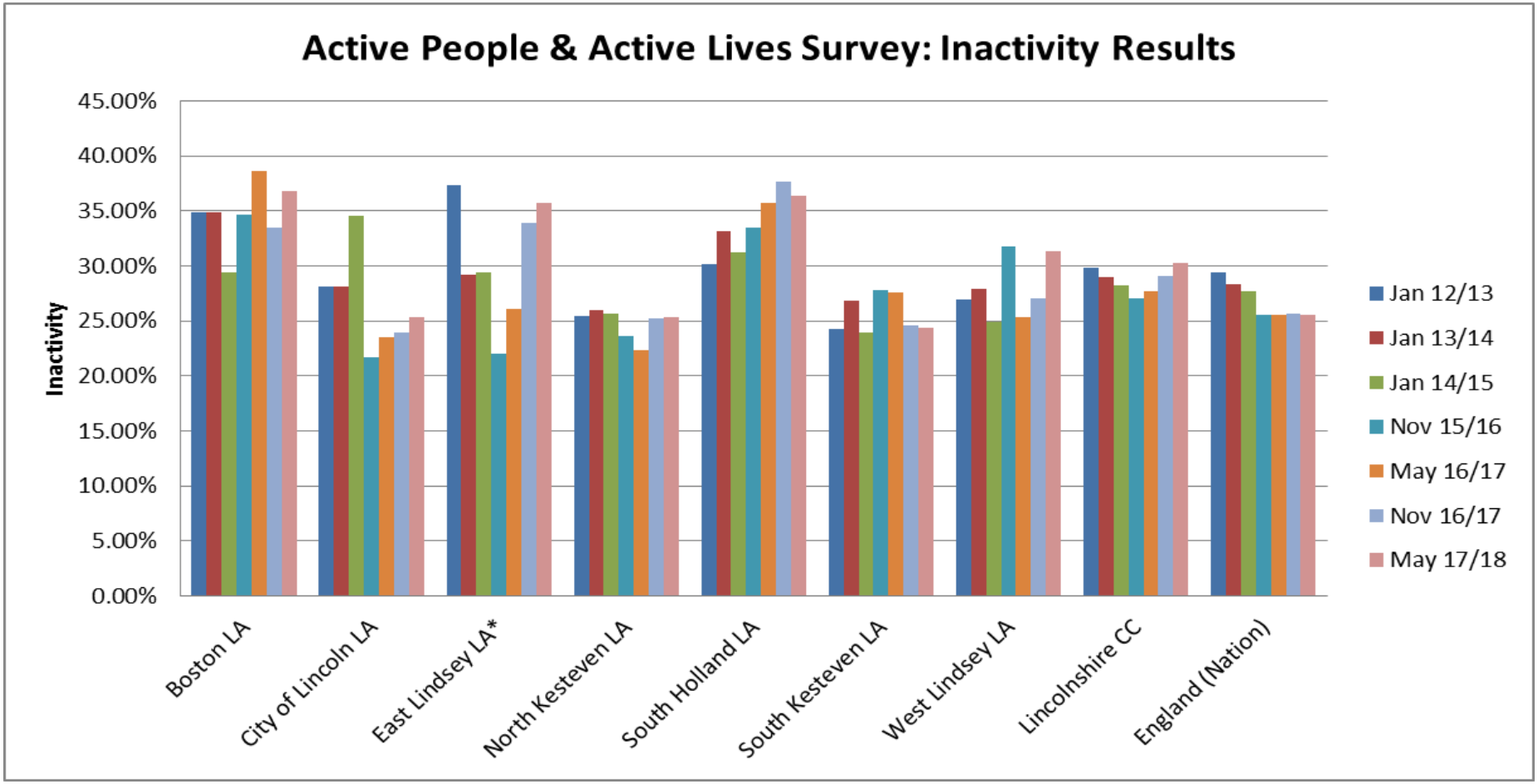


Figure: Inactive Status by Local Authorities: 2012-18



L-PAT Membership and Terms of Reference **Appendix C**

Members of the Executive Group	
Dr. Jayne Mitchell	Chair of the Taskforce
Cllr Sue Woolley / Dr Mike Thompson	ChairmanH&W Board
Robin Bellamy	Wellbeing Commissioning Manager
Bill Skelly	Chief Constable Lincolnshire Police
Ian Fytche	Chief Executive, North Kesteven District Council
Cllr Donald Nannestad	H&W Board member (Dictrict Councils)
TBC	NHS / STP
Dean Fathers	GLLEP/Private Sector
Sport England	Open invitation
Louise O'Reilly	Director of Strategy & Insight, Active Lincolnshire
Philip Garner	Strategic Programme Manager, L-PAT

LINCOLNSHIRE PHYSICAL ACTIVITY TASKFORCE (L-PAT)

EXECUTIVE GROUP

Terms of Reference

Constitution

1. Active Lincolnshire, as coordinating organisation for the Lincolnshire Physical Activity Taskforce (L-PAT), approved by Lincolnshire Health and Wellbeing Board to develop and deliver a *'Blueprint for a More Active Lincolnshire'* (the Blueprint), has established an Executive Group to oversee the development and implementation of the Blueprint. The L-PAT Executive Group (the Executive) shall be responsible to Active Lincolnshire Board and accountable to the Lincolnshire Health and Wellbeing Board.

Membership

2. There shall be no fewer than *six* members; a quorum shall be at least *four* members. The Chair of the Executive should normally be recruited, selected and approved by the Active Lincolnshire Board, as the coordinating organisation.

3. Membership of the Executive shall normally consist of senior staff representatives of L-PAT organisations. The L-PAT Strategic Programme Manager will also normally be a member of the Executive. The Executive may, if it considers it necessary or desirable, co-opt members with particular expertise.

4. Members are expected to attend all meetings of the Executive, or give timely apologies if absence is unavoidable.

5. The likely overall time commitment required of the Executive is around six days per year including attendance at four Executive Group meetings and other L-PAT events.

6. Membership of the Executive is not remunerated.

7. Any member, or their nominee, who has been absent from meetings for a period of longer than eight months, except for a reason approved by the Chair, shall cease to be a member. Any member who is judged by the Executive to be unable or unfit to discharge the functions of a member shall cease to be a member of the Executive.

Term of Office

8. The formal start date of appointment to the Executive and / or any subgroups will be confirmed in liaison with the L-PAT Strategic Programme Manager. Appointment is for an initial term of 12 months, is reviewed annually and, subject to the requirements in the Blueprint, is eligible for reappointment for the duration of the L-PAT.

Voting

9. All members of the Executive shall be entitled to vote.

    a. In the event of an equal vote on any matter, the Chair shall have a second and casting vote.
    b. Any co-opted member of the Executive in attendance shall not have voting rights.

Frequency of meetings

10. Meetings shall normally be held at least four times each year.

Authority

11. The Executive is authorised to investigate and direct matters relating to the development and delivery of the Blueprint and its objectives. It is authorised to seek any information it requires from L-PAT staff, member organisations, contracted third party or delivery partner. All L-PAT staff are directed to co-operate with any request made by the Executive.

12. The Executive will review the progress of the development and delivery of the Blueprint and its objectives by receiving regular reports from the L-PAT Steering Group.

13. The L-PAT Steering Group shall undertake detailed scrutiny of the implementation of the Blueprint, comprising; Project Plans; Resources and Budget; Milestones and Measures of Success; Governance and Management; Risk Management; Composition of L-PAT, and provide to the Executive, for approval; progress reports with its recommendations and all documentation, completed in full and to specification, required by Active Lincolnshire Board and the Lincolnshire Health and Wellbeing Board.

14. The Executive is authorised to carry out any other duties delegated to it by the coordinating organisation, Active Lincolnshire, and / or Lincolnshire Health and Wellbeing Board.

15. The Executive is not authorised to make decisions on any matters which are specified in the Lincolnshire Joint Health and Wellbeing Strategy as being the prerogative of Lincolnshire Health and Wellbeing Board, or its sub-groups or specified in the individual strategies of any member organisation as being the prerogative of that organisation.

Duties

16. The duties of the Executive shall be to:

    a. Provide strategic leadership for the Blueprint, ensuring that the objectives meet the needs and priorities set by the Lincolnshire Health and Wellbeing Board
    b. Advise the coordinating organisation, Active Lincolnshire, and the Lincolnshire Health and Wellbeing Board on matters relating to the development and delivery of the Blueprint and its objectives;
    c. Develop and lead an approach to ‘whole system change’ required to support active lives across Lincolnshire, ensuring that physical activity becomes a central feature in policy and practice related to planning, transport, health and social care, economic development, education, and the environment.
    d. Direct the strategic investment needs, identified within the Blueprint, that prioritise engaging inactive people and those demographic groups who are currently underrepresented with physical activity and sport.
    e. Ensure that appropriate risk management and safeguarding arrangements are in place and appropriately maintained;
    f. Consider such matters as may be referred to it by the coordinating organisation (Active Lincolnshire) and/or the Lincolnshire Health and Wellbeing Board and make recommendations as appropriate
    g. Receive and approve regular reports on the progress of the development and delivery of the Blueprint and its objectives from the L-PAT Steering Group, direct its activities and hold the Group to account against agreed action plans.
    h. Act as an advocate and champion within their own organisation, county-wide and nationally, where appropriate, for the L-PAT, ensuring opportunities for collaboration and communication are optimised.

Reporting procedures

17. The minutes (or a report) of meetings of the Executive will be circulated to all members of the Executive.

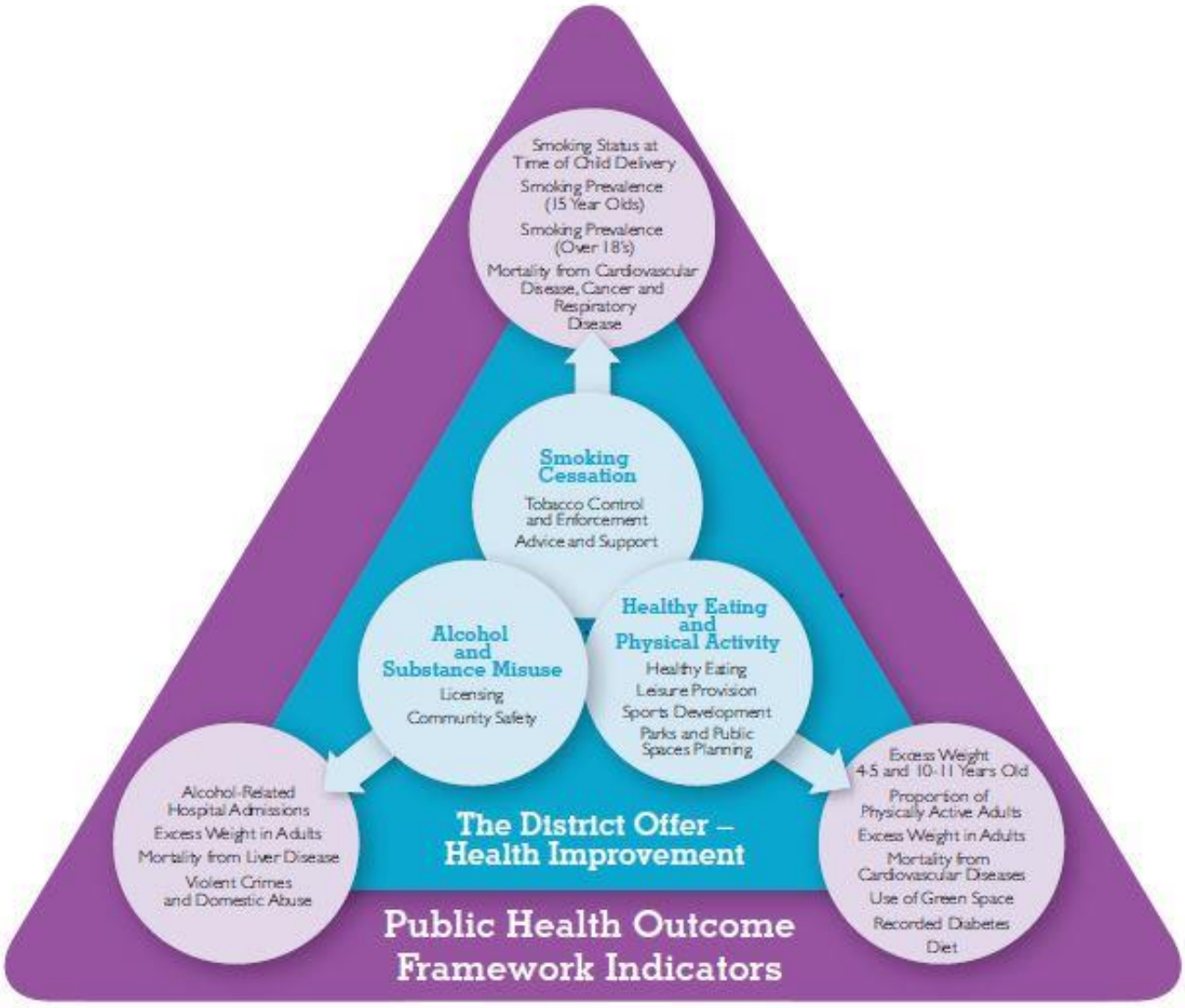
18. The Executive will report progress on the development and delivery of the Blueprint and its objectives to the Active Lincolnshire Board and the Lincolnshire Health and Wellbeing Board in keeping with the schedule determined by Active Lincolnshire and Lincolnshire County Council.

Clerking arrangements

19. The Clerk to the Executive will be the L-PAT Strategic Programme Manager.

Appendix D

Regulatory Powers and Responsibilities for Local Authorities regarding Health Improvement



Source: District Action Public Health,

Appendix E

Goals and Objectives

Goal 1: Active Society:

Create a paradigm shift in Lincolnshire by enhancing knowledge and understanding of, and appreciation for, the multiple benefits of regular physical activity, according to ability and at all ages

Objective 1.1 (information, knowledge and communication)
Implement best practice communication campaigns, linked with community-based programmes, to heighten awareness, knowledge and understanding of, and appreciation for, the multiple health benefits of regular physical activity and less sedentary behaviour.

Objective 1.2 (raising the profile, awareness and understanding)
Conduct county-wide, district-specific and community-based campaigns to enhance awareness and understanding of, and appreciation for, the social, economic, and environmental co-benefits of physical activity

Objective 1.3 (engagement and participation for all, by all)
Implement regular mass participation initiatives in public spaces, engaging entire communities, to provide access to enjoyable and affordable, socially- and culturally-appropriate experiences of physical activity

Goal 2: Active Place:

Create and maintain environments that promote and safeguard opportunities for all people, of all ages, to have equitable access to safe places and spaces, in which to engage in regular physical activity, according to ability

Objective 2.1 (urban and transport planning)
Strengthen the integration of urban and transport planning policies to deliver highly connected neighbourhoods,

Objective 2.2 (active travel)
Improve the level of service provided by the transport infrastructure, to enable and promote active travel in urban, sub-urban and rural communities, with due regard for the principles of safe, universal and equitable access by people of all ages and abilities

Objective 2.3 (active transport)
Improve road safety and the personal safety of people engaged in active transport

Objective 2.4 (open spaces and facilities)
Strengthen access to good-quality public and green open spaces, green networks, recreational spaces (including river and coastal areas) and sports facilities by all people, of all ages and of diverse abilities in urban, sub-urban and rural communities

Objective 2.5 (work, education, public and recreation spaces)
Strengthen the policy, regulatory and design guidelines and frameworks, at the county and district levels, as appropriate, to promote public amenities, schools, health care, sports and recreation facilities, workplaces and social housing that are designed to enable

occupants and visitors with diverse abilities to be physically active in and around the facilities

Goal 3: Active People:

Create and promote access to opportunities and programmes, across multiple settings, to help people of all ages and abilities to engage in regular physical activity as individuals and communities

Objective 3.1 (children and young people education providers)
Strengthen provision of good-quality physical education and more positive experiences and opportunities for active recreation, sports and play for children and young people in early years, primary, secondary and tertiary educational institutions, to establish and reinforce lifelong health and physical literacy, and promote the enjoyment of, and participation in, physical activity, according to capacity and ability.

Objective 3.2 (community-based programmes)
Enhance provision of, and opportunities for, more physical activity programmes and promotion in parks and other natural environments (such as beach, rivers and coastlines) as well as in private and public workplaces, community centres, recreation and sports facilities and faith-based centres, to support participation in physical activity, by all people of diverse abilities

Objective 3.3 (older adults)
Enhance the provision of, and opportunities for, appropriately tailored programmes and services aimed at increasing physical activity and reducing sedentary behaviour in older adults, according to ability, in key settings such as local and community venues, health, social and long-term care settings, assisted living facilities and family environments, to support healthy ageing.

Objective 3.4 (engaging the least active groups)
Strengthen the development and implementation of programmes and services, across various community settings, to engage with, and increase the opportunities for, physical activity in the least active groups, as identified by each district, embracing positive contributions by all people.

Goal 4: Active Systems:

Create and strengthen leadership, governance, multi-sectoral partnerships, workforce capabilities, advocacy and information systems across sectors to achieve excellence in resource utilisation and implementation of coordinated county-wide and district-level action to increase physical activity and reduce sedentary behaviour

Objective 4.1 (policy framework, engagement and coordination)
Strengthen policy frameworks, leadership and governance systems, at the county-wide and district levels, to support implementation of actions aimed at increasing physical activity and reducing sedentary behaviours. This includes multi-sectoral engagement and coordination mechanisms; policy coherence across sectors; guidelines, recommendations and actions plans on physical activity and sedentary behaviour and progress monitoring and evaluation to strengthen accountability.

Objective 4.2 (evidence-based decision making, monitoring and accountability)

Enhance data systems and capabilities at the county and, where appropriate, district-specific levels, to support: regular population surveillance of physical activity and sedentary behaviour, across all ages and multiple domains; development of monitoring systems of wider sociocultural and environmental determinants of physical inactivity; and regular multi-sectoral monitoring and reporting on policy implementation to ensure accountability and inform policy and practice.

Objective 4.3 (research, innovation and evaluation)
Strengthen the county-wide research and evaluation capacity and stimulate innovation to accelerate the development and implementation of effective policy solutions aimed at increasing physical activity and reducing sedentary behaviour.

Objective 4.4 (advocacy and leadership in Lincolnshire)
Escalate advocacy efforts to increase awareness and knowledge of, and engagement in, joint action at the county-wide and district-specific levels, targeting key audiences, including but not limited to high-level leaders, policy-makers across multiple sectors, the media, the private sector, city and community leaders, and the wider community.

Objective 4.5 (education and training)
Strengthen pre- and in-service training of professionals to increase knowledge and skills related to their roles and contributions in creating inclusive, equitable opportunities for an active society including, but not limited to, the sectors of: transport, urban planning, education, tourism and recreation, sports and fitness, as well as in grassroots community groups.

Objective 4.6 (primary and secondary health services)
Implement and strengthen systems of patient assessment and counselling on increasing physical activity and reducing sedentary behaviour, by appropriately trained health, community and social care providers, as appropriate, in primary and secondary health care and social services, as part of universal health care, ensuring community and patient involvement and coordinated links with community resources, where appropriate.

Objective 4.7 (long-term sustainability and resource management)
Strengthen financing mechanisms to secure sustained implementation of county-wide and district-specific action and the development of the enabling systems that support the development and implementation of policies aimed at increasing physical activity and reducing sedentary behaviour.

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Lincolnshire COUNTY COUNCIL
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LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Lincolnshire's Clinical Commissioning Groups and the Sustainability and Transformation Partnership

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**11 December 2018**
Subject:	**Neighbourhood Working – The Social Prescribing project**

Summary:

This paper updates the Health and Wellbeing Board on the progress being made in implementing a Social Prescribing model into Lincolnshire that has been part funded by the Health and Wellbeing Grant Fund.

The Social Prescribing project is being run as a 'proof of concept' and is an integral part of the Neighbourhood Working programme. It is also closely linked to the NHS England Personalised Care Demonstrator sites of which Lincolnshire is one of three across the Country.

This paper sets out how the project has been expanded from its initial conception in Gainsborough to rolling out across the County from September this year, the progress to date, some of the early findings and the actions that are needed to be able to demonstrate to the system the value and importance of social prescribing to the health and care community.

Actions Required:

The Health and Wellbeing Board is asked to:

a. Note the content of this report
b. Note the current progress and key actions
c. Discuss and agree how the interface between the Neighbourhood Working programme and the Health and Wellbeing Board can be developed and strengthened – in particular in the development of a strategic approach for social prescribing in Lincolnshire.

1. Background

National Context

There is a national commitment that by 2023 all local health and care systems will implement social prescribing connector schemes to support the government's aim to have a universal social prescribing national offer available in GP practices. The Lincolnshire health and care system has been selected as a personalised care demonstrator site and a key element of the programme being the delivery of social prescribing connector schemes.

The NHS England personalised care team are developing programmes to support social prescribing which includes:

- Publication of a best practice guide to coincide with the long term plan for the NHS;
- Launching an online social prescribing platform;
- Developing regional social prescribing networks;
- Publishing a common outcomes framework for social prescribing;
- Piloting new accredited learning programmes for social prescribing link workers.

Local Response

In September 2017 the Health and Wellbeing Board agreed that the remaining unallocated funds from the Health and Wellbeing Grant fund should be transferred to the four CCGs to support the development of neighbourhood working, with a particular focus on building resilience in the infrastructure of the Voluntary and Community Sector to enable high quality multi-agency cooperation.

The purpose of the award was;

- To support neighbourhood working to engage effectively in enabling local people to meet their own needs through the community and voluntary sector; and
- Ensure the developments are focused on the system goals of shifting towards preventative and self-care interventions.

The initial agreement was to utilise the funding as part of a match funded submission to the Department of Health's Voluntary, Community and Social Enterprise Health and Wellbeing Fund 17/18: Social Prescribing. In March 2018 we were made aware that we had not been successful.

Therefore the System Executive Team (SET) agreed that the funding should be pooled to be able to demonstrate social prescribing as a proof of concept in Lincolnshire, recognising that the funding was non recurrent and would therefore need to be able to demonstrate both impact on people, as well as financial and social value return on investment.

The decision was made locally to expand on the social prescribing pilot that had already started in Gainsborough as part of the Neighbourhood Working programme.

Voluntary Centre Services (VCS) and Lincolnshire CVS are Lincolnshire-based charities working together to deliver sector support and development services to voluntary and community groups across Lincolnshire. The organisations are well placed, not only geographically, but also through reputation and the breadth and strength of their

connections within the local community, to provide consistent, coordinated referral hub services for local GPs and clinical practitioners. Their established networks of local organisations, charities and informal community-based self-help groups provide services and activities across the themes of mental health, dementia care (including carer support), physical sport and activity, youth provision and more.

2. Social Prescribing – National definition

When medical help alone is not enough, social prescribing enables people to focus on what else matters to them, through referral to non-medical link workers. Their role is to connect people to community groups and other services for practical and emotional support. This could include befriending, volunteering or activity groups.

The benefits of social prescribing for individual outcomes and creating the headroom for sustainable health and social care transformation are well rehearsed. The important thing now is to make sure that we understand how social prescribing, as a policy tool, can work best in Lincolnshire to ensure that people, mainly those who are on the frailty pathway and/or isolated, are able to stay healthier for longer through prevention and self-care

3. Project outline

Following the successful pilot in Gainsborough (June 2017-May 2018), and the increasing body of evidence from other areas of the country, social prescribing is now established as a vital component of Neighbourhood Working (NW)

The release of Health and Wellbeing Fund (HWBF), with additional funding from the CCG's, is being used to scale up and deliver social prescribing across the county. Central to this is improved patient outcomes, which continue to be evident in Gainsborough and in other areas where NW is being established. The HWBF has been essential in enabling capacity on the ground.

