County Offices
Newland
Lincoln
LN1 1YL

17 September 2018

Lincolnshire Health and Wellbeing Board

A meeting of the **Lincolnshire Health and Wellbeing Board** will be held on **Tuesday, 25 September 2018 at 2.00 pm in Committee Room One, County Offices, Newland, Lincoln LN1 1YL** for the transaction of the business set out on the attached Agenda.

Yours sincerely

Keith Ireland
Chief Executive

MEMBERS OF THE BOARD (*)

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

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

District Council: Councillor Donald Nannestad

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

Healthwatch Lincolnshire: Sarah Fletcher

NHS England: Jim Heys

Police and Crime Commissioner: Marc Jones

Lincolnshire Co-Ordinating Board: Elaine Baylis

LINCOLNSHIRE HEALTH AND WELLBEING BOARD AGENDA
TUESDAY, 25 SEPTEMBER 2018

actions to reduce the demand on policing from mental health, with benefits for the entire health and care system)

7c **Consultation on the Contracting arrangements for Integrated Care Providers (ICPs)** 127 - 172

(To receive a report by Derek Ward (Director of Public Health) on the NHS England consultation on the contract arrangements for Integrated Care Providers)

7d **Social Housing Green Paper Consultation** 173 - 182

(To receive a report from the Housing Health and Care Delivery Group on the social housing green paper consultation. The consultation outlines the government's proposals for addressing some of the issues raised by social housing tenants following the Grenfell Tower tragedy. The paper asks the Board if it wishes to respond to the consultation)

8 Information items

8a **An Action Log of Previous Decisions** 183 - 184

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

8b **Lincolnshire Health and Wellbeing Board Forward Plan** 185 - 186

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

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

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

Contact details set out above.

All papers for council meetings are available on:
www.lincolnshire.gov.uk/committeerecords

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LINCOLNSHIRE HEALTH AND WELLBEING BOARD
5 JUNE 2018

PRESENT: COUNCILLOR MRS S WOOLLEY (CHAIRMAN)

Lincolnshire County Council: Councillors Mrs W Bowkett, R L Foulkes, C R Oxby and N H Pepper

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

District Council: Councillor Donald Nannestad (District Council)

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

Healthwatch Lincolnshire: Sarah Fletcher

NHS England: Hayley Jackson

Police and Crime Commissioner: Joanne Davison

Lincolnshire Co-Ordinating Board: Elaine Baylis

Officers In Attendance: Andrea Brown (Democratic Services Officer) (Democratic Services), Alison Christie (Programme Manager, Health and Wellbeing Board), Ruth Cumbers (Urgent Care Programme Director, Lincolnshire East CCG), Hayley Jackson (NHS England (Leicestershire and Lincolnshire Area)), Tony McGinty (Interim Director of Public Health), David Stacey (Programme Manager, Public Health), Councillor Dr Michael Ernest Thompson and Melanie Weatherley (Chair of Lincolnshire Care Association (LinCA))

1 ELECTION OF CHAIRMAN

RESOLVED

That Councillor Mrs S Woolley be elected as the Chairman of the Lincolnshire Health and Wellbeing Board for 2018/19.

COUNCILLOR MRS SUE WOOLLEY IN THE CHAIR

2 ELECTION OF VICE-CHAIRMAN

RESOLVED

That Dr Sunil Hindocha be elected as the Vice-Chairman of the Lincolnshire Health and Wellbeing Board for 2018/19.

3 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillors C E H Marfleet, Mrs P A Bradwell and C N Worth, G Garrod and Dr S Baird.

Apologies for absence were also received from Marc Jones (Police and Crime Commissioner), who was replaced by Joanne Davison (Partnerships and Delivery Manager, Office of the Police and Crime Commissioner), and Jim Heys (NHS England) was replaced by Hayley Jackson (NHS England).

4 DECLARATIONS OF MEMBERS' INTEREST

There were no declarations of Members' interest received at this point of the proceedings.

5 MINUTES OF THE MEETING OF THE LINCOLNSHIRE HEALTH AND WELLBEING BOARD HELD ON 27 MARCH 2018

RESOLVED

That the minutes of the meeting held on 27 March 2018 be confirmed and signed by the Chairman as a correct record.

6 ACTION UPDATES FROM THE PREVIOUS MEETING

RESOLVED

That the completed actions, as detailed, be noted.

7 CHAIRMAN'S ANNOUNCEMENTS

The Chairman referred to the announcements published within the agenda pack and those circulated to the Board under separate cover.

In relation to the Ofsted Report, the Executive Director for Children's Services confirmed that the team was delighted at the outcome. The staff had worked tirelessly and achieved a good outcome following the focussed visit by Ofsted. It was acknowledged that further work was required to improve services but the overall outcome was that the authority was working extremely well to improve outcomes for children.

RESOLVED

That the Chairman's announcements be noted.

8 DECISION/AUTHORISATION ITEMS

8a Terms of Reference and Procedure Rules, Roles and Responsibilities of Core Board Members

Consideration was given to a report by Alison Christie (Programme Manager Health and Wellbeing) which invited the Board to reaffirm the Terms of Reference, Procedure Rules and roles and responsibilities of Board Members.

It was agreed that the Key Roles and Responsibilities of Individual Core Members, as listed on pages 46 and 47 of the agenda pack, should also include the Office of the Police and Crime Commissioner and the Chairman of the Lincolnshire Coordination Board of the STP.

One Member suggested that the information items should be circulated via email only and not be included on the agenda at Board meetings. This was acknowledged and the Board advised that this was the intention.

RESOLVED

That the Terms of Reference, Procedural Rules and Board Members' Roles and Responsibilities, with the amendment noted above, be reaffirmed.

8b Joint Health and Wellbeing Strategy for Lincolnshire 2018

Consideration was given to a report by David Stacey (Programme Manager Strategy and Performance) which asked the Board to formally sign-off the new Joint Health and Wellbeing Strategy for Lincolnshire and all associated delivery plans.

The four key elements of the report were highlighted to the Board:-

1. New Joint Health and Wellbeing Strategy;
2. Delivery Plans;
3. Governance and Accountability Framework; and
4. Feedback from Engagement.

The following priority areas for the new Joint Health and Wellbeing Strategy (JHWS) had been agreed by the Board and it was confirmed that Obesity remained a key priority for consideration:-

- Mental Health and Emotional Wellbeing (Children & Young People);
- Mental Health (Adults);
- Carers;
- Physical Activity;
- Housing;

- Obesity; and
- Dementia.

Each of the Priority Delivery Groups had been working on the development of more detailed delivery plans for each of their respective priority areas within the JHWS.

The Governance and Accountability Framework provided a more formalised governance arrangement and included a process for the Board to undertake regular reviews and updates following further prioritisation discussions as and when required.

A summary of engagement feedback was included within the report and was intended to share and discuss the outcomes with each of the priority delivery groups to ensure this was considered within ongoing delivery planning, where appropriate.

There were no questions asked of officers in relation to this report.

RESOLVED

1. That the publication of the Joint Health and Wellbeing Strategy document be agreed;
2. That the basis for progressing the delivery of the Joint Health and Wellbeing Strategy for Lincolnshire by way of Delivery Plans be agreed;
3. That the adoption of the proposed Governance and Accountability Framework by the Lincolnshire Health and Wellbeing Board be agreed; and
4. That the feedback from the most recent online engagement be noted.

9 DISCUSSION ITEMS

Due to the availability of officers, it was agreed that agenda item 9b – "*Health and Care Workforce – Recruitment and Retention*" be taken prior to item 9a – "*Winter review and Planning*".

9a Health and Care Workforce - Recruitment and Retention

Dr Adrian Tams (Workforce Transformation Manager (Lincolnshire)) gave a presentation which highlighted the issues faced in Lincolnshire and the steps being taken to address staff shortages and skills gaps.

The presentation included the following slides:-

- Lincolnshire Workforce Challenges;
- Context;
- Lincolnshire isn't alone……;
- July 2017 – May 2018 STP Data;
- Local Workforce Context (Planned and Current Workforce Data across Providers);
- Lincolnshire Issues
    - Attraction, Recruitment and Retention;
    - Workforce Supply, Demand and Planning;

- Addressing the Issues
    - Local Workforce Action Board & Sustainability and Transformation Partnership;
    - Workforce Transformation: A to B Plan;
    - Talent Academy – 'Grow our own';
    - University of Lincoln & Medical School; and
    - National Centre for Rural Health and Social Care;
- 5 NHS Priorities
    - Mental Health;
    - Cancer;
    - Urgent and Emergency Care;
    - Integrated Care and Public Health; and
    - Maternity
- Workforce Action Groups (programmes of work to ensure the delivery of the Workforce and OD Strategies)
    - STP Programme Board;
    - Workforce Delivery Group (HR Streamlining; Partnership; and Talent Academy);
    - LWAB;
    - Workforce & OD Programme Board;
- LWAB/STP – Partnership Working;
- Workforce Transformation – Whole Systems Partnership;
- Workforce Development;
- Conclusions
    - Lincolnshire Healthcare Workforce is suffering from a number of workforce issues;
    - Considerable partnership working with Health Education England, providers, social care and HEI's although more collaboration needed;
    - Issues are being addressed in Lincolnshire;
    - Health and Wellbeing Board – integrated partnership, collaboration and inclusion into the STP, Workforce and OD Programme Board and Workforce Planning activities.

Members were invited to ask questions, during which the following points were noted:-

- It was explained that a lot of work was ongoing with Lincolnshire Partnership NHS Foundation Trust (LPFT), jointly with the CCGs, in relation to children and young people and mental health issues;
- The comparison between Lincolnshire and other areas was discussed and noted that Nottingham had considerably higher staff shortages within mental health than Lincolnshire. In comparison to neighbouring counties, Lincolnshire was reported to be favoured reasonably. Additionally, contracts within LPFT were being reviewed to consider amendments in order to make it easier for staff to work across boundaries;
- The Director of Human Resources and Organisational Development at United Lincolnshire Hospitals NHS Trust (ULHT) explained that there had been difficulty in attracting children's nurses and paediatricians although there had been more success recently in attracting nurses. He continued to explain that

middle grade doctors remained an issue for the Trust but that work continued to attract doctors from overseas;

- Although NHS standards for recruitment remained, there had been a considerable amount of work done locally to reduce the length of time taken to recruit staff;
- The Chairman of the Lincolnshire Coordinating Board for the STP reported that she had met with the Minister of State for Health and Social Care, who fully understood the challenges in relation to delivery of health services in rural counties which could help to support future plans;
- Health Education England fully supported work with local universities and the development of a fast track programme but acknowledged that retention of students following the completion of degrees remained an issues;
- Clearer workforce plans were required to improve the overall issues in Lincolnshire. There was now better partnership working between organisations which meant that workforce plans were more detailed and focussed. However, it was stressed that any support that the Health and Wellbeing Board could give in this area would be appreciated;
- The expectation of the public would require effective management, to ensure that the way in which healthcare was delivered by GPs in the future was clear as this provision would be very different; and
- The Board was reminded that there were over 20,000 people employed within health and social care who were not employed by the NHS.

