ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref no.
Scheme name
Wellbeing and Prevention
What is the strategic objective of this scheme?
• A preventative service, designed to enhance wellbeing, and reduce or delay escalation to statutory support services • Improve accessibility to support services for individuals to access services more easily when they need them • Improve mobility throughout service provision, that will enable people to seamlessly get help where required • Deliver services that are fit for purpose and proactively identify need; adopting a principled approach to commissioning to ensure that services are fit for purpose and provision is balanced across the county
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Background and current position: The Wellbeing Service was developed following the end of the Supporting People programme and as a result of the prevention strategy within Lincolnshire County Council. This was influenced by priority themes, objectives and measures in Lincolnshire's Joint Health and Wellbeing Strategy (JHWS). In October 2011 The Executive of Lincolnshire County Council took the decision to change Adult Social Care's eligibility criteria threshold from moderate and above to substantial and critical only. The Health and Social Care Act 2013 seeks to increase integration and simplification of service 'journeys' for vulnerable people. Whilst this legislation pertains particularly to adults, similar directions of travel are clear in children's and young person's services. These legislative drivers are accompanied by unprecedented pressure on resources across all public sector organisations. Those pressures require innovation, targeting

of resources and rapid decision making on commissioning approaches to maintain sustainability.

The Wellbeing Service includes six elements:

- Trusted Assessment;
- Installation of Equipment, Minor Adaptations and TeleCare;
- A Short Term Intervention of Generic Support;
- Monitoring of TeleCare/community alarms;
- A Rapid Response Service;
- Home from Hospital (Home safe).

A key element of this service is having assessors who are skilled and trained to identify needs, establish how to meet those needs and either carry out the tasks themselves or organise others within the Wellbeing Service to do so. Under this model, the purchaser requires a timely assessment and where practical the immediate installation of small aids and Telecare, plus adaptations within 24 hours. The assessors will be used effectively so that they can carry out or arrange many tasks at the time of the assessment and record them in the support plan.

The assessment will also identify other needs outside of the Wellbeing Service and ensure the person is helped if required to access them. This will involve introducing people to new groups or activities to support their wellbeing and social inclusion.

The provider will deliver practical help where needed for a fixed term period; with up to six weeks being the average amount of time; to help people get back on their feet for example after a hospital admission, a family crisis or bereavement. This could include help with shopping, claiming benefits, making and keeping appointments and support to ensure that the person gets back to their optimum independence.

The installation of a range of community equipment that includes simple aids to daily living (SADLs) and TeleCare, plus minor adaptations is also integral to the service. Following an assessment of need and the consent of the service user and where applicable the landlord, the provider will install equipment as required. Where the person does not qualify or want Adult Care to fund these items the provider should offer options for purchase or rent of the items.

The Countywide Monitoring Centre monitors and initiates the appropriate response as agreed with the service user. Monitoring will be for service users in receipt of either TeleCare or community alarms and will include advising assessors or other professionals about trends and concerns from the service user use of the equipment eg if they are falling more frequently.

The Rapid response service is designed to respond to a non-critical emergency in a person's home. Promoting independence by enabling a person to be confident that when support is required that doesn't require an ambulance, a responder would be available to go to their home, this is available 24 hours 7 days a week

Home Safe is a transport and resettling service for individuals returning home from hospital. Drivers and support staff will take the individual home where they will be

met by a Home Safe Responder, who will ensure safe access and all facilities are switched on and working. They will also test equipment such as Lifeline units and inform the monitoring centre of their return, as well as informing care providers, family members or neighbours. They will ensure that the person is comfortable and has essentials such as medication, food and refreshments, additional shopping can be collected if required. This element of service operates seven days a week (including bank holidays) from 10am to 10 pm (last referral 9.30pm) to support admission avoidance and delayed discharge. Early evidence shows that WBS intervention at A&E is enabling people to return home and avoid admission.

Client Group:

This service is available to individuals aged 18 years and over who have assessed needs that can be met with the provision of a short term intervention, equipment and/or TeleCare/alarm service.

