Updated September 2014 - VERSION KH11 (050914)

Better Care Fund planning template – Part 1

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

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

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

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Lincolnshire County Council**
Clinical Commissioning Groups	**West CCG**
	East CCG
	South West CCG
	South CCG
Boundary Differences	**The population of Lincolnshire is 740,158. The GP registered population of the four CCGs combined is 761,002.**
Date agreed at Health and Well-Being Board:	**11/09/2014**
Date submitted:	**19/9/2014**
Minimum required value of BCF pooled budget: 2014/15	**£15.4m**
2015/16	**£48.4m**
Total agreed value of pooled budget: 2014/15	**£70.8m**
2015/16	**£197.3m**

b) Authorisation and signoff

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

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

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

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

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

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

c) Related documentation

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

Document or information title	**Synopsis and links**
First BCF Submission dated 4/4/14	

2) VISION FOR HEALTH AND CARE SERVICES

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

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

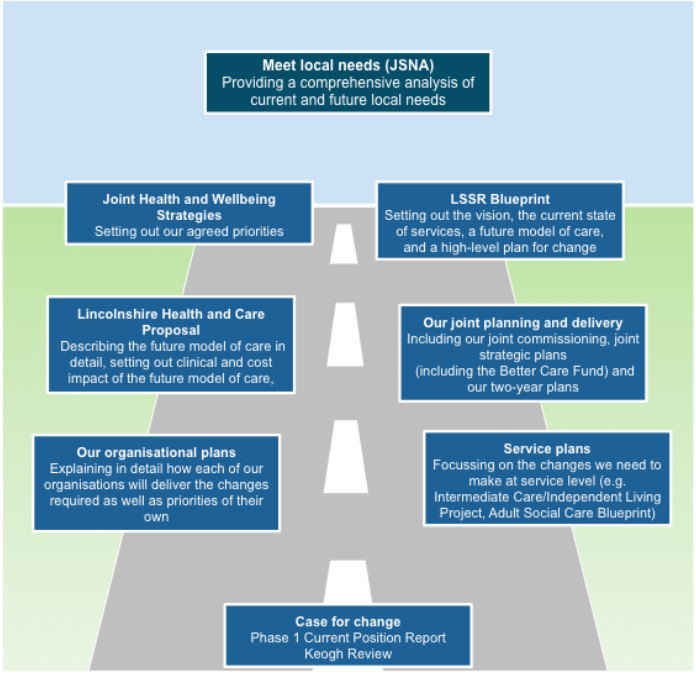
Pricewaterhouse Coopers (PwC) have operated as our strategic partner throughout. Their Care Market Re-Set approach has been used – see section 8.

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

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

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

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



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

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

By 2018/19 we will:

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

To do this we will:

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

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

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

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

What comes next

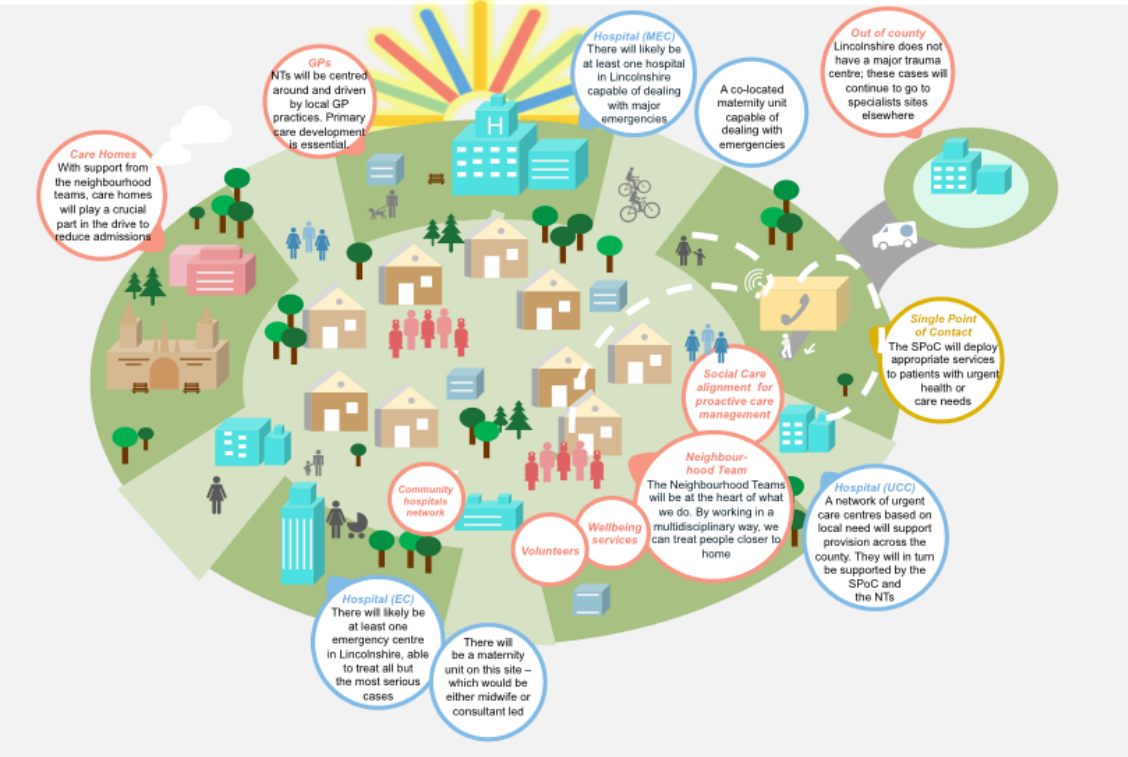
There are three key areas for immediate development:

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

That will mean:

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

For further information please also see the individual scheme description.

3) CASE FOR CHANGE

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

The timeframe in which we plan to begin to deliver transformation to health and social care services in Lincolnshire takes place over three years and began with Phase 1 during 2012/13 and the publication of the Lincolnshire Sustainability Review. Phase 2 – our current phase - will see further detailed planning before a formal period of public consultation takes place during 2015 for a period of three months. Please see the diagram below for further detail.

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

The Early Implementers in our first BCF submission were:

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

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

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

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

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

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

working for improved outcomes for people.

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

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

Case Study – Preventing an escalation of need.

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

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

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

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

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

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

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

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

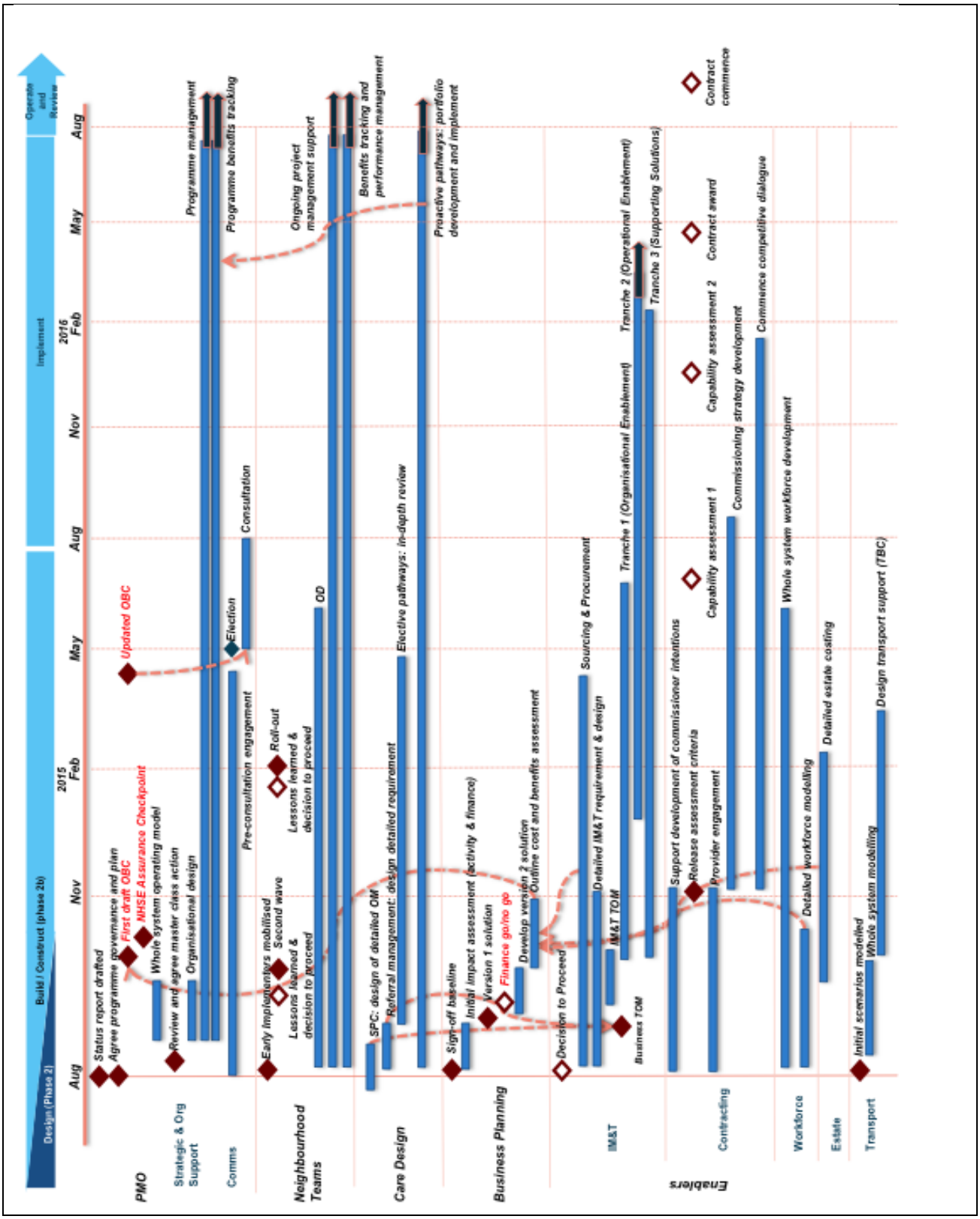
Our ambition is to increasingly combine services, based on a clear understanding of what works best and where synergies can be obtained. This will mean the merging of currently disparate services that may exist across several organisations. We will progress single service configurations through a collective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