CCG Area	INT areas	Capacity	Start dates
West	Gainsborough Lincoln North Lincoln City South Lincoln South	1 FTE Lead 2.8 FTE Navigators/Link Workers	June 2017 Sept 2018 October 2018 Sept 2018
South & South West	Grantham & Rural Sleaford & Rural Stamford Spalding Bourne and The Deepings Holbeach and the Suttons	1 FTE Lead 3 FTE Navigators/Link Workers	Sept 2018 Sept 2018 October 2018 June 2018 November 2018 November 2018
East	Boston Skegness & Coast East Lindsey North and Middle	1 FTE Lead 2.8 FTE Navigators/Link Workers	Aug 2018 Posts currently vacant – interviews held November 2018

Each CCG area is supported by a senior/lead who is responsible for managing the local referral hub and social prescribing team and, importantly, plays a key role in ensuring integration with NW and care navigation, developing key strategic and operational

relationships, identifying and supporting the development of community-based social prescribing networks (capacity building) and developing quality assurance.

Each NW area has a Navigator/Link Worker who provides the face-to-face support to clients, works with the core teams on care and support planning, works with clinical practitioners, neighbourhood teams and other stakeholders to enhance the person-centred support.

Project administration staff provide central support, coordinating referrals, managing our database system, supporting groups and key volunteers and providing an essential administrative function for the navigators.

The HWBF, alongside CCG funding, will initially fund the service for a period of 12-18 months across the county. During this period, VCS / LCVS will;

- Play a direct role in delivering the aims of the Joint Health and Wellbeing Strategy;
- Support others who are delivering the Joint Health and Wellbeing Strategy Priorities (e.g. Active Lincolnshire, the Wellbeing Service and the integrated Lifestyle Support);
- Support implementation of the Library of information and services;
- Work together to develop consistent social prescribing services based on a countywide model with locally nuanced delivery;
- Extend the delivery of MECC+ training and awareness to a wide audience of health care professionals and community organisations.

4. Progress to date

Activity Area	**Progress June-November 2018**
Service development & working alongside Integrated Neighbourhood Working	• Social prescribing standard operating procedures developed. • Social prescribing outcome measures developed that sits within the suite of system outcome measures, demonstrate value and support return on investment modelling. • Staff teams appointed and embedded within the Neighbourhood Networks. • Staff training undertaken. • Referral routes and processes developed. • Referral hubs established to support INW and enable consistent referral pathways to social prescribing advice and services. • Lincolnshire Social Prescribing Network developed to ensure consistency across Lincolnshire, creating an opportunity for staff to come together and discuss issues, challenges, best practice and opportunities. • Supporting the Neighbourhood Leads to embed navigation and integrate with the GP forward developments. • Enabling NH Leads through engaging with Multi professionals and project group meetings, including widening voluntary sector representation.
Partnership working and cross-sector engagement	• Cross sector networking, stakeholder engagement events and Voluntary Sector Forums have been facilitated across the county to increase awareness of NW and social prescribing. The events

	have been very well received with between 30 and 90 attendees at each. Health-focused events were held in Gainsborough, Lincoln, Lincoln South, Boston and Stamford, complementing our existing networking programme for the sector. • Continued development of the NCVO 'increasing voluntary sector involvement in the STP' working group following initial workshops in Manchester. The working group has focused on building on cross sector partnership working and enhancing the prospect of streamlined engagement with the voluntary sector at all levels, resulting in the establishment of a Voluntary Executive Team of senior execs drawn from across the spectrum of third sector stakeholders. • Supported wider engagement of the community and voluntary sector through Involving Lincs and development of the Health and Wellbeing Engagement Strategy. • Engagement and relationships established with core partners including the Wellbeing Service, LCC Adult Care and Community Wellbeing Service, Carers First, St Barnabas, Lincs Fire & Rescue and Age UK.
Person centred, community-based support	• Commenced 1-2-1 support and navigation for individuals to access community support to promote a preventative approach. • Started recruiting volunteer 'champions' to support social prescribing activity. • Navigators / Link workers undertaking Helen Sanderson training on Personal Care and Support Planning. • Commenced development of the navigation role alongside the GP forward view within GP surgeries, integrating Bronze, Silver and Gold levels of navigation support. • Navigators/Link workers regularly working from GP practices and hot desking spaces (e.g. John Coupland Hospital, Birchwood Medical Practice, Nettleham Medical Practice, Hereward Practice Bourne and Stamford Hospital, with plans developing to link in with GP practices and INW hubs in line with local developments) • Development of community advice sessions and community cafés to offer a weekly opportunity that enables people to begin their self-care journey. • Commenced delivery of the care navigation element of the Making Every Contact Count (MECC) training framework developed by Public Health. Training scheduled to be rolled out across GP practices within the County. • Referrals primarily received through the Neighbourhood Teams with other referrals received directly from GP's, LPFT, DWP, Fire & Rescue, Adult Care, Carers First, St Barnabas and the Wellbeing Service. • Initial referrals highlighting key areas of mental health, loneliness and social isolation
Promotion and awareness raising	• General wide promotion of social prescribing, increasing GP and local partner awareness. Through engagement activity, one-to-one meetings, social media and engagement with the GP lead for the INT areas.

	• Promotion of the community offer for individuals, spreading key messages around self-care and prevention, therefore enabling and empowering individuals, rather than reactive problem solving (Co-ordinated through the Self Care delivery group, Neighbourhood meetings and engagement with the CCG's). • Promotional activity as part of key health campaigns, such as Self Care Week.
Support for the community and voluntary sector	• Work with local partners and Volunteer Centre staff to increase knowledge and awareness of local activities, groups and services in INW areas. • Support to increase resilience of local organisations within the SP network. • Support to develop and increase the range and diversity of local activities within the SP network. • Launch of the Adult Care Community Development Fund to support capacity building in local groups and organisations. • Commenced initial work to identify and address gaps within localities. Early gaps include an urgent need for mentoring and befriending support services in some areas of the county.
Quality Assurance	• Quality assurance workshops facilitated with community providers in partnership with Every-One, in line with national activity taking place around quality assurance, supported by NHS England. • 5 core principles agreed as good practice for community groups in Lincolnshire: o Welcoming & Accessible o Safe o Well Governed o Supporting People to Grow o Making A Difference to Wellbeing • The 5 core principles built into support to community providers and the Adult Care community grants funding guidance.
Data & Outcomes Monitoring	• Development and implementation of the 'V-base Lincolnshire' social prescribing database. • Development of tools to measure quantitative and qualitative impact of social prescribing including the 'How am I doing' web. • Contributed to the development of the neighbourhood working outcomes framework, taking the lead on social prescribing and care navigation. • Implementation of the Social Value Engine as a tool to measure the impact and social return on investment. Social Prescribing metrics/measures identified and agreed.

5. Outcomes so far…

Activity levels from 1st September – 19th November 2018 (6 weeks)

There has been a recent rapid growth of referrals where social prescribing offers have been introduced and where GP engagement has been high – this is particularly evident in the Lincoln area, Gainsborough, Bourne and Spalding.

Area	Referrals
Boston	1
Bourne & Deepings	13
Crowland	1
East Lindsey	1
Gainsborough	24
Grantham	5
Lincoln City South	16
Lincoln North	13
Lincoln South	14
Out of County/ Unknown/ Other	8
Sleaford	5
Spalding	17
Stamford	6
TOTAL	**124**

The level of activity and engagement is really encouraging with an average of 20 referrals per week – and recognising that in the East of the County the Neighbourhood Working and social prescribing offer is less mature than in other parts of the County.

As the project is in such an early stage of implementation it has not been possible to report on the outcome measures that have been developed for the project however the qualitative feedback from staff and individuals has been very positive. Appendix A is the first draft of the outcome measures and financial proxies that have been developed for this project, it is hoped that early in the New Year is will be possible to report on them and this will be shared in the next report to the Health and Wellbeing Board.

Feedback from Neighbourhood Leads:

'I see social prescribing as a key foundation stone within the neighbourhood; enabling people to take proactive steps towards managing their future health, care and social needs'.

Victoria Sleight, Neighbourhood Lead – Lincoln City South

'GPs in Lincoln South are engaged with social prescribing and are already referring into the service. In one practice we are looking at how our social prescriber can work with a possible volunteer to build capacity in the village to support people – working in partnership'.

Angela Shimada, Neighbourhood Lead for Lincoln South

'Nettleham are excited to see how social prescribing can fit with the chaplaincy service. They are hoping by being present in the surgery they will be able build strong relationships with our social prescribers'.

Beckie McConville, Neighbourhood Lead – Lincoln North

Feedback from GP Care Co-ordinator

"Social prescribing is absolutely life changing for patients and families. I think social prescribing will be the key in driving change in our health and social acre system'.

Carly-Jayne Fisher, Practice Care Co-ordinator, Hereward Practice, Bourne

Case Study 1 - Ms P

P has Parkinson's and a history of low mood and low motivation. She lives with her partner and main carer who is 90yrs. In the past she had tried the day centre in Bourne which she did not enjoy and went to a Parkinson's group but found both quite isolating as no one wanted to sit with her. In the past P has enjoyed walks, crocheting, bowls and social activities without her partner but sometimes becomes quite nervous at having to attend these on her own or how to access these and what is available. One of the most important things to her is getting some enjoyment and purpose back in her life. During the last two years P has become very isolated.

P often speaks of just wanting to die.

P and her partner often argue for no reason other than they are both struggling with health challenges and vulnerability. Both need more support to help them with day to day.

Since the social prescriber visit P's mood has lifted. The social prescriber took a holistic approach to help her clear her head of things that were of concern. Some of the issues were not something that the social prescriber could deal with directly and referrals have been made to Carer Sitters, Carers First and the Wellbeing Service. The social prescriber took P to the U3A open day on a Saturday morning and after the first midweek session took her shopping for crochet needles and wool.

P now attends a 'crochet group' run by the U3A group. The attendees are very friendly and have taken her under their wing and given her 1-1 support with her crocheting. P is quite frail and does struggle but she is given such wonderful support which seems to be boosting her confidence. The social prescriber has attended this group with her and will do for the next 10 weeks or until P feels confident to go their alone. Carer sitters are going to visit P on a regular basis and take here for a little walk.

At the moment P feels that this is enough for her because she does get very tired but she has said that the social prescriber has made her feel so much better.

The social prescriber has reported to the Bourne INW that P's partner needs more support and a better support plan for him to confidently care for P. This is being reviewed and actions will be taken to ensure that they are happier in their own home and have access to services that could make a substantial difference.

One key outcome from this has been support for the carer in addition to the primary referral.

Case Study 2 - MY

MY completely lost her confidence since being hospitalised for falling; "My physical strength was poor and I was struggling with everyday tasks. My mood was low. I had not been outside because I was scared of falling again. I was relying on friends and neighbours to get my shopping for me."

The community OT referred MY to the SP team as she recognised that lack of confidence was delaying her recovery.

MY said; “The SP link worker has been invaluable in helping me see that I didn’t have to accept my current situation as final. She has supported me and at the same time challenged me to think and act differently. I would not have had the confidence without this support and would have probably been unable to leave the house and become frailer and socially isolated. My link worker took me out for a drive and then for a coffee. This was the first time I had left the house for a few months and I was very nervous but she helped me to overcome my fears. We also went to a seated exercise class for three weeks to help me to build my physical strength further.”

Outcome: “I have had small successes along the way such as being able to use my hoover and start cooking again. My physical strength and mood have improved significantly. I am regularly practising exercises at home and have been motivated to do so because I can see the difference it has made. I am now hoping to build up my strength so that I can take part in a 30 min walking for health walk in December.”

6. Risks, Issues and Mitigation

Risk / Issue	Project mitigation	System mitigation
Non – recurrent funding for Social Prescribing	All posts are fixed term contracts. Exploring the potential for attracting social investment through Social Impact Bonds with the CCGs and Lincolnshire Community Foundation and social investors.	Identified as one of the system intentions for 19/20.
A lack of strategic direction for Social Prescribing in Lincolnshire	Being able to demonstrate a proof of concept through this project.	Recruitment to a fixed term post to lead the self-care and social prescribing agenda for Lincolnshire. Raising the awareness of a need for a Lincolnshire strategy for social prescribing that is sustainable and funded appropriately.
Not being able to demonstrate financial impact of Social Prescribing	Working with Rose Regeneration and the University of Lincoln to put in place a model for tracking outcomes and measuring return on investment.	National evidence is now readily available to be able to demonstrate the ROI of Social Prescribing to a wider Health and care system.
A lack of scale and pace.	Demonstrating a proof of concept. Using the wider community networks and resources	Being part of the National Integrated accelerator programme will raise the profile of social prescribing in Lincolnshire – and will require a system response in terms of true commitment social prescribing.
Engagement with GP’s and wider community	Local engagement to continue as part of the Neighbourhood working programme – GP advocates to be identified.	Needs to form part of the wider system communication and engagement approach

Public engagement and understanding of the value of Social Prescribing	Local engagement to continue as part of the Neighbourhood working programme – sharing stories and outcomes.	Needs to form part of the wider public engagement and

7. Conclusion

Although the project in Lincolnshire is being run as a 'proof of concept' with non-recurrent funding, the national evidence and the very clear commitment from NHS England is that social prescribing is an offer that should be available to the health and care community by 2023.

Over the next 6-9 months as the pilot to continues to develop and expand and we start to understand the outcomes better from an individual, financial and social value perspective, it is our opportunity to come together as a system to develop a strategic approach for social prescribing that will bring together all the key partners to co-produce a sustainable and well-resourced offer for Lincolnshire.

Therefore, it is timely to work with the HWB to identify opportunities for closer working and support with this, that maybe available via the HWB's work programme.

8. Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy

The Council and Clinical Commissioning Groups must have regard to the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

The social prescribing project is focused on supporting the health and wellbeing of the local neighbourhoods in Lincolnshire, with a particular focus on social isolation, mental health and older people – however no one is excluded.

9. Consultation

N/A

10. Appendices

These are listed below and attached at the back of the report	
Appendix A	A copy of the Social Value Engine – outcomes and financial proxies (Draft – not confirmed)

11. Background Papers

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

This report was written by Kirsteen Redmile, Lead Change Manager Integrated Care, who can be contacted on 01522 307315 or kirsteen.redmile@lincs-chs.nhs.uk

Social Prescribing – Social Value Engine - Outcomes and Financial Proxies

Appendix A

Bristol Accord[1] Impact Area	Outcome	Financial Proxy	Unit
Active, Inclusive and Safe	1a. Improved well-being through cultural, recreational and sports activities	Contribution of sport to wellbeing	Per person
	1b. Improved social capital, community ties and strengthened civic engagement through greater use of community resources	Cost of mental health problems exacerbating a long-term health condition	Per person
	1d. Increased volunteering and potential for grater community participant and development	Value per volunteer in the UK	Per volunteer
	1e. Reduced social isolation for community members	Value of befriending adults and elderly	Per person per hour
Well Run	2c. Strengthened public and civil engagement.	Value to an individual of being a member of a social group	Per person per year
Environment	3e. Growing	Per Capita costs of obesity to society (£49.6bn/£64,000,100 population	Per person
Well Connected	5b. Improved health and well-being for local residents	Ambulance journey to hospital & A&E Attendance	Per visit
		Cost of a fall	Per person
		Improved mental health	Per person
		Cost of a GP visit	Per person
	5d. Improve access to public, private and consumer for local residents	Additional cost in a rural area I terms of access to services	Per household
Thriving	7e. Skills development and improvement for residents workers (Including migrant workers	Value to an individual of moving from unemployment to a secure job	Per person
	7f. Learning/Participation	Average cost of a personal development course	Per person
Well Served	8a. More substantive links between organisations and service providers	dfT estimation of business time savings	Saved by organisation per year
	8e. Improved access to local facilities for local residents	Savings from transaction services online rather than face to face, by telephone or by post. Calculation from the average number of transactions multiplied by the difference between the average cost of an offline transaction vs an online.	Per transaction
	8f Improved community health and services provision	Cost of community health visit	Per visit
		Average cost of an inpatient stay in hospital	Per person
		Unit cost of reduced benefit payments and health impact	Per person

[1] The Bristol Accord is a national tool developed to measure social impact.

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LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**11 December 2018**
Subject:	**Connect to Support Lincolnshire**

Summary:

This report updates the Board on the development and launch of the partnership information and advice service. The service consists of an online directory of services and information called **Connect to Support Lincolnshire** and for those who are not as confident online, a telephone and live chat support service provided by **Lincs2Advice**.

Its aim is to guide people to access the most appropriate care and support for their needs. Through self-service people will be able to find and select the services that will help to keep them healthy, independent and safe. Those people with relevant needs can then be directed, as appropriate, to social care and health services for further assistance.

The service was 'live' at the start of December 2018. Further work is planned to develop the service along the following lines

- Phased addition of directory and page content
- Work with a user panel to shape use and future developments
- Expansion of the service to include an e-marketplace
- Introduction of a customer portal and integration with case management system MOSAIC

A short demonstration of the online service is planned as part of this item.

Actions Required:

1. For the Board to note the launch of the Connect to Support service
2. For the Board members to publicise the service
3. For the Board members to advise the author and presenters of potential content and uses for the service

1. Background

In Summer 2017, Lincolnshire County Council (LCC) and NHS Sustainability and Transformation Partnership (STP) agreed on the development of a partnership health and care library of services. This service would allow the Council to meet Care Act requirements and support the development of the self-care and integrated neighbourhood working agenda, a key objective of the Joint Health and Wellbeing Strategy.

A working group developed a specification for the service and commenced market testing and procurement in early 2018. The Connect to Support service outlined in this paper is the product of the joint work. The principles behind the service are a preventative approach which supports people to take responsibility for their own health and well-being, increases the opportunities to self-serve, and builds up social capital. In this way choice and control can become part of the health and social care approaches to achieving wellbeing.

The development of the service will also allow consolidate the numerous sources of information and directories already available – supporting Adult Social care, Public Health and NHS STP priorities. LCC has led on the procurement of the service, but has been supported by NHS and community sector partners. The need for a library of services has, for a number of years been a central part of care and health modernisation plans through Lincolnshire Health and Care (LHAC) and now STP.

The concept of the Lincolnshire service goes far beyond providing a static list of care providers on a webpage, its aim is to guide people to access the most appropriate care and support for their needs. Through self-service (which can be supported if required) people can find, select (and pay for) the services that will keep them healthy, independent and safe. Those people with relevant needs can then be directed to council and partner organisations for further assistance.

Connect to support online service
The provider for the provision of a web-based library/directory is Public Consulting Group (PCG) Technology Solutions through its connect to support branded product. PCG is working in partnership with Servelec to allow integration with the social care case management system MOSAIC. The Connect to Support solution is a 'best of breed' product which offers potential to expand with e-marketplace, online budget monitoring and artificial intelligence modules – all linked to MOSAIC case management system.

The first phase of development of Connect to Support is live now and offers;

- Directory of care and support services
- Information and advice content
- Listing of activities and events

The facility allows searches to be personalised by location, need and age.

Lincs2Advice
The provider for the support service providing remote support via telephone, email and live chat is Lincs2Advice. This is a Lincolnshire-based service, provided by AgeUK Lincoln & South Lincolnshire, which has an established and well regarded presence in the county in providing quality signposting to sources of information and advice. The service will be available to support users during core times six days a week, however the

selection of AgeUK L&SL will allow some out of hours contacts through their emergency provision.

Communications & Promotion
As the service is established in December 2018 and into 2019, there will be a programme of promotional work. This will be with the intention of increasing use of the service and encourage providers to list their offer on the service. Planned engagement to gather content and promote the use of the service includes;

- Neighbourhood working teams
- Social care practitioners
- Lincs2Advice connections with user and carer groups
- Public Health consultants
- NHS STP

Future Developments
The content present on the site at launch is a baseline position which will be expanded following commencement of use of the service. This is largely content based on registered care and support providers. A second phase of content upload from the administrators based in LCC will include listings of smaller community groups and activities throughout the county. Future updates to content on the site will depend on organisations and individuals self-registration and partner organisations providing content.

The Connect to Support solution offers the ability to further develop the online service in the following areas.

- Link to the MOSAIC case management system
- Establishment of the e-marketplace of services
- Manage personal budgets through the virtual wallet
- Artificial intelligence to guide users to the most appropriate services for them

The online service will be demonstrated at the meeting.

2. Conclusion

The Connect to Support Service and its future development will support NHS and Council objectives to promote self-care, neighbourhood and out of hospital working.

3. Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy

The Council and Clinical Commissioning Groups must have regard to the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

The service directly supports the objective in the strategy 'harness digital technology to provide people with tools that will support prevention and self-care'

4. Consultation

The development of the specification has been guided by consultation with Lincolnshire residents, workers and council members. A clear need outlined by this consultation was that the service should support those people who were not able to self-serve or access a wholly online service. This view which was consistently held across the engagement resulted in the commissioning of the telephone and live chat support service.

The further development and shaping of the service will be guided by a user panel which will be recruited in early 2019.

5. Background Papers

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

This report was written by Theo Jarratt, who can be contacted on 01522 555177 or theo.jarratt@lincolnshire.gov.uk

Lincolnshire COUNTY COUNCIL
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LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of the Housing, Health and Care Delivery Group

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**11 December 2018**
Subject:	**A memorandum of understanding to support joint action in Lincolnshire on improving health through housing**

Summary:

The role of housing in achieving and maintaining good health, and the need to connect housing services with health and social care agencies, 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 now 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 the preventive role that housing can play in achieving good health outcomes and sustaining independence.

Actions Required:

The HWB is asked to:

1. Support and work towards achieving the aims and ambitions in this Memorandum of Understanding.
2. Be the conduit for gaining formal signatures from all relevant stakeholders.
3. Agree to promote this MoU, its aims and ambitions, at every opportunity within individual organisations and relevant partnerships.

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 preventative 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 fourteen (out of 151) HWB 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 priority in the Joint Health and Wellbeing Strategy (JHWS).

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.

2. Conclusion

In Lincolnshire we should be proud of our achievements so far. To drive forward further action, we HHCDG would like all HWB members and other stakeholders to adopt this

MoU as a set of shared, common aims and principles for housing, health and care. Some agencies have already taken this through their own governance arrangements to secure support for this.

3. Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy

The County Council and Clinical Commissioning Groups must have regard to the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

The MoU will help in focussing people on elements identified in the JSNA housing and health topic, and help to support the housing priority in the JHWS across a range of stakeholders.

4. Consultation

All members of the HHCDG were invited in June / July 2018 to comment on a draft MoU to create this final version. Feedback was received from Council Officers (both District Councils and Lincolnshire County Council) and elected members. All of the responses were broadly supportive of the need for a local MoU. The majority of the comments received were around the need to include statements linked to legislation and policy (both local and national), including:

- Children and Social Work Act (2017)
- Children's Act (1989)
- Homelessness Reduction Act (2017)
- Health and Social Care Act (2012)
- JSNA AND JHWS
- Transforming Care agenda
- Importance of green space

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	A memorandum of understanding to support joint action in Lincolnshire on improving health through housing

6. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were use 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**
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 are in place to support closer working, problem solving and escalation processes. Ensure the MoU covers key areas of legislation such as the Homelessness	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 funding and budget savings "we are in it together". Capture areas of improved practise due to	Cllr Bowkett Derek Ward	July/Sept 2018 Agree yearly dates for annual effectiveness review.

