Appendix A (Part 1)

Better Care Fund planning template – Part 1 (Final Submission)

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

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

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Lincolnshire County Council**
Clinical Commissioning Groups	**West CCG**
	East CCG
	South West CCG
	South CCG
Boundary Differences	**The population of Lincolnshire is 740,158. The GP registered population of the four CCGs combined is 761,002. The distribution of the CCG population is as described below in boundary details**
Date agreed at Health and Well-Being Board:	**25/3/2014**
Date submitted:	**4/04/2014**
Minimum required value of ITF pooled budget: 2014/15	**£15.4m**
2015/16	**£48.4m**
Total agreed value of pooled budget: 2014/15	**£70.8m**
2015/16	**£197.3m**

Boundary Details - how we propose to deal with the different populations between CCGs and LCC
As part of the work supporting the Blueprint detailed analysis suggests there are significant issues to address across Lincolnshire but also across the four Clinical Commissioning Groups. Modelling has taken place to understand current utilisation of

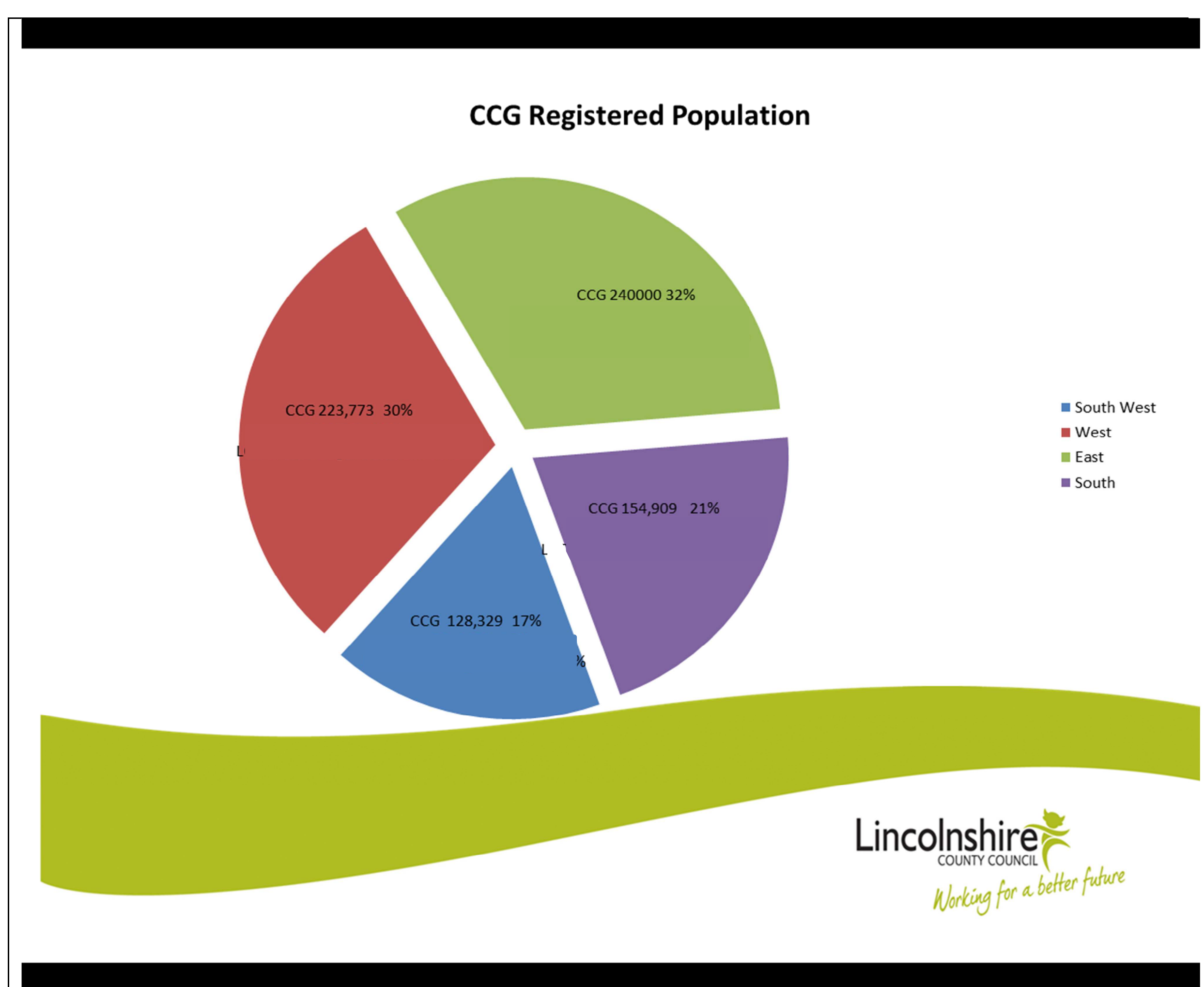
service but more significantly what will be required in five years' time. Demographic trends lead us to believe that the population will age rapidly, with the West and South West ageing most.