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

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

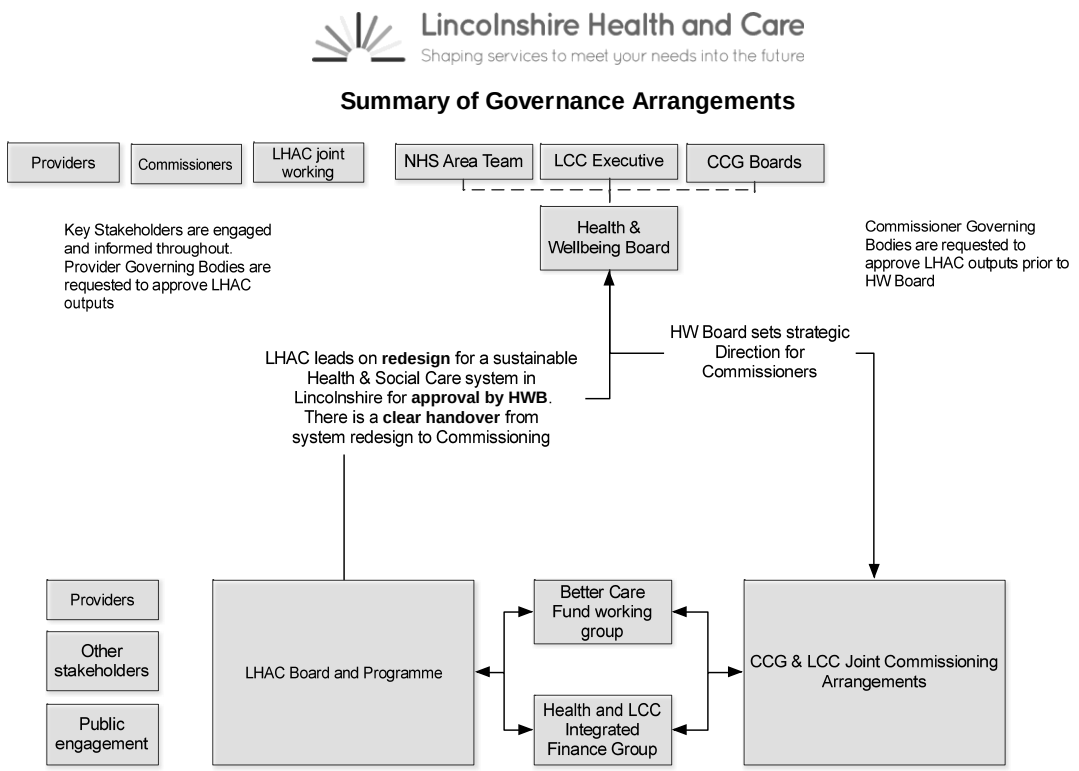
4) PLAN OF ACTION

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

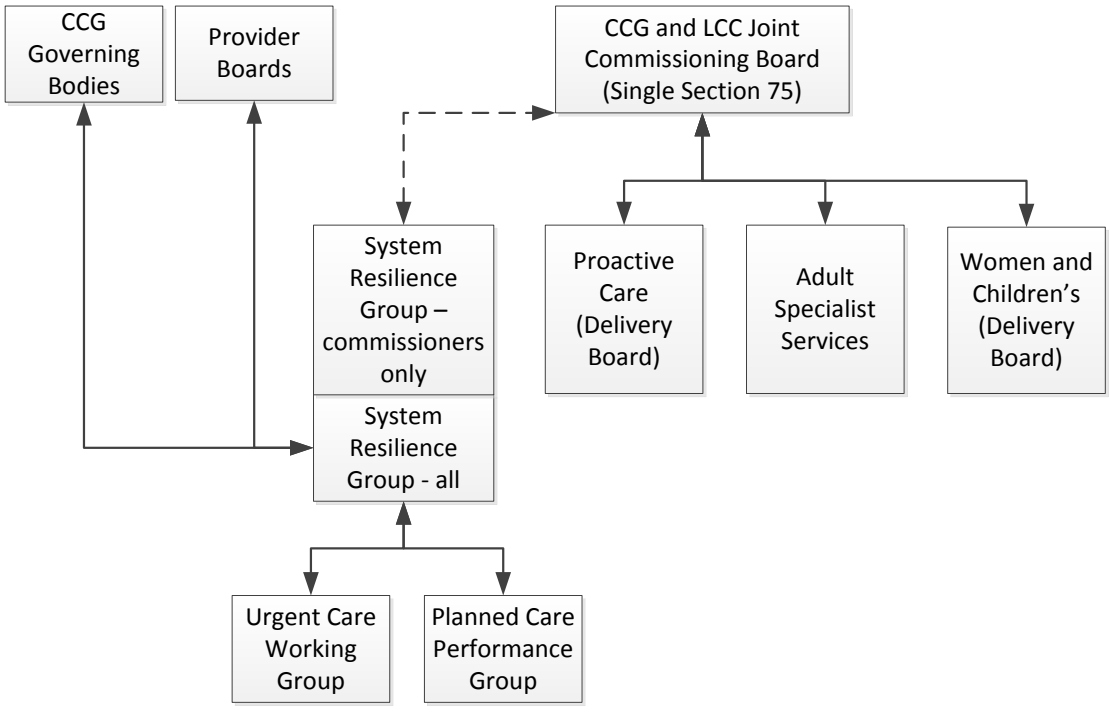


b) Please articulate the overarching governance arrangements for integrated care locally

Lincolnshire's arrangements are summarised diagrammatically below.



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



Key points to note are that:

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

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

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

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

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

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

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

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

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

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

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

d) **List of planned BCF schemes**

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

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

5) RISKS AND CONTINGENCY

a) Risk log

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

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

Better Care Fund Risk Assessment

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

b) Contingency plan and risk sharing

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

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

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

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

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

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

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

6) ALIGNMENT

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

Alignment is being secured in a number of ways:

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

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

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

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

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

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

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

See also Section c.

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

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

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

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

7) NATIONAL CONDITIONS

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

a) Protecting social care services

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

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

1. That the current eligibility for Adult Social Care will be maintained at substantial and critical in line with the requirements anticipated from implementation of the Care Act.
2. Section 75 agreements, whether existing or new, will not reduce or impact negatively on performance or quality of adult social care services in securing agreed levels of future funding and performance.
3. The design of new models for commissioning and supplying social care services will not detrimentally affect performance against ASCOF (notably those detailing hospital discharge, personalisation and reviews); from the baseline of March 2013.