Objective	Key Deliverables/Actions	Linked Theme	Outcome	Lead Responsibility	Timescale
	Reduction Act 2017		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.		
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	1, 3 & 5	Create housing champions in neighbourhood teams and wellbeing service. Deliver MECC training to a		2019

Objective	Key Deliverables/Actions	Linked Theme	Outcome	Lead Responsibility	Timescale
	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.		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.		
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 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.	1, 3 & 5	Established cross sector senior group with a clear delivery plan and oversight of the county wide homelessness strategy. Improved evidence and understanding of rough sleeping and an agreed plan of	Amanda Pauling	2018/19

Objective	Key Deliverables/Actions	Linked Theme	Outcome	Lead Responsibility	Timescale
	Improve access to health and treatment services to reduce or prevent homelessness.		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 people in Lincolnshire and how this can inform health service provision.		
Ensure people have the knowledge and capability to	Develop and Embed a Sustainable Housing Plan for vulnerable people	1, 3 & 5			2018/19

Objective	Key Deliverables/Actions	Linked Theme	Outcome	Lead Responsibility	Timescale
access and maintain appropriate housing	(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				
Review supported housing arrangements across partners to support vulnerable people with complex presenting needs, (including extra care and DFG)	All stakeholders and partners to contribute and agree with a proactive programme to deliver much needed extra care beds. 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	1, 2, 3 & 5	Improved time scales and process Improved joint working for BCF outcomes Improved	Moving Forward DFG Group	Sept 2018

Objective	Key Deliverables/Actions	Linked Theme	Outcome	Lead Responsibility	Timescale
	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.		evidence of data to drive improvements		
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 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	1 & 2		Lisa Loy Rachel Redgrave Sem Neal	2018/19

Objective	Key Deliverables/Actions	Linked Theme	Outcome	Lead Responsibility	Timescale
	intelligence presented by DTOC targeted work with LPFT to created new Housing pathways				
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 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	1, 2, 3 & 5		Housing, Health and Care Delivery Group	2019

Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH & WELLBEING BOARD

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

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**11 December 2018**
Subject:	**Better Care Fund Scheme Review**

Summary:

This report provides the Lincolnshire Health and Wellbeing Board (HWB) with an update on Lincolnshire's BCF plan for 2018/19 including proposed revisions to allocations made in the original plan and a description of the next steps required in implementing those changes.

The plans were originally presented to the Joint Executive Team earlier in the summer with approval of the plan given by relevant senior officer of the Lincolnshire CCG's in November.

Actions Required:
That the Board review the proposed changes and provide a recommendation for the changes to be approved at the next available Health and Wellbeing Board

1. Background

The original planning template describing the Lincolnshire Better Care Fund (BCF) plan totals for 2017-2019 was submitted in September 2017 and approved without any conditions to the original plan on 31st October 2017.

The total value of the BCF within the original plan was £226m for 2017/18 and £235m for 2018/19. Those values were revised prior to the end of the 2017/18 financial year with the BCF totalling £222m and £230m respectively.

An updated BCF operating guidance was published on 18th July 2018 which set out:

- An updated accountability structure and funding flow diagrams reflecting recent changes to relevant government departments

- Funding conditions which have now reduced from eight to four
- Refreshed Metric Plans for 2018-19
- Confirmation of the combined quarterly reporting process for BCF and IBCF funds
- Updated support, intervention and escalation processes.

The guidance also allowed systems to review existing plans in the second year of the two year agreement, giving systems the opportunity to make changes where necessary.

Lincolnshire County Council (LCC) and the Lincolnshire CCG's took this opportunity to review the Lincolnshire BCF plans existing plans for 2018/19 and make amendments to reflect any further clarification received along with any changes in local priorities and investment strategies.

The proposed changes are highlighted in Appendix A which provides an analysis of:

- The existing plan for the period 2017-2020
- A revised plan for the period 2018-2020
- A summary of the funding allocated against the three national priorities for the Improved Better Care Fund (iBCF), those being

    a) Meeting Adult Social Care Need
    b) Reducing Pressures on the NHS
    c) Stabilising the Social Care Market

Whilst the existing BCF Plan is due to expire on 31st March 2019, it is anticipated that future planning guidance for BCF plans for 2019/20 will be broadly similar to existing plans and colleagues from the regional BCF support team have suggested that 2018/19 BCF plans will simply be allowed to roll over into 2019/20. That being the case appendix A also includes projected allocations for 2019/20 on the basis that Lincolnshire's existing plans and priorities will remain unchanged.

2. Revised BCF Analysis

The main purpose for the revision of 2018/19 plan is to reflect any further national clarification received and changes in local priorities and investment strategies. In addition to this the revision affords us with the opportunity to review the existing plan, reduce the number of schemes by consolidation and adjust the value of some of the schemes to reflect the actual cost incurred in prior years where this varies from the original plan.

The details below are organised in order of the differing funding streams that have been allocated to the BCF over recent years, these being:

- Mandated CCG BCF Contribution for the Protection of Adult Care Services (BCF)
- Improved Better Care Fund (iBCF)
- Supplementary Improved Better Care Fund (Supplementary iBCF)
- CCG/LCC Allocations prior to BCF

The changes describe below should be read alongside Appendix A.

Changes to the Mandated CCG BCF Contribution

The original plan assumed inflationary changes between years 2017/18, 2018/19 and 2019/20 were 1.8% and 1.7% respectively. Inflationary increases for 2018/19 were published in July 2017 confirming an increase of 1.9%. This has now been reflected in the revised 2018/19 plan with the same percentage (1.9%) also applied in 2019/20 estimates. This has the effect of increasing the official minimum contribution towards the protection of Adult Care that CCGs have to contribute and is illustrated below.

	Original		Revised	
2017/18	**2018/19**	**2019/20**	**2018/19**	**2019/20**
£ 17,130,000	£ 17,438,340	£ 17,734,792	£ 17,455,470	£ 17,787,125

However it should be noted that the net contribution to the Council for the Protection of Adult Care was reduced from £17.130m to £15.900m to reflect the additional funding received from CCGs for Learning Disability Services at the time. This was reflected in a separate S76 agreement between CCG's and LCC for the difference to be was passed back to CCG's.

It is anticipated that this arrangement will continue over the next two years; however projected totals will need to be amended to reflect the change in inflation, although the changes described below are not material.

POAC	**2017/18**	**Original**		**Revised**	
		2018/19	**2019/20**	**2018/19**	**2019/20**
BCF POAC	£ 17,130,000	£ 17,438,340	£ 17,734,792	£ 17,455,470	£ 17,787,125
CCG POAC	£ 15,900,000	£ 16,186,200	£ 16,461,365	£ 16,202,100	£ 16,509,940
S76 Value	£ 1,230,000	**£ 1,252,140**	**£ 1,273,427**	**£ 1,253,370**	**£ 1,277,185**

In addition the total values of other schemes which are funded via this route will also change to reflect the change in inflation; these being:

- Reablement
- Community Integrated Reablement Service and Agency Staffing
- 7 Day Working

Protection of Adult Care BCF – Provider of Last Resort/Care Act

It is proposed that allocations originally earmarked for Care Act and Provider of Last resort be used to fund the increases in residential costs following rate negotiations. This has the effect of ensuring the Council meets its on-going Care Act obligation of Market Shaping by promoting quality services, including through workforce development and remuneration and ensuring appropriately resourced care and support. The scheme will also be renamed "Residential Market Rates".

Protection of Adult Care BCF – Adult Frailty Demographic Growth

Totals have changed to reflect the additional inflation and the scheme will be renamed "AF&LTC Historic Demographic Growth" reflecting that the original investment has been incorporated into the Council's base budget.

Protection of Adult Care BCF – Specialist Adults Demographic Growth/Pooled Fund Section 75

These schemes have been consolidated as they fund the same S75 agreement for Learning Disabilities. Totals have also changed to reflect the additional inflation. The scheme will be renamed "LD S75 Historic Pooled Fund Investment" again reflecting that the original investment has been incorporated into the Council's base budget.

Protection of Adult Care BCF – Mental Illness Prevention Fund

Historically this scheme was entirely funded via Protection of Adult Care funding (POAC), with the amounts split between POAC and iBCF in 2017/18. It is proposed that the scheme is funded via iBCF in its entirety for 2018/19 and 2019/20.

Changes to iBCF and Supplementary iBCF

Total funding for both tranches of income are illustrated below

	2017/18	2018/19	2019/20
iBCF	£ 2,105,730	£ 14,249,038	£ 25,770,902
Supplementary iBCF Funding	£ 15,265,596	£ 9,608,578	£ 4,110,611
Total	£ 17,371,326	£ 23,857,616	£ 29,881,513

For the purposes of the original plan schemes were allocated to specific funding tranches over the three year cycle, however it was recognised that as one funding source reduces over time and another increases this becomes problematic. As a result it is proposed that for the purposes of planning and reporting the funding is consolidated and schemes are amended to reflect this consolidation. This has the effect of significantly reducing the number schemes funded by both income streams over the three years from 42 to 22.

iBCF – AFLTC Inflation & NLW/Demographic Growth

These schemes have been consolidated as they fund the same area of service with the scheme renamed "AFLTC Inflation & Demographic Growth". There have been no changes in the value of both schemes combined for 2018/19; however the combined 2018/19 value has been reduced from £11.241m to £11.106m to ensure that the total BCF requirement is in line with total 19/20 BCF allocation.

iBCF – Market Stabilisation Homecare/Residential Care/Direct Payments

Market Stabilisation funds for Homecare, Residential and DP (AFLTC) have been consolidated with the level of funding for homecare and residential care being maintained at 2017/18 levels as there is no inflationary impact. A proportion of the allocation for Direct Payments has been split between homecare and residential care as there has been no impact in this area. The scheme will be renamed "Market Stabilisation"

iBCF – Staffing

The allocation for additional front line staff has been reduced to £1.300m from £1.500m following discussion with Assistant Director for Adult Frailties and Long Term Conditions to better reflect the likely outcome of the ongoing recruitment process. This then reduces to £1m in 2019/20.

iBCF – SAS Inflation & NLW/Demographic Growth

These schemes have been consolidated as they fund the same area of service with the scheme renamed "SAS Inflation & Demographic Growth". There have been no changes in the value of both schemes combined for 2018/19 or 2019/20.

iBCF – SAS Market Stabilisation Direct Payments

The Market Stabilisation fund for Learning Disability Direct Payment has been redirected to cover additional costs to cover CCG Continuing Healthcare Cost up to a maximum of £0.700m as requested by the Executive Director of Adult Care and Community Wellbeing. The scheme has been renamed "CCG CHC Pressures"

iBCF – Nursing Associates
Funding for this scheme has been extended for 2018/19 only.

iBCF - Programme Support Costs
Support costs are better aligned to reflect the actual cost incurred of managing the Better Care Fund in its entirety. Costs are reduced in 2019/20 reflecting the primary use of iBCF as means of funding base costs and Market stabilisation costs.

Changes LCC/CCG Existing Allocations

These relate to schemes and agreements that further enhance integration between LCC & CCGs but were in place prior to the current BCF arrangements but have been included within the original planning template documentation.

These schemes are subject to their own separate governance arrangements however any changes between 2017/18 and 2018/19 are restricted to changes in the level of funding.

Schemes that have seen a change in agreed contributions are as follow:

- Learning Disability Section 75 Agreement
- Mental Health S75 Agreement (LCC/LPFT)
- Mental Health (CCG/LPFT)
- Transitional Beds S75 Agreement (LCC/LCHS)

Financial Impact of Changes

The financial impacts of the changes described are illustrated below:

- An amount of iBCF funding totalling £0.384m has been made available in 2018/19 with a proposal to allocate this funding to CCG's to help meet the increasing cost of Learning Disability Continuing Healthcare cases.
- The value of BCF schemes in 2019/20 is now balanced against the funding used to deliver them; this was previously oversubscribed by £1.000m.
- 2018/19 BCF total has increased to £232.123m (from £229.059m)
- 2019/20 BCF total has increased to £238.917m (from £235.379m

3. Next Steps

On the assumption that the proposed amendments are accepted by the HWB further work will be required to ensure that changes are properly reflected in the BCF plan.

The first obligation was to confirm the proposed changes to the regional Better Care Support Team (BCST) by 24th August 2018, however recognising that this deadline was unlikely to be met the revised guidance allows for confirmation of the proposed plans to be provided by the deadline and approval by the relevant HWB to be given retrospectively.

Having consulted the BCST on the proposed changes, it was agreed that that confirmation of the changes can be communicated by way of a letter to the BCST with no requirement to resubmit plans. Therefore a letter was issued to BCST confirming the changes ahead of 24th August 2018 deadline (Appendix B). This was confirmed to the HWB in September 2018.

It has also been agreed by the Joint Executive Team that there is no requirement to amend any of the original BCF S75 agreements as they allow for minor changes in the plan, so long as they are communicated to the relevant governing bodies.

4. Conclusion

This report provides the HWB with an update on Lincolnshire's BCF plan for 2018/19. Including proposed revisions to allocations made in the original plan and a description of the next steps required implementing those changes.

An amount of iBCF funding totalling £0.384m is now available in 2018/19 to be allocated to any additional single year schemes.

The value of BCF schemes in 2019/20 is now balanced against the funding used to deliver them; this was previously oversubscribed by £1.000m.

2018/19 BCF total has increased to £232.123m (from £229.059m) and the 2019/20 BCF total has increased to £238.917m (from £235.379m).

The total number of schemes included within the analysis has reduced from 67 to 40.
HWB are asked to review the proposed changes and provide a recommendation for the changes to be approved at the next available HWB meeting.

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Proposed BCF & iBCF Analysis 18-19
Appendix B	Lincolnshire Letter to BCST – August 2018

6. 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 Steven Houchin who can be contacted on (01522 554293) or (Steven.Houchin@Lincolnshire.gov.uk)

Expenditure	**2017/18**	**2018/19**	**2019/20**
BCF	£ 17,130,000	£ 17,438,340	£ 17,734,792
iBCF	£ 2,105,730	£ 14,249,038	£ 25,770,902
Supplementry iBCF Funding	£ 15,265,596	£ 9,608,578	£ 4,110,611
Total	***£ 34,501,326***	***£ 41,295,956***	***£ 47,616,305***

Funding	**2017/18**	**2018/19**	**2019/20**
BCF	-£ 17,130,000	-£ 17,438,340	-£ 17,734,792
iBCF	-£ 2,105,730	-£ 14,249,039	-£ 25,120,225
Supplementry iBCF Funding	-£ 15,265,596	-£ 9,608,577	-£ 4,761,288
Total	***-£ 34,501,326***	***-£ 41,295,956***	***-£ 47,616,305***

Variance	**£ 0**	**£ -**	**£ -**

Market Stabilisation	£ 5,744,313.90	£ 6,215,218.26	£ 5,453,450.26
System Pressure	£ 3,933,730.00	£ 13,579,538.00	£ 20,365,203.00
DTOC	£ 7,693,282.00	£ 4,062,860.00	£ 4,062,860.00
Total	£ 17,371,325.90	£ 23,857,616.26	£ 29,881,513.26

Market Stabilisation	33%	26%	18%
System Pressure	23%	57%	68%
DTOC	44%	17%	14%
Total	100%	100%	100%

Better Care Funding (BCF) Allocation of Resources - 2016/17 to 2019/20 (at 22 March 2017)

		Scheme Investments From Original BCF									
		Scheme	**Quarterly Return classification**	**Scheme Type**		**Scheme Review Date**	**Project Manager**	**Allocation for 2017/18 (Submitted)**	**Allocation for 2018/19 (Submitted)**	**Allocation for 2019/20 (Proposed)**	
Proactive Care	1	Reablement		IC	System Pressure	N/A	Lynne Bucknell	£ 2,200,000	£ 2,239,600	£ 2,277,673	Ongoing Base Pressure
	2	Transitional Care	Additional CCG Investment		DTOC	N/A	Jo Wright	£ 1,230,000	£ 1,252,140	£ 1,273,427	
	3	Community Integrated Reablement Service and Agency Staffing		IC & NEA/DTOC	DTOC	N/A	Lynne Bucknell	£ 1,400,000	£ 1,425,200	£ 1,449,428	Ongoing Base Pressure
	4	Provider of Last Resort		OOH	System Pressure	N/A	Lynne Bucknell	£ 1,500,000	£ 1,527,000	£ 1,552,959	
	5	7 Day Working		NEA/DTOC	DTOC	N/A	Lynne Bucknell	£ 300,000	£ 305,400	£ 310,592	
	6	Demographic growth		PACS	System Pressure	N/A	Pete Sidgwick	£ 2,125,000	£ 2,163,250	£ 2,200,025	Ongoing Base Pressure
	7	Care Act		PACS	System Pressure	N/A	Pete Sidgwick	£ 1,712,500	£ 1,743,325	£ 1,772,962	
	8	Carers breaks OP		**Carers**	System Pressure	Review	Jane Mason	£ -	£ -	£ -	
	9	Co-Responders		OOH	DTOC	Reviewed	Nick Borrill	£ -	£ -	£ -	
		Total Proactive care						**£ 10,467,500**	**£ 10,655,915**	**£ 10,837,066**	
Specialist Adults	10	Demographic growth		PACS	System Pressure	N/A	Justin Hackney	£ 2,125,000	£ 2,163,250	£ 2,200,025	Ongoing Base Pressure
	11	LPFT Mental Illness Prevention work		PACS	DTOC	Reviewed	Justin Hackney	£ 137,500	£ 139,975	£ 142,355	
	12	Pooled Fund Section 75		PACS	System Pressure	N/A	Justin Hackney	£ 4,400,000	£ 4,479,200	£ 4,555,346	Ongoing Base Pressure
	13	Carers breaks LD		Carers	System Pressure	Reviewed	Jane Mason	£ -	£ -	£ -	
	14	Integrated Personal Commissioning		PACS	System Pressure	N/A	Jo Wright	£ -	£ -	£ -	
		Total Prevention						**£ 6,662,500**	**£ 6,782,425**	**£ 6,897,726**	
		Better Care Funding Total						**£ 17,130,000**	**£ 17,438,340**	**£ 17,734,792**	
		Scheme investments From Improved iBCF									
Proactive Care	15	Carers breaks OP	Preventitive Investment	Carers	System Pressure	Review	Jane Mason	£ 100,000	£ 100,000	£ 100,000	
	16	Co-Responders	Preventitive Investment	OOH	DTOC	Reviewed	Nick Borrill	£ 400,000	£ 400,000	£ 400,000	
	17	Care Act	Infrastructure Investment	PACS	System Pressure	N/A	Pete Sidgwick	£ 287,500	£ 287,500	£ 287,500	
	18	Inflation & NLW	Market Investment	PACS	System Pressure	N/A	Pete Sidgwick	£ -	£ 5,001,574	£ 8,772,238	Ongoing Base Pressure
	19	Demography	Market Investment	PACS	System Pressure	N/A	Pete Sidgwick	£ -	£ 316,710	£ 2,468,770	Ongoing Base Pressure
	20	Enhanced Health (Care) in Care Home programme	Health Investment	NEA DTOC	DTOC	New Scheme	Lynne Bucknell	£ -	£ 200,000	£ 200,000	
	21	Trusted Assessors	Infrastructure Investment	OOH	DTOC	Review	Melanie Wetherall	£ 100,000	£ 100,000	£ 100,000	
	22	Dementia Family Friends	Preventitive Investment	NEA DTOC	DTOC	Being Reviewed	Pete Sidgwick	£ 420,000	£ 420,000	£ 420,000	
	23	Neighbourhood Team Development	Infrastructure Investment	NEA DTOC	DTOC	New Scheme	John Turner	£ 120,000	£ 120,000	£ 120,000	
	24	Housing for Independence	Preventitive Investment	OOH	DTOC	New Scheme	Tony McGinty	£ 250,000	£ 250,000	£ 250,000	
	25	Adult Safeguarding	Preventitive Investment	PACS	DTOC	New Scheme	Daryl Pearce	£ -	£ -	£ 490,000	
	26	Making every contact count - PH Preventative	Preventitive Investment	NEA DTOC	DTOC	New Scheme	Sarah Chaudhary	£ 42,000	£ 42,000	£ 42,000	
	27	Market Stabilisation - AF HomeCare	Market Investment	PACS	Market Stabilisation	N/A	Pete Sidgwick	£ -	£ -	£ 1,517,854	
	28	Market Stabilisation - AF Direct Payments	Market Investment	PACS	Market Stabilisation	N/A	Pete Sidgwick	£ -	£ -	£ 513,516	Ongoing Base Pressure
	29	Market Stabilsation - AF Residential Care	Market Investment	PACS	Market Stabilisation	N/A	Pete Sidgwick	£ -	£ -	£ 1,392,829	
		Total Adult Frailty						**£ 1,719,500**	**£ 7,237,784**	**£ 17,074,707**	
Specialist Adults	30	Carers breaks LD	Preventitive Investment	Carers	System Pressure	Reviewed	Jane Mason	£ 50,000	£ 50,000	£ 50,000	
	31	LPFT Mental Illness Prevention work	Preventitive Investment	PACS	DTOC	Reviewed	Martin Vokes	£ 237,500	£ 237,500	£ 237,500	
	32	Integrated Personal Commissioning	Infrastructure Investment	PACS	System Pressure	N/A	Jo Wright	£ 100,000	£ 100,000	£ 100,000	
	33	Waking Nights	Market Investment	PACS	Market Stabilisation	N/A	Justin Hackney	£ -	£ 1,500,000	£ 500,000	Ongoing Base Pressure
	34	Inflation & NLW 18/19	Market Investment	PACS	System Pressure	N/A	Justin Hackney	£ -	£ 939,714	£ 1,767,342	Ongoing Base Pressure
	35	Demography 18/19	Market Investment	PACS	System Pressure	N/A	Justin Hackney	£ -	£ 3,470,809	£ 5,819,353	Ongoing Base Pressure
	36	Market Stabilisation SAS - Direct Payments	Market Investment	PACS	Market Stabilisation	N/A	Justin Hackney	£ -	£ -	£ 722,000	Ongoing Base Pressure
	37	Carers - Everyone	Preventitive Investment	Carers	System Pressure	New Scheme	Jane mason	£ -	£ 75,000	£ -	
	38	Carers Outreach	Preventitive Investment	Carers	System Pressure	New Scheme	Jane mason	£ -	£ 500,000	£ 500,000	
	39	Other One Off Investment/Reduction	Infrastructure Investment		System Pressure			-£ 1,270	£ 138,231	-£ 1,000,000	
		Total Specialist Adults						**£ 386,230**	**£ 7,011,254**	**£ 8,696,195**	
		Total iBCF Funding						**£ 2,105,730**	**£ 14,249,038**	**£ 25,770,902**	
		Supplementary iBCF Funding									
	40	Market Stabilisation - AF HomeCare	Market Investment	PACS	Market Stabilisation	N/A	Pete Sidgwick	£ 1,877,969	£ 2,325,105	£ 807,251	
	41	Market Stabilisation - AF Direct Payments	Market Investment	PACS	Market Stabilisation	N/A	Pete Sidgwick	£ 412,367	£ 225,284	£ -	
	42	Market Stabilisation SAS - Direct Payments	Market Investment	PACS	Market Stabilisation	N/A	Justin Hackney	£ 579,000	£ 772,000	£ -	Ongoing Base Pressure
	43	Market Stabilsation - AF Residential Care	Market Investment	PACS	Market Stabilisation	N/A	Pete Sidgwick	£ 1,124,977	£ 1,392,829	£ -	Ongoing Base Pressure
	44	Staffing	Infrastructure Investment	PACS	System Pressure	N/A	Pete Sidgwick	£ 562,500	£ 1,500,000	£ 1,500,000	Ongoing Base Pressure
	45	Quick Response Service/Reablement	Preventitive Investment	NEA DTOC	DTOC	New Scheme	Pete Sidgwick	£ 1,383,782	£ 1,803,360	£ 1,803,360	
	46	Mosaic & Information Systems	Infrastructure Investment	PACS	System Pressure	N/A	Emma Scarth	£ 2,300,000	£ 1,000,000	£ -	
	47	Mental Health Awareness Training	Infrastructure Investment	PACS	System Pressure	N/A	Fiona Thomson	£ 20,000		£ -	
	48	Adult Safeguarding	Preventitive Investment	PACS	DTOC	New Scheme	Daryl Pearce	£ 490,000	£ 490,000	£ -	
	49	Nursing Associates	Health Investment	OOH	DTOC	New Scheme	Melanie Wetherall	£ 50,000		£ -	
	50	Enhanced Health (Care) in Care Home programme	Health Investment	NEA DTOC	DTOC	New Scheme	Lynne Bucknell	£ 200,000		£ -	
	51	DTOC	Health Investment	TBC	DTOC	TBC	TBC	£ 4,000,000		£ -	
	52	Waking Nights	Market Investment	PACS	Market Stabilisation	N/A	Justin Hackney	£ 1,500,000		£ -	
	53	Carers Outreach	Preventitive Investment	Carers	System Pressure	New Scheme	Jane Mason	£ 375,000		£ -	
	54	Carers - Everyone	Preventitive Investment	Carers	System Pressure	New Scheme	Jane mason	£ 40,000		£ -	
	55	Shared Lives	Infrastructure Investment	PACS	Market Stabilisation	N/A	Justin Hackney	£ 250,000		£ -	
	56	Programme Support Costs	Infrastructure Investment	PACS	System Pressure	N/A	Glen Garrod	£ 100,000	£ 100,000	£ -	
								£ 15,265,596	**£ 9,608,578**	**£ 4,110,611**	
		Existing Agreements									
	57	Intermediate Care	Additional CCG Investment					£ 5,700,000	£ 5,700,000	£ 5,700,000	
	58	Neighbourhood Team	Additional CCG/LCC Investment					£ 26,586,557	£ 26,586,557	£ 26,586,557	
	59	CAMHS S75 Agreement	Existing Allocations					£ 7,009,163	£ 7,009,163	£ 7,009,163	
	60	Disabled Facilities Grant	District Funding					£ 5,291,093	£ 5,698,071	£ 5,698,071	
	61	ICES	Existing Allocations					£ 5,800,000	£ 5,800,000	£ 5,800,000	
	62	Existing Section 256 Agreement Adults	Existing Allocations					£ 646,000	£ 646,000	£ 646,000	
	63	Existing Section 256 Agreement Childrens	Existing Allocations					£ 521,000	£ 521,000	£ 521,000	
	64	Learning Disability Section 75 Agreement	Existing Allocations					£ 61,079,154	£ 61,079,154	£ 61,079,154	
	65	Mental Health S75 Agreement (LCC/LPFT)	Existing Allocations					£ 5,868,000	£ 5,868,000	£ 5,868,000	
	66	Mental Health (CCG/LPFT)	Existing Allocations					£ 66,974,487	£ 66,974,487	£ 66,974,487	
	67	Transitional Beds S75 Agreement (LCC/LCHS)	Existing Allocations					£ 1,880,556	£ 1,880,556	£ 1,880,556	
								£ 187,356,010	**£ 187,762,988**	**£ 187,762,988**	
								£ 221,857,336	£ 229,058,944	£ 235,379,293	