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

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

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

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



b) Authorisation and sign-off

Signed on behalf of the Clinical Commissioning Group	South West Lincolnshire
By	Allan Kitt
Position	Chief Operating Officer
Date	25/03/2014

Signed on behalf of the Clinical Commissioning Group	West Lincolnshire
By	Sarah Newton
Position	Chief Operating Officer
Date	25/03/2014

Signed on behalf of the Clinical Commissioning Group	East Lincolnshire
By	Gary James
Position	Chief Operating Officer
Date	25/03/2014

Signed on behalf of the Clinical Commissioning Group	South Lincolnshire
By	Gary Thompson
Position	Chief Operating Officer
Date	25/03/2014

Signed on behalf of the Council	Lincolnshire County Council
By	Tony McArdle
Position	Chief Executive
Date	01/04/2014

Signed on behalf of the Health and Wellbeing Board	Lincolnshire Health & Wellbeing Board
By Chair of Health and Wellbeing Board	Cllr Sue Woolley
Date	25/03/2014

c) Service provider engagement

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

The Lincolnshire Sustainable Services Review (LSSR), during Phase 1, included the three NHS Provider Trusts within Lincolnshire as stakeholders. These are also heavily involved in Phase 2 which is currently underway. They are United Lincolnshire Hospitals NHS Trust, Lincolnshire Community Health Services NHS Trust, and Lincolnshire Partnership NHS Foundation Trust. In addition, the East Midlands Ambulance Service NHS Trust have been involved throughout. The LSSR Phase 1 review document is attached below in Related Documentation.

Social Care providers, housing providers and third sector providers have also been involved in the production of the LSSR. An approach to securing ongoing engagement with the large and diverse independent social care and housing provider market has been concluded. This will utilise the Executive Board of Social Care providers (called 'LinCA') to support the work of delivering the LSSR which subsumes this two year plan. LinCA has designed a series of events during the next phase (Phase 2) of the LSSR to ensure a wide level of engagement. It is also intended that this work (LSSR and BCF) will also incorporate local preparations for the advent of both the 'Care Bill' and social care funding reforms.

In addition, colleagues in Public Health have engaged with District and City Councils and third sector providers to ensure their participation in key elements of this BCF and the LSSR. Specifically, in developing the Wellbeing Strategy which forms the core of the preventative work that we are progressing in Lincolnshire. This, in time, will subsume both the Integrated Community Equipment Services (ICES) and the DFG component of the BCF.

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

Executive and the Trust Medical Director.

In the development of the LSSR Review document – described as 'the blueprint', constituent organisations tasked professionals and representatives from 3rd sector and carer groups across Lincolnshire to work together to co-design, how care will be delivered in the future.

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

We are now engaged in Phase 2 of the LSSR programme and have secured Price Waterhouse Coopers to support our work. Provider and public engagement is a critical component of this and we are in the process of securing additional capacity at a strategic and operational level. We anticipate being on schedule for formal public engagement later this spring.

d) Patient, service user and public engagement

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

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

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

As mentioned in Section C above Phase 2 has now commenced and "care design groups" have been formed to develop the detail of health and social care services. At the end of further design work in Phase 2 - anticipated for April 2014, there will follow a formal process of public engagement for three months (May, June, July). We are currently seeking options on how best to ensure this period of public engagement will satisfy a level of scrutiny across both health and social care communities.