4. Each Delivery Board and ultimately the Health and Wellbeing Board will monitor progress to ensure this definition is observed.

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

We recognise that there is little protection for either Health or Social Care services unless we take a profound step towards integration as detailed in LHAC. Only in this way are we likely to secure services to meet Health & Social Care needs in Lincolnshire. The Executive of the County Council expect that Social Care Services will be protected as much as possible as we develop more pooled budget arrangements based on agreed and shared outcomes. Notwithstanding this ambition, further reductions to Government funding to the County Council will inevitably lead to some reductions in Adult Care. The County Council will continue to monitor performance and outcomes using benchmarking data, trend analysis and ASCOF. Adult Care has a robust and comprehensive quality assurance system in situ that will also ensure services are not impaired as the proposed changes detailed in this plan and LHAC are progressed.

Our approach to transformation is to ensure that there is stability in areas of core health and social care provision. Through LHAC we will implement transformation in an incremental way so there is a risk management approach to change management and social care services will be protected. To enable us to plan change whilst protecting vulnerable people, we will utilise some BCF funding to protect services so there is stability through change management.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b) 7 day services to support discharge

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

See also the relevant scheme description in Annex 1.

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

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

United Lincolnshire Hospital Trust

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

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

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

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

Lincolnshire Community Health Services

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

In the shorter term, immediate actions have been taken to restructure elements of the

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

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

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

Lincolnshire Partnership Foundation Trust

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

Primary Care

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

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

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

Lincolnshire County Council

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

Generally

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

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

c) Data sharing

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

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

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

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

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

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

There is an overarching Information Sharing Protocol agreed between the health and social care community in Lincolnshire which includes consent, access and security procedures, subject access requests, protocol management procedures, data protection and Caldicott requirements.