IC - Intermediate Care
OOH - Out of Hospital
PACS - Protection Of Adult Care Services

Better Care Funding (BCF) Allocation of Resources - 2018/19 to 2019/20

Scheme	Reporting Required	Quarterly Return classification	Funding Classification	Project Lead	Base Pressure	2018/19	2019/20	Notes
Reablement	Yes	Not Applicable	System Pressure	Tracy Perrett	Yes	£ 2,241,800	£ 2,284,394	No Change
Transitional Care	Yes		DTOC	Jo Wright	No	£ 1,253,370	£ 1,277,184	
Community Integrated Reablement Service and Agency Staffing	Yes		DTOC	Tracy Perrett	Yes	£ 1,425,200	£ 1,449,428	No change
Residential Market Rates	No		System Pressure	Tracy Perrett	Yes	£ 3,424,000	£ 3,510,129	Allocations originally earmarked for Care Act and Provider of Last resort have been used to fund the increases in residential costs to reflect the ongoing requirement following rate negotiations. This has the effect of ensuring the Council meets its ongoig Care Act obligations of Market Shaping by promoting quality services, including through workforce development and remuneration and ensuring appropriately resourced care and support
7 Day Working	Yes		DTOC	Tracy Perrett	Yes	£ 305,400	£ 310,592	No change
AF&LTC Historic Demographic Growth	No		System Pressure	Carolyn Nice	Yes	£ 2,163,250	£ 2,200,025	No change
LD S75 Historic Pooled Fund Investment	No		System Pressure	Justin Hackney	Yes	£ 6,642,450	£ 6,755,372	No change
Minimum POAC Total						**£ 17,455,470**	**£ 17,787,125**	

iBCF Scheme Investments								
AFLTC Inflation & Demographic Growth	No	Market Investment	System Pressure	Carolyn Nice	Yes	£ 5,318,284	£ 11,106,240	Separate inflation & demographic growth funds combined into one total. 19/20 allocated amemded to ensure that the total BCF requirement is in line with total 19/20 BCF allocations
Enhanced Health (Care) in Care Home programme	Yes	Health Investment	DTOC	Tracy Perrett		£ 200,000	£ 200,000	No Change
Trusted Assessors	Yes	Infrastructure Investment	DTOC	Melanie Wetherall		£ 100,000	£ 100,000	No Change
Dementia Family Friends	Yes	Preventative Investment	DTOC	Carolyn Nice		£ 420,000	£ 420,000	No Change
Neighbourhood Team Development	Yes	Infrastructure Investment	DTOC	John Turner		£ 120,000	£ 120,000	No Change
Market Stabilisation	Yes	Market Investment	Market Stabilisation	Carolyn Nice		£ 3,943,218	£ 3,943,218	Market Stabilisation funds for Homecare, Residential and DP (AF) combined. DP fund to be split between the other two as there is no impact in this area. Level of funding maintained across both years,as there are inflationary factors to consider.
Staffing	No	Infrastructure Investment	System Pressure	Carolyn Nice	Yes	£ 1,300,000	£ 1,000,000	The allocation for additional front line staff has been reduced to £1m from £1.5m following discussion with Assistant Director for Adult Frailties and Long Terms Conditions to better reflect the likely outcome of the ongoing recruitment process
Quick Response Service/Reablement	Yes	Preventative Investment	DTOC	Carolyn Nice		£ 1,803,360	£ 1,803,360	No Change
Total Adult Frailty						**£ 13,204,862**	**£ 18,692,818**	

Integrated Personal Commissioning	Yes	Infrastructure Investment	System Pressure	Jo Wright		£ 100,000	£ 100,000	No Change
Waking Nights	Yes	Market Investment	Market Stabilisation	Justin Hackney	Yes	£ 1,500,000	£ 500,000	No Change
SAS Inflation & Demographic Growth	No	Market Investment	System Pressure	Justin Hackney	Yes	£ 4,410,523	£ 7,586,695	Seperate Inflation & Demographic growth funds combined into one total. No change in the combined totals for both years
CCG CHC Pressures	Yes	Market Investment	Market Stabilisation	Justin Hackney	Yes	£ 700,000	£ 700,000	Market Stabilisation fund for LD DP's redirected to cover additional costs to cover CCG CHC cost which have been allocated following a request by GG
LPFT Mental Illness Prevention Fund	Yes	Preventative Investment	DTOC	Justin Hackney	Yes	£ 370,000	£ 370,000	Original plan had the funding for this scheme split between POAC funds and iBCF. MIPF is now funded in it's entirety from iBCF.
Total Specialist Adults						**£ 7,080,523**	**£ 9,256,695**	

Housing for Independence	Yes	Preventative Investment	DTOC	Lisa Loy		£ 250,000	£ 250,000	No Change
Adult Safeguarding	Yes	Preventative Investment	DTOC	TBC		£ 490,000	£ 490,000	No Change
Making Every Contact Count	Yes	Preventative Investment	DTOC	Sarah Chaudhary		£ 42,000	£ 42,000	No Change
Carers - Everyone/Outreach/Breaks	Yes	Preventative Investment	DTOC	Emma Krasinska		£ 725,000	£ 650,000	All Carers costs have been combined into one scheme including AF & SAS Carers Breaks
Nursing Associates	Yes	Preventative Investment	DTOC	Melanie Wetherall		£ 31,500	£ -	Funding for this project has been extended for a futher year to be funded via iBCF
Total Wellbeing						**£ 1,538,500**	**£ 1,432,000**	

Mosaic & Information Systems	No	Infrastructure Investment	System Pressure	Emma Scarth		£ 1,000,000	£ -	No Change
Programme Support Costs	Yes	Infrastructure Investment	System Pressure	Glen Garrod		£ 250,000	£ 100,000	Support costs are better aligned to relfect the actual cost incurred of managing the Better Care Fund in its entireity. Costs are reduced in 2019/20 reflecting the primary use of iBCF as means of funding base costs and Market stablisation costs.
Co-Responders	Yes	Preventative Investment	DTOC	Nick Borrill		£ 400,000	£ 400,000	No Change
To Be Allocated		TBC	TBC	TBC		£ 383,731		Available for new funds, however subject to change once 18/19 contributions are confirmed
Total Corporate						**£ 2,033,731**	**£ 500,000**	

Intermediate Care	Yes	Additional CCG Investment		Jo Wright		£ 5,700,000	£ 5,700,000	
Neighbourhood Team	Yes	Additional CCG/LCC Investment		Carolyn Nice/Jo Wright		£ 26,586,557	£ 26,586,557	
CAMHS S75 Agreement	Yes	Existing Allocations		Jonas Gibson		£ 7,009,163	£ 7,009,163	
ICES	Yes	Existing Allocations		Robin Bellamy		£ 5,800,000	£ 5,800,000	
Disabled Facilities Grant	Yes	District Funding		Lisa Loy		£ 5,698,071	£ 6,136,253	
Existing Section 256 Agreement Adults	Yes	Existing Allocations		Justin Hackney		£ 646,000	£ 646,000	
Existing Section 256 Agreement Childrens	Yes	Existing Allocations		Jonas Gibson		£ 521,000	£ 521,000	
Learning Disability Section 75 Agreement	Yes	Existing Allocations		Justin Hackney		£ 59,276,496	£ 59,276,496	
Mental Health S75 Agreement (LCC/LPFT)	Yes	Existing Allocations		Justin Hackney		£ 6,100,000	£ 6,100,000	
Mental Health (CCG/LPFT)	Yes	Existing Allocations		Jo Wright		£ 70,722,568	£ 70,722,568	
Transitional Beds S75 Agreement (LCC/LCHS)	Yes	Existing Allocations		Carolyn Nice		£ 2,750,000	£ 2,750,000	
Total Existing						**£ 190,809,855**	**£ 191,248,036**	

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County Offices, Newland,
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Lincolnshire COUNTY COUNCIL
Working for a better future

Wendy Hoult
Better Care Implementation Manager

Lincolnshire County Council
County Offices
Newland
Lincoln
LN1 1YL

VIA EMAIL

24th August 2018

Our Ref: GG/SH/BCF

Dear Wendy

LINCOLNSHIRE BETTER CARE FUND 2018/19 UP

I am writing on behalf of both the Joint Executive Team, for Lincolnshire and the Lincolnshire Health and Wellbeing Board, to confirm the changes that will be made to the Lincolnshire Better Care Fund 2017-19 ahead of the 24th August refresh deadline with regards to the following elements:

1. 2018-19 target for the reablement metric;
2. 2018-19 target for the residential admissions metric; and
3. 2018-19 expenditure plans.

In relation to points 1 and 2 I can confirm that there will be no changes made to the 2017-19 plans, however in relation to the point 3, I can confirm that there will be a number of minor changes to our BCF expenditure plans. These are as a result of the following:

- The consolidation of a number of similar schemes into a single total
- A change to a scheme funded via Protection of Adult Care BCF funding which will now be used for an alternative purpose but which still meets the scheme requirements as set out in the original allocation.
- Changes as a result of updated inflation parameters
- Changes to some "aligned" schemes as a result of changes in the amount invested. This includes the removal of values as a result of double counting.

The changes described above will result in the overall value of Lincolnshire's BCF planning total to reduce from £235.415m as set out in the original Care Fund Template to £232.123m.

The nationally directed changes to Non-Elective Admissions and Delayed Transfers of Care metrics have been noted and included within the local performance monitoring for 2018-19. For assurance purposes, this confirmation will be reported retrospectively through our local governance structures as follows:

1. Joint Executive Team on Tuesday 11th September 2018; and
2. Lincolnshire Health and Wellbeing Board on Tuesday 26th September 2018.

I do not anticipate any further changes to the expenditure plan in 2018/19, however should that not be the case I will ensure that you are made aware of any such changes.

Yours sincerely

Steven Houchin
Head of Finance Adult Care & Community Wellbeing

Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**11 December 2018**
Subject:	**Better Care Fund Update**

Summary:

This report provides the Lincolnshire Health and Wellbeing Board (HWB) with an update on Lincolnshire's BCF plan for 2017-2019. There is also a finance and performance update showing the current position

Actions Required:

Lincolnshire Health and Wellbeing Board are asked to note the BCF report update.

1. Background

The original plan submitted for 2017 – 2019 shows sums of £226m for 2017/18 and £235m for 2018/19. The values for 2018/19 have since been revised to £232.123m

Formal approval – without any conditions - to the original plan was given on 31 October 2017 with all relevant agreements put in place by 28 November 2017.

BCF 2017/18 and 2018/19

The BCF Narrative Plan and related Planning Template were submitted to NHSE on 11 September as required on 31 October 2017.

The key **financial** elements of the plan include:-

- An overall BCF Plan now totalling £222m for 2017/18 and £232m for 2018/19

- Agreement that the 'Minimum Mandated Expenditure on Social Care from the CCG minimum' complies with national requirements for a 1.79% and then 1.9% increase, making the amount provided for the Protection of Adult Care Services £17.130m in 2017/18 and £17.465m in 2018/19.
- Over the three years of the overall iBCF funding to March 2020 the funding will be invested in:

	17/18 to 19/20
Meeting Adult Social Care Need	53%
Reducing Pressures on the NHS	22%
Stabilising the Social Care Market	24%

The key **performance** elements of the BCF Plan relate to:-

- Delayed Transfers of Care (DTOC) - An increased focus has been placed on the DTOC metric, and increasingly the success of the BCF Plan is nationally seen to depend on being successful in reducing DTOC. The Lincolnshire plan assumes that both the local authority and the CCGs will achieve their respective – and collective - nationally set DTOC targets
- Non Elective Admissions (NEAs) – the BCF Plan also assumes that the nationally set target for NEAs is also achieved.
- In both the above areas the plan is required to identify whether 'stretch targets' should be set. This challenge has been discussed within LCC and the 4 CCGS, at the SET and also at the Lincolnshire A&E Delivery Board. It has been agreed that we will not include a stretch target in either of these areas.

BCF Planning conditions allow for the current plan to be revised from time to time, to reflect changes in assumptions that may give rise to a change in the planning total.

2. General BCF Update

An updated BCF operating guidance was published on 18th July 2018, the purpose of which sets out:

- An updated accountability structure and funding flow diagrams reflecting recent changes to relevant government departments
- Funding conditions which have now reduced from eight to four
- Refreshed Metric Plans for 2018-19
- Confirmation of the combined quarterly reporting process for BCF and IBCF funds
- Updated support, intervention and escalation processes.

Lincolnshire County Council (LCC) and the Lincolnshire CCG's took the opportunity to review the Lincolnshire BCF plan which resulted in minor changes to BCF expenditure plans. These were agreed by the Lincolnshire Joint Executive Team (JET), and a letter issued to regional Better Care Support Team confirming the changes (BCST).

The changes described above will result in the overall value of Lincolnshire's BCF planning total increasing to £232.123m.

Monthly teleconferences are held by members of the BCST who provide day to day support to BCF leads within the East Midlands. BCST also provide regular updates on

the current developments both regionally and nationally, and at the most recent teleconference help on 9th November, the following updates were given.

- BCF 19/20 - The process for the 19/20 BCF will be broadly the same as the 2017-19 planning guidance which suggests that 19/20 will simply be a roll-forward of existing plans.
- DTOC – The BCST are still waiting for clarity over 19/20 DTOC targets. The regional view is that new targets should reflect progress made in particular areas (some well performing areas now have a "zero" target), however any fundamental change in targets are likely to take effect from April 2020 onwards.
- 19/20 Minimum Contributions – There are still on-going debates at a national level regarding the value of minimum contributions via CCGs for 19/20. Discussions are centred on a choice between an increase in funding linked to inflation or a link to the level of increase in NHS revenue.
- NHS Long Term Plan due mid-November, with BCF requirements and policy framework together with the NHS Operating Plan in early December. The Green Paper looking at the future funding of Adult Social Care is now likely to be published early next year.
- BCF Review – Departments are also working on a review of the BCF, the review will look into :

    - The purpose and role of the fund.
    - How funding flows can be managed in a way that is clearer and allows more focus on improving outcomes.
    - How the fund can be administered with fewer burdens to local systems.

    There is still uncertainty about how local engagement will happen and plans are unlikely to be finalised until well into 2019.

3. Finance

The finance update is shown as Appendix A which describes the current outturn position against the current budgeted BCF for 2018/19 (£232m) and includes:-

- CCG funding for the Protection of Adult Care Services - £17.465m
- iBCF funding announced in the November 2015 budget - £14.249m
- iBCF Supplementary funding announced in the March 2017 budget - £9.209m
- Disabled Facilities Grant (DFG) allocations to District Councils - £5.698m
- Existing agreements included within the BCF as a whole - £185.502m

Current analysis as at 31 October 2018 suggests that spend against the BCF will total £236.377m this financial year. This represents an overspend of £4.254m (2.13%) against the total allocation of £232.123m.

Spending against the first four principle funding areas of the BCF is projected to produce a small underspend of £0.379m against their respective allocations (£46.621m), This is linked to the an amount of iBCF funding totalling £0.379m that remains unallocated following the review of BCF schemes earlier in the year, however it has been proposed that this funding be allocated to CCGs to help fund the increasing cost of LD Continuing Health Care costs in 18/19.

The area of overspend is linked to existing agreements and is limited to the following areas:

- Learning Disability S75 Agreement is projected to produce an overspend of £3.499m against a budget of £70.329m. This has been reported to the LD Joint Delivery Board. This is reduced to £2.799m with the application of additional CHC funding via the iBCF totalling £0.700m

- Integrated Community Equipment Services (ICES) S75 Agreement is also projected to produce an overspend of £1.284m against a budget of £5.800m. This has been reported to the ICES Strategic Partnership Board.

- Mental Health S75 agreement between LCC and LPFT is projected to overspend by £0.550m in 2018/19

In each case any projected overspend will be dealt with via existing risk arrangements detailed in each of the relevant S75 agreements. The projected risk payments due are expected to be in the region of £2.487m for LCC and £2.145m for the four CCGs. An analysis of potential risk payments for each CCG is shown below.

CCG	Value
East	£719,375.34
West	£637,114.52
South	£435,056.96
South West	£353,202.17
Total	£2,144,749.00

Work is also on-going to develop a schedule of reviews for each of the BCF schemes over a twelve month period between October 2018 and September 2019. A working draft of the schedule has been produced and is included as Appendix B to this report.

The first review, into the Learning Disability S75 took place in October and also included a review of the existing Section 256 agreement for the provision of Crisis Housing for adults with a learning disability. A copy of the presentation given to the finance group can be found in Appendix C.

4. Performance

An expanded BCF performance report for Quarter 2 2018/19 is shown as Appendix D, a long term analysis of NEA and DTOCs including a comparison against the national picture can be seen in Appendix E. Highlights from the latest available ratified data include:

- ***Non-Elective Admissions –*** A total of 20,738 admissions were made during the quarter, which is an average of 6,912 per month – this trend of admissions is higher than in 2017/18 (20,690) and has not met the target level.

- ***Residential Admissions*** – there have been 460 older people (65+) admitted to permanent Residential care to date in 2018/19. This is 115 lower than the target trajectory for the year and some 151 admissions below the level at the same point last year.

- ***Delayed Days –*** There have been 6,848 delayed days in Quarter 2 2018/19. This exceeds the target level but is higher than in the same period of 2017/18 (6,539).

  The average delayed beds per day was 78 at the end of Q2, this is higher than the expected target for Lincolnshire to be achieved by September, which was set at 58.7.

- ***Reablement*** - This measure is based on a 3 month window where older people discharged from hospital between October and December, are checked to see their status 91 days later. The confirmed performance for the most recent window in 2017/18 was 80.0% against a target of 80.5% for the BCF. This is an improvement on 16/17 where the outturn was 75.4%.

  This has been assisted by improved volume and outcomes performance of the reablement providers in Lincolnshire. Although we will not be able to report this 91 day indicator on a quarterly basis, we will monitor reablement activity and performance to provide assurance for this key area.

- **iBCF and Local Measures** - A number of local data measures have been added to the performance report for the BCF, some of which are used as part of the information that is provided to NHSE on a quarterly basis and others as a purely local measure to assess the impact of the additional investment in any particular area. The aim is to give a more thorough and granular picture of performance and activity funded by the BCF in Lincolnshire through the various schemes. Measure include:

  - Number of clients in receipt of Home Care
  - Total number of Care Home placements
  - Number of reablement hours delivered
  - Number of Weekend Hospital Discharges
  - Hospital Discharges with Social Care Involvement
  - Number of Carers supported by Adult Care

- The report is not yet complete and as such is subject to change, but data development activity will be on-going throughout the year to expand the suite of measures for additional schemes such as CAMHS, Co-responders and Trusted Assessors.

5. Conclusion

The Board is asked to note the information provided both in this report and the appendices attached

6. Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy

The Council and Clinical Commissioning Groups must have regard to the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

7. Consultation

None required.