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

Document or information title	Synopsis and links
Attachment 1 - Lincolnshire Sustainable Services Review (Phase 1).	LSSR_Blueprint_11112013.pdf
Attachment 2 – LSSR JHWS Matrix Summary	LSSR JHWS Matrix Summary.docx

2) VISION AND SCHEMES

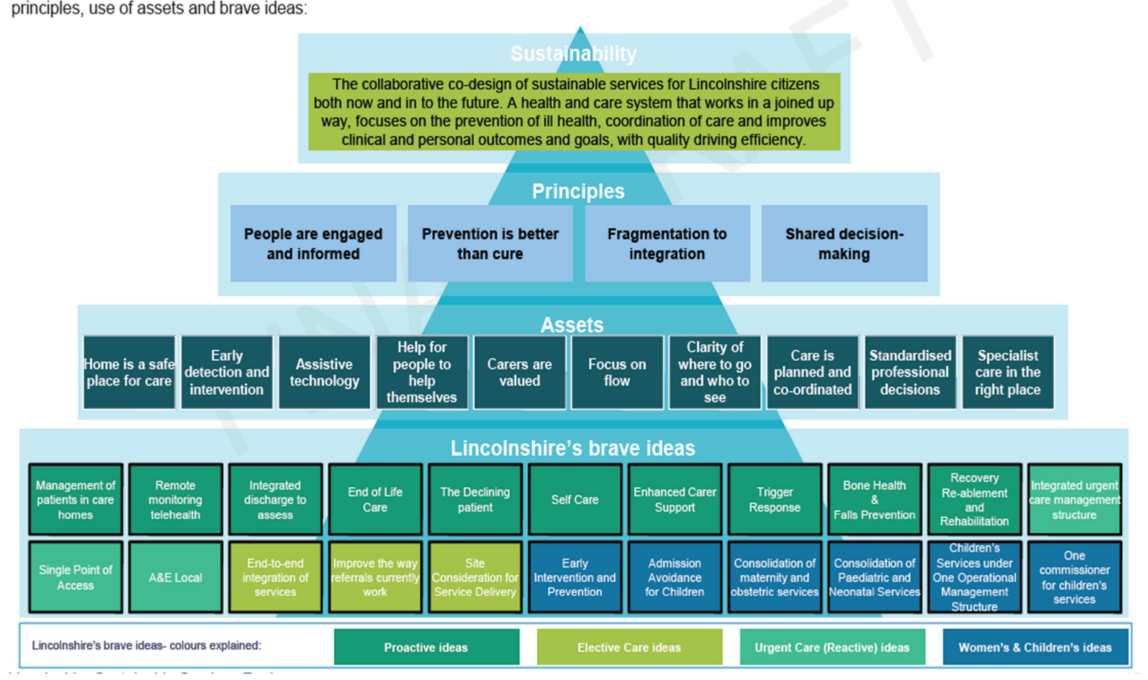
a) Vision for health and care services

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

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

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

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



Aims and objectives

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

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

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

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

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

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

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

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

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

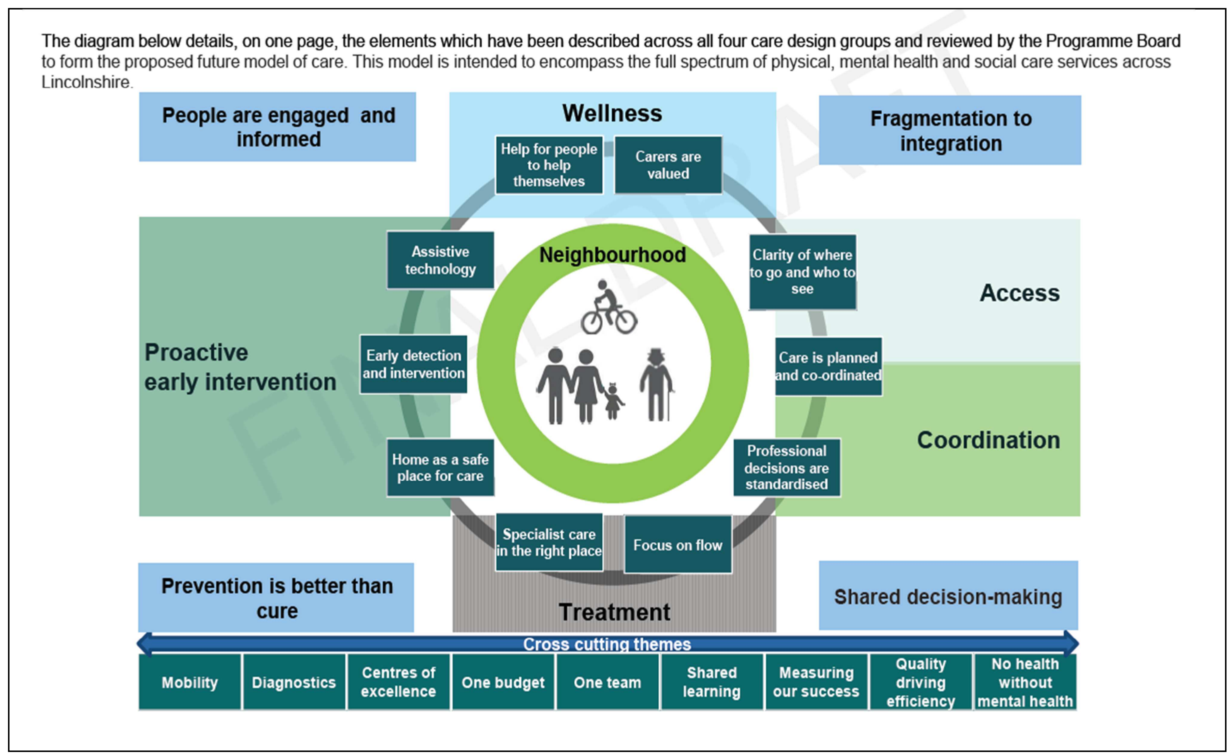
Joint Health and Wellbeing Strategy Outcomes mapped to LSSR Themes and National Outcomes Frameworks

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

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

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

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



b) Description of planned changes

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

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

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

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

The Early Implementers are:

1. The development of **'neighbourhood teams**' at 4 locations across Lincolnshire reflecting GP clusters.

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

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

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

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

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

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

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

   We see improved support to carers as a key component of our preventative work. An additional £200k has been allocated from the BCF to support targeted groups of carers such as those elderly carers supporting profoundly learning disabled individuals and those supporting a relative with dementia. Additionally, a revised carers strategy and reconfiguration of existing services is expected to further improve "our offer" to carers in Lincolnshire. As noted previously the Lincolnshire Carers and Young Carers Partnership (LC&YCP) was involved in the production of Phase 1 of the LSSR and is involved in Phase 2.

Case Study – Preventing an escalation of need.