The Chairman invited representatives from educational establishments within the county to address the Board:-

- Professor Scott Fleming (Executive Dean – Research, Knowledge Exchange and External Engagement at Bishop Grosseteste University) confirmed that the National Centre for Rural Health and Care would be housed at Bishop Grosseteste University and would take residence once the building had been renovated;
- Mark Locking (Managing Director Education and Training – Lincoln College) explained that this had been an area which the college had not been particularly productive in. They were now seriously considering this type of pathway and were currently in discussions with a large national healthcare provider looking at study programmes for 16-18 year olds. The challenge for the college was staffing and being able to secure the appropriate level of lecturers to be able to successfully deliver these pathways. Additionally, there was a need to find a way to promote this work to young people who, generally, were not interested in pursuing this type of pathway. The college also offered apprenticeships but struggle to recruit to them as young people did not see the long term benefits. Additionally, full funding for very low income households for adult learning was available and part-funding of certain qualifications for adults. However, exertion of political pressure to part or fully fund qualifications would help colleges to do more; and
- Professor Andrew Hunter (Deputy Vice Chancellor – University of Lincoln) explained that there was an enormous amount of preparatory work being done by the university to ensure the Medical School would be ready to recruit

students from 2019. A visit from the General Medical Council (GMC) was expected on 20 July 2018. The Board was advised that these students would not qualify as practitioners until 2024. Recruitment of lecturers was also being pursued from existing staff within NHS Trusts in Lincolnshire.

The Chairman gave thanks for the frank updates and looked forward to working together to pursue this area further.

RESOLVED

That the report and presentation be noted.

9b Winter Review and Planning

Consideration was given to a report by the Lincolnshire Urgent Care and Emergency Care Delivery Board which provided details of system resilience during Winter 2017/18 and the forward planning process across the health and care system.

Ruth Cumbers (Urgent Care Programme Director – SRO STP Urgent Care Programme) introduced the report which provided detail on the following areas:-

- Background;
- Local Context;
- What is behind the pressures?
- Local and national responses to increased pressures;
- Patient Impact;
- Forward Planning Winter 2018/19;
- Governance and Assurance Links;
- Seasonally related illness;
- Winter Communications Plan;
- Business Continuity Plans;
- Demand and Capacity Modelling;
- Supporting the Acute Trust: minimising admissions, improving flow and reducing DTOCs;
- Primary Care;
- Lincolnshire Partnership Foundation NHS Trust (LPFT);
- Lincolnshire Community Health Services (LCHS);
- East Midlands Ambulance Service NHS Trust (EMAS); and
- Lincolnshire County Council (LCC).

The Chairman advised that the report had been thorough and to the point before inviting Members to ask questions, during which the following points were noted:-

- It was reported that a Medical Fit for Discharge Procedure had been finalised and approved and would be fully implemented by September 2018;
- Urgent care streaming had been imposed on Trusts by NHS England and this was to be done within a certain timescale. It was explained that those timescales had been met in Lincolnshire although it was known that the model implemented at such short notice would not be effective. As a result of that, a

new specification had been put in place from 1 May 2018, with LCHS delivering the service in Lincoln and Boston;

- Urgent care streaming had also been implemented at Grantham Hospital following the overnight closure but it was stressed that this facility had never been a Minor Injuries Unit as the demand had not been enough to justify the service and it was discontinued;
- It was confirmed that interim beds were still available but stressed that these were interim and that people should go home. The decision was made to better utilise the reablement service to ensure patients could be independent on discharge. It was suggested that patients became dependent once admitted to an acute bed. Unfortunately, convalescence was not a national policy;
- It was suggested to be beneficial to hold further discussions in relation to pressures in acute paediatrics, child protection medical and the requirements needed to be able to work jointly.

RESOLVED

That the report and contents be considered and noted.

10 INFORMATION ITEMS

10a Better Care Fund

The Board received a report by Glen Garrod (Executive Director of Adult Care and Community Wellbeing) which provided an update on the Better Care Fund (BCF) in Lincolnshire for 2017-2019 and included the current position in relation to finance and performance.

RESOLVED

That the report for information be received.

10b Health and Wellbeing Grant Fund - Update

The Board received a report from Alison Christie (Programme Manager Health and Wellbeing) which provided the half-yearly information on Health and Wellbeing Grant Fund Projects.

RESOLVED

That the report for information be received.

10c An Action Log of Previous Decisions

The Board received a report which noted the decisions taken since June 2017.

RESOLVED

That the report for information be received.

10d Lincolnshire Health and Wellbeing Board Forward Plan

The Board considered the Forward Plan of the Lincolnshire Health and Wellbeing Board which provided Members with an opportunity to discuss the items for future meetings which would, subsequently, be included on the Forward Plan.

A suggestion was made to consider the STP in September as a Discussion Item rather than an Information Item. Further to discussion, it was agreed that this would be a Discussion Item and that direction of travel and process to-date could be discussed in the public domain.

The Chairman of the Lincolnshire Coordinating Board of the STP agreed to bring a paper to the next meeting in order to share as much information and progress as possible.

RESOLVED

That the report for information be received.

10e Future Scheduled Meeting Dates

The Board received the scheduled meeting dates for the remainder of 2018 and for 2019, all of which will commence at 2.00pm:-

Tuesday 25 September 2018;
Tuesday 4 December 2018;
Tuesday 26 March 2019;
Tuesday 11 June 2019;
Tuesday 24 September 2019; and
Tuesday 3 December 2019.

It was confirmed that electronic appointments would be sent to the Board in due course.

RESOLVED

That the meeting dates be noted.

The meeting closed at 3.45 pm

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Meeting Date	Minute No	Agenda Item & Action Required	Update and Action Taken
05.06.18	**8a**	**TERMS OF REFERENCE AND PROCEDURE RULES, ROLES AND RESPONSIBILITIES OF CORE BOARD MEMBERS** Key roles and responsibilities of individual core members, as listed on pages 46 and 47 of the agenda pack, should also include the Office of the Police and Crime Commissioner and the Chairman of the Lincolnshire Coordination Board of the STP	The key roles and responsibilities have been updated to include the Office of the Police and Crime Commissioner and the Chairman of the Lincolnshire Coordination Board of the STP.
	8b	**JOINT HEALTH AND WELLBEING STRATEGY FOR LINCOLNSHIRE 2018** • That the publication of the Joint Health and Wellbeing Strategy document be agreed; • That the basis for progressing the delivery of the Joint Health and Wellbeing Strategy for Lincolnshire by way of Delivery Plans be agreed; • That the adoption of the proposed Governance Accountability Framework by the Lincolnshire Health and Wellbeing Board be agreed;	The Joint Health and Wellbeing Strategy, along with the delivery plans and supporting documentation, have been published on the council's website. Communications have been sent to key partners and stakeholders to promote the strategy and an article has appeared in June's HWB newsletter. Over the summer the Chairman, Director of Public Health and the Programme Managers have attended a number of events and meetings around the county to promote the strategy. Ongoing engagement will be built into the JHWS programme over the life span of the strategy.

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Lincolnshire Health and Wellbeing Board – 25 September 2018

Chairman's Announcements

Joint Health and Wellbeing Strategy – update

I am pleased to report that a meeting is scheduled to take place on 16 October 2018 with key partners to discuss the establishment of a specific delivery group for the obesity priority in the Joint Health and Wellbeing Strategy. The multi-agency group will be tasked with tackling the issue of obesity in Lincolnshire by building on good practice from elsewhere, such as the Whole Systems Obesity Programme. The new strategic delivery group will be supported by and accountable to the Health and Wellbeing Board.

In addition, a workshop has been arranged on 26 November 2018 with all the JHWS delivery groups In order to identify the linkages and independences between the JHWS priorities. It will also provide an opportunity to identify opportunities common issues that require joint working or action planning. An update on this event will be shared with the Board at the next meeting.

Sustainability & Transformation Partnership – update

STPs are five year plans covering aspects of NHS planning and care delivery in England. The Lincolnshire STP is one of 44 'footprints' established nationally and is in year two of the five year plan. During 2017/18, STPs have evolved from plans, to partnerships and current national thinking describes STPs as working at a system level with a co-ordinating function. There is a clear expectation that all STP 'footprints' including Lincolnshire, move towards system working in the best interests of patient care and the NHS as a whole.

The Lincolnshire STP, as a plan, has been through an intense period of planning and preparation, and the majority of the work in 2017/18 has been focused on the initial mobilisation which is seeing real improvements for our patients and staff in areas such as mental health and learning disabilities services, the '100' day improvement programme for dermatology, diabetes and ophthalmology and the development of community services such as neighbourhood integrated working. This year, the Lincolnshire STP is working on four key priorities which are System Working, Out of Hospital Delivery, Acute Service Delivery and Operational Efficiency. As we continue to further develop and put our plans into action this year, we are fully committed to continuing to engage and involve our stakeholders, including the public, our staff and partners. The STP priorities for 2018/19 are summarised in Appendix A.

A detailed progress report on the Lincolnshire's STP was presented to the Health Scrutiny Committee for Lincolnshire in June. A copy of that report can be accessed on the council's website.

Lincolnshire Safeguarding Adults Board Strategic Plan 2018 -2021

The Lincolnshire Safeguarding Adults Board (LSAB) have issued a new 3 year Strategic Plan. The development of the plan, which was approved at the LSAB meeting in June 2018, has been informed by the requirements of legislation, consultation with stakeholders and the outcome of a Peer Review. The strategic objectives are:

- to develop and improve our early help and preventive practice

- to develop effective service user and carer engagement
- to develop a quality and assurance framework
- to continue to develop the ethos and practice of Making Safeguarding Personal (MSP)
- to measure and demonstrate the success of our policies and practice.

The new governance arrangements will come into effect from the LSAB Executive Board meeting on 26 September 2018.

A copy of the Strategic Plan is available at: https://www.lincolnshire.gov.uk/lsab/the-lsab/127496.article

Police and Crime Commissioner Annual Report 2017/18

The Police and Crime Commissioner (PCC) Annual Report sets out the achievements made during 2017/118 to deliver on the promised in the Safer Together Plan (the local Community Safety, Policing and Criminal Justice Plan).

A key focus for the PCC has been to ensure that Lincolnshire Police has the capability to help prevent harm in the county's communities as well as find, intercept and arrest criminals. The Annual Report also details how the PCC office has brought partners together from the health service, local authorities, chief officers, criminal justice and the third sector to draw up and deliver strategies on a range of joint issues.