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

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

d) Joint assessment and accountable lead professional for high risk populations

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

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

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

In Lincolnshire a new pathway was created in November 2013; all adults at risk of a hospital admission are referred to a multi-agency contact centre where the adult is assessed based on all available information by an appropriate health / social care professional into a pathway for the right support to enable the person to remain in their own home or as close as possible. In Lincolnshire; for this winter, the commissioners have in place 2 contact centres based on the prime need of the person being either physical or mental health. The contact centres provide a 24 hour a day, 7 day service across the County to all health and social care professionals.

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

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

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

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

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

See also the section above regarding seven-day working.

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

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

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

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

8) ENGAGEMENT

a) Patient, service user and public engagement

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

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

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

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

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

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

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

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

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

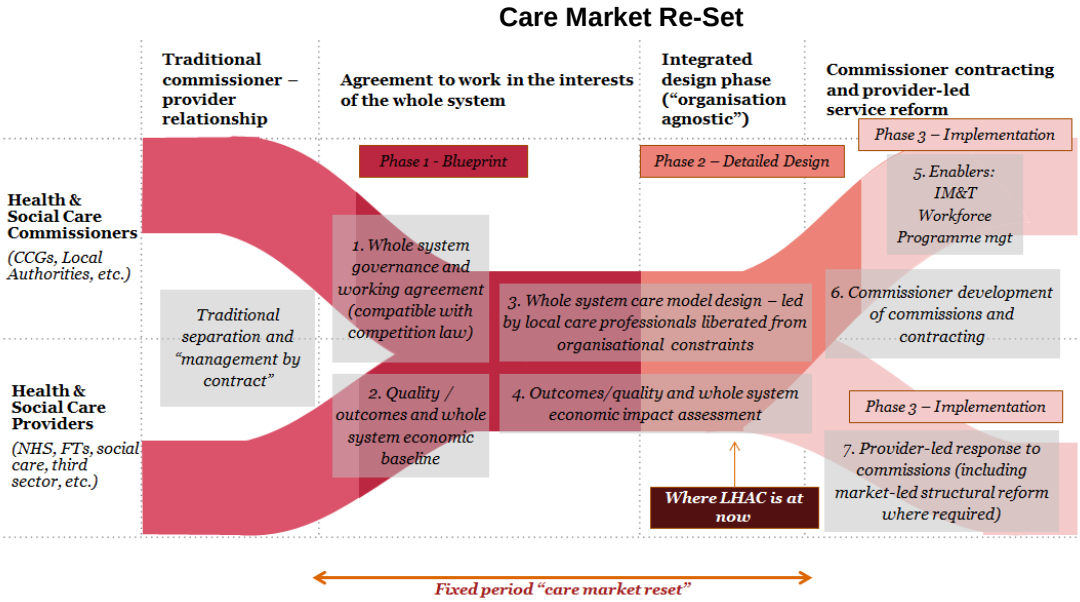
There will be formal consultation with the public at an appropriate time and following NHS assurance.

b) Service provider engagement

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

i) NHS Foundation Trusts and NHS Trusts

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



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

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

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

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

A workforce summit and briefings have included all providers.

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

Additional sessions are now being organised within provider workplaces.

ii) Primary care providers

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

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

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

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

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

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

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

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

A selection of comments made by a range of stakeholders …

c) Implications for acute providers

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

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

LHAC defines Lincolnshire's vision for service reconfiguration including very significant reduction in acute bed capacity from the acute sector by 2016/17 and the strengthening of community based services with extended 7 day working wrapped around Neighbourhood teams. This objective is consistent with the national requirement to reduce emergency admissions by 3.5% in 2015/16. Performance metrics for this are in Part 2. Years 2014/15 and 2015/16 are key transitional years during which time momentum for change must be galvanised into targeted delivery. Failure to deliver will result in a significant financial gap across Lincolnshire Health and Social Care Services as identified in LHAC Phase 1. For the two transitional years focus is being given to commencing a reduction of acute hospital bed capacity by further preventing non elective

admissions, reducing delayed transfers of care and ensuring that the valuable acute sector facilities are utilised to best effect for those most in need of specialised acute hospital care. Implementation of the Urgent Care Board strategy will be critical to support the delivery of targets. Due consideration is being given to the acute sector clinical strategy which is currently undergoing early clinical consultation.

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

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

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