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

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

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

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

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

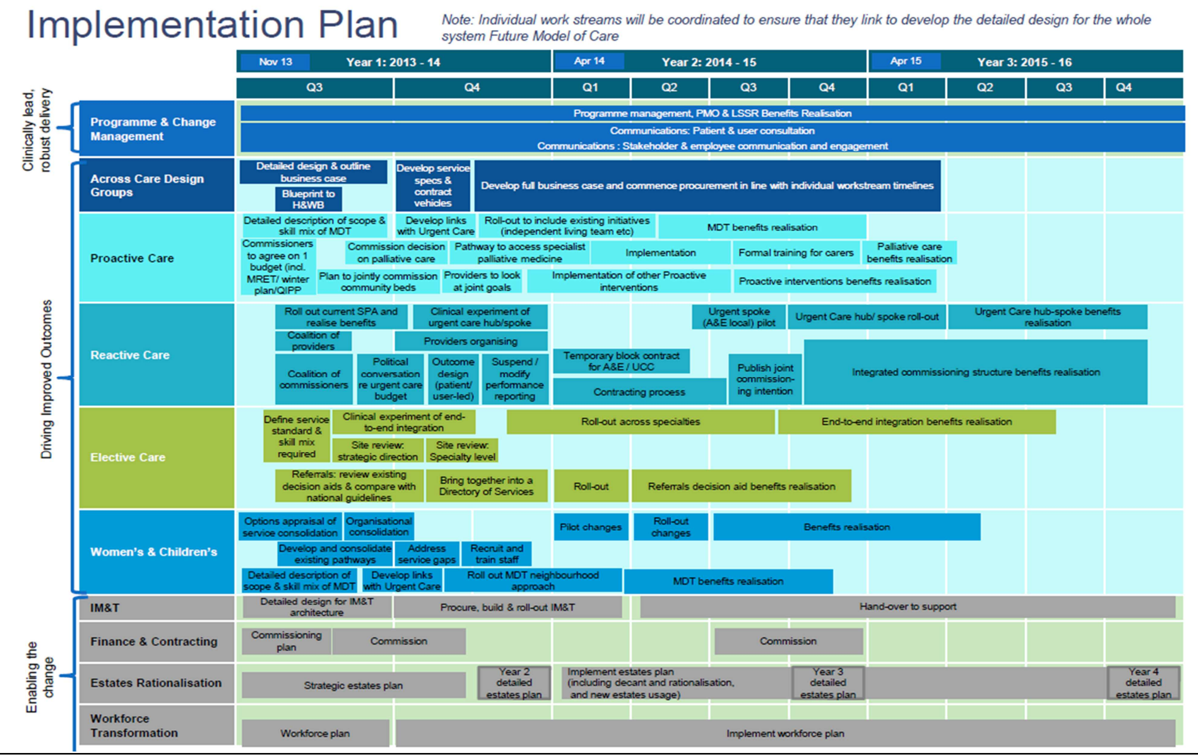
5. **Enablers** notably estates, organisational development and IMT. We consider organisational development and indeed workforce development as critical enablers to successful integration. To this end the Lincolnshire Education and Training Board (LETB) will be approached to secure additional support outwith this BCF allocation.

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

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