A copy of the Annual Report is available at: https://lincolnshire-pcc.gov.uk/transparency/what-our-priorities-are-and-how-we-are-doing/annual-reports/

Beyond Barriers: how older people move between health and care in England

This report, published by the Care Quality Commission, looks at how services are working together to support and care for people aged 65 and over. Many older people have complex and long term care needs that need more than one professional and more than one service. Their experience depends on how well services work together with and for them, their families and carers.

The report is based on the findings from 20 reviews undertaken by the CQC of local health and care systems which found:

- Organisations intended to work together but mostly focused on their own goals
- Although there was good planning between services, the way services were funded did not support them to work together
- Organisations:
    - were prioritising their own goals over shared responsibility to provide person centred care
    - did not always share information with each other which meant they weren't able to make informed decisions about people's care
    - were not prioritising service which keep people well at home
    - planned their workforce in isolation to other services.
- The regulatory framework focuses only on individual organisations.

The full report is available at: https://www.cqc.org.uk/publications/themed-work/beyond-barriers-how-older-people-move-between-health-care-england

Out of hours service in Lincolnshire – Care Quality Commission Inspection

On 20 August 2018, the Care Quality Commission published its inspection report on the Lincolnshire out of hours service, which is operated by Lincolnshire Community Health Services NHS Trust. The overall finding from the inspection was '*Good'.* Although the service was previously rates as *Good* in 2017, improvements acknowledged with the report include:

- progress with the implementation of the medical workforce model, including employing GPS rather than using locums;
- an increase in the number of advanced clinical practitioners; and
- systems in place to ensure medicines are dispensed safely and in the appropriate packaging.

The full report is available at: https://www.cqc.org.uk/location/RY5H1

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The Four System Priorities

1. System working

Commitment to system working, with common purpose, standards and outcomes for the benefit of the Lincolnshire population. Application of all of our collective resources to deliver better outcomes, while ensuring that we live within the funds available across the system.

2. Out of Hospital Delivery

Ensuring out-of-hospital care becomes a much larger part of what the NHS in Lincolnshire does: moving care and resources from acute hospitals to neighbourhood networks providing care closer to home

3. Acute Services Delivery

Developing a smaller but more resilient acute hospital sector: considering current and projected future needs for hospital services, taking into account planned developments in prevention, supported self-care and out of hospital care in line with the STP

4. Operational Efficiencies

Maximising NHS service efficiency to increase resources available for frontline services: reducing management costs, increasing the use of technology, procuring more effectively, reducing costly duplication and maximising the benefits of scale

2018/19 programmes of work

- System Coordination
- Meeting national STP requirements
- Strategic Planning
- System Finance & Contracting
- Analytics & Performance
- Diagnostics
- Transport
- Large scale change & OD
- IM&T & Information Governance
- Estates and Capital
- Workforce
- Communications & Engagement
- System Equality and Diversity Assessment
- System Programme Management Office

- ***Out of Hospital Delivery Programme:*** align & design of services; population health management
- ***Integrated Neighbourhood Working and Self Care***: developing core teams, clear pathways including frailty; care home support; neighbourhood networks; strengthen transitional care; determine the role of community hospitals
- ***Primary Care***: delivering GP Five Year Forward View
- ***Cancer***: supporting people living with & beyond cancer
- ***Continuing healthcare***
- ***Urgent & Emergency Care***: supporting self-care; extended use of CAS; commission integrated CAS, OOH & streaming; develop Urgent Treatment Centres
- ***Planned Care***: demand & referral management; community pain management service
- ***Mental Health***: transforming community services
- ***Women & Children***: redesigning community paediatrics; delivering Better Births standards

- ***Acute Services Review (ASR):*** engagement; developing the pre-consultation business case for the new models of care; consultation
- ***Delivering 2018/19 ASR priorities***: Increase elective activity at Louth and elective orthopaedics & general surgery at Grantham; enhance ambulatory pathways at Lincoln PAU; 7 day acute stroke community rehab
- ***Urgent & Emergency Care***: A&E redesign
- ***Planned Care***: MSK pathway service redesign
- ***Cancer***: delivering the Cancer High Impact changes; acute pathway for breast services; prostate rapid diagnosis pathway
- ***Women & Children***: redesigning acute paediatrics; delivering the Better Births standards
- ***Mental Health***: reducing out of area placements

- ***Pharmacy and prescribing:*** Countywide QIPP pharmacy & prescribing programme ; rationalisation of prescribable products & Off FP10 Supply; electronic prescribing and robotic dispensing in acute care; clinical pharmacists in primary care; repeat prescription management – prescription ordering direct
- ***Procurement transformation:*** Maximising procurement efficiencies
- ***Estates efficiency***: Review of estate by corporate functions
- ***Workforce efficiency***
- ***Corporate services transformation***: review and implementation of shared services arrangements

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Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**25 September 2018**
Subject:	**Better Care Fund**

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

Actions Required:

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

1. Background

The Lincolnshire Better Care Fund for 2016/17 was £196.5m. The original plan submitted for 2017 – 2019 shows sums of £226m for 2017/18 and £235m for 2018/19. The values were revised in 2017/18 to £222m and £230m respectively.

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

BCF 2017/18 and 2018/19

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

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

- An overall BCF Plan now totalling £222m for 2017/18 and £230m for 2018/19

- Agreement that the 'Minimum Mandated Expenditure on Social Care from the CCG minimum' complies with national requirements for a 1.79% and then 1.9% increase, making the amount provided for the Protection of Adult Care Services £17.13m in 2017/18 and £17.465m in 2018/19.
- Over the three years of the overall iBCF funding to March 2020 the funding will be invested in:

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

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

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

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

2. General BCF Update

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

- An updated accountability structure and funding flow diagrams reflecting recent changes to relevant government departments
- Funding conditions which have now reduced from eight to four (as announced last year) those being:

    i. That a BCF Plan, including at least the minimum contribution to the pooled fund specified in the BCF allocations, must be signed off by the local Health & Wellbeing Board, and by the constituent Local Authority and Clinical Commissioning Groups;
    ii. A demonstration of how the area will maintain in real terms the level of spending on social care services from the CCG minimum contribution to the fund in line with inflation;

iii. That a specific proportion of the area's allocation is invested in NHS-commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement; and
iv. All areas to implement the High Impact Change Model for Managing Transfer of Care to support system-wide improvements in transfers of care.

- Refreshed Metric Plans for 2018-19
- Confirmation of the combined quarterly reporting process for BCF and IBCF funds
- Updated support, intervention and escalation processes.

A copy of the guidance is included in Appendix A

The guidance provides a brief update on the Graduation process suggesting that shortlisted areas for Graduation will be confirmed in 2018-19. In addition to the changes described above the guidance also give BCF systems the opportunity to revise existing plans and confirm any changes to regional Better Care Support Teams (BCST)

The Lincolnshire BCF has recently been reviewed which will result in minor changes to BCF expenditure plans which are as follows.

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

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

These have been agreed in principle by the Lincolnshire Joint Executive Team (JET), and a letter issued to BCST confirming the changes ahead of 24th August 2018 deadline (Appendix B). Guidance allows formal confirmation to be given retrospectively and once formally approved by JET approval will be sought through the Lincolnshire Health and Wellbeing Board at the earliest opportunity.

3. Finance

The finance update is shown as Appendix C which describes the current outturn position against the current budgeted BCF for 2018/19 (£230m) and includes:-

- CCG funding for the Protection of Adult Care Services - £17.465m
- iBCF funding announced in the November 2015 budget - £14.249m
- iBCF Supplementary funding announced in the March 2017 budget - £9.209m
- Disabled Facilities Grant (DFG) allocations to District Councils - £5.698m
- Existing agreements included within BCF as a whole - £183.027m

Current analysis as at 31 July 2018 and illustrated by Appendix C suggests that total spend against the BCF will total £233.108m this financial year. This represents an overspend of £3.460m (1.51%) against the total allocation of £229.648m.

Spending against the first four principle funding areas of the BCF is projected to balance against their respective allocations (£46.621m).

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

- Learning Disability S75 Agreement is projected to produce an overspend of £2.278m against a budget of £72.607m. This has been reported to the LD Joint Delivery Board.

- Integrated Community Equipment Services (ICES) S75 Agreement is also projected to produce an overspend of £1.182m against a budget of £5.800m. This has been reported to the ICES Strategic Partnership Board.

In both cases any projected overspend will be dealt with via existing risk arrangements detailed in both of the relevant S75 agreements.

4. Performance

An expanded BCF performance report for Quarter 1 2018/19 is shown as Appendix D. Highlights from the latest available ratified data include:

- ***Non-Elective Admissions –*** A total of 20,197 admissions were made during the quarter, which is an average of 6,732 per month – this is a lower average than last year at 6,993. It is also lower than the same period in 2017/18 when the total was 21,032.

- ***Residential Admissions*** – Permanent Residential admissions for older people Quarter 1 have continued the trend of last year in remaining lower than expected, with 125 placements being made in the quarter.

- ***Delayed Days –*** The Quarter 1 total of 6,117 delayed days exceeded the target of 6,547 by a 6.6% difference. The number of delays is lower (1,329 days) compared to the same period in 17/18. The proportion of social care delays has increased from 9% in Q4 17/18 to 13% however the proportion of NHS delays has fallen from 72% to 68% in Q1 while proportion of joint delays has remained fairly consistent at 19%. From April 18 to June 18 there has been a 3.2 decrease on the average number of delays per day.

  The average delayed beds per day was 64.7 at the end of Q1, the expected target for Lincolnshire has been set at 58.7 to be achieved by September 2018. This will require further reductions in delayed bed days over July, August and September.

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

improvement on 16/17 where the outturn was 75.4%. This has been assisted by improved volume and outcomes performance of the reablement providers in Lincolnshire. Although we will not be able to report this 91 day indicator on a quarterly basis, we will reablement activity and performance to provide assurance for this key area.

- **iBCF and Local Measures** - A number of local data measures have been added to the performance report for the BCF. The aim is to give a more thorough and granular picture of performance and activity funded by the BCF in Lincolnshire through the various schemes and projects. The report is not yet complete, but data development activity will be ongoing throughout the year to expand the suite of measures with robust and timely data.

5. Conclusion

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

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

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

7. Consultation

None required.

8. Appendices

These are listed below and attached at the back of the report	
Appendix A	BCF Operating Guidance - July 2018
Appendix B	Lincolnshire Letter to BCST – August 2018
Appendix C	BCF Finance Report 2018-19 - August 2018
Appendix D	BCF Performance Report – Q1 2018-19

9. Background Papers

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

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

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NHS England

Department of Health & Social Care

Ministry of Housing, Communities & Local Government

The Integration and Better Care Fund

Operating Guidance For 2017-19

Published 18 July 2018

Integration and Better Care Fund

Gateway publication reference 08287

CONTENTS

1. PURPOSE OF THIS DOCUMENT

1. This document is for local partners that agree and administer Better Care Fund 2017-19 plans – Clinical Commissioning Groups (CCGs), local authorities (LAs) and Health and Wellbeing Boards (HWBs).