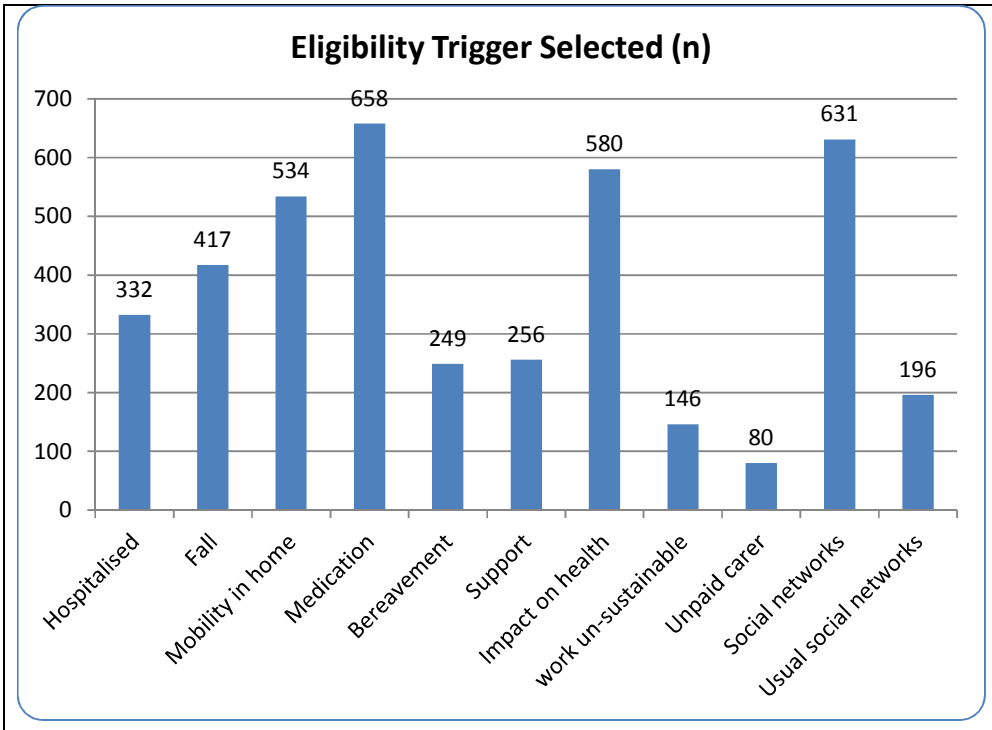
Headline Performance Issues:

- From 1 April 2014 up until 13 July 2014 there have been 891 eligibility checks, 844 (95%) have been referred through to the Wellbeing Service to undertake a face to face assessment and the remaining 47 were signposted either directly to the Wellbeing Service Partners for the self-funding route, or to a more appropriate agency.

- Prior to the WBS 60% of people who called up for Adult Care Service were sign posted to other agencies. With the Wellbeing Service in place there is now an opportunity to support these people earlier through easier access to low level support and equipment services.

- Previously these 891 would have likely been sign posted, as these people would generally fall under the Low/Moderate criteria for Adult Care service, as such they would not have received a service.

The four leading eligibility triggers which have been the most hit are with medication, social network (isolation), impact on heath and mobility at home being.



The table above shows the 11 eligibility triggers for the WBS and which ones are most commonly identified.

Emerging Outline Strategy:

The Wellbeing Service is a key driver within a number of programmes within Lincolnshire and fundamental to the emerging Wellbeing Strategy. This commissioning strategy aims to assist improvements in the health and wellbeing of the population as a whole; it covers advice, information and preventative services.

The Wellbeing service will identify gaps in provision, services and customer need as the service delivers and progresses. This will inform and influence commissioners as part of the commissioning cycle. The WBS is delivered by four providers across the county – one being the countywide monitoring service. With the non-monitoring elements of the WBS being delivered across the county by three providers, including two District Council emerging service delivery solutions will be identified, tested and integrated where appropriate.

The service will be independently evaluated along with ongoing internal review, assessment against objectives.