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

The Health and Wellbeing Board will have overall responsibility for ensuring a high degree of consistency and congruence between our developing knowledge of local communities, their needs, wishes and aspirations, coupled with a clear understanding of what good looks like. The Health and Wellbeing Board will be supported by a small number of Delivery Boards for aspects of this plan. Led by senior officers from both health and social care organisations and with dedicated programme support to ensure resources and skills are brought together for best effect.



c) Implications for the acute sector

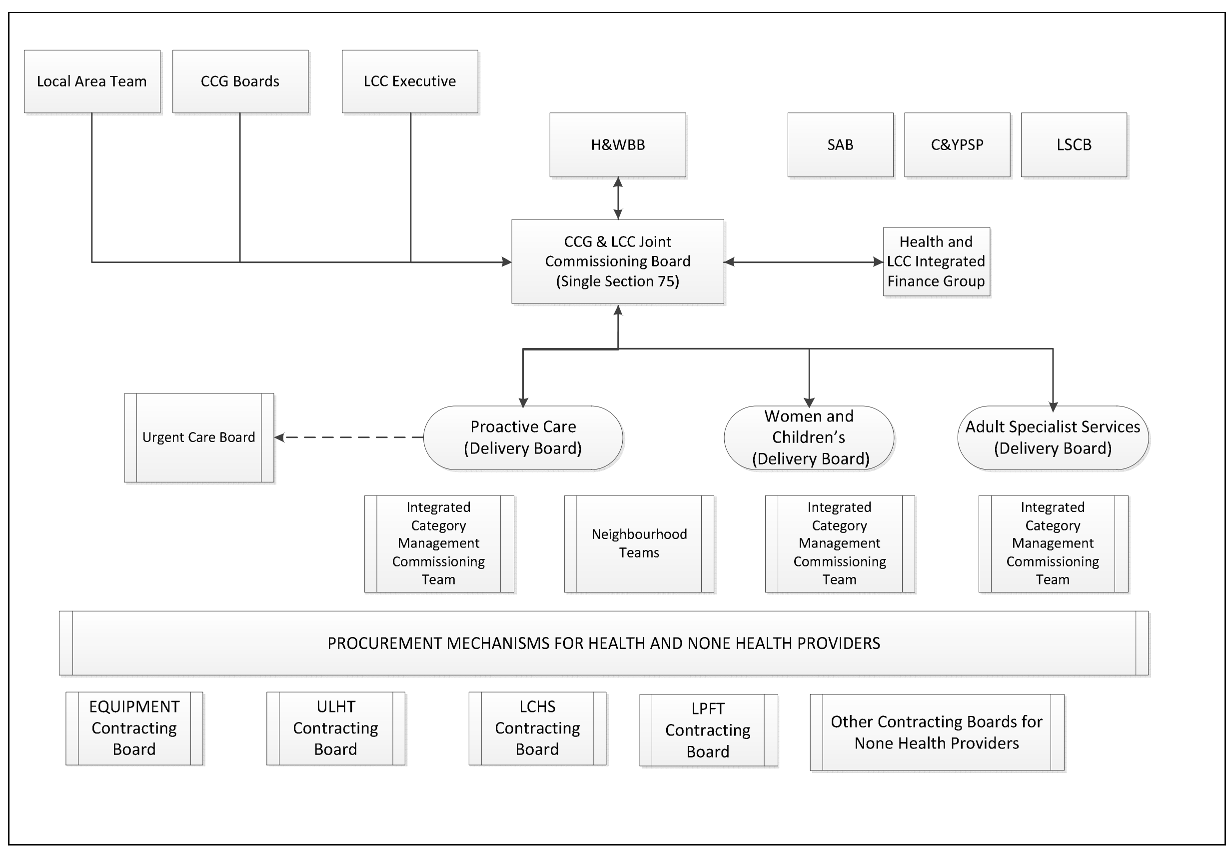
Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings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