2. This document sets out refreshed operating guidance for approved Better Care Fund (BCF) plans for 2017-19.

3. This document sets out:

   - accountability structures and funding flows for 2017-19 plans
   - refreshed metric plans for 2018-19
   - guidance on amending BCF plans
   - guidance on reporting on and continued compliance with BCF 2017-19 conditions
   - the support, intervention and escalation process
   - the legislation that underpins the BCF

4. This document should be read alongside the 2017-19 Integration and Better Care Fund Policy Framework (the Policy Framework)[1], published by Department of Health (now the Department of Health and Social Care or DHSC) and the Department for Communities and Local Government (now the Ministry of Housing, Communities and Local Government or MHCLG) and the Integration and Better Care Fund Planning Requirements for 2017-19 (the Planning Requirements), published by NHS England, the Department of Health and the Department for Communities and Local Government.[2] If there is any disparity between the Planning Requirements and this operating guidance then this operating guidance will take precedence. This includes changes to Delayed Transfer of Care metrics, legal powers and the process for escalation.

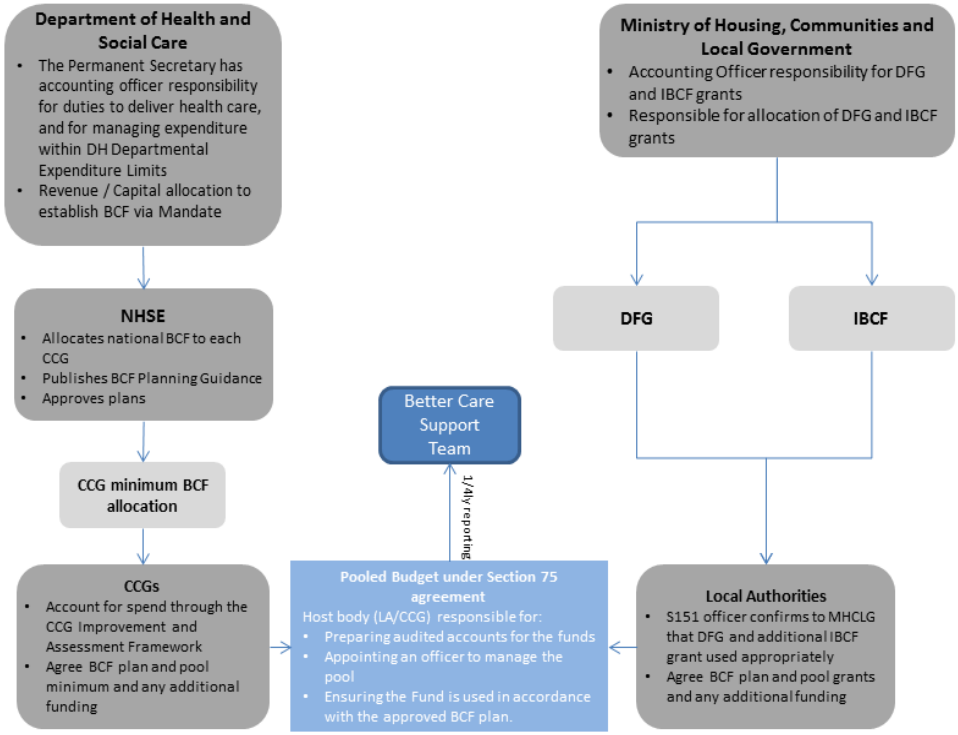
5. This document replaces the BCF Operating Guidance for 2016-17 and has been co-produced in consultation with BCF national partners.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/607754/Integration_and_BCF_policy_framework_2017-19.pdf

[2] https://www.england.nhs.uk/wp-content/uploads/2017/07/integration-better-care-fund-planning-requirements.pdf

2. ACCOUNTABILITY STRUCTURES AND FUNDING FLOWS IN 2017-19

6. The below diagram sets out the accountability arrangements and flow of funding for the BCF.



7. In summary, at a national level:

- The BCF funding for CCGs is part of NHS England's budget allocation.
- From 2017-18, the Improved Better Care Fund (iBCF) is paid to Upper Tier Local Authorities by the MHCLG and is part of the MHCLG's Departmental Expenditure Limit.
- MHCLG provides funding for the Disability Funding Grant (DFG), and MHCLG is accountable for the allocation of funds to local authorities, as well as for the policy framework. A Memorandum of Understanding, signed by both DHSC and MHCLG, governs this arrangement. A Grant Determination issued under section 31 of the Local Government Act 2003 requires that the DFG is spent in accordance with a BCF spending plan jointly agreed between the local authority and relevant CCGs.
- The BCF minimum funding allocation must be transferred into one or more pooled funds as established under section 75 of the NHS Act 2006 (s.75).
- The NHS England Accounting Officer (the Chief Executive) is accountable for the effective use of the BCF funding allocation to CCGs made by NHS England via the reporting requirements set out in NHS England's mandate from Government.
- Section 151 Officers (Chief Finance Officers) in local authorities are required to certify that the additional iBCF (the 2017 Spring Budget money) is being used exclusively on adult social care in 2018-19.The BCF funding allocations from the

CCGs to the BCF will pass from NHS England to CCGs through 2017-19 allocations, and then from CCGs to pooled budgets (via s.75 agreements).

- The iBCF and DFG funding will flow from MHCLG to LAs, and then into the pooled budget via s.75 agreements. In two tier areas, DFG funding will flow from the county to the districts (in full, unless jointly agreed to do otherwise).
- The monies will then be spent on services in line with the approved BCF spending plan for 2017-19.

8. At a local level:

    - As legal recipients of the funding, CCGs and LAs are the accountable bodies for the respective elements of the BCF allocated to them, and therefore responsible for ensuring the appropriate use of the funds. This means that they retain responsibility for spending decisions and monitoring the proper expenditure of the funding in accordance with the approved plan and their general duties.
    - CCGs (Accountable Officers) will be the accountable body for the BCF funding allocation allocated to them by NHS England (and any additional monies they plan to voluntarily add to the pooled fund), and will be held to account by NHS England for the appropriate use of BCF resources locally; and
    - LAs (section 151 officers) will be the accountable body, under the terms of their grant agreements, for the DFG and iBCF grant funding that comes from MHCLG (and any additional monies they plan to voluntarily add to the pooled fund).

9. HWBs are expected to continue to oversee the strategic direction of the BCF and the delivery of better integrated care, as part of their statutory duty to encourage integrated working between commissioners[3]. Given they are a committee of the LA, HWBs are accountable to elected members and ultimately to the electorate. Where members of a HWB include providers delivering care that is or could be commissioned under BCF, particular care should be taken to ensure that any conflicts of interest are dealt with appropriately.

10. The regulations[4] governing s.75 agreements require the agreement to set out (amongst other provisions):

    - the arrangements for monitoring the delivery of the services that it covers;
    - who the “host” organisation is that will be responsible for accounting and audit; and
    - who the “pool manager” is that will be responsible for submitting to the partners quarterly reports, and an annual return, about income and expenditure from the pooled fund, and other information by which partners can monitor the effectiveness of the pooled fund arrangements.

11. Therefore, arrangements for monitoring delivery, accounting and audit should be governed by the local s.75 agreement, in addition to the separate reporting and accountability arrangements each partner organisation will have for their share of the funding being pooled.

[3] Section 195 of the Health and Social Care Act 2012

[4] NHS Bodies and Local Authorities Partnership Agreements Regulations 2000

12. Guidance and support[5] is available from the Better Care Support Team (BCST) for local areas in developing their local s.75 agreements where required. Traditionally, s.75 agreements are governed by a partnership board made up of the bodies that have signed up to the agreement. Each individual who has signed the agreement should be authorised to act on behalf of their employing organisation, so the partnership board is able to make joint decisions.

13. Where a risk sharing arrangement linked to the Non-Elective Admissions (NEA) activity is put in place by the HWB through the planning process for 2017-19, local areas should ensure that arrangements for this are clear and there is a process in place for monitoring this locally. This should be detailed within s.75 agreements. If the local area chooses to use the model for a risk sharing arrangement set out by NHS England in the Planning Requirements (and summarised here at annex 1), then CCGs should ensure that they have withheld the funding related to NEA activity from the pooled fund at the beginning of the year as set out.

14. In order for the HWB to review performance of the BCF and consider future work, it would need to have the appropriate information reported to it from a partnership board. HWBs can require CCGs that are represented on the HWB, and the LA that established the HWB, to provide it with relevant information, for example the quarterly reports and annual report. This can be done under section 199 of the Health & Social Care Act 2012. For the purposes of the BCF, there should be a partnership board with minimum representation across the relevant CCG(s) and LA(s) – many localities will already have a partnership board in place and where this is the case there is no need to set up one specifically for the BCF.

15. In setting up, and overseeing, the s.75 agreement, it is strongly recommended to CCGs and LAs:
    - that a partnership board is in place to govern the s.75 agreement;
    - that the s.75 agreement includes a clause that sets out what information should be included in the host partner's quarterly reports and annual reports. This is to ensure the ability to monitor the effectiveness of the pooled fund arrangements and provide assurance to BCF national partners as to the appropriate use of the fund (this is explained in more detail in the next section); and
    - that a clause is included to ensure the quarterly reports and annual returns are signed off by the HWB.

Conditions of the Better Care Fund

16. As in previous years every CCG has a set of standard conditions placed on its BCF funding in 2017-19. These conditions are set in the BCF Planning Requirements for 2017-19. The legal basis for imposing these conditions is set out below. It is a requirement that in each area the BCF funding is transferred into one or more pooled budgets, established under s. 75, and that plans are approved by NHS England in consultation with DHSC and MHCLG.

[5] http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/risk-sharing/

17. Grant Conditions for the iBCF and DFG require that the grants are transferred into one or more pooled budgets and their use agreed, in line with the grant conditions, through the BCF Plan.

18. The Planning Requirements apply the four national conditions from the Policy Framework to ensure plan approval, as set out in the BCF Planning Requirements. In summary these four conditions require:
    i) That a BCF Plan, including at least the minimum contribution to the pooled fund specified in the BCF allocations, must be signed off by the HWB, and by the constituent LAs and CCGs;
    ii) A demonstration of how the area will maintain in real terms the level of spending on social care services from the CCG minimum contribution to the fund in line with inflation;
    iii) That a specific proportion of the area's allocation is invested in NHS-commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement; and
    iv) All areas to implement the High Impact Change Model for Managing Transfer of Care to support system-wide improvements in transfers of care.