8. Appendices

These are listed below and attached at the back of the report	
Appendix A	BCF Finance Report 2018-19 - November 2018
Appendix B	Draft BCF S75 Finance Review Work Plan 18/19
Appendix C	LD S75 VFM Presentation – October 2018
Appendix D	BCF Performance Report – Q2 2018-19
Appendix E	ADASS DTOC Overview Slide September 2018

9. Background Papers

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

This report was written by Steven Houchin who can be contacted on (01522 554293) or (Steven.Houchin@Lincolnshire.gov.uk)

Better Care Fund Agreement Tables 2018/19

									Key In Data							
		CCG Budget					LCC Budget	Total Budget	Spend to Date	Projected Outturn	LCC Variance	CCG Variance				
Line	Proactive Care	£'000 East	£'000 West	£'000 South	£'000 South W.	£'000 TOTAL	£'000 LCC	£'000 Total	£'000 Total	£'000 Total	£'000 LCC	£'000 East	£'000 West	£'000 South	£'000 South W.	£'000 TOTAL
1	Intermediate Care	£1,911,850	£1,693,230	£1,156,231	£938,689	£5,700,000	£0	£5,700,000	£3,325,000	£5,700,000	£0	£0	£0	£0	£0	£0
2	Transitional care	£420,396	£372,323	£254,243	£206,408	£1,253,370	£0	£1,253,370	£731,133	£1,253,370	£0	£0	£0	£0	£0	£0
3	Neighbourhood Team	£2,209,213	£1,956,588	£1,336,067	£1,084,689	£6,586,557	£20,000,000	£26,586,557	£15,508,825	£26,586,557	£0	£0	£0	£0	£0	£0
4	DFG Grant	£0	£0	£0	£0	£0	£5,698,071	£5,698,071	£3,323,875	£5,698,071	£0	£0	£0	£0	£0	£0
5	Reablement (Allied)	£751,927	£665,944	£454,744	£369,185	£2,241,800	£0	£2,241,800	£1,307,717	£2,241,800	£0	£0	£0	£0	£0	£0
6	Community Integrated Reablement Service and Agency Staffing	£478,030	£423,367	£289,098	£234,705	£1,425,200	£0	£1,425,200	£831,367	£1,425,200	£0	£0	£0	£0	£0	£0
7	Residential Market Rate Agreement	£1,148,452	£1,017,126	£694,550	£563,872	£3,424,000	£0	£3,424,000	£1,997,333	£3,424,000	£0	£0	£0	£0	£0	£0
8	Co-responders	£0	£0	£0	£0	£0	£400,000	£400,000	£233,333	£400,000	£0	£0	£0	£0	£0	£0
9	AF&LTC Inflation & NLW	£0	£0	£0	£0	£0	£5,318,284	£5,318,284	£3,102,332	£5,318,284	£0	£0	£0	£0	£0	£0
10	7 Day Working	£102,435	£90,721	£61,950	£50,294	£305,400	£0	£305,400	£178,150	£305,400	£0	£0	£0	£0	£0	£0
11	AF&LTC Historic Demographic Growth	£725,581	£642,610	£438,810	£356,249	£2,163,250	£0	£2,163,250	£1,261,896	£2,163,250	£0	£0	£0	£0	£0	£0
12	Trusted Assessors	£0	£0	£0	£0	£0	£100,000	£100,000	£58,333	£100,000	£0	£0	£0	£0	£0	£0
13	Dementia Family Friends	£0	£0	£0	£0	£0	£420,000	£420,000	£245,000	£420,000	£0	£0	£0	£0	£0	£0
14	Neighbourhood Team Development	£0	£0	£0	£0	£0	£120,000	£120,000	£70,000	£120,000	£0	£0	£0	£0	£0	£0
15	Housing for Independence	£0	£0	£0	£0	£0	£250,000	£250,000	£145,833	£250,000	£0	£0	£0	£0	£0	£0
16	Making Every Contact Count	£0	£0	£0	£0	£0	£42,000	£42,000	£24,500	£42,000	£0	£0	£0	£0	£0	£0
17	Market Stablisation	£0	£0	£0	£0	£0	£3,943,218	£3,943,218	£2,300,211	£3,943,218	£0	£0	£0	£0	£0	£0
18	Staffing	£0	£0	£0	£0	£0	£1,300,000	£1,300,000	£758,333	£1,300,000	£0	£0	£0	£0	£0	£0
19	Quick Response Service/Reablement	£0	£0	£0	£0	£0	£1,803,360	£1,803,360	£1,051,960	£1,803,360	£0	£0	£0	£0	£0	£0
20	Mosaic & Information Systems	£0	£0	£0	£0	£0	£1,000,000	£1,000,000	£583,333	£1,000,000	£0	£0	£0	£0	£0	£0
21	Adult Safeguarding	£0	£0	£0	£0	£0	£490,000	£490,000	£285,833	£490,000	£0	£0	£0	£0	£0	£0
22	Enhanced Health (Care) in Care Home programme	£0	£0	£0	£0	£0	£200,000	£200,000	£116,667	£200,000	£0	£0	£0	£0	£0	£0
23	Carers - Everyone/Outreach/Breaks	£0	£0	£0	£0	£0	£725,000	£725,000	£422,917	£725,000	£0	£0	£0	£0	£0	£0
24	Nursing Associates	£0	£0	£0	£0	£0	£31,500	£31,500	£18,375	£31,500	£0	£0	£0	£0	£0	£0
25	Programme Support Costs	£0	£0	£0	£0	£0	£250,000	£250,000	£145,833	£250,000	£0	£0	£0	£0	£0	£0
26	To Be Allocated	£0	£0	£0	£0	£0	£378,731	£378,731	£0	£0	-£378,731	£0	£0	£0	£0	£0
	TOTAL PROACTIVE CARE s(75)	**£7,747,884**	**£6,861,911**	**£4,685,691**	**£3,804,091**	**£23,099,577**	**£42,470,164**	**£65,569,741**	**£38,028,089**	**£65,191,010**	**-£378,731**	**£0**	**£0**	**£0**	**£0**	**£0**

Line	TABLE 1 Specialised LD S(75): LD schedule 1	£'000 East	£'000 West	£'000 South	£'000 South W.	£'000 TOTAL	£'000 LCC	£'000 Total	£'000 Total	£'000 Total	£'000 LCC	£'000 East	£'000 West	£'000 South	£'000 South W.	£'000 TOTAL
27	LD S(75) CCG & LCC Contribution	£3,991,407	£3,534,988	£2,413,885	£1,959,719	£11,900,000	£47,376,496	£59,276,496	£36,217,214	£62,075,477	£1,175,944	£544,387	£482,136	£329,229	£267,285	£1,623,037
28	Inflation & Demographic Growth	£0	£0	£0	£0	£0	£4,410,523	£4,410,523	£2,572,647.00	£4,410,523	£0	£0	£0	£0	£0	£0
29	LD S75 Historic Pooled Fund Investment	£2,227,960	£1,973,192	£1,347,404	£1,093,894	£6,642,450	£0	£6,642,450	£3,874,763.00	£6,642,450	£0	£0	£0	£0	£0	£0
	s(75) LD POOLED RESOURCES	**£6,219,367**	**£5,508,180**	**£3,761,290**	**£3,053,613**	**£18,542,450**	**£51,787,019**	**£70,329,469**	**£42,664,624**	**£73,128,450**	**£1,175,944**	**£544,387**	**£482,136**	**£329,229**	**£267,285**	**£1,623,037**

Line	TABLE 2 Specialised LD S(75): LD schedule 2	£'000 East	£'000 West	£'000 South	£'000 South W.	£'000 TOTAL	£'000 LCC	£'000 Total	£'000 Total	£'000 Total	£'000 LCC	£'000 East	£'000 West	£'000 South	£'000 South W.	£'000 TOTAL
30	Existing S(256) Adults	£216,676	£191,899	£131,039	£106,385	£646,000	£0	£646,000	£376,833	£646,000	£0	£0	£0	£0	£0	£0
31	IPC/Personal Health budget	£0	£0	£0	£0	£0	£100,000	£100,000	£58,333	£100,000	£0	£0	£0	£0	£0	£0
32	CCG CHC Pressures	£0	£0	£0	£0	£0	£700,000	£700,000	£0	£700,000	£0	£0	£0	£0	£0	£0
33	Waking Nights	£0	£0	£0	£0	£0	£1,500,000	£1,500,000	£875,000	£1,500,000	£0	£0	£0	£0	£0	£0
34	LPFT Mental Illness Prevention Fund	£0	£0	£0	£0	£0	£375,000	£375,000	£218,750	£375,000	£0	£0	£0	£0	£0	£0
	LD Schedule 2	**£216,676**	**£191,899**	**£131,039**	**£106,385**	**£646,000**	**£2,675,000**	**£3,321,000**	**£1,528,917**	**£3,321,000**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**
	TOTAL Learning Disability Services	**£6,436,043**	**£5,700,080**	**£3,892,329**	**£3,159,998**	**£19,188,450**	**£54,462,019**	**£73,650,469**	**£44,193,541**	**£76,449,450**	**£1,175,944**	**£544,387**	**£482,136**	**£329,229**	**£267,285**	**£1,623,037**

Line	CAMHs S(75)	£'000 East	£'000 West	£'000 South	£'000 South W.	£'000 CCG	£'000 LCC	£'000 Total	£'000 Total	£'000 Total	£'000 LCC	£'000 East	£'000 West	£'000 South	£'000 South W.	£'000 TOTAL
35	CAMHs S(75) CCG contribution	£2,107,924	£1,866,882	£1,274,810	£1,034,958	£6,284,574	£724,589	£7,009,163	£4,088,678	£7,009,163	£0	£0	£0	£0	£0	£0
36	Existing S(256) Childrens	£174,750	£154,767	£105,684	£85,799	£521,000	£0	£521,000	£303,917	£521,000	£0	£0	£0	£0	£0	£0
	CAMHs S(75)	**£2,282,674**	**£2,021,649**	**£1,380,494**	**£1,120,758**	**£6,805,574**	**£724,589**	**£7,530,163**	**£4,392,595**	**£7,530,163**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**

Line	PARTNERSHIP FRAMEWORK	£'000 East	£'000 West	£'000 South	£'000 South W.	£'000 CCG	£'000 LCC	£'000 Total	£'000 Total	£'000 Total	£'000 LCC	£'000 East	£'000 West	£'000 South	£'000 South W.	£'000 TOTAL
37	ICES original	£1,050,512	£930,385	£635,318	£515,785	£3,132,000	£2,668,000	£5,800,000	£3,804,114	£7,083,694	£761,983	£174,988	£154,978	£105,828	£85,917	£521,711
	PARTNERSHIP FRAMEWORK	**£1,050,512**	**£930,385**	**£635,318**	**£515,785**	**£3,132,000**	**£2,668,000**	**£5,800,000**	**£3,804,114**	**£7,083,694**	**£761,983**	**£174,988**	**£154,978**	**£105,828**	**£85,917**	**£521,711**

Line	Aligned Budgets	£'000 East	£'000 West	£'000 South	£'000 South W.	£'000 CCG	£'000 LCC	£'000 Total	£'000 Total	£'000 Total	£'000 LCC	£'000 East	£'000 West	£'000 South	£'000 South W.	£'000 TOTAL
38	Mental Health S75 Agreement (LCC/LPFT)	£0	£0	£0	£0	£0	£6,100,000	£6,100,000	£3,558,333	£6,650,000	£550,000	£0	£0	£0	£0	£0
39	Mental Health (CCG/LPFT)	£22,575,465	£27,001,877	£10,057,455	£11,087,770	£70,722,567	£0	£70,722,567	£41,254,831	£70,722,568	£0	£0	£0	£0	£0	£1
40	Transitional Beds S75 Agreement (LCC/LCHS)	£586,972	£519,851	£354,983	£288,194	£1,750,000	£1,000,000	£2,750,000	£1,604,167	£2,750,000	£0	£0	£0	£0	£0	£0
	PARTNERSHIP FRAMEWORK	**£23,162,437**	**£27,521,728**	**£10,412,438**	**£11,375,964**	**£72,472,567**	**£7,100,000**	**£79,572,567**	**£46,417,331**	**£80,122,568**	**£550,000**	**£0**	**£0**	**£0**	**£0**	**£1**

	Grand Total	**£40,679,549**	**£43,035,753**	**£21,006,271**	**£19,976,596**	**£124,698,168**	**£107,424,772**	**£232,122,940**	**£136,835,670**	**£236,376,885**	**£2,109,196**	**£719,375**	**£637,115**	**£435,057**	**£353,202**	**£2,144,749**

Key					
	16,611,457	14,711,931	10,046,119	8,155,969	49,525,475
CCG Contribution to POAC	33.54%	29.71%	20.28%	16.47%	100.00%
Input LCC & CCG Variances Manually					
CCG Totals					

Total Variance	£4,253,946

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8a_Appendix B - Draft BCF S75 Finance Review Work Plan 1819

Key
Detailed Review (Additional Analysis Required)
Light touch Review (Use of Existing Analysis)
No Review Planned

CCG Programme	CCG FMR line	Line	Description	Total	Mar-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
Community	Proactive Care	1	Intermediate Care	£5,700,000										DTOC/NEA			
Community	Proactive Care	2	Transitional care	£1,253,370													
Community	Proactive Care	3	Neighbourhood Team	£26,586,557										NT Dashboard			
Community	Proactive Care	4	DFG Grant	£5,698,071													
Community	Proactive Care	5	Reablement (Allied)	£2,241,800										Salt Flow			
Community	Proactive Care	6	Community Integrated Reablement Service and Agency S	£1,425,200										DTOC/NEA			
Community	Proactive Care	7	Residential Market Rate Agreement	£3,424,000													
Community	Proactive Care	8	Co-responders	£400,000													
Community	Proactive Care	9	AF&LTC Inflation & NLW	£5,318,284										Salt Flow			
Community	Proactive Care	10	7 Day Working	£305,400										DTOC/NEA			
Community	Proactive Care	11	AF&LTC Historic Demographic Growth	£2,163,250										Salt Flow			
Community	Proactive Care	12	Trusted Assessors	£100,000										DTOC/NEA			
Community	Proactive Care	13	Dementia Family Friends	£420,000													
Community	Proactive Care	14	Neighbourhood Team Development	£120,000										NT Dashboard			
Community	Proactive Care	15	Housing for Independence	£250,000													
Community	Proactive Care	16	Making Every Contact Count	£42,000													
Community	Proactive Care	17	Market Stablisation	£3,943,218													
Community	Proactive Care	18	Staffing	£1,300,000										DTOC/NEA			
Community	Proactive Care	19	Quick Response Service/Reablement	£1,803,360										DTOC/NEA			
Community	Proactive Care	20	Mosaic & Information Systems	£1,000,000													
Community	Proactive Care	21	Adult Safeguarding	£490,000													
Community	Proactive Care	22	Enhanced Health (Care) in Care Home programme	£200,000										DTOC/NEA			
Community	Proactive Care	23	Carers - Everyone/Outreach/Breaks	£725,000													
Community	Proactive Care	24	Nursing Associates	£31,500										DTOC/NEA			
Community	Proactive Care	25	Programme Support Costs	£250,000													
Community	Proactive Care	26	To Be Allocated	£378,731													
Mental Health	Learning Disabilities	27	LD S(75) CCG & LCC Contribution	£59,276,496		Complete											
Mental Health	Learning Disabilities	28	Inflation & Demographic Growth	£4,410,523		Complete											
Mental Health	Learning Disabilities	29	LD S75 Historic Pooled Fund Investment	£6,642,450		Complete											
Mental Health	Learning Disabilities	30	Existing S(256) Adults	£646,000		Complete											
Mental Health	Learning Disabilities	31	IPC/Personal Health budget	£100,000													
Mental Health	Learning Disabilities	32	CCG CHC Pressures	£700,000		Complete											
Mental Health	Learning Disabilities	33	Waking Nights	£1,500,000		Complete											
Mental Health	Learning Disabilities	34	LPFT Mental Illness Prevention Fund	£375,000													
Mental Health	CAMHS	35	CAMHs S(75) CCG contribution	£7,009,163													
Mental Health	CAMHS	36	Existing S(256) Childrens	£521,000													
Community	LCHS	37	ICES original	£5,800,000													
Mental Health	LPFT	38	Mental Health S75 Agreement (LCC/LPFT)	£6,100,000													
Mental Health	LPFT	39	Mental Health (CCG/LPFT)	£70,722,567													
Community	LCHS	40	Transitional Beds S75 Agreement (LCC/LCHS)	£2,750,000													

Month of Review	Scheme No's	Area	Specifc Area
Oct-18	27	Specialist Adult Services	LD S(75) CCG Contribution
	28		Inflation & Demographic Growth
	29		LD S75 Historic Pooled Fund Investment
	30		Existing S(256) Adults
	32		CCG CHC Pressures
	33		Waking Nights
Nov-18	31	Specialist Adult Services	IPC/Personal Health budget
Dec-18	35	CAMHS	CAMHs S(75) CCG contribution
	36		Existing S(256) Childrens
Jan-19	21	Proactive Care	Adult Safeguarding
	23		Carers - Everyone/Outreach/Breaks
Feb-19	7	Proactive Care	Residential Market Rate Agreement
	17		Market Stablisation
	40		Transitional Beds S75 Agreement (LCC/LCHS)
Mar-19	8	Proactive Care	Co-Responders
Apr-19	4	Proactive Care	DFG Grant
	15		Housing for Independence
May-19	37	Aligned	ICES
Jun-19	1	Proactive Care (Light Touch)	Intermediate Care
	3		Neighbourhood Team
	5		Reablement (Allied)
	6		Community Integrated Reablement Service and Agency Staffing
	9		AF&LTC Inflation & NLW
	10		7 Day Working
	11		AF&LTC Historic Demographic Growth
	12		Trusted Assessors
	14		Neighbourhood Team Development
	18		Staffing
	19		Quick Response Service/Reablement
	22		Enhanced Health (Care) in Care Home programme
	24		Nursing Associates
Jul-19	34	Aligned	LPFT Mental Illness Prevention Fund
	38		Mental Health S75 Agreement (LCC/LPFT)
	39		Mental Health (CCG/LPFT)
Sep-19	13	Proactive Care	Dementia Family Friends

LD S75 VFM Presentation

Quality matters

Lincolnshire COUNTY COUNCIL

Working for a better future

Contents

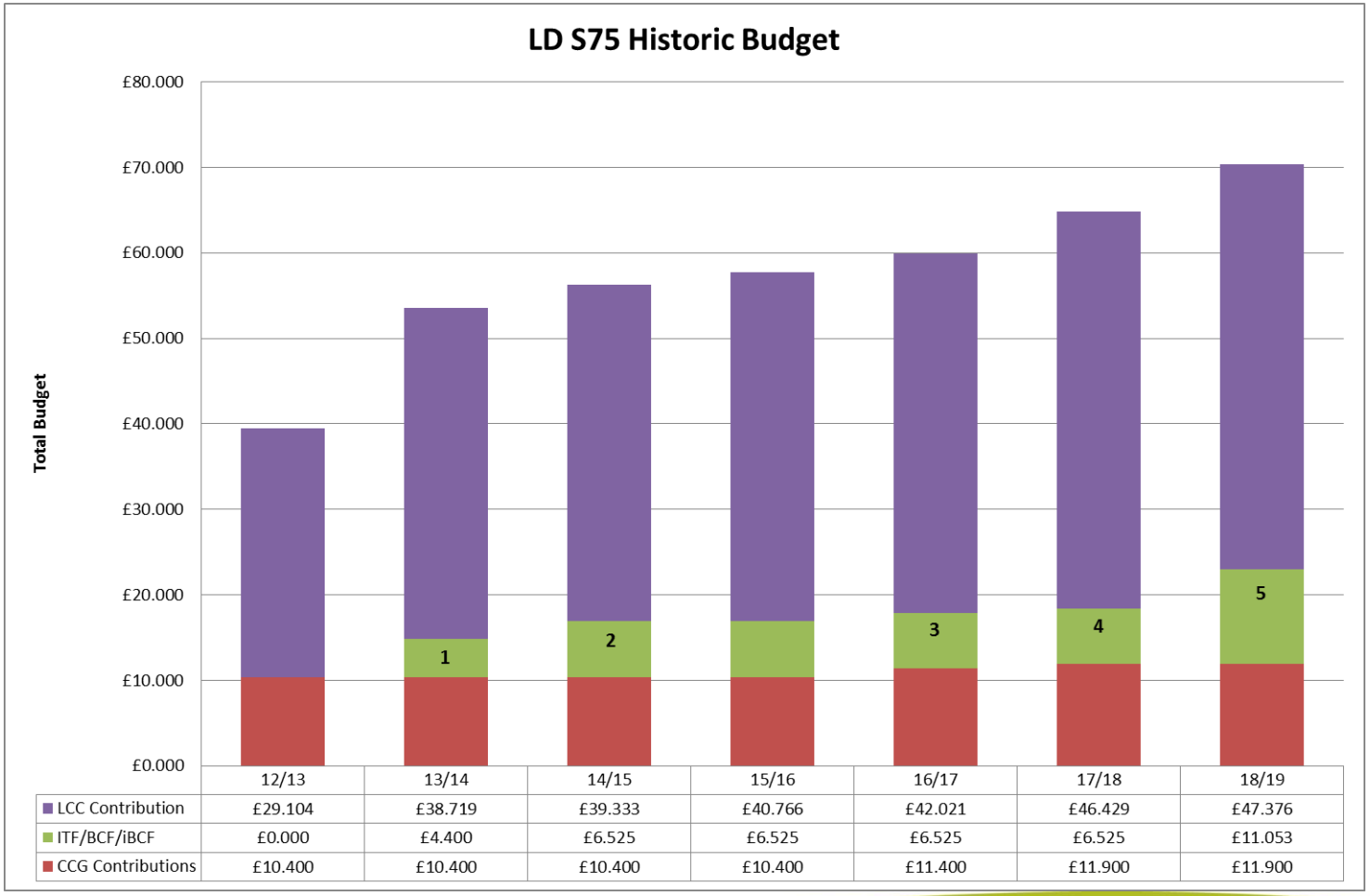
- Background & Budget History
- Current Analysis
- Benchmarking

Background & Budget History

Background

- Original Agreement in place since 31st March 2015
- Annual Change to Finance Schedule
- Agreement due to expire 31st March 2020
- Value of the agreement has risen by 22% since implementation
- Some changes to agreement
  - CHC cost split
  - Review of S117 cases and cost split
- Agreement is governed by Joint Delivery Board which meets monthly
- Represents 30% of the total value of Lincolnshire BCF

Background & Budget History



	12/13	13/14	14/15	15/16	16/17	17/18	18/19
LCC Contribution	£29.104	£38.719	£39.333	£40.766	£42.021	£46.429	£47.376
ITF/BCF/iBCF	£0.000	£4.400	£6.525	£6.525	£6.525	£6.525	£11.053
CCG Contributions	£10.400	£10.400	£10.400	£10.400	£11.400	£11.900	£11.900

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Background & Budget History

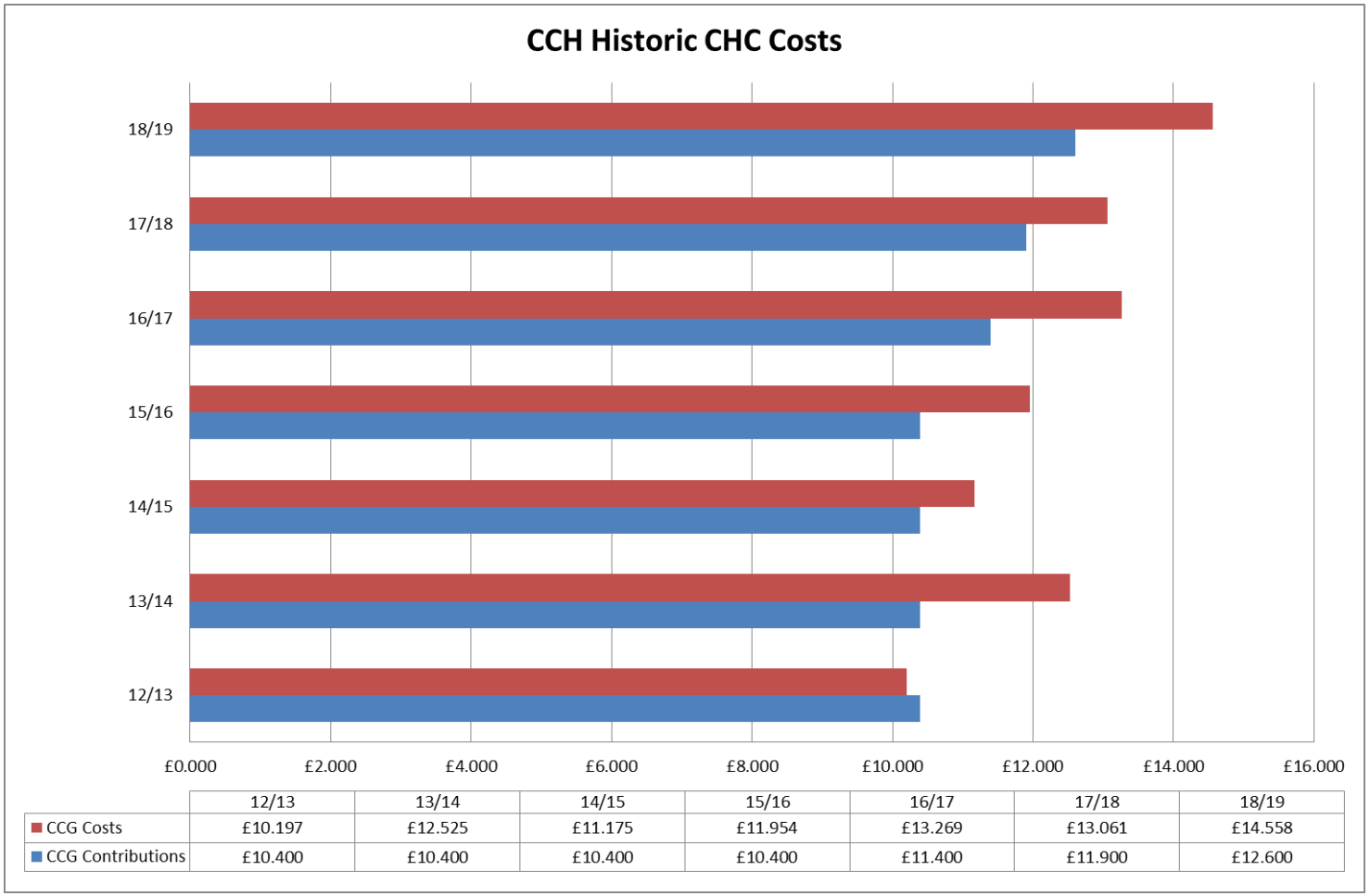
Budget History

- Funding originally split between LCC and CCG inputs
- BCF is now intrinsically linked within financial the financial structure of the agreement

1. Original ITF funding of £4.400m in 2013/14
2. Addition of BCF funding of £2.125m in 2014/15
3. Increase in CCG CHC contributions of £1.000m in 2016/17
4. Increase in CCG CHC contribution £0.500m in 2017/18 (via risk agreement)
5. Addition of iBCF funding of £4.411m in 2018/19 (plus inflation on the first two allocations)

- All BCF Funding (£11.053m) is allocated to the base budget
- Reporting is therefore based on the total fund, it is not possible to report against specific lines of funding except CHC & LCC spend
- LCC base Funding has increased by 16% (£6.610m)
- CCG base funding by 15%

Background & Budget History



	12/13	13/14	14/15	15/16	16/17	17/18	18/19
CCG Costs	£10.197	£12.525	£11.175	£11.954	£13.269	£13.061	£14.558
CCG Contributions	£10.400	£10.400	£10.400	£10.400	£11.400	£11.900	£12.600

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Background & Budget History

Budget History

- CHC costs have mostly outstripped CCG investment
- LCC has underwritten the shortfall, effectively operating ultra vires for a number of years
- New finance schedule removes this anomaly with agreement to fund any costs over and above £12.6m (includes additional £0.700m via iBCF)
- It is important therefore that CHC costs represent value for money for the additional investment.