The LSSR Blue print defines Lincolnshire's vision for service reconfiguration including very significant reduction in acute bed capacity from the acute sector by 2016/17 and the strengthening of community based services with extended 7 day working wrapped around Neighbourhood teams. This objective is consistent with the national requirement to reduce emergency admissions by 15%. Performance metrics for this are in Part 2. Years 2014/15 and 2015/16 are key transitional years during which time momentum for change must be galvanised into targeted delivery. Failure to deliver will result in a significant financial gap across Lincolnshire Health and Social Care Services as identified in LSSR Phase 1. For the two transitional years focus is being given to commencing a reduction of acute hospital bed capacity by further preventing avoidable acute hospital admissions, reducing delayed transfers of care and ensuring that the valuable acute sector facilities are utilised to best effect for those most in need of specialised acute hospital care. Implementation of the Urgent Care Board strategy will be critical to support the delivery of targets. Due consideration is being given to the acute sector clinical strategy which is currently undergoing early clinical consultation.

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

d) Governance

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



ALIGNING LEAD RESPONSIBILITY TO DELIVERY BOARDS

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

The above table provides additional clarity concerning which Delivery Board in the governance structure previously described would take lead responsibility for the five "early implementers" within the BCF, the pooled budget figure to be achieved in 15/16 and relevant BCF performance targets described in Part 2 of this submission. Furthermore, lead responsibility for commissioning strategies is detailed.

The design phase of LSSR will see the creation of a number of design groups. These groups will liaise with relevant Delivery Boards as described above.

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

3) NATIONAL CONDITIONS

a) Protecting social care services

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

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

1. That the current eligibility for Adult Social Care will be maintained at substantial and critical.
2. Section 75 agreements, whether existing or new, will not reduce or impact negatively on performance or quality of adult social care services in securing agreed levels of future funding and performance.
3. The design of new models for commissioning and supplying social care services will not detrimentally affect performance against ASCOF (notably those detailing hospital discharge, personalisation and reviews); from the baseline of March 2013.
4. Agreement has been reached with the 4 CCGs concerning the allocation of the BCF in 2015/16 which helps secure the necessary level of investment in adult social care services. Of the monies available £20m will be allocated for this purpose which represents approximately 40% of the total revenue available.
5. We estimate the cost of the Care Bill and future funding reforms will be £2.8m in 2015/16. The sum agreed in 4 above includes this requirement. However, beyond 2015/16 there is no clarity of future funding. See also 'Risks' below.