19. The Planning Requirements also sets the four national metrics for which each area must agree ambitions in their BCF plans. Some of these are discussed further below. The BCST collect quarterly monitoring data for each of these metrics as well as progress against and compliance with the national conditions of the fund.

3. REFRESHING METRIC PLANS FOR 2018-19

20. The BCF Policy Framework 2017-19 applies for a two year period and BCF plans have already been submitted and assured for this period. This section updates some of the national expectations for metrics for 2018-19.

Non Elective Admissions (NEAs)

21. The baseline for the NEA metric in the BCF for 2018-19 is the target set for NEAs in CCG Operating Plans for 2017-19. Local BCF plans could set additional reductions over and above the NEA CCG Operating Plans where there was local agreement. For 2018-19, areas can consider and submit revisions to these additional reductions or apply additional reductions where none are in place currently. Areas that set additional NEA reduction targets as part of their BCF plan for 2018-19 should confirm any changes, by resubmitting a planning template with details of any retained or amended additional reduction targets.

22. Revisions to the baseline NEA CCG Operating Plans are not required to be submitted, via the BCF planning template unless they impact on any additional reductions agreed in the original 2017-19 BCF plan, as this is sourced nationally from Unify.

23. For the 'Residential admissions' and 'Reablement' metrics, local areas can submit revisions to the planned metrics for 2018-19 on their planning templates with an accompanying note summarising the rationale for this revision.

Delayed Transfers of Care (DTOCs)

24. As part of the BCF 2017-19 planning round, all areas were required to set a metric for reducing DTOCs to meet nationally set expectations and to submit a separate monthly trajectory to the end of March 2018. This plan was used as the basis for assurance of DTOC metrics in 2017-19 BCF plans, rather than the quarterly plans submitted via the BCF main planning template.

25. The Government's mandate to the NHS for 2018-19 has set an overall ambition for reducing delays to around 4,000 hospital beds occupied by patients delayed without discharge by September 2018. Based on this national ambition, Departments and NHS England have agreed updated expectations for each local BCF plan for 2018-19, in consultation with local government partners and regions. These expectations have been sent to individual HWBs and will be published shortly on the GOV.UK website along with a more detailed explanation of the methodology. The guidance to CCGs and NHS Trusts[6] for refreshing 2018-19 plans has also set an expectation that local health and social care commissioners will work together to reduce delays to the equivalent of around 4,000 daily delays.

26. The expectations for each HWB for 2018-19 include centrally set expectations for reducing DTOCs attributable the NHS and social care, based on the principle that both health and social care contribute equally to reducing delays. Joint delays are expected to remain at their current level. These expectations have applied an updated baseline (Q3 2017-18) and the scale of the expected reduction has been set according to the distance each area is from the national target rate – with areas further away from this rate expected to contribute a larger reduction.

27. Areas will be expected to agree a DTOC metric for 2018-19 that meets the nationally set HWB level expectations for 2018-19. Areas should plan based on the assumption that the expectation will be met by the end of September 2018 and that this level will be maintained or exceeded thereafter. Further detail can be found in Annex 3. Where more than one CCG is signatory to a BCF plan, the CCGs can agree the level of the reduction of delays that they will each be responsible for.

28. If there is a change in expectation to that set in 2017-18, CCGs, local authorities and NHS acute, community and mental health trusts, should revisit local plans for reducing delays to ensure that they are still fit for purpose and agree amendments where necessary. This could include:

- Consideration of implementation plans for the High Impact Change Model (HICM) (national condition four of the BCF in 2018-19).
- Other BCF schemes that contribute towards reducing delays and managing transfers.

6 https://www.england.nhs.uk/wp-content/uploads/2018/02/planning-guidance-18-19.pdf

29. Overall performance in reducing DToC has been encouraging, with the national rate of delays reducing from a peak of over 6,500 daily delays in February 2017, to under 4,500 in May 2018. We are grateful for the considerable effort and collaboration that has delivered this and to those areas that have met challenging expectations in 2017/18. In 2018/19 it is important that all local partnerships continue to focus on minimising DToCs and for areas that remain furthest from their expected levels address this. National partners will continue to offer support to areas to reduce DTOCs and your local Better Care Manager (BCM) will be able to discuss available support with you as well as share information on schemes and good practice from other areas.

30. For all BCF metrics, areas should agree any changes at their HWB, or seek delegated approval from all local partners. Any revised metrics, besides adoption of revised DTOC ambitions, should be submitted to the BCST, copied to BCMs.

4. AMENDING BCF PLANS

31. Better Care Fund plans were agreed for two years (2017-18 and 2018-19). Places are not, therefore, required to revise their plans for 2018-19 other than in relation to metrics for DTOC as set out above. Places can, if they wish, amend plans to:
    - Modify or decommission schemes
    - Increase investment, including new schemes.

32. Any changes to plans that impact on schemes or spending in the assured BCF planning template must be jointly agreed between the LA and the CCGs that are signatory to the plan and be accompanied with an updated Planning Template and brief rationale.

33. Amended plans must continue to meet all planning requirements and conditions. Please speak to your BCM if you are planning to refresh your BCF plan. Amended plans should be submitted to the BCST, copied to BCMs by 24 August 2018**.** These plans will be scrutinised by your BCM to ensure that they continue to meet the requirements of the Fund.

34. Similarly, if a change is made in-year that impacts on schemes or spending in assured BCF planning template, this change should be jointly agreed between the LA and CCGs that are signatory to the plan and a revised template and rationale should be sent to the BCST and your BCM.

5. REDUCING THE NUMBER OF PATIENTS WITH LONG STAYS OF 21 DAYS OR MORE IN HOSPITAL

35. NHS England and NHS Improvement have recently set out their ambition for reducing long stays in hospital by 25% to reduce patient harm and bed occupancy. NHS England and NHS Improvement have asked trusts and CCGs to work with local government partners to agree local sectoral ambitions to achieve this reduction. Figures have been shared with local systems that show the baseline (average number of beds occupied by patients in hospital for 21 days or more) and the expected reduction.by December 2018. These ambitions are intended to reduce the number of long stay patients by 4,000 nationally. The percentage reduction required from each system is based on their baseline rate of long stay patients. The level of improvement expected from each system is based on the proportion of beds occupied by long stay patients, with the most challenged systems expected to make the greatest levels of improvement.

36. Achieving this will require concerted effort across the health and care leadership system: at least half the opportunity rests within the direct control of hospitals, and the remainder in joint working with GPs, local authorities, community health, social care providers and others.

37. BCF plans will support delivery of this reduction through the continuing focus on delivery of the local DTOC expectations (paras 24-30) and through the implementation of national condition four – the High Impact Change model. Particular focus in relation to length of stay should be given to the implementation of the HICM in relation to systems to monitor patient flow, seven day services and trusted assessors (changes two, five and seven). National partners will give consideration to applying additional requirements for 2019/20, including through the BCF where appropriate, for local areas and NHS bodies that have made insufficient progress in reducing the number of people experiencing long stays in hospital during 2018/19. Any revisions to existing plans for implementing the High Impact Change model should be reflected in Better Care Fund quarterly reporting.

6. REPORTING ON AND CONTINUED COMPLIANCE WITH THE BCF NATIONAL CONDITIONS OVER 2017-19

Monitoring continued compliance with the conditions of the fund

39. Better Care Managers (BCMs) and the wider BCST will monitor continued compliance against the national conditions through the BCF quarterly reporting process described below and their wider interactions with local areas.

40. If an area is not compliant with any of the standard conditions of the BCF, or if the funds are not being spent in accordance with the agreed plan resulting in a risk to meeting the national conditions, the BCST, in consultation with national partners, may make a recommendation to NHS England to initiate an escalation process. Any intervention will be appropriate to the risk or issue identified.

41. The intervention and escalation process (outlined in subsequent sections) ultimately leads to NHS England exercising its powers of intervention provided by NHS Act 2006, in consultation with DHSC and MHCLG, as the last resort. These powers and interventions are summarised in subsequent sections.

Quarterly Reporting in 2017-19

42. The primary purpose of the Better Care Fund quarterly reporting is to provide national partners with a clear and accurate account of compliance with the key requirements and conditions of the fund as set out in the Policy and the Planning Requirements. The secondary purpose is to inform policy making and the national support offer by providing a fuller insight, based on narrative feedback from systems, on local progress, issues and highlights on implementation of the BCF plans
43. To serve these purposes, areas are required to provide quarterly reporting for the BCF over 2017-19.

44. It is expected that these reports are discussed and signed-off by HWBs (or with appropriate delegation) as part of their responsibility for overseeing BCF plans locally. National partners recommend that this approach is built into s. 75 agreements. Quarterly monitoring will include confirmation that s. 75 agreement is in place.

45. The quarterly reporting template will be made available to the local systems with associated guidance and timetables via the Better Care Exchange, an online platform that all Better Care leads are able to access. For the first time this also includes the reporting template for the additional improved Better Care Fund, as collected by MHCLG, responding to calls to align and integrate reporting.

7. SUPPORT, INTERVENTION AND ESCALATION PROCESS

Support

46. The Better Care Support Programme leads and facilitates the delivery of the Better Care Fund policy. This includes bespoke support for areas, performance management, formal guidance and, where needed, intervention. This section describes these functions and advises areas of the support available. Areas should speak to their BCM if they have concerns over the delivery of their BCF plan or performance against metrics.

47. The support programme constitutes:

    a. the national Better Care Support Team (BCST)
    b. the regional Better Care Managers (BCM)
    c. the national and regional Better Care Support Offer
    d. the Better Care Exchange

48. The BCST and BCMs are responsible for ensuring that local systems continue to comply with the conditions of the BCF and for improving performance against the national metrics, as well as supporting the wider ambition in relation to the overall integration of health and social care. This includes:

    - Support and advice through the national BCST
    - Formal support to address high levels of DTOC
    - Intervention where there are performance or compliance concerns, including:
        - Performance discussions with regional leads;
        - Formal escalation to national partners;
        - Use of NHS England intervention powers, including the power to direct CCGs regarding expenditure

49. The Better Care support offer for 2017-19 is delivered through two streams: the centrally-led national support programme and the regionally-led support offer. The scope of this support focuses on plan, delivery and improvement.

50. The centrally-led national support consists of a number of elements:

    - **Better Care Advisers**: a pool of advisers that local areas can draw upon to provide senior level support where requested or required.
      This hands on support will be available to areas who wish to drive their integration agenda forward, whether that be through facilitated discussions and workshops, or peer-led interviews, it will enable areas to challenge themselves and share learning from other areas.

This strand continues to provide independent facilitation for local areas that are facing difficulties or disagreements, as well as support any assurance requirements.