Current Analysis

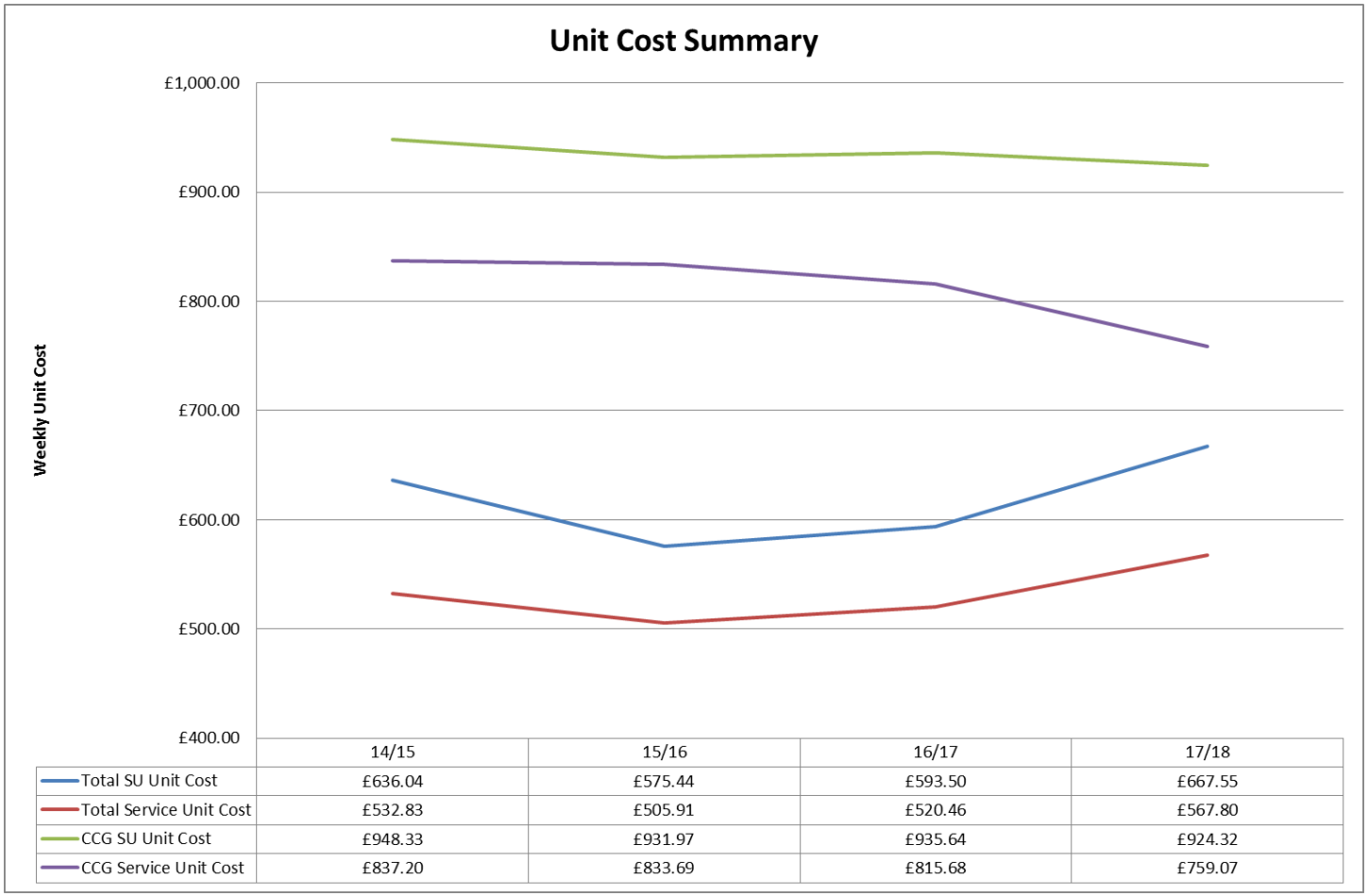
- Analysis presented last year has been revisited
- Apply the full year effect of 17/18 to get a four year assessment of costs
- Includes an analysis of 18/19 activity and costs to date
- 18/19 does not include future attrition, analysis is therefore a worse case scenario
- Data cleansing exercise to ensure all recharge lines have been removed and multiple packages of care and mid year changes in care packages does not skew the analysis
- Base data will be shared after this session

Current Analysis

- Overall LD S75 SU number has grown by 22% in 4 years to end of 2017/18
- Overall activity (packages of care) have grown by 27%
- Overall gross costs have increased 33%
- Overall average SU unit costs have only increased by 5% since 2014/15 and packages of care by 7%

- CHC activity increased by 20% overall
- CHC Packages of care have increased by 29%
- CHC gross costs have increased 17%
- However SU unit costs have fallen by 3% and package of care by 9%.

Current Analysis



	14/15	15/16	16/17	17/18
Total SU Unit Cost	£636.04	£575.44	£593.50	£667.55
Total Service Unit Cost	£532.83	£505.91	£520.46	£567.80
CCG SU Unit Cost	£948.33	£931.97	£935.64	£924.32
CCG Service Unit Cost	£837.20	£833.69	£815.68	£759.07

- This hides some interesting variation:-

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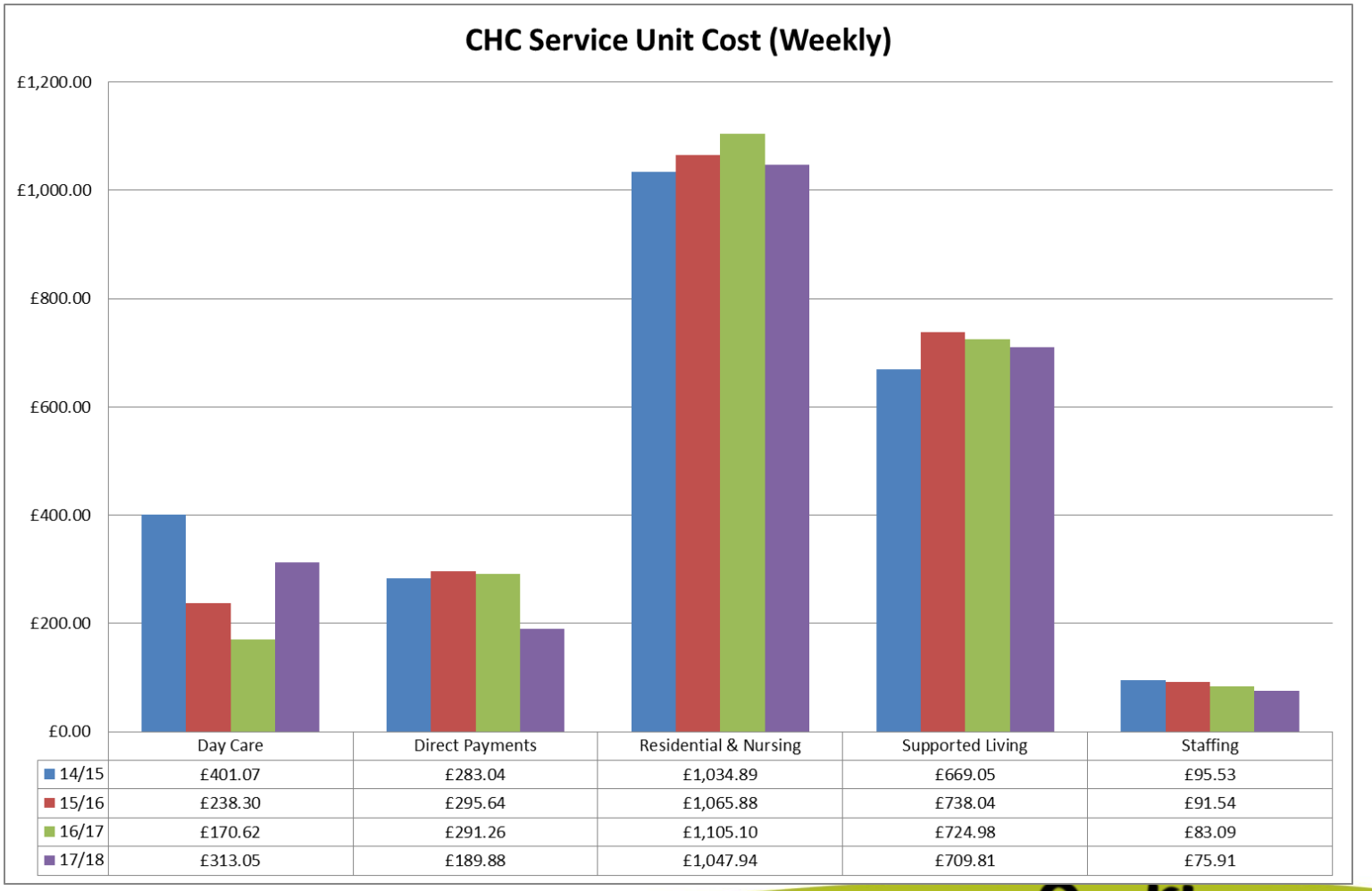
Current Analysis



	Day Care	Direct Payments	Residential & Nursing	Supported Living	Staffing
14/15	£401.07	£283.04	£1,034.89	£669.05	£95.53
15/16	£238.30	£295.64	£1,065.88	£738.04	£91.54
16/17	£170.62	£291.26	£1,105.10	£724.98	£83.09
17/18	£313.05	£189.88	£1,047.94	£709.81	£75.91

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Current Analysis

CHC Service Analysis

- 17/18 Unit cost reduces as a result of change in treatment of Joint Funded cases
- The impact of this is most marked with Direct Payments where the vast majority of CHC cases are joint funded
- Day care cost seem to fluctuate. A lot of these costs relate to package delivered in care home settings so those costs have been moved to residential in 18/19 along with the activity
- Residential and CSL unit prices have been less affected which suggests an underlying pressure in these areas.
- Staffing number have remained static therefore unit costs have reduced over time

Current Analysis

18/19 Activity

Despite these excellent results we cant afford to rest:-

- Significant increase in activity over the first six months of the year:-
  - 113 new packages of care in CSL and DP (6% of 17/18 total)
  - 58% were previously unknown to the service
- New packages are presenting with greater levels of complexity
- 93 packages have been increased on review
- Therefore packages are care are increasing

Current Analysis

Total projected weekly unit costs for 18/19:

- Residential & Nursing - £932 (17/18 = £833)
- Community Supported Living - £721 (17/18 = £663)
- Direct Payments - £267 (17/18 = £255)
- Day Care - £279 (17/18 £200)

CHC projected weekly unit costs for 18/19:

- Residential & Nursing - £1034 (17/18 = £1045)
- Community Supported Living - £750 (17/18 = £710)
- Direct Payments - £247 (17/18 = £190)
- Day Care - £422 (17/18 £313)

Again worst case scenario

Current Analysis

Even on in this basis:-

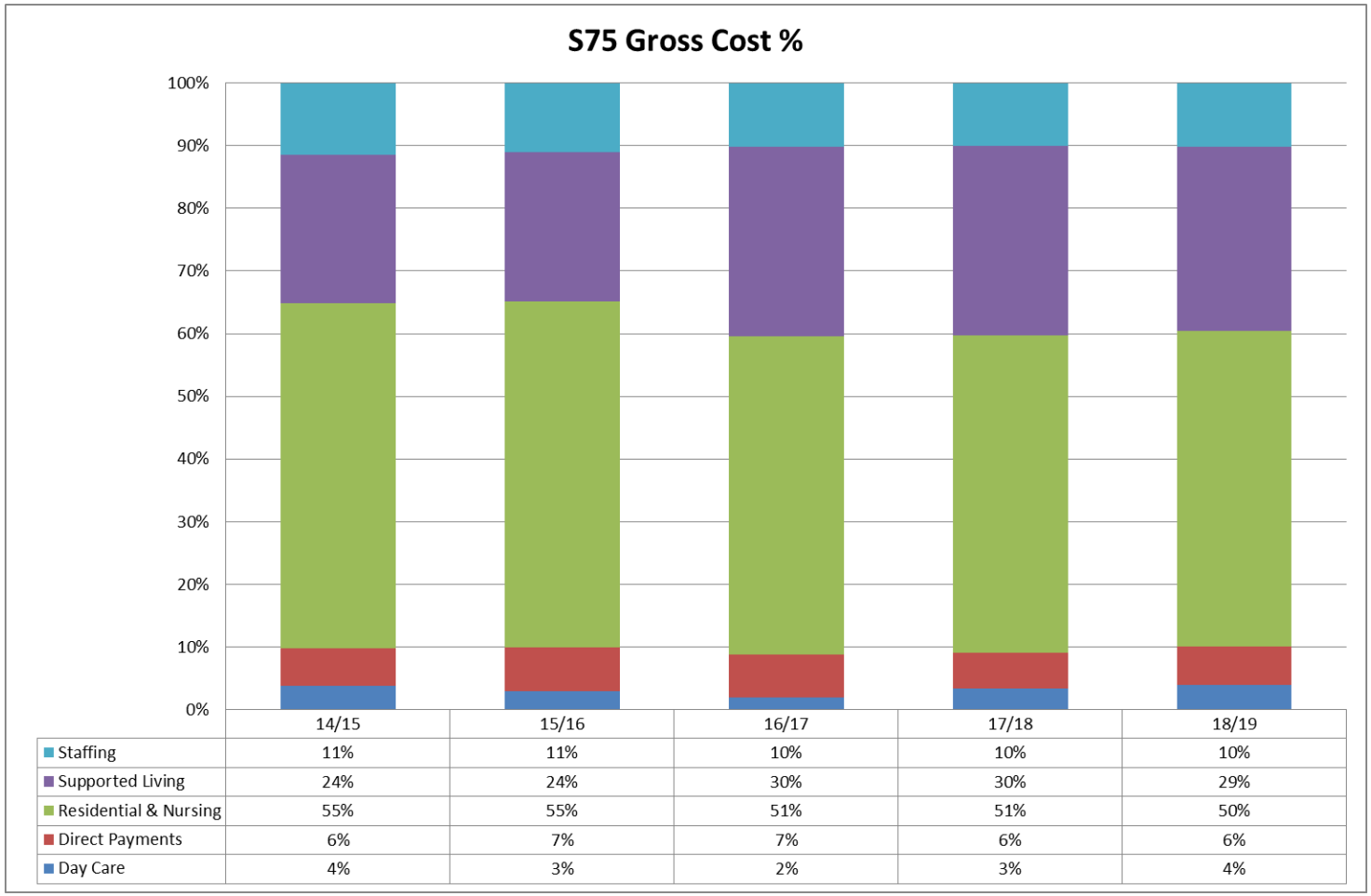
- Total unit cost increase over 5 years is 12%
- CHC unit cost increase over 5 years is -2%

- General inflation has increased by 9% over same period
- NMW/NLW has increased by 20.46%
- LCC LD Residential Rate staffing costs represent 60% of total cost on average

However we will still need to look at future trends

- CSL
- DP
- Day Care

Current Analysis



	14/15	15/16	16/17	17/18	18/19
Staffing	11%	11%	10%	10%	10%
Supported Living	24%	24%	30%	30%	29%
Residential & Nursing	55%	55%	51%	51%	50%
Direct Payments	6%	7%	7%	6%	6%
Day Care	4%	3%	2%	3%	4%

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Current Analysis

- Residential & Nursing cost represented 51% of totals costs in 2017/18, a reduction of 4% over four years.
- 18/19 Projection is 50%
- Anecdotal evidence suggests that LA's should spend no more than 40% of total cost on Residential & Nursing Care

- Focus on ensuring that SU are placed in the community rather than in residential units
- Direct Payments even better

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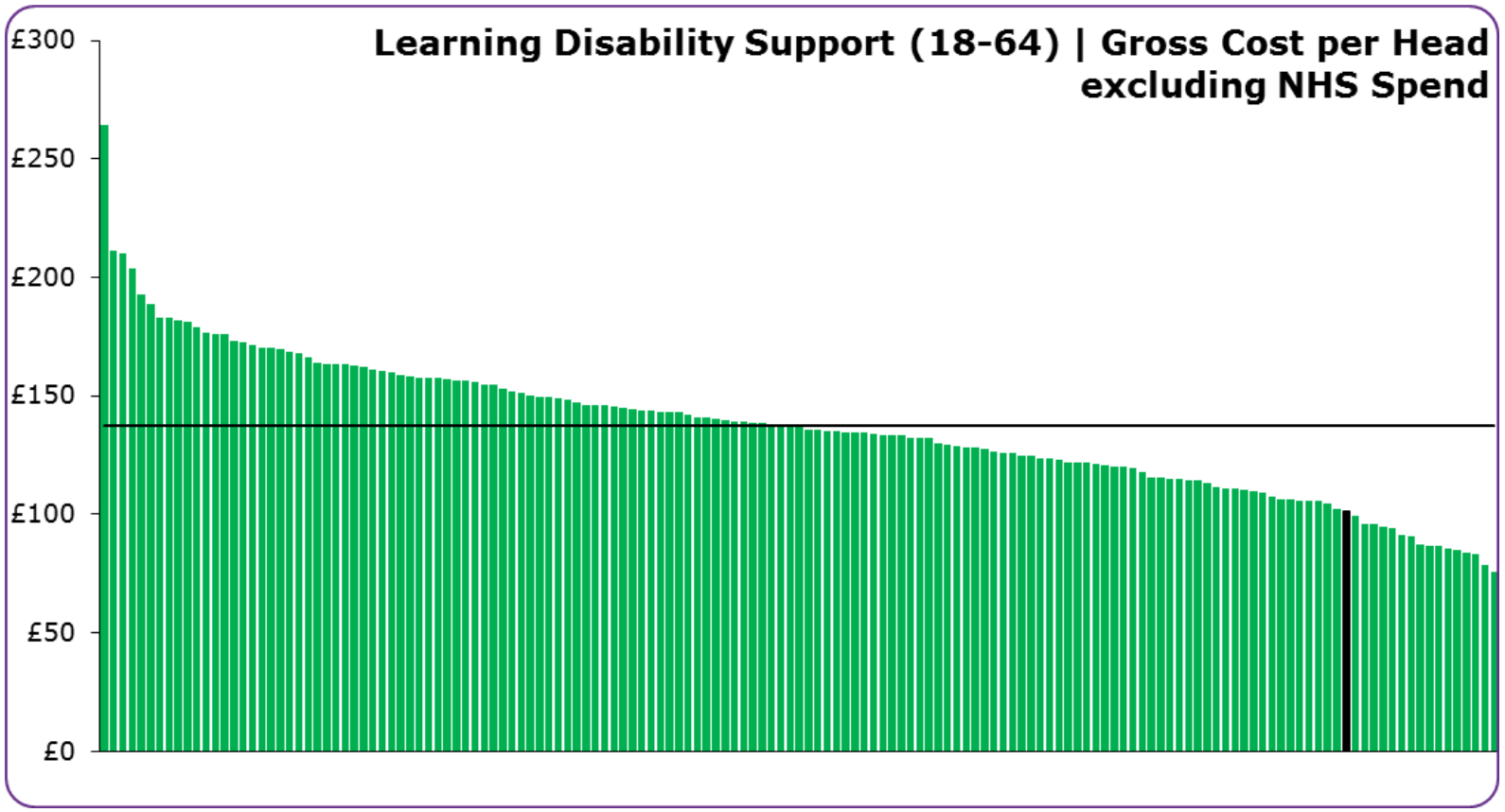
Benchmarking

- Lincolnshire LD costs have been consistently one of the lowest regionally and nationally
- Data is based in ASC-FR Statutory report from CIPFA Benchmarking club
- Data analysed by
  - All members
  - Nearest Statistical Neighbour
  - Counties

Benchmarking (All 151 Councils)



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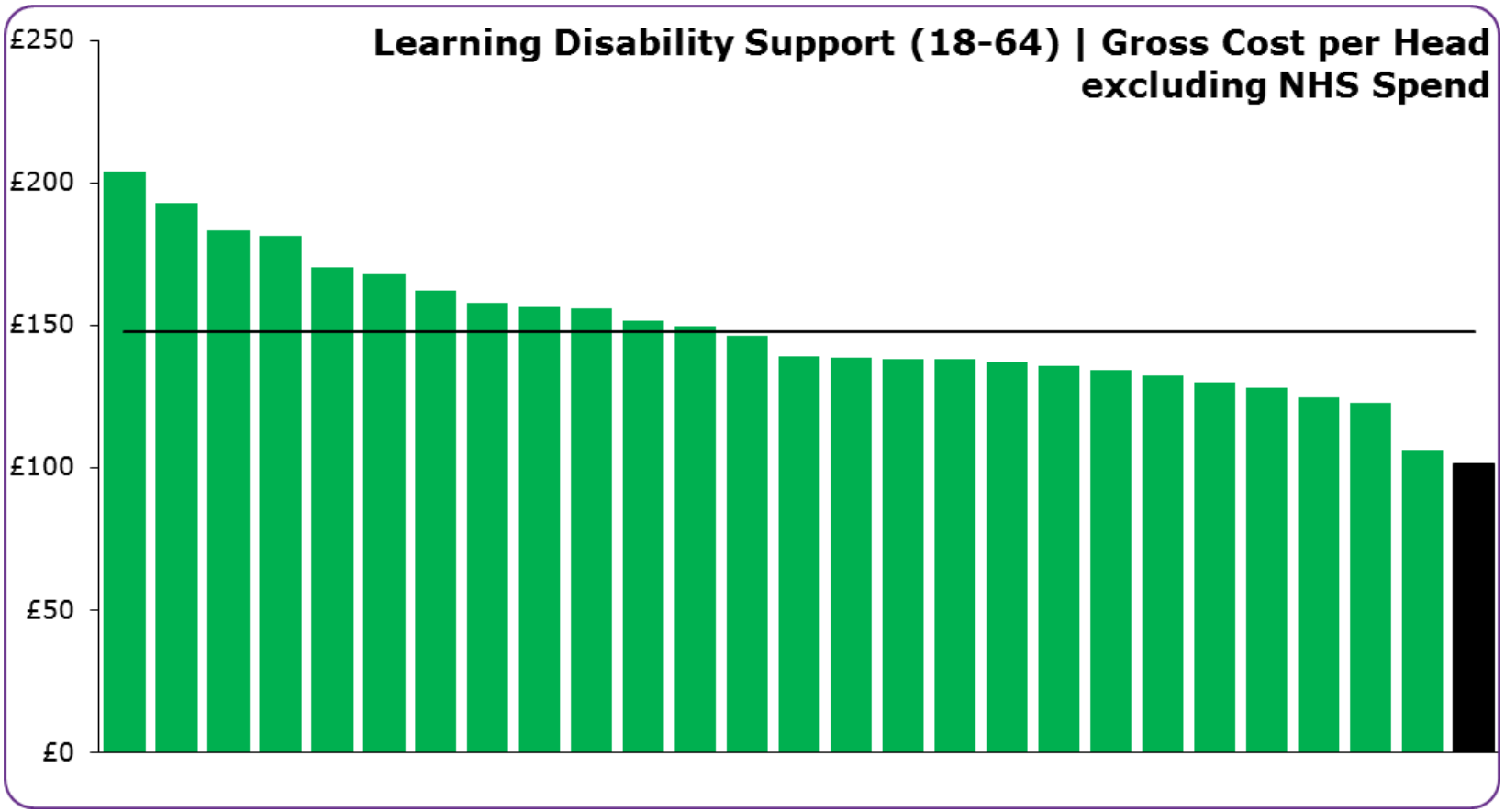
Benchmarking (By County)