Anticipated benefits and outcomes:

The overarching service outcomes are:

- People have easy access to a wide range of information that will enable them to make informed decisions about their own wellbeing, in good time to plan ahead

- People receive targeted preventative services or assistance at an early stage that will help them remain independent in their own homes and communities
- People, particularly those who are frail and vulnerable, feel secure, cared for, have a good quality of life and feel part of a supportive, enabling community

The Wellbeing Service is designed to help local people achieve multiple outcomes for as long as possible. The support provided should contribute to all of the following National outcomes:

- NHS Outcomes Framework 2.3.i Reduced unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
- NHS Outcomes Framework 2.6ii Effective post-diagnosis care in sustaining independence and improving quality of life
- NHS Outcomes Framework 2 Enhanced quality of life for people with long term conditions
- NHS Outcomes Framework 3.6.i Increased proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into enablement/rehabilitation services
- Adult Social Care Outcomes Framework 1G Increased proportion of adults with a learning disability who live in their own home
- Adult Social Care Outcomes Framework 2A Reduced admissions to residential and nursing care homes
- Adult Social Care Outcomes Framework 1B Increased proportion of people who use services have control of their daily life
- Adult Social Care Outcomes Framework 2A Reduced/delayed permanent admissions to residential care homes
- Public Health Outcomes Framework 4.11 Reduced emergency readmissions within 30 days of discharge from hospital
- Public Health Outcomes Framework 4.16 Dementia and its impacts (placeholder)
- Public Health Outcomes Framework 1.6 Increased number of people with a mental illness and/or disability in settled accommodation.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The service described above is jointly commissioned by:

- Public Health
- Adult Social Care
- Health (in relation to the Home safe element)

The service is provided by:

- North Kesteven District Council
- East Lindsey District Council
- Lincolnshire Independent Living Partnership
- Mears 24/7

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Joint Strategic Needs Assessment (p16) highlights the need for Wellbeing and Older People in particular in relation to falls prevention, income maximisation and support.

http://www.research-lincs.org.uk/Joint-Strategic-Needs-Assessment.aspx

Public Health Market Position Statement (p7-10) evidences the current supply and demand of clients and services. (p13) states what is needed to meet this demand, including prevention, telecare, partnership working and improved access to information.

http://www.lincolnshire.gov.uk/residents/adult-social-care/for-providers/key-documents/market-position-statement-2013/116472.article

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Benefits:
- All elements within Wellbeing will be preventative, designed to enhance well-being, and reduce or delay escalation to higher level services.
- Better self-management of health issues leading to an increased level of independent living and less demand on emergency services.
- Improved accessibility to services by introducing a signposting service, removing entry criteria, and boundaries; vulnerable people will be able to access services more easily when they need them.
- Improved mobility throughout service provision - the service will be a joined up matrix of personalised support services that will enable people to seamlessly get help when required. Services offered will be part of an integrated pathway with social care and NHS community services.
- The model will offer an exit route for those clients whose Adult Social Care services have been reduced.
- Fit for purpose services - the new service model will enable Public Health to redesign its commissioning strategy within Lincolnshire. By proactively identifying need early and adopting a principled approach to commissioning; commissioners

can ensure that services are fit for purpose and provision is balanced across the county.

- Will enable the potential for a consortia approach to commissioning which will encourage partnership working.
- Developed specifications will demonstrate increased capacity, demand management and added value.

Volumes expected to be supported:

District	Total number of current users	Estimated percentage of growth need	Projected total number of users
Boston	1,051	16%	1,219
East Lindsey	1,562	14%	1,781
City of Lincoln	1,244	17%	1,455
North Kesteven	1,660	12%	1,859
South Holland	1,256	14%	1,432
South Kesteven	1,578	13%	1,783
West Lindsey	1,058	13.50%	1,201
County Wide Services	182	14%	207
Total In Scope	6,369		7,298

The current level of service provision is **estimated at 6369** service users; we expect this to increase during the life of the contract. The growth percentage is derived from the Market Position Statement.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

At a strategic level the Wellbeing Service is overseen by Public Health Directorate Management Team, and overseen by the Proactive Care Working Group feeding directly in to the Proactive Care Board and the Health and Wellbeing Board.

At an operational level, success will be measured utilising the Public Health Quality Assessment Framework and performance data.

The key elements looked at are:

- Assessment and Support Planning
- Security, Health and Safety
- Safeguarding and Protection from Abuse
- Fair Access, Diversity and Inclusion
- Client Involvement and Empowerment

What are the key success factors for implementation of this scheme?

- Improve wellbeing and independence of vulnerable adults.

- Delay escalation of vulnerable adults into higher level health and social care interventions
- Greater personalisation of services
- Greater focus on outcomes not activities
- More effective partnership working and co-production
- Greater focus on reablement and support that maximises independence
- Service users and carers have more choice and control over how their needs are met
- Ensuring value for money by improving efficiency and performance against Government targets for service delivery
- Safeguarding of vulnerable people