- **Intensive support for better managing transfers of care**: the BCST and national partners will offer a range of support to assist local areas in working together to ensure people benefit from speedy and safe transfers of care from hospital to their community. This will include:

    - Workshops on the High Impact Change Model
    - DToC counting workshops
    - National CQC learning events
    - Local area peer reviews
    - Bespoke peer support

- **National workshops**: a programme of workshops focussing on the key challenges associated with integrated care. The thematic workshops are intended to look at and share different approaches and experiences around a theme of interest at national level. They are expected to bring together the most up to date information, insight and solutions on priority themes associated with integrated care.

- **Regional workshops**: regionally-led events focussed on sharing experiences and dealing with challenges locally. This aspect of the support programme is concerned with creating the links and relationships between peers from different health and social care systems within a region, to encourage peer-to-peer support, learning and challenge. Workshops can cover a theme of specific importance/interest to the region.

- **Programme of guidance and insight**:

    - Case studies
    - Webinars
    - Guide to the Better Care Fund

- **Integrated Care Learning Programme**: Access to two learning programmes developed in conjunction with the Social Care Institute for Excellence (SCIE). One tailored to BCMs and the other for local area BCF leads, which will count towards Continuous Professional Development (CPD).

51. The programme of support for 2018-19 is intended to build on the 2017-18 offer. Support will continue to be developed utilising ongoing feedback from local areas through the quarterly reporting, discussions with BCMs, key partners, the 2018-19 needs assessment and in response to national policy.

52. The regionally-led support offer consists of funding that has been allocated to each region, in order to enhance and support regions' capacity and capability to achieve the overall aims and vision for the Better Care Fund. BCMs are in place across each region to gather learning and co-ordinate support to local areas. Regions can commission bespoke packages of support to respond to regionally identified needs, generate shared solutions at a regional level and tailor national resources and products to regional needs.

53. The Better Care Exchange is the collaboration platform operated by the BCST. The purpose of the exchange is to provide a shared collaboration space for individuals from both health and social systems who work on delivering the BCF plans or work closely with the BCF with the shared agenda of health and social integration. The platform the forum for operational communication, providing quarterly reporting and other BCF related templates and to share information and insight.

54. If further information is of interest on the components of the Better Care Fund Support Programme, please contact <ENGLAND.bettercaresupport@nhs.net> which is the primary point of contact for the BCST.

Intervention and escalation

55. Where an area remains non-compliant, or performance remains poor, further intervention will be considered.

56. If it becomes apparent that local implementation is not in line with the approved BCF plan, and that this resulted in one or more requirements of the BCF not being met in an area – for instance through the quarterly monitoring process or through information given to the BCM or BCST– the BCST will consider commencing an escalation process.

57. Prior to escalation, for a plan that has previously been approved, the BCST will work with national partners, the BCF Programme Board and BCF Senior Responsible Officer (SRO), the BCM for the area and local partners to consider options to resolve the issues, including use of Better Care Advisor support. Senior staff from the LA and the CCG(s) will need to attend a formal discussion with regional NHS England and local government representatives and their BCM to attempt to agree a resolution or recovery plan.

58. Escalation will be considered if there is evidence that:

- One or more of national conditions 1-4 are no longer being met.
- There have been changes to spending made without agreement, particularly those that would impact on continued compliance with the national conditions.
- There are significant concerns over performance against any of the BCF metrics.
- The area does not locally agree a compliant metric for reducing DTOCs in 2018-19.

59. As outlined in the Planning Requirements, the purpose of escalation in the event of a non-compliant plan is to:

    "… assist areas to reach agreement on ***a compliant plan and is not an arbitration process.*** *Senior representatives from all parties required to agree a plan will be invited to an Escalation Panel meeting to discuss concerns and identify a way forward."*

60. Escalation is not arbitration, mediation or legal advice. The single aim of the escalation process is to ensure that an area has and maintains a compliant Better Care Fund plan. More details on escalation as part of the assurance process is set out in the Integration and Better Care Fund Policy Framework 2017-19; Integration and Better Care Fund Planning Requirements 2017-19; and the Better Care Fund 2017-19: A guide to assurance of plans.

61. If an area that is performing poorly against BCF metrics is unable, following support and local intervention, to make improvements, then escalation will be considered. The purpose of escalation will be to consider the actions that the area is taking to address underperformance and whether further intervention or use of powers of direction is warranted. National Partners will review progress against 2018-19 DToC expectations once data for September 2018 are available. Progress on reducing DToC will continue to be monitored by national partners and will be taken into account in setting expectations for 2019-20.

62. Appendix 2 describes the steps involved in escalation as applicable to the ongoing BCF compliance. The escalation process which will be initiated if any of the conditions of the BCF are not met following the return of the quarterly reports and wider information collected by BCMs.

63. The BCST will support the escalation process, which will involve DHSC, MHCLG, NHS England and the LGA.

64. The Escalation Panel members will take into account all relevant information, including financial and performance issues. This could include:
    - Wider financial context, such as whether the LA has taken sufficient action to protect its funding for social care – including, but not limited to, making use of precepting powers, the balance of financial risk between parties and appropriate use of reserves;
    - Whether all financial commitments mandated in the BCF have been met, including passporting of Care Act funding, funding for social care managed reablement and carers' breaks (see paragraphs 35, 36 and 37 of the Planning Requirements);
    - Whether agreed spending on social care services funded by CCG minimum contributions has been maintained in real terms i.e. taking into account inflation. This will also include consideration of transfers prior to the establishment of the BCF;

- Previous and current diagnostic reports that have been prepared by Better Care Advisers or those appointed to work with the area, such as on enhanced support for DTOC.

65. NHS England has the ability to direct use of the CCG minimum contribution to a local BCF fund where an area fails to meet one of the BCF conditions. This includes the requirement to develop a plan that has been locally agreed and approved by NHS England. If a local plan cannot be agreed, any proposal to direct use of the fund and/or impose a spending plan on a local area, and the content of any imposed plan, will be subject to consultation with DHSC and MHCLG, , with the final decision then taken by NHS England.

66. The Escalation Panel may make recommendations that an area should amend plans that relate to spending of the DFG or iBCF. This money is not subject to NHS England powers to direct. Departments will consider recovering grant payments or withholding future payments of grant if the conditions continue to not be met.

67. A summary of the approach to support, escalation and intervention is at Annex 2.

8. GRADUATION

68. We hope that a first wave of shortlisted areas eligible for graduation from the Better Care Fund will be confirmed in 2018-19. National partners would then work with shortlisted areas to test readiness for full graduation and co-produce what a meaningful graduation model would look like. . NHS England, MHCLG, DHSC and the LGA will agree a memorandum of understanding with graduate areas, setting out the BCF requirements that will be removed or relaxed and any expectations of graduate areas, including:
    - Participation in learning events
    - Commitment to work with BCF national partners to develop models of integration, informing development of Integrated Care Systems and the health and care integration agenda.
    - Areas for improvement – for instance on specific metrics
    - Expectations for light touch self-certification process.

69. Through 2018-19, DHSC, MHCLG, NHS England, the LGA and the BCST, will work with these areas to develop the model for graduation further.

BCF 2018-19

70. The mandate to NHS England for 2018-19[7] has been published and contains deliverables around the BCF.

[7] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/691998/nhse-mandate-2018-19.pdf

71. NHS England will be using section 223G(4) to impose conditions on the allotment of BCF funding to CCGs that is identified in the mandate to NHS England for 2018-19.

72. The conditions that NHS England is imposing are again those set out in the 2017-19 BCF Policy Framework (page 16) and the BCF Planning Requirements for 2017-19 (pages 9-14) i.e. the four national conditions plus establishing a pooled fund under section 75 of the NHS Act 2006 and agreeing plans locally with sign off by the relevant local authority and CCG(s)

73. The funding awarded by NHS England under section 223G is also conditional on the fact that if the national conditions are not met, future payments of minimum BCF funding can be withheld and minimum BCF payments already made can be clawed back by NHS England at NHS England's discretion. Under section 223G(6), NHS England may direct CCGs as to the expenditure of the allotment of BCF funding. In practice this means that the interventions available to NHS England if conditions are not met are the same from 2018-19 as for 2017-18.

ANNEXES

ANNEX 1 – REQUIREMENTS FOR RISK SHARE AGREEMENTS

1. National condition three of the 2017-19 Better Care Fund required areas that had agreed additional target to reduce Non Elective Admissions over and above the metrics in CCG operating plans to consider holding a portion of the CCG minimum contribution in contingency against the additional costs of these targets not being met. The Planning Requirements set out circumstances in which local areas are expected to consider including a risk sharing arrangement which is specifically linked to the delivery of their plan for Non-Elective Admissions in 2017-19. Where this is the case the arrangements are described within narrative plans.

2. In addition, the finance and activity data underpinning the arrangements should be detailed within the BCF planning return template on the metrics tab. The Planning Requirements set out the mechanism for calculating the maximum value of the contingency.

3. If the planned levels of activity are achieved and, as such, value is delivered to the NHS in that way, then this funding may be released to be spent as agreed by the HWB. Otherwise it is retained as a contingency fund to cover the cost of any additional activity which results from BCF schemes not having the expected impact in reducing demand. Arrangements will need to demonstrate how and when it will be agreed to release this funding from the contingency into the pooled budget if it is not required.