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

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

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

b) 7 day services to support discharge

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

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

The multi-agency Lincolnshire Urgent Care Group will oversee the development of 7 day services. It is recognised that any move to seven day working within Lincolnshire hospitals will bring greatest benefit if it is part of a move to seven day working across all organisations and agencies that provide care to the people of Lincolnshire either in hospital, their own homes. The approach being taken by each of our main providers is set out below.

United Lincolnshire Hospital Trust

In order to make the move to seven day working in unscheduled care, across all ULHT sites a number of actions have already been taken these. In November 2013 a broad cross section of clinical leaders (supported by senior managers) met to outline which medical, diagnostic, therapeutic and support services need to be available to support seven day unscheduled care. Building upon this dialogue and taking account the draft standards for 7 day working published by NHS England; guidance from learned bodies (eg Royal colleges and Professional organisations), and experience elsewhere across the NHS, a framework is being developed setting out the services required to deliver unscheduled care services across ULHT. In turn each hospital site within the Trust providing unscheduled care will be required to develop proposals for the delivery of those elements of service on their site. This will ensure consistent standards of service across the Trust whilst allowing for site-specific approaches to delivery.

Once proposals for delivery have been developed they will then be the subject of scrutiny by a multi-disciplinary group. This will ensure:-

- the model of delivery is capable of delivering the benefits in terms of mortality reduction, improved patient experience and reduction to length of stay
- Ensuring that any proposed increase to the cost of delivery is justifiable.

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

Lincolnshire Community Health Services

LCHS are committed to delivering high quality, safe services throughout the 7 day working week. To achieve this in the longer term, the organisation intends to undertake significant transformational change in the way services are delivered.

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

In addition the organisation has introduced an attendance management tool which supports front-line staff to maximise their capacity and performance manage attendance

across a 7 day period, 365 days of the year. This has been supported by the implementation of a roster policy which embeds the principles of improving working lives, whilst ensuring that safe levels of staffing are available to maximise and sustain the delivery of services in the community. Performance management of attendance across community teams is now being formally monitored via internal processes, with significant challenge being applied to areas where there is evidence of in- efficient utilisation of available resource. This is particularly pertinent in times of predicted peak activity.
A review of our existing community work force is being undertaken. The aim of this review is to ensure a baseline for safe staffing levels are established in the community. Pending the outcome of the review, there may be the potential for some movement of key clinical personnel around the county or indeed evidence of additional investment being required to support a robust community service provision.

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

Lincolnshire Partnership Foundation Trust

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

Primary Care

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

The CCG will work closely with NHS England's Leicester and Lincolnshire Area Team who commission primary care services, to ensure the emerging Primary Care Strategy, is fully aligned and supports the implementation of the Lincolnshire Strategic Services Review.

Lincolnshire County Council

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

Generally

We recognise the need for a step change in seven day working across the health and social care community in Lincolnshire. This necessary development will proceed through the care design groups detailed earlier as part of the LSSR Phase 2 work. In particular there is an expectation that neighbourhood teams and intermediate care (both early enablers) will operate on this basis. The wellbeing service which forms the bedrock of our preventative 'offer' is being re-commissioned on this basis and will commence across Lincolnshire on 1 April 2014.

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

c) Data sharing

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

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

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

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

We can confirm that we are committed to adopting systems based on Open APIs and Open Standards.

In social care we have procured a new case management system from Core Logic for implementation in January 2015. The software solution will implement a multi-agency case management system for social care that will act as an enabler to countywide, joint service delivery and empower greater flexibility and efficiency via secure, shared data

services.

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

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

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

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

d) Joint assessment and accountable lead professional

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

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

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

In Lincolnshire a new pathway was created in November 2013; all adults at risk of a hospital admission are referred to a multi-agency contact centre where the adult is assessed based on all available information by an appropriate health / social care professional into a pathway for the right support to enable the person to remain in their own home or as close as possible. In Lincolnshire; for this winter, the commissioners

have in place 2 contact centres based on the prime need of the person being either Physical or Mental health. The contact centres provide a 24 hour a day, 7 day service across the County to all Health and Social Care Professionals.