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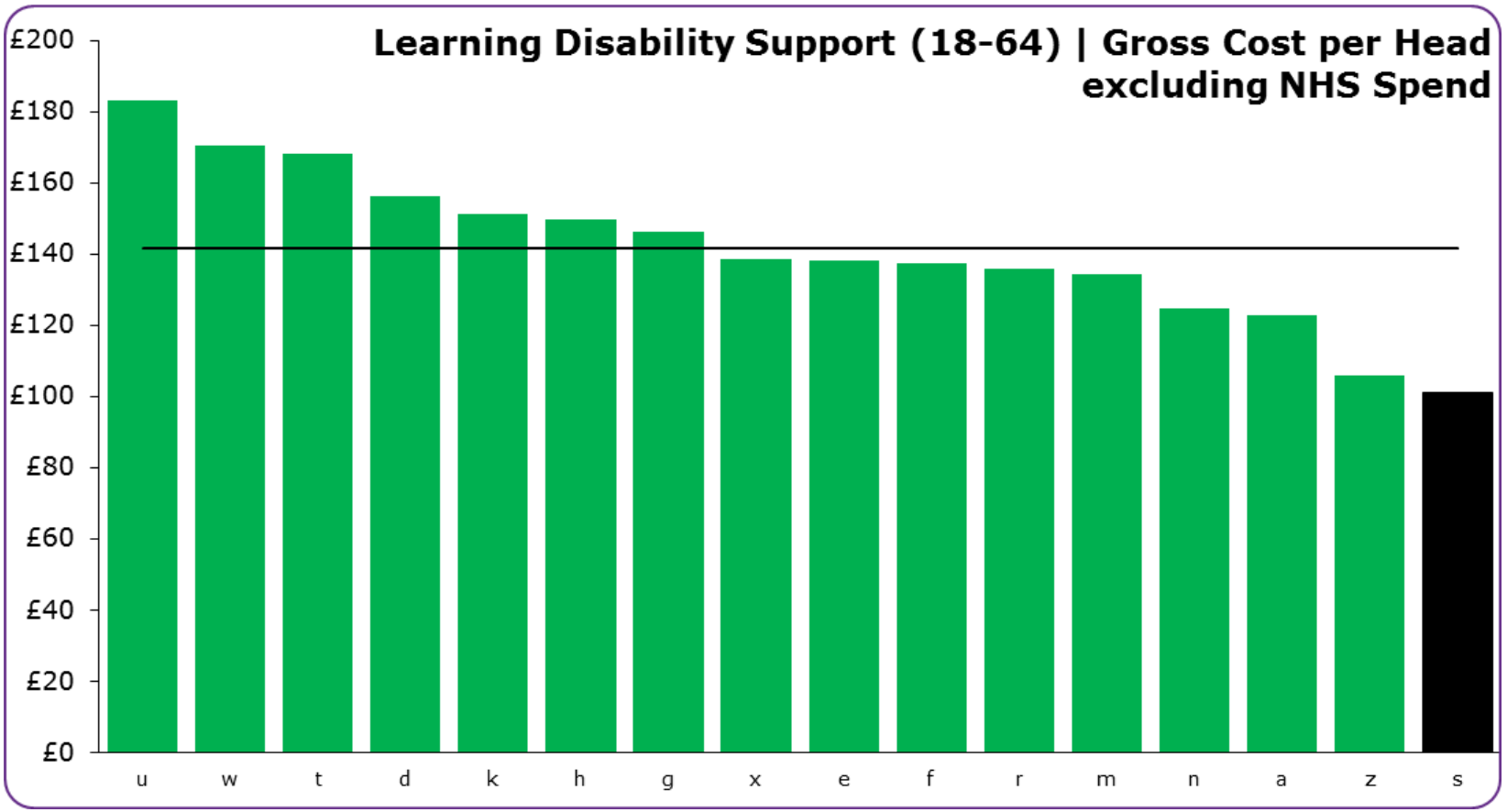
Benchmarking (By Statistical Neighbour)



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Comments?

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Better Care Fund - 2018/19

Performance Report

Quarter 2 Report

Produced November 2018

Performance Alerts	Summary BCF metrics
Performance is on or ahead of target	Achieved: 1
Performance is behind target, with no improvement	Not achieved: 2
Performance is behind target, with some improvement	Improving but not achieved: 0
Performance is not reported in this period	Not reported in period: 1
Total measures	4

Produced by Lincolnshire County Council, Adult Care Performance & Intelligence Team
ASC_Performance@lincolnshire.gov.uk

A detailed analysis of the national BCF measures is provided later in this report, showing baselines, trends, measure calculations, CCG breakdown and targets, with charts where appropriate. Guidance is also provided for each measure below the measure descriptor for ease of reference.

For 2018/19 each BCF measure has been assigned a suggested lead officer, which once agreed will be invited to provide an operational insight into performance of the indicator. The Targets presented within the report are provisional and subject to agreement.

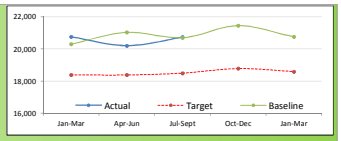
Polarity	Indicator Description	Responsibility / Suggested Lead Officer	Previous Years		2018/19 Current -September 18		
			2016/17	2017/18	Actual	Plan	Alert
Health and Wellbeing Better Care Fund Metrics							
Smaller is Better	1. Total non-elective admissions into hospital : General and Acute	NHS / Carol Cottingham	6,148 (average per month)	6,993 average per month)	20,738	18,491	Not achieved
Smaller is Better	2. Permanent admissions to residential and nursing care homes - aged 65+ **ASCOF 2A part 2**	LCC / Carolyn Nice	1,031	1,020	460	575	Achieved
Bigger is Better	3. % people (65+) at home 91 days after discharge from hospital into Reablement/rehabilitation **ASCOF 2B part 1**	NHS / LCC Tracy Perrett	75.4%	80.5%			Not reported in period
Smaller is Better	4. Delayed transfers of care: Delayed days from hospital, aged 18+ **Overall** **(proxy to ASCOF 2C part 1)**	NHS / LCC	2,987 (average per month)	2,267 (average per month)	6,848	5,483	Not achieved
	Of which attributable to ***NHS***	NHS Ruth Cumbers	2103 (average per month)	1,679 (average per month)	4,839	3,884	Not achieved
	Of which attributable to **Social care and Joint** **(proxy to ASCOF 2C part 2)**	LCC Tracy Perrett	884 (average per month)	587 (average per month)	2,009	1,628	Not achieved
IBCF Measures							
	5. Number of home care packages provided			4,581 (Mar 19)	3,589		
	6. Total number of paid hours of homecare for the whole of 18/19			1,456,768 (Mar 19)	714,479		
	7. Total number of care home placements in year			3,271 (Mar 19)	0		
Local Measures							
	8. Reablement - Hours delivered by Allied				60,089		
	9. Reablement - % reabled to no service				94%	95%	
	10. 7 Day Services - % discharged on a weekend			12..4% (Qtr 4)	11.9%		
	11. Hospital Discharges with Social Care Team Involvement			2,923 (Qtr 4)	2,715		
	12. Carers Supported by Carers Service and Adult Care (**Council Business Plan)**			1,631	1,678	1,730	Achieved

Health and Wellbeing Better Care Fund Metrics

1: Total non-elective admissions in to hospital (general and acute)

Definition: The total number of emergency admissions for people of all ages where an acute condition was the primary diagnosis, that would not usually require hospital admission.

Frequency / Reporting Basis: Monthly / Cumulative within quarter only
Source: MAR data (Monthly NHS England published hospital episode statistics)



Performance observations from the data:
A total of 20,738 admissions have been made so far within Q2, 2,247 more than target and an increase of 0.23% on the same period last year.

Operational observations:

To be provided by operational lead officer when agreed.

Prior Year

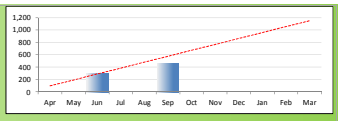
	2017/18 BCF (Calendar Year)											
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
In Month	7,246	6,943	6,843	7,110	6,722	6,858	7,375	7,104	6,967	7,361	6,411	6,978
In Quarter (cumulative)	7,246	14,189	21,032	7,110	13,832	20,690	7,375	14,479	21,446	7,361	13,772	20,750

Current Year

		2018/19 BCF (Calendar Year)											
		Quarter 1			Quarter 2			Quarter 3			Quarter 4		
		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
In Month		6,640	6,976	6,581	6,937	7,015	6,786						
In Quarter		6,640	13,616	20,197	6,937	13,952	20,738						
HWB NEA Plan - Target		6,125	12,250	18,375	6,164	12,327	18,491						
Actual reduction (negative indicates an increase)	number	-515	-1,366	-1,822	-773	-1,625	-2,247						
	%	-7.75%	-10.03%	-9.02%	-11.15%	-11.64%	-10.83%						
Performance		Not achieved	Not achieved	Not achieved	Not achieved	Not achieved	Not achieved						

2: Admissions to residential / nursing care homes - aged 65+ per 100,000 population (ASCOF 2A part ii)

Definition: The total number of admissions to permanent residential or nursing care during the year
(excluding transfers between homes unless the type of care has changed from temporary to permanent)
Frequency / Reporting Basis: Monthly / Cumulative YTD
Source: Mosaic data: Local Adult Care Monitoring (LTC admissions report & SALT return).
Note: Figure reported cumulatively, so monthly figures show increases in placements recorded & not necessarily within that month



Performance observations from the data:
The number of new admissions to care homes has increased to 460, and is exceeding target by 115. Compared to this time last year admissions are down 24.7%.

Operational comments:
The low number of admissions may be due to delays in processing financial assessments and this will be better understood by quarter 2.

Prior Year

	2017/18 BCF (Financial Year)											
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
In month	94	114	84	89	111	119	92	88	69	73	51	36
Cumulative YTD	94	208	292	381	492	611	703	791	860	933	984	1,020

Current Year

	2018/19 BCF (Financial Year)											
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Placements per month												
Cumulative YTD			296			460						
Denominator			172,133			172,133						
Rate per 100,000			172.0			267.2						
Target (admissions)			**288**			**575**						
Target (per 100k)			167			334						
Performance			Achieved			Achieved						

3: % people (65+) at home 91 days after discharge from hospital into Reablement/rehabilitation (ASCOF 2B part 1)

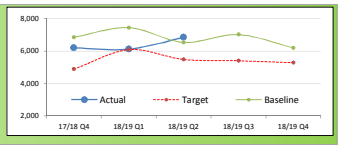
Definition: The percentage of older people (within a 3 month sample period) discharged from an acute or non-acute hospital to their own home/residential or nursing care home/ extra care housing for rehabilitation, where the person is at home 91 days after their date of discharge from hospital.
Frequency / Reporting Basis: Yearly / Cumulative for sample period
Source: Reablement - external service provider - Allied Healthcare, rehabilitation - LCHS

Observations from the data:

18/19 data is not available until Q4. Data for 17/18 shows 80.5% of hospital discharges into reablement were still at home 91 days after discharge, against a target of 80%. This in an improvement on 16/17 where the outturn was 75.4%. in 17/18 there was also an increase in number of episodes of reablement following hospital discharge (719) compared to 16/17 (668).

	2017/18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Numerator	579												
Denominator	719												
Value	80.5%												
Target	**80.0%**												
Performance	Achieved												

4: Delayed transfers of care (delayed days) from hospital for adults aged 18+, per 100,000 population



Definition: The number of delayed transfers of care (days) for adults who were ready for discharge from acute and non-acute beds, expressed as the rate per 100,000 of the adult population of Lincolnshire.
Frequency / Reporting Basis: Monthly / Cumulatively within the quarter
Source: NHSE Published Delayed Days Report (Sitrep)

Table note: In the analysis by delay reason below, the organisation that the delay reason is attributable to in included in parentheses i.e. NHS, SSD, NHS or SSD, BOTH.

Performance observations from the data:
The Q2 total of 6,848 delayed days, exceeded the target of 5,483 by a 24.9% difference. The number of delays is higher (309 days) compared to the same period in 17/18. The social care delays has increased by 8.8% between Q1 and Q2 (70 days) also NHS delays has risen by 16.8% between Q1 and Q2 (699 days) while proportion of joint delays has decreased by 3.2% between Q1 and Q2. The overall proportion of all delays 13% are down to social care, 69% are NHS with the remaining 18% being joint delays.

Prior Year

	2017/18 BCF (Financial Year)											
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Numerator	2,391	5,095	7,446	1,958	4,226	6,539	2,263	4,533	7,015	2,056	3,802	6,198
Denominator	602,877	602,877	602,877	602,877	602,877	602,877	602,877	602,877	602,877	606,565	606,565	606,565
Actual	**396.6**	**845.1**	**1,235.1**	**324.8**	**701.0**	**1,084.6**	**375.4**	**751.9**	**1,163.6**	**339.0**	**627**	**1,022**

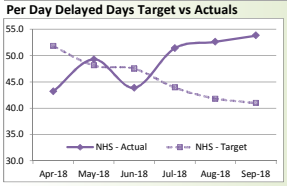
Current Year

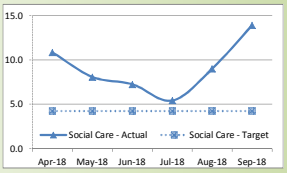
		2018/19 BCF (Financial Year)											
	Qtr 4 1718	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Average Per Day	74.5	67.9	68.9	64.7	70.1	75.2	78						
In month	2396	2,039	2,136	1,942	2,174	2,334	2,340						
In Quarter (cumulative)	6198	2,039	4,175	6,117	2,174	4,508	6,848						
Denominator	606565	602,877	602,877	602,877	602,877	602,877	602,877						
Rate per 100,000 population	1022	338.2	692.5	1,014.6	360.6	747.7	1,135.9						
Target (days) -based on revised HWB plan	**4,883**	**2,096**	**4,125**	**6,087**	**1,895**	**3,723**	**5,483**						
Target (per 100k)	805.0	347.6	684.2	1,009.6	314.3	617.5	909.5						
Performance		Achieved	Not achieved	Not achieved	Not achieved	Not achieved	Not achieved						

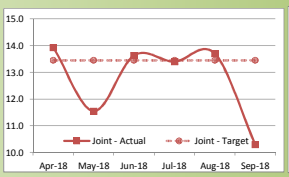
by Type of Care

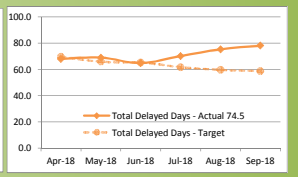
	2017/18 Q4	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Acute	5,423	1,816	3,788	5,537	1,913	3,976	1,999						
Non Acute	775	223	387	580	261	532	341						
Total	**6,198**	**2,039**	**4,175**	**6,117**	**2,174**	**4,508**	**2,340**						
	2017/18 Q4	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**
Acute	87%	89%	91%	91%	88%	88%	85%						
Non Acute	13%	11%	9%	9%	12%	12%	15%						

Per Day Delayed Days Target vs Actuals









	1718	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
NHS - Actual	55.2	43.2	49.3	43.9	51.4	52.6	53.8						
NHS - Target		51.8	48.1	47.5	44	42	**41**	41	41	41	41	41	41
Social Care - Actual	7.1	10.8	8.1	7.2	5.4	9	13.9	0	0	0	0	0	0
Social Care - Target		4.2	4.2	4.2	4	4	4	4	4	4	4	4	4
Joint - Actual	12.2	13.9	11.5	13.6	13.4	13.7	10.3						
Joint - Target		13.5	13.5	13.5	13	13	13	13	13	13	13	13	13
Total Delayed Days - Actual	74.5	68.0	68.9	64.7	70.1	75.3	**78**						
Total Delayed Days - Target		69.5	65.8	65.2	62	59	59	59	59	59	59	59	59

by Responsible Organisation

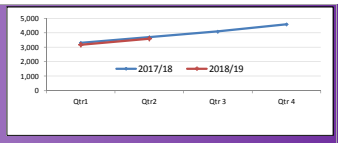
	2017/18 Q4	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
NHS	4,437	1,296	2,824	4,140	1,593	3,225	4,839						
Target (days)	**3,020**	1,555	3,045	4,470	1,360	2,654	3,884						
Target (per 100k)	497.9	257.9	505.0	741.4	225.5	440.3	644.3						
Performance		Achieved	Achieved	Achieved	Not achieved	Not achieved	Not achieved						
Social Care (SSD)	548	325	575	792	166	444	862						
Target (days)	1,403	127	259	386	131	263	390						
Target (per 100k)	231	21.1	42.9	64.0	21.8	43.6	64.7						
Performance		Not achieved	Not achieved	Not achieved	Not achieved	Not achieved	Not achieved						
Joint	1,213	418	776	1,185	415	839	1,147						
Target (days)	460	404	821	1,225	417	834	1,238						
Target (per 100k)	76	67.0	136.2	203.1	69.2	138.4	205.3						
Performance		Not achieved	Achieved	Achieved	Achieved	Achieved (within 5% tolerance)	Achieved						
Total	**6,198**	**2,039**	**4,175**	**6,117**	**2,174**	**4,508**	**6,848**	-	-	-	-	-	-
	2017/18 Q4	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**
NHS	72%	64%	68%	68%	73%	72%	71%						
Social Care (SSD)	9%	16%	14%	13%	8%	10%	13%						
Both	20%	21%	19%	19%	19%	19%	17%						

iBCF Measures

5: Number of Home Care packages provided for the whole of 18/19

Definition: Cumulative YTD number of all clients who have received a permanent home care package during the year

Frequency / Reporting Basis: Monthly / Cumulative within quarter only
Source: Brokerage weekly service returns



Observations from the data: In 1718 the number of clients that received home care in Q1 was 3308 and by the Q4 it had increased to 4581 If 1819 follows a similar sort of trend than the estimated Q4 figure will be 4402. The figures represented below may be slightly down due to some data being missing at present.

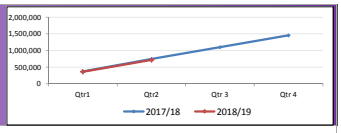
Prior Year		2017/18 (Financial Year)											
		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Clients in receipt of homecare (YTD)				3,308			3,703			4,090			4,581

Current Year		2018/19 (Financial Year)											
		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Clients in receipt of homecare (YTD)				3,179			3,589						

6: Total number of paid hours of Home Care for the whole of 18/19

Definition: Cumulative YTD number of all paid hours of homecare delivered

Frequency / Reporting Basis: Monthly / Cumulative within quarter only
Source: Brokerage weekly service returns



Observations from the data:
In 1718 the number of paid hours home care delivered in Q1 365,067 and by Q4 the hours delivered over the full year had increased to 1,456,769 .

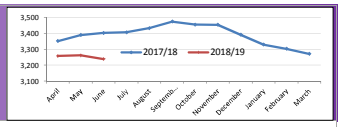
Prior Year		2017/18 (Financial Year)											
		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Hours Delivered				365,067			740,314			1,100,642			1,456,769

Current Year		2018/19 (Financial Year)											
		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Hours Delivered				357,266			714,479						

7: Total number of care home placements in year

Definition: Number of clients that are in a care home setting (Residential or Nursing) at the end of each month.

Frequency / Reporting Basis: Monthly
Source: BO Report - Long Term Care (Summary)



Observations from the data:
Long stay care clients have slowly been declining since Oct-17, and comparing Jul-18 with this time last year there has been a 6.1% decrease in number of LTC clients.

Prior Year		2017/18 (Financial Year)											
		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Care Home Placements (YTD)		3,351	3,389	3,402	3,406	3,433	3,474	3,455	3,454	3,391	3,329	3,303	3,271

Current Year		2018/19 (Financial Year)											
		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Care Home Placements (YTD)		3258	3,261	3,238									

Local Schemes

8. Reablement

Number of Hours Delivered by Allied (Cumulative)
Definition: Number of Hours Delivered by Allied (face to face contact time)

Frequency / Reporting Basis: Quarterly
Source: Allied KPI's

Observations from the data:
Allied on average delivers 10,463 hours per month of face to face contact time, if this stays the average for the rest of the months by March 19 the approx. hours delivered will be 125,556.
In Q1 Allied averaged 10,463 hours per month however in Q2 this as dropped to 10,094 a 3.5% decrease.

Current Year		2018/19 (Financial Year)											
	Mar-18 YTD	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Cumulative Hours	128,272	10,730	21,228	31,389	40,366	50,375	60,089						
Hours Delivered		10,730	10,498	10,161	10,558	10,009	9,714						

9. Reablement

% of people reabled to no service (or a lower service)

Observations from the data:
The target for this new measure has been achieved in Q2. Allied continue to work closely with Adult Care and health colleagues to facilitate timely discharge from hospital across the area. The target achieved demonstrates the skills of the team to reable service users to the full potential.

Current Year		2018/19 (Financial Year)											
	2017/18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
	Q4			Q1 1819			Q2 1819			Q3 1819			Q4 1819
Numerator				637			1,142						
Denominator				648			1,211						
Actual				98.3%			94.3%						
Target				95%			95%						
Performance				Achieved			Achieved						

10. 7 Day Services

% of hospital discharges which occur on a weekend
Definition: Clients discharged from a hospital on a weekend

Frequency / Reporting Basis: Quarterly
Source: BO Report: Hospital Discharges

Observations from the data:
Hospital discharges on the weekend has decreased by 1.0%

Current Year		2018/19 (Financial Year)											
	2017/18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
	Q4			Q1 1819			Q2 1819			Q3 1819			Q4 1819
Numerator	362			355			324						
Denominator	2,923			2,741			2,715						
Actual	12..4%			12.9%			11.9%						
Target													
Performance													

11. Hospital Discharges With Social Care Team Involvement

Number of discharges
Definition: Discharged clients where social care teams help facilitate the discharge

Frequency / Reporting Basis: Quarterly
Source: BO Report: Hospital Discharges

Observations from the data:
The number of discharges with social team involvement in Q1 was 2,741 with 90.2% being in the age range of 65+. In Q2 that number went down to 2,715 but overall the percentage of 65+ went up to 90.9%.