ANNEX 2 SUPPORT AND INTERVENTION 'LADDER'

Where performance issues or concerns over compliance with the requirements of the BCF are identified, the BCST and BCM will take steps to return the area to compliance. Broadly this will involve the following steps:

1. **Trigger** - identification of BCF non-compliance or significant concerns about performance on BCF metrics	The BCM and regional partners in consultation with the BCST and the Programme's Director will consider whether to recommend specific support or if the area should be recommended for escalation. Initially support may be appropriate or a defined timescale set for the issue to be rectified.
2. Informal support	If appropriate, the BCM will work with the area to advise on the issue and consider, with local leaders, what further support may be provided. This may include support through regional NHS or Local Government structures. Alternatively, it may be decided that it is appropriate to move straight to formal support or a formal regional meeting.
3. Formal Support	The BCM will work with the BCST to agree provision of a Better Care Advisor, multi-disciplinary consultancy or other support, including provision of specific support to address compliance and/or high levels of DTOC.
4. Formal regional meeting	Areas will be invited to a formal meeting with NHS England regional and regional local government representatives to discuss the compliance or performance concerns, the area's plans to address these and a timescale for addressing the issues identified.
5. Pre-escalation meeting	Discussion with BCST, BCM and regional representatives from NHS England and local government. This meeting will seek to agree a set of actions to address issues without the need to escalate further. A timescale for completion of these actions will be agreed at the meeting.
6. **Commencing Escalation** as part of non-compliance	If, following the pre escalation meeting, a solution is not found or performance issues are not addressed in the timescale agreed, escalation to national partners will be considered. If escalation is recommended, the members of the Integration Partnership Board will be consulted on next steps. To commence escalation, a formal letter will be sent, setting out the reasons for escalation, consequences of non-compliance and informing the parties of next steps, including date and time of the Escalation Panel.
7. The **Escalation Panel**	The Escalation Panel will be jointly chaired by MHCLG and DHSC senior officials with representation from: • NHS England • LGA/Association of Directors of Adult Social

	Services (ADASS) Representation from the local area needs to include the: • Health and Wellbeing Board Chair • Accountable Officers from the relevant CCG(s) • Senior officer/s from local authority
8. **Formal letter and clarification** of agreed actions	The local area representatives will be issued with a letter, summarising the Escalation Panel meeting and clarifying the next steps and timescales for submitting a compliant plan or addressing performance issues. If support was requested by local partners or recommended by the Escalation Panel, an update on what support will be made available will be included.
9. **Confirmation** of agreed actions	The BCM will track progress against the actions agreed and ensure that the issues are addressed within the agreed timescale. Any changes to the timescale must be formally agreed with the BCST.
10. Consideration of **intervention options**	If it is found at the escalation meeting that agreement is not possible or that the concerns are sufficiently serious then intervention options will be considered. Intervention will also be considered if actions agreed at an escalation meeting do not take place in the timescales set out. Intervention could include: • Agreement that the Escalation Panel will work with the local parties to agree a plan • Appointment of an independent expert to make recommendations on specific issues and support the development of a plan to address the issues – this might be used if the local parties cannot reach an agreement on elements of the plan. • Appointment of an advisor to develop a compliant plan, where the Escalation Panel does not have confidence that the area can deliver a compliant plan • Appointment of an advisor or support to address performance issues, including progress towards agreed DTOC metrics. • Clawback of BCF funding already paid • Withholding BCF payments that are due to be made • Directing the CCG as to how the minimum BCF allocation should be spent The implications of intervention will be considered carefully and any action agreed will be based on the principle that patients and service users should, at the very least, be no worse off.

Annex 3 – revision of DToC metrics - methodology.

In order to ensure that the expected contributions to continued reduction in DTOC are proportionate and achievable in each area of England, national partners have agreed to revise the existing HWB-level expectations.

In approaching this year's ambition setting, we have determined key guiding principles to steer this work: providing a clearer, easier to explain methodology with a consistent rationale, and balancing fairness and stretch across local systems.

The expectations have been set as follows:

- A common baseline for (i) NHS and (ii) adult social care delays (October to December 2017).
- Expectations set to deliver an equal reduction in the number of daily delays attributable to each of the NHS and social care.
- Expected progress from this baseline calculated for NHS and adult social care delays is based on the distance from a target rate. The target rates are 5.5 daily delays per 100,000 population for NHS delays and 2.6 daily delays per 100,000 of the population for adult social care.
- The level of improvement expected depends on the distance from the target rate – this is set out in more detail below.
- The maximum target reduction is capped at 30% for NHS delays and 40% for Adult Social Care. The target date for achieving these reductions is the end of September 2018. As in 2017-18, joint delays are expected to remain the same and no stretch target has been set.

The bandings are shown below:

Baseline	**Expectation**
Adult Social Care	
DTOC rate below 2.6 daily delays per 100,000 18+ population	Maintain that rate
DTOC rate between 2.6 and 4.3 daily delays per 100,000 18+ population	Reduce to 2.6 daily delays per 100,000 18+ population
DTOC rate over 4.3 daily delays per 100,000 18+ population	Reduce delays by 40%
NHS	
DTOC rate below 5.5 daily delays per 100,000 18+ population	Maintain that rate
DTOC rate between 5.5 and 7.9 daily delays per 100,000 18+ population	Reduce to 5.5 daily delays per 100,000 18+ population
DTOC rate over 7.9 daily delays per 100,000 18+ population	Reduce delays by 30%
Joint	
Average number of jointly attributed daily delays October to December 2017 per 100,000 18+ population	Remain at or below this rate

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Lincolnshire COUNTY COUNCIL
Working for a better future

Wendy Hoult
Better Care Implementation Manager

Lincolnshire County Council
County Offices
Newland
Lincoln
LN1 1YL

VIA EMAIL

24th August 2018

Our Ref: GG/SH/BCF

Dear Wendy

LINCOLNSHIRE BETTER CARE FUND 2018/19 UP

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

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

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

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

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

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

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

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

Yours sincerely

Steven Houchin
Head of Finance Adult Care & Community Wellbeing

Better Care Fund Agreement Tables 2018/19

Key In Data

Line	Proactive Care	CCG Budget £'000 East	CCG Budget £'000 West	CCG Budget £'000 South	CCG Budget £'000 South W.	CCG Budget £'000 TOTAL	LCC Budget £'000 LCC	Total Budget £'000 Total	Spend to Date £'000 Total	Projected Outturn £'000 Total	LCC Variance £'000 LCC	CCG Variance £'000 East	CCG Variance £'000 West	CCG Variance £'000 South	CCG Variance £'000 South W.	CCG Variance £'000 TOTAL
1	Intermediate Care	£1,911,850	£1,693,230	£1,156,231	£938,689	£5,700,000	£0	£5,700,000	£1,900,000	£5,700,000	£0	£0	£0	£0	£0	£0
2	Transitional care	£426,096	£377,372	£257,690	£209,207	£1,270,365	£0	£1,270,365	£423,455	£1,270,365	£0	£0	£0	£0	£0	£0
3	Neighbourhood Team	£2,209,213	£1,956,588	£1,336,067	£1,084,689	£6,586,557	£20,000,000	£26,586,557	£8,862,186	£26,586,557	£0	£0	£0	£0	£0	£0
4	DFG Grant	£0	£0	£0	£0	£0	£5,698,071	£5,698,071	£1,899,357	£5,698,071	£0	£0	£0	£0	£0	£0
5	Intermediate Care	£751,190	£665,291	£454,297	£368,822	£2,239,600	£0	£2,239,600	£746,533	£2,239,600	£0	£0	£0	£0	£0	£0
6	NHT - Comm int. reablement agency staff	£478,030	£423,367	£289,098	£234,705	£1,425,200	£0	£1,425,200	£475,067	£1,425,200	£0	£0	£0	£0	£0	£0
7	Carers OP	£0	£0	£0	£0	£0	£100,000	£100,000	£33,333	£100,000	£0	£0	£0	£0	£0	£0
8	7 day working - provider of last resort	£512,175	£453,607	£309,748	£251,470	£1,527,000	£0	£1,527,000	£509,000	£1,527,000	£0	£0	£0	£0	£0	£0
9	NHT - Co-responders	£0	£0	£0	£0	£0	£400,000	£400,000	£133,333	£400,000	£0	£0	£0	£0	£0	£0
10	AF&LTC Inflation & NLW	£0	£0	£0	£0	£0	£5,001,574	£5,001,574	£1,667,191	£5,001,574	£0	£0	£0	£0	£0	£0
11	AF&LTC Demography	£0	£0	£0	£0	£0	£316,710	£316,710	£105,570	£316,710	£0	£0	£0	£0	£0	£0
12	7 day working - assessments and care	£102,435	£90,721	£61,950	£50,294	£305,400	£0	£305,400	£101,800	£305,400	£0	£0	£0	£0	£0	£0
13	NHT- Demographic growth	£725,581	£642,610	£438,810	£356,249	£2,163,250	£0	£2,163,250	£721,083	£2,163,250	£0	£0	£0	£0	£0	£0
14	Care Act	£584,733	£517,868	£353,629	£287,095	£1,743,325	£287,500	£2,030,825	£676,942	£2,030,825	£0	£0	£0	£0	£0	£0
15	Trusted Assessors	£0	£0	£0	£0	£0	£100,000	£100,000	£33,333	£100,000	£0	£0	£0	£0	£0	£0
16	Dementia Family Friends	£0	£0	£0	£0	£0	£420,000	£420,000	£140,000	£420,000	£0	£0	£0	£0	£0	£0
17	Neighbourhood Team Development	£0	£0	£0	£0	£0	£120,000	£120,000	£40,000	£120,000	£0	£0	£0	£0	£0	£0
18	Housing for Independence	£0	£0	£0	£0	£0	£250,000	£250,000	£83,333	£250,000	£0	£0	£0	£0	£0	£0
19	Making Every Contact Count	£0	£0	£0	£0	£0	£42,000	£42,000	£14,000	£42,000	£0	£0	£0	£0	£0	£0
20	Market Stablisation AF Homecare	£0	£0	£0	£0	£0	£2,325,105	£2,325,105	£775,035	£2,325,105	£0	£0	£0	£0	£0	£0
21	Market Stabilisation - AF Direct Payments	£0	£0	£0	£0	£0	£225,284	£225,284	£75,095	£225,284	£0	£0	£0	£0	£0	£0
22	Market Stabilsation - AF Residential Care	£0	£0	£0	£0	£0	£1,392,829	£1,392,829	£464,276	£1,392,829	£0	£0	£0	£0	£0	£0
23	Staffing	£0	£0	£0	£0	£0	£1,500,000	£1,500,000	£500,000	£1,500,000	£0	£0	£0	£0	£0	£0
24	Quick Response Service/Reablement	£0	£0	£0	£0	£0	£1,803,360	£1,803,360	£601,120	£1,803,360	£0	£0	£0	£0	£0	£0
25	Mosaic & Information Systems	£0	£0	£0	£0	£0	£1,000,000	£1,000,000	£333,333	£1,000,000	£0	£0	£0	£0	£0	£0
26	Adult Safeguarding	£0	£0	£0	£0	£0	£490,000	£490,000	£163,333	£490,000	£0	£0	£0	£0	£0	£0
27	Enhanced Health (Care) in Care Home programme	£0	£0	£0	£0	£0	£200,000	£200,000	£66,667	£200,000	£0	£0	£0	£0	£0	£0
28	Carers Outreach	£0	£0	£0	£0	£0	£75,000	£75,000	£25,000	£75,000	£0	£0	£0	£0	£0	£0
29	Carers Everyone	£0	£0	£0	£0	£0	£500,000	£500,000	£166,667	£500,000	£0	£0	£0	£0	£0	£0
30	Programme Support Costs	£0	£0	£0	£0	£0	£100,000	£100,000	£33,333	£100,000	£0	£0	£0	£0	£0	£0
	TOTAL PROACTIVE CARE s(75)	**£7,701,302**	**£6,820,655**	**£4,657,520**	**£3,781,220**	**£22,960,697**	**£42,347,433**	**£65,308,130**	**£21,769,377**	**£65,308,130**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**

Line	TABLE 1 Specialised LD S(75): LD schedule 1	£'000 East	£'000 West	£'000 South	£'000 South W.	£'000 TOTAL	£'000 LCC	£'000 Total	£'000 Total	£'000 Total	£'000 LCC	£'000 East	£'000 West	£'000 South	£'000 South W.	£'000 TOTAL
31	LD S(75) CCG Contribution	£3,991,407	£3,534,988	£2,413,885	£1,959,719	£11,900,000	£47,376,496	£59,276,496	£22,170,994	£61,554,330	£1,209,010	£358,497	£317,503	£216,808	£176,016	£1,068,824
32	SAS Inflation & NLW	£0	£0	£0	£0	£0	£939,714	£939,714	£313,238	£939,714	£0	£0	£0	£0	£0	£0
33	SAS Demography	£0	£0	£0	£0	£0	£3,470,809	£3,470,809	£1,156,936	£3,470,809	£0	£0	£0	£0	£0	£0
34	Specialist Services - Demographic Growth	£725,581	£642,610	£438,810	£356,249	£2,163,250	£0	£2,163,250	£721,083	£2,163,250	£0	£0	£0	£0	£0	£0
35	Specialist Services - Future Risk Sharing	£1,502,379	£1,330,582	£908,595	£737,645	£4,479,200	£0	£4,479,200	£1,493,067	£4,479,200	£0	£0	£0	£0	£0	£0
	s(75) LD POOLED RESOURCES	**£6,219,367**	**£5,508,180**	**£3,761,290**	**£3,053,613**	**£18,542,450**	**£51,787,019**	**£70,329,469**	**£25,855,318**	**£72,607,303**	**£1,209,010**	**£358,497**	**£317,503**	**£216,808**	**£176,016**	**£1,068,824**

Line	TABLE 2 Specialised LD S(75): LD schedule 2	£'000 East	£'000 West	£'000 South	£'000 South W.	£'000 TOTAL	£'000 LCC	£'000 Total	£'000 Total	£'000 Total	£'000 LCC	£'000 East	£'000 West	£'000 South	£'000 South W.	£'000 TOTAL
36	Existing S(256) Adults	£216,676	£191,899	£131,039	£106,385	£646,000	£0	£646,000	£215,333	£646,000	£0	£0	£0	£0	£0	£0
37	Carers	£0	£0	£0	£0	£0	£50,000	£50,000	£16,667	£50,000	£0	£0	£0	£0	£0	£0
38	IPC/Personal Health budget	£0	£0	£0	£0	£0	£100,000	£100,000	£33,333	£100,000	£0	£0	£0	£0	£0	£0
39	Market Stabilisation SAS - Direct Payments	£0	£0	£0	£0	£0	£772,000	£772,000	£257,333	£772,000	£0	£0	£0	£0	£0	£0
40	Waking Nights	£0	£0	£0	£0	£0	£1,500,000	£1,500,000	£500,000	£1,500,000	£0	£0	£0	£0	£0	£0
41	Other One Off Investment/Reduction	£0	£0	£0	£0	£0	£138,231	£138,231	£46,077	£138,231	£0	£0	£0	£0	£0	£0
42	Specialist - Mental Illness Prevention	£46,949	£41,581	£28,394	£23,051	£139,975	£237,500	£377,475	£125,825	£377,475	£0	£0	£0	£0	£0	£0
	s(75) LD POOLED RESOURCES	**£263,626**	**£233,480**	**£159,433**	**£129,436**	**£785,975**	**£2,797,731**	**£3,583,706**	**£1,194,569**	**£3,583,706**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**
	TOTAL LD S(75)	**£6,482,993**	**£5,741,660**	**£3,920,723**	**£3,183,049**	**£19,328,425**	**£54,584,750**	**£73,913,175**	**£27,049,887**	**£76,191,009**	**£1,209,010**	**£358,497**	**£317,503**	**£216,808**	**£176,016**	**£1,068,824**

Line	CAMHs S(75)	£'000 East	£'000 West	£'000 South	£'000 South W.	£'000 CCG	£'000 LCC	£'000 Total	£'000 Total	£'000 Total	£'000 LCC	£'000 East	£'000 West	£'000 South	£'000 South W.	£'000 TOTAL
43	CAMHs S(75) CCG contribution	£2,107,924	£1,866,882	£1,274,810	£1,034,958	£6,284,574	£724,589	£7,009,163	£2,336,388	£7,009,163	£0	£0	£0	£0	£0	£0
44	Existing S(256) Childrens	£174,750	£154,767	£105,684	£85,799	£521,000	£0	£521,000	£173,667	£521,000	£0	£0	£0	£0	£0	£0
	CAMHs S(75)	**£2,282,674**	**£2,021,649**	**£1,380,494**	**£1,120,758**	**£6,805,574**	**£724,589**	**£7,530,163**	**£2,510,054**	**£7,530,163**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**

Line	PARTNERSHIP FRAMEWORK	£'000 East	£'000 West	£'000 South	£'000 South W.	£'000 CCG	£'000 LCC	£'000 Total	£'000 Total	£'000 Total	£'000 LCC	£'000 East	£'000 West	£'000 South	£'000 South W.	£'000 TOTAL
45	ICES original	£1,050,512	£930,385	£635,318	£515,785	£3,132,000	£2,668,000	£5,800,000	£1,579,212	£6,982,201	£761,199	£141,209	£125,062	£85,399	£69,332	£421,002
	PARTNERSHIP FRAMEWORK	**£1,050,512**	**£930,385**	**£635,318**	**£515,785**	**£3,132,000**	**£2,668,000**	**£5,800,000**	**£1,579,212**	**£6,982,201**	**£761,199**	**£141,209**	**£125,062**	**£85,399**	**£69,332**	**£421,002**

Line	Aligned Budgets	£'000 East	£'000 West	£'000 South	£'000 South W.	£'000 CCG	£'000 LCC	£'000 Total	£'000 Total	£'000 Total	£'000 LCC	£'000 East	£'000 West	£'000 South	£'000 South W.	£'000 TOTAL
46	Mental Health S75 Agreement (LCC/LPFT)	£0	£0	£0	£0	£0	£6,100,000	£6,100,000	£2,033,333	£6,100,000	£0	£0	£0	£0	£0	£0
47	Mental Health (CCG/LPFT)	£22,890,888	£20,273,308	£13,843,733	£11,239,072	£68,247,002	£0	£68,247,002	£22,749,001	£68,247,002	£0	£0	£0	£0	£0	£0
48	Transitional Beds S75 Agreement (LCC/LCHS)	£586,972	£519,851	£354,983	£288,194	£1,750,000	£1,000,000	£2,750,000	£916,667	£2,750,000	£0	£0	£0	£0	£0	£0
	PARTNERSHIP FRAMEWORK	**£23,477,860**	**£20,793,159**	**£14,198,717**	**£11,527,267**	**£69,997,002**	**£7,100,000**	**£77,097,002**	**£25,699,001**	**£77,097,002**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**

	Grand Total	**£40,995,340**	**£36,307,509**	**£24,792,771**	**£20,128,078**	**£122,223,698**	**£107,424,772**	**£229,648,470**	**£78,607,530**	**£233,108,505**	**£1,970,209**	**£499,706**	**£442,565**	**£302,208**	**£245,348**	**£1,489,826**

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

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Better Care Fund - 2018/19

Performance Report

Quarter 1 Report

Produced August 2018

Performance Alerts
Performance is on or ahead of target
Performance is behind target, with no improvement
Performance is behind target, with some improvement
Performance is not reported in this period
Total measures

Summary

BCF metrics	
Achieved	2
Not achieved	1
Improving but not achieved	0
Not reported in period	1
	4

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

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

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

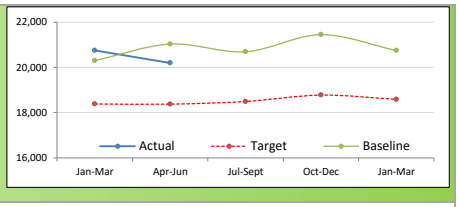
Polarity	Indicator Description	Responsibility / Suggested Lead Officer	Previous Years		2018/19 Current - June 18		
			2016/17	2017/18	Actual	Plan	Alert
Health and Wellbeing Better Care Fund Metrics							
Smaller is Better	1. Total non-elective admissions into hospital : General and Acute	NHS / Carol Cottingham	6,148 (average per month)	6,993 average per month)	20,197	18,375	Not achieved
Smaller is Better	2. Permanent admissions to residential and nursing care homes - aged 65+ **ASCOF 2A part 2**	LCC / Carolyn Nice	1,031	1,020	125	288	Achieved
Bigger is Better	3. % people (65+) at home 91 days after discharge from hospital into Reablement/rehabilitation **ASCOF 2B part 1**	NHS / LCC Tracy Perrett	75.4%	80.5%			
Smaller is Better	4. Delayed transfers of care: Delayed days from hospital, aged 18+ **Overall (proxy to ASCOF 2C part 1)**	NHS / LCC	2,987 (average per month)	2,267 (average per month)	6,117	6,547	Achieved
	Of which attributable to ***NHS***	NHS Ruth Cumbers	2103 (average per month)	1,679 (average per month)	4,140	4,901	Achieved
	Of which attributable to **Social care and Joint (proxy to ASCOF 2C part 2)**	LCC Tracy Perrett	884 (average per month)	587 (average per month)	1,977	1,646	Not achieved
IBCF Measures							
	5. Number of home care packages provided			4,581	3,179		
	6. Total number of paid hours of homecare for the whole of 18/19			1,456,769	357,266		
	7. Total number of care home placements in year			3,271	3,238		
Local Measures							
	8. Reablement - Hours delivered by Allied				31,389		
	9. Reablement - % reabled to no service				98%	95%	
	10. 7 Day Services - % discharged on a weekend			12..4%	12.9%		
	11. Hospital Discharges with Social Care Team Involvement			2,923	2722		
	12. Carers Supported by Carers Service and Adult Care (**Council Business Plan)**			1,631	1,640	1,730	Not achieved

Health and Wellbeing Better Care Fund Metrics

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

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

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



Performance observations from the data:
A total of 20,197 admissions have been made so far within Q1, 1,822 more than target but a 3.97% decrease on the same period last year.

Operational observations:

To be provided by operational lead officer when agreed.

Prior Year

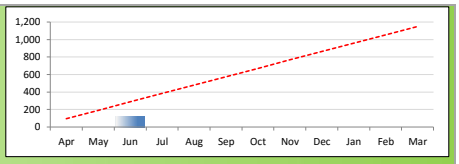
	2017/18 BCF (Calendar Year)											
	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
In Month	7,246	6,943	6,843	7,110	6,722	6,858	7,375	7,104	6,967	7,361	6,411	6,978
In Quarter (cumulative)	7,246	14,189	21,032	7,110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

Current Year

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

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

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



Performance observations from the data:
The number of new admissions to care homes is unusually low in Quarter 1, and is exceeding target