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

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

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

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

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

See also the section above regarding seven-day working.

4) RISKS

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

We have undertaken a Risk Assessment which is detailed below. We would highlight the level of resource invested in securing adequate capacity to ensure progress in both this BCF (notably with respect to the "Early Implementers") and the LSSR. Specifically, three senior appointments have been made to add capacity to the Delivery Boards identified in Section 2d (this included two jointly appointed Assistant Director grades). Health and Social Care commissioners along with the Area Team have added to this capacity by commissioning highly respected and skilled organisations to work alongside us. In phase 1 for example, PWC were commissioned to provide support and expertise. Further work is underway to identify how financial risk will be shared across the health and social care community. However, the detail for this is not available prior to publication of this final submission document. We have already detailed the costs falling to Adult Care as a result of the Care Bill and future funding reforms. We estimate for 15/16 approximately £2.8m will be needed though the true figure in Lincolnshire over 10 years is likely to reach in excess of £100m. For 15/16 the allocation of £20m to protect Adult Care will incorporate the £2.8m. We are currently working with the County Councils Network to reinforce the point to Government that the funding figures currently being used are not sufficient to cover the true costs of these new legislative requirements..

Better Care Fund Risk Assessment

Risk No	Risk Description		Inherent Risk Score		
	Risk Source	**Risk Consequences and mitigation**	**Probability**	**Impact**	**Score**
001	Lack of capacity to transform and integrate w ill result in failure to maintain current performance and customer satisfaction, or failure to achieve integration	Investment in phase one of a county-w ide review of the Health and Social Care Economy (Lincolnshire Sustainable Services Review) is completed and has provided an holistic view of key areas and high level models for integration. Non-recurrent funding for phase tw o w ill provide the necessary investment in capacity and infrastructure to support detailed mapping and impact analysis of models identified in phase one. Funding for phase 2 and phase 3 has been identified and the external consultancy has now been sourced w hich w ill provide additional capacity. The County Council has also added capacity to secure necessary progress.	1	4	4
002	An improved integrated pathw ay focused on prevention and keeping people safe in their homes is achieved but fails to deliver key performance improvements across health and social care economy resulting in reduced funding and an insufficient financial envelope to support core activity	Modelling from phase one of the services review considered key data, but includes a number of assumptions. This data w ill be further detailed in phase tw o allow ing develop development of co-directed detailed business case and informed decision making. Phase 2 w hich w ill provide the necessary design is shortly to commence. Public Health has commissioned a new Well Being Service that w ill form part of the overall prevention 'offering'. This is due to begin 1/04/14.	2	4	8
003	Service providers, voluntary sector and community groups are unable to respond adequately to the re-modelling of commissioned services to achieve the vision	Phase tw o of the sustainable services review has a strong focus on consultation and collaboration and w ill build on the co-design of phase one across the provider and community landscape to fully understand and plan for the required level of support and investment to deliver an integrated vision. A robust governance structure w ith joint commissioning responsibilities w ill assist in securing necessary service levels and quality. Further, both NHS and Social Care Providers are engaged in the phase 2 w ork and overall governance of LSSR.	2	4	8
004	The anticipated financial impact of the care bill w hich has planned Royal Ascent in 2014 in not fully quantifiable although financial modelling and planning have been undertaken to an extent. This has potential to impact on the delivery and sustainability of current plans	An initial impact assessment has been completed and has been considered during phase one of the sustainable services review by Adult Care. Future planning needs to consider the risks and benefits of the bill to ensure a sustainable model is developed. The financial effect of new legislation has been reported. The government have indicated that the full cost of implementation w ill be fully funded.	2	4	8
005	The model chosen for an integrated health and social care system in Lincolnshire does not deliver sufficient w hole systems base budget savings and the forecast deficit is not mitigated	The health and social care system re-design planned for in the Lincolnshire Sustainable Services Review has to demonstrate not only improvements for customer outcomes and experience, but sufficient radical re-engineering to deliver a balance budget across the Health and Social Care Economy. The earlier analysis in phase 1 and the detailed design w ork in phase 2 are supported by an external consultancy w hich provides a level of analysis and modelling based on best practice elsew here.	2	4	8