Current Year		2018/19 (Financial Year)											
	2017/18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Age at Contact	Q4			Q1 1819			Q2 1819			Q3 1819			Q4 1819
18-64	217			259			238						
65+	2,696			2,473			2,467						
Unknown	10			9			10						
Total Number	**2,923**			**2,741**			**2,715**						
% of 65+	92.2%			90.2%			90.9%						
Target													
Performance													

12. Carers Supported by Carers Service and Adult Care

Definition: Rolling 12 month period (Qtr 1: June 1718 -1819)

Frequency / Reporting Basis: Quarterly
Source: Council Business Plan

Observations from the data:
In the 12 month period up to 30 September 2018 over ten thousand (10,238) carers of adults have been supported by the Carers Service and Adult Care. This is an increase of 232 carers compared to the Quarter 1 figure. This figure does not include any data from Children's Services and as such does not include parent carers or young carers.
1,028 (10.3%) carers have received a Personal Budget as a Direct Payment.
655 (6.5%) cared-for adults have been provided with short term respite services to allow their carer to take a break.
8555 (85.5%) carers have received information and advice, including those supported by Carers FIRST's universal offer.
Note - the target for this financial year has been increased to 1730 carers supported per 100,000 over 18 population. This equates to a target of approximately 500 additional carers supported by the end of the year.
The denominator for this target has increased to 6.1. This is based on the latest over 18 population estimate for 2018 (606,565 - source: Office of National Statistics). The 6.1 relates to 'one hundred thousands

	2017/18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
	Q4			Q1 1819			Q2 1819			Q3 1819			Q4 1819
Numerator	9,689			10,006			10,238						
Denominator	5.94			6.1			6.1						
Actual	**1,631**			**1,640**			**1,678**						
Target	1,440			1,730			1,730						

13. Making every contact count

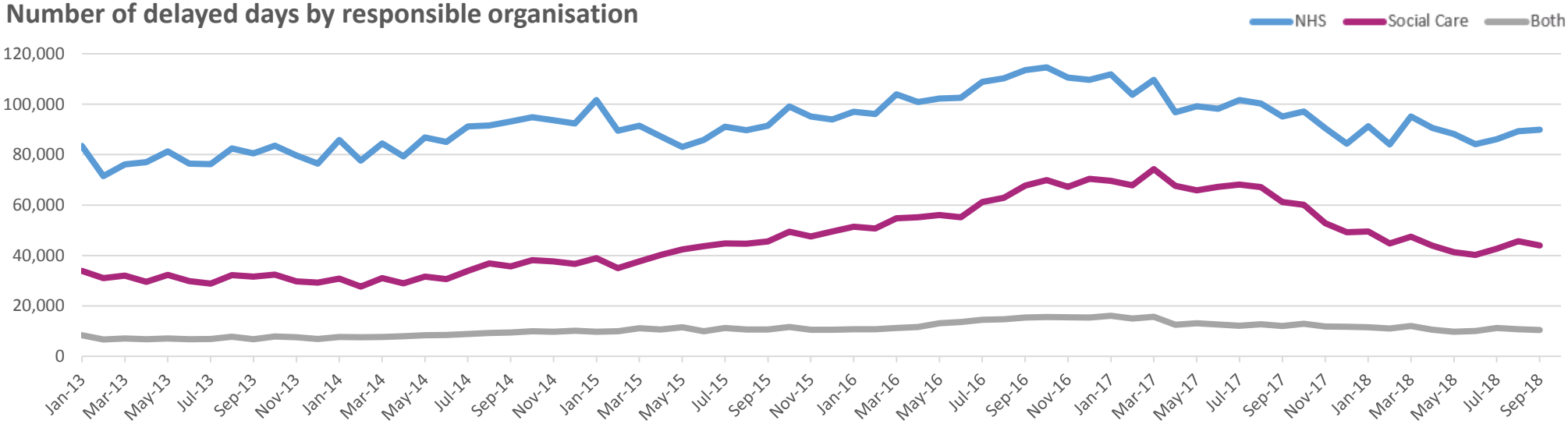
Narrative:
Quarter 1 figure is low as time has been spent on reviewing the service and planning an evaluation strategy, which has had an impact on capacity to deliver MECC training sessions. As with 2017 – 18, when quarter 1 and 2 figures were low, it is expected that performance will catch up over quarters 3 and 4 and still predicting to meet annual target of 1000.

Current Year		2018/19 (Financial Year)											
		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Numbers Trained (YTD)				187			350						

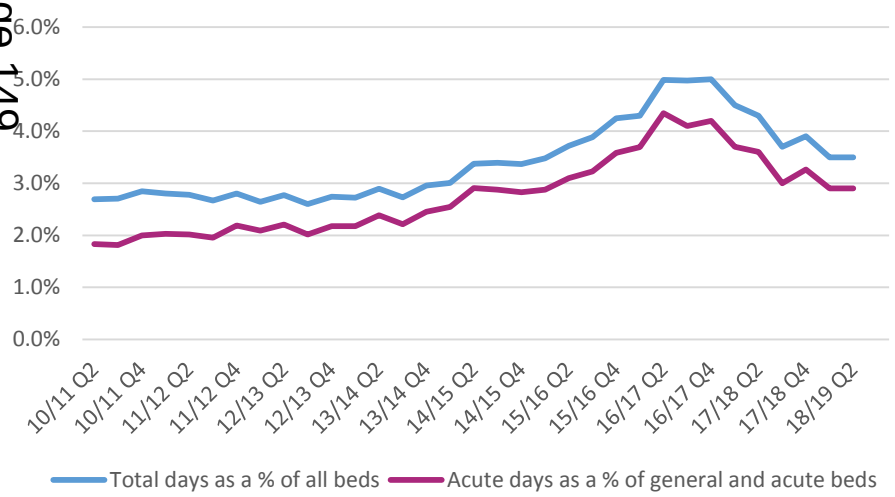
Areas for development
Measures that are in development for future returns. Data will be collected for these measures and commentary provided once processes have been established to collect the data.

Area	Suggested measure
Supporting Carers	Increased awareness of carers with employers
Mental Health Care Network	Increased number of managed schemes in operation
Mental Health Care Network	Increased number of proposed beneficiaries
Trusted Assessors	
Early Intervention vehicle	

Number of delayed days by responsible organisation

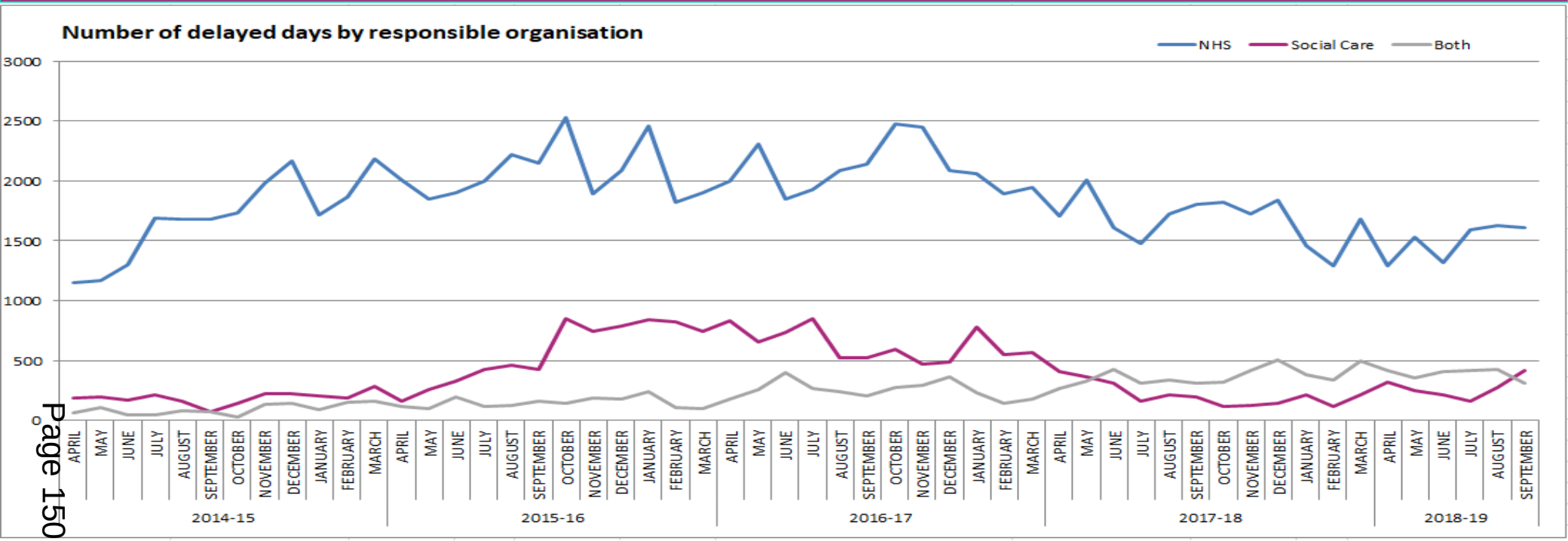


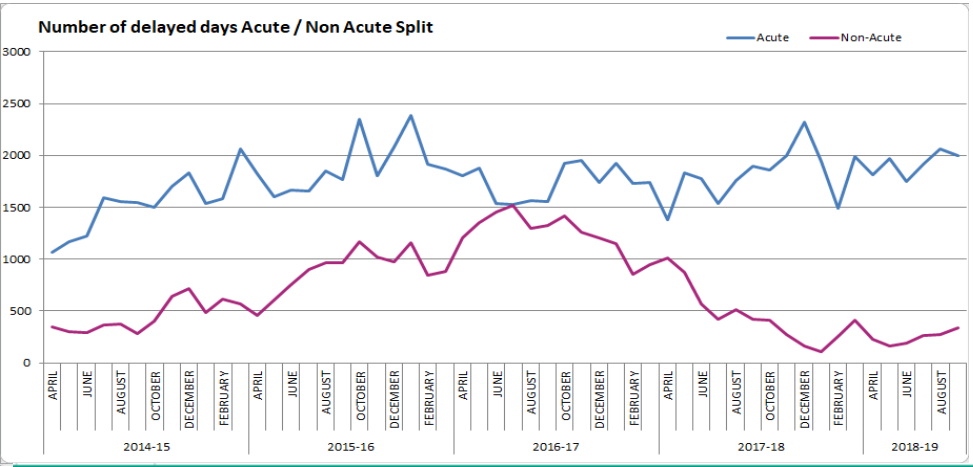
Number of delayed days as % of available beds



		Sept 18	Sept 17	Change
Total	Number of delayed days, of which	144,267	168,041	-14.1%
	…attributable to NHS	89,873	95,348	-5.7%
	…attributable to social care	43,960	60,396	-27.2%
	… attributable to both sectors	10,434	12,297	-15.2%
		Sept 18	Sept 17	Change
	Number of DTOC beds, of which	4,809	5,601	-14.1%
	…attributable to NHS	2,996	3,178	-5.7%
	…attributable to social care	1,465	2,013	-27.2%
	…attributable to both sectors	348	410	-15.1%

62.3%	of all delayed days were attributed to the NHS (Sept-18)	**24.7%**	of these were due to patients awaiting further non-acute NHS care
30.5%	of all delayed days were attributed to social care (Sept-18)	**35.3%**	of these were due to patients awaiting care package in their own home



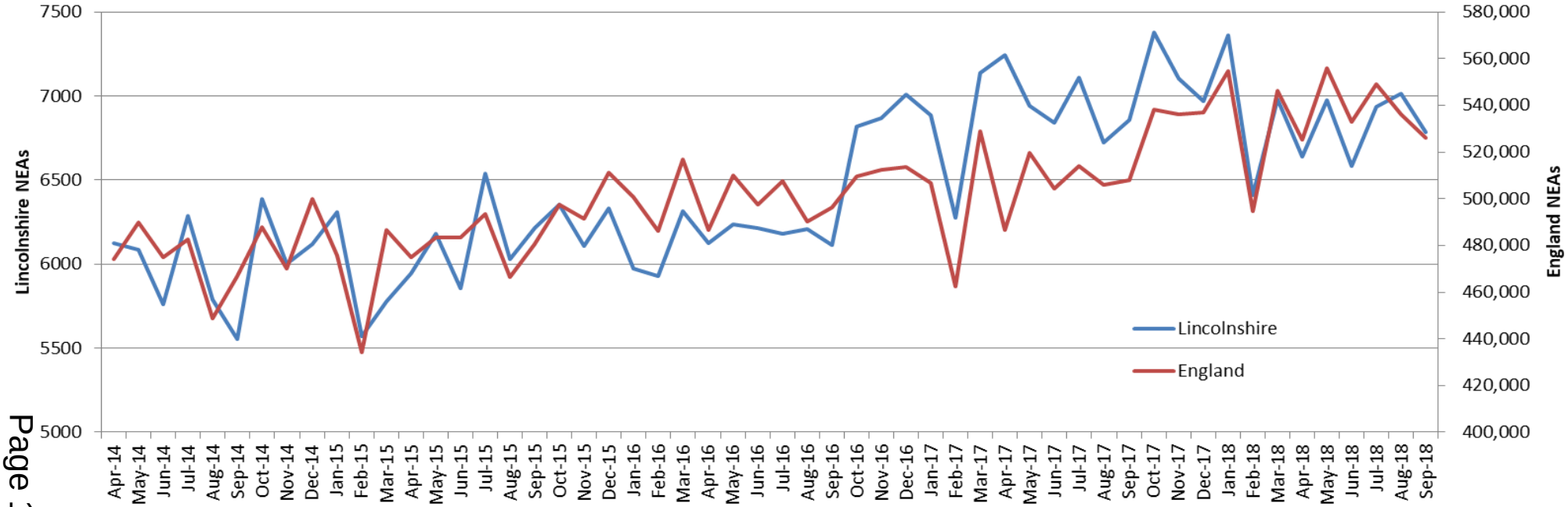


		Sep-18	Sep-17	Change	*Quartile
Total	Number of delayed days, of which	2,340	2,313	1.2%	3rd
	...attributable to NHS	1,614	1,804	-10.5%	4th
	...attributable to social care	418	201	108.0%	2nd
	... attributable to both sectors	308	308	0.0%	4th
		Sep-18	Sep-17	Change	
	Number of DTOC beds, of which	78	77	1.2%	
	...attributable to NHS	54	60	-10.5%	
	...attributable to social care	14	7	108.0%	
	...attributable to both sectors	10	10	0.0%	

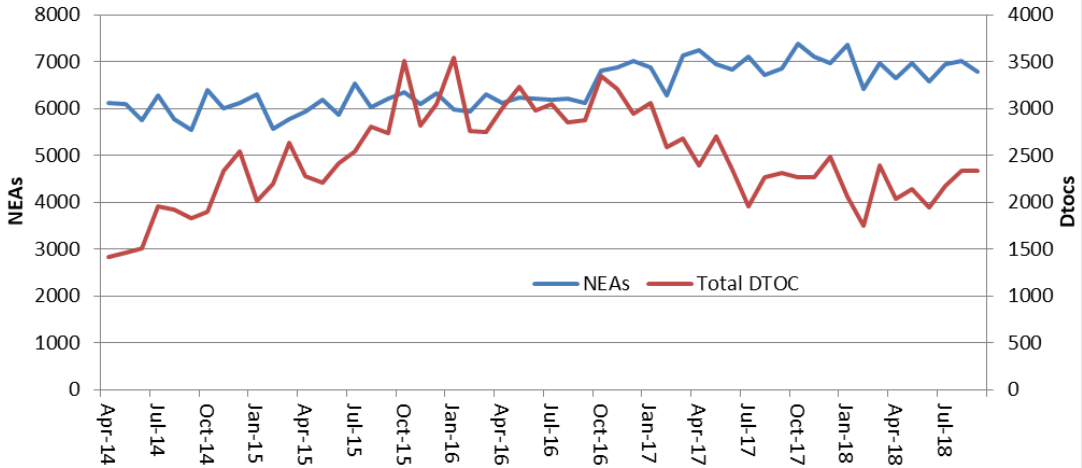
***Based on delayed days per 100k population for English County Local Authorities**

69.0%	of all delayed days were attributed to the NHS (Sep-18)	**32.8%**	of these were due to **awaiting further non acute NHS care**
17.9%	of all delayed days were attributed to social care (Sep-18)	**67.9%**	of these were due to **awaiting care package in their own home**

Lincolnshire NEAs Compared to England NEAs



Total Lincolnshire Delayed Days and Non Elective Admissions



NEAs	Sept-18	Sept-17	Change
Lincolnshire	6,786	6,858	-1.0%
England	535,995	505,781	3.6%

Lincolnshire	Sept-18	Sept-17	Change
Total DTOC	2,340	2,313	1.2%
Total NEAs	6,786	6,858	-1.0%

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Health and Wellbeing Board – Decisions from 5 June 2018

Meeting Date	Minute No	Agenda Item & Decision made
5 June 2018	**1**	**Election of Chairman** That Councillor Mrs S Woolley be elected as the Chairman of the Lincolnshire Health and Wellbeing Board for 2018/19
	2	**Election of Vice-Chairman** That Dr Sunil Hindocha be elected as the Vice-Chairman of the Lincolnshire Health and Wellbeing Board for 2018/19
	5	**Minutes** That the minutes of the Lincolnshire Health and Wellbeing Board meeting held on 27 March 2018, be confirmed by the Chairman as a correct record.
	6	**Action Updates from the previous meeting** That the completed actions as detailed be noted.
	8a	**Terms of Reference, Procedural Rules, Roles and responsibilities of Core Board Members** That the Terms of Reference. Procedure Rules and Board Members Roles and Responsibilities be re-affirmed subject to the inclusion of the Office of the Police and Crime Commissioner and Chairman and the Chairman of the Lincolnshire Co-ordination Board of the STP.
	8b	**Joint Health and wellbeing Strategy for Lincolnshire 2018** That the publication of the Joint Health and Wellbeing Strategy document be agreed; That the basis for progressing the delivery of the Joint Health and Wellbeing Strategy for Lincolnshire by way of Delivery plans be agreed; That the adoption of the proposed Governance and Accountability Framework by the Lincolnshire Health and Wellbeing Board be agreed; and That the feedback from the most recent online engagement be noted.
	9a	**Health and care Workforce – Recruitment and Retention** That the report and presentation be noted.
	9b	**Winter Review and Planning** That the report and contents be considered and noted.
	10a	**Better Care Fund** That the report for information be received.
	10b	**Health and Wellbeing Grant Fund –Update** That the report for information be received.
	10c	**An Action log of Previous Decisions** That the report for information be received.
	10d	**Lincolnshire Health and Wellbeing Board – Forward Plan** That the report for information be received
	10e	**Future Scheduled Meeting Dates** That the following scheduled meeting dates for the remainder of 2018 and for 2019 be noted. Tuesday 25 September 2018 Tuesday 4 December 2018

		Tuesday 26 March 2019 Tuesday 11 June 2019 Tuesday 24 September 2019 Tuesday 3 December 2019 (All the above meetings to commence at 2.00pm)
25 September 2018	**13**	**Minutes** That the minutes of the meeting held on 5 June 2018 be signed by the Chairman and confirmed and a correct record.
	14	**Action Updates from the Previous Meeting** That the completed actions, as detailed, be noted.
	16a	**Better Care Fund** That the Lincolnshire Health and Wellbeing Board note the BCF report update
	16b	**Lincolnshire Joint Strategy for Dementia 2018-2021** That the Health and Wellbeing Board approve the draft Joint Strategy for Dementia as shown in Appendix A of the report; That a summary document for the Strategy be developed; That the Health and Wellbeing Board Note that the Strategy will also be presented to the Adult Care and Community Wellbeing Scrutiny Committee
	17a	**Multi-agency review of Mental Health Crisis Services** That the Health and Wellbeing Board note the recommendations of the review and oversee the implementation of those recommendations agreed by lead commissioners
	17b	**Working Together to Create Safe, Well Communities – Policing and Mental Health Development Plan** That further work be carried out to identify how this would link with current strategies.
	17c	**Consultation on the Contracting arrangements for Integrated Care Provision (ICPs)** That the implications of the ICP consultation be noted. That a response to the consultation be produced on behalf of the Board by the Director of Public Health and the programme Manager and circulated to members for comment.
	17d	**Social Housing Green Paper Consultation** That a response on behalf of the Lincolnshire Health and Wellbeing Board would be drafted by the Housing, Health and Care Delivery Group.
	18a	**An Action Log of Previous Decisions** That the report for information be received.
	18b	**Lincolnshire Health and Wellbeing Board Forward Plan** That the report for information be received.

Lincolnshire Health and Wellbeing Board Forward Plan December 2018 to June 2019

Items for the Lincolnshire Health and Wellbeing Board are shown below:

11 December 2018, 2pm, Committee Room 1, County Offices, Lincoln		
Item & Rationale	**Presenter/Contributor**	**Purpose**
Developing a Blueprint for a more active Lincolnshire To receive a report from the Lincolnshire Physical Activity Taskforce on the developments to establish the Taskforce and the approach being taken to produce a Blueprint for a more active Lincolnshire.	Jayne Mitchell, Chairman L-PAT Louise O'Reilly, Director of Strategy & Insight, Active Lincs Phil Garner, L-PAT Strategic Programme Manager	JHWS Priority Delivery Group Update
Neighbourhood Working – The Social Prescribing project To receive a report on behalf of the Lincolnshire Clinical Commissioning Groups and the Sustainability and Transformation Partnership on implementing a social prescribing model in Lincolnshire which is being part funded by the Health and Wellbeing Grant Fund.	Kirsteen Redmile, Lead Change Manager – Integrated Care STP System Delivery Unit	Discussion
NHS Planning – Update To receive a verbal update from John Turner, Chief Officer South Lincolnshire CCG on the National NHS Long Term Plan and the Lincolnshire Sustainability and Transformation Plan.	John Turner, Chief Officer South Lincolnshire Clinical Commissioning Group (for Lincolnshire CCGs)	Discussion
Connect to Support Lincolnshire To receive a report on behalf of the Executive Director for Adult Care and Community Wellbeing on the development and launch of a new information and advice service called Connect to Support Lincolnshire which aims to help people access the most appropriate care and support for their needs.	Theo Jarrett, County Manager – Quality and Information	Discussion
A Memorandum of understanding to support joint action in Lincolnshire on improving health through housing To receive a report from the Housing, Health and Care Delivery Group which asks the Board to support the Housing Memorandum of Understanding (MOU). The MOU articulates the benefits of collaborative working and considers the role housing has in supporting good health outcomes and sustaining independence.	Sem Neal, Chief Commissioning Officer, Public Health Lisa Loy, Housing for Independence Programme Manager	Discussion
Better Care Fund Scheme Review To receive a report on behalf of the Executive Director of Adult Care and Community Wellbeing which updates the Board on Lincolnshire's BCF plan for 2018/19 including proposed revisions to allocations made in the original plan and a description of the next steps required to implement the changes.	Steven Houchin, Head of Finance – Adult Care and Community Wellbeing	Discussion
Better Care Fund To receive an information report on behalf of the Executive Director of Adult Care and Community Wellbeing providing the quarterly finance and performance update on Lincolnshire's BCF Plan 2017/19	Steven Houchin, Head of Finance – Adult Care and Community Wellbeing	Information

Lincolnshire Health and Wellbeing Board Forward Plan December 2018 to June 2019

Planned items for future Lincolnshire Health and Wellbeing Board are shown below:

26 March 2019, 2pm, Committee Room 1, County Offices, Lincoln		
Item & Rationale	**Presenter/Contributor**	**Purpose**
Joint Health and Wellbeing Strategy – Progress Report To receive a report on behalf of the Director of Public Health providing an update on the JHWS, including engagement plans for each of the JHWS Priorities.	David Stacey, Programme Manager Strategy and Performance	Discussion
CCG Commissioning Plans – 2019/20 To receive a report on behalf of the Clinical Commissioning Groups which asks the Board to review the commissioning intentions/operational plans for 2019/20 against the priorities in the Joint Health and Wellbeing Strategy	TBC	Discussion
Green Paper on Social Care for Older People Item to be confirmed	TBC	Discussion
JHWS Obesity Priority To receive a report on behalf of the JWHS Obesity Delivery Group on the development of the delivery group and the Whole System Approach to obesity.	TBC	JHWS Priority Delivery Group Update
Better Care Fund To receive an information report on behalf of the Executive Director of Adult Care and Community Wellbeing providing the quarterly finance and performance update on Lincolnshire's BCF Plan 2017/19	Steven Houchin, Head of Finance – Adult Care and Community Wellbeing	Information

11 June 2019, 2pm, Committee Room 1, County Offices, Lincoln		
Item & Rationale	**Presenter/Contributor**	**Purpose**
Terms of Reference and Procedural Rules, roles and responsibilities of core Board members Annual review and formal agreement	Alison Christie, Programme Manager Health and Wellbeing	Decision
Health and Wellbeing Board Annual Report	Alison Christie, Programme Manager Health and Wellbeing	Decision
Joint Health and Wellbeing Strategy Dashboard Reports	Alison Christie, Programme Manager Health and Wellbeing David Stacey, Programme Manager Strategy and Performance	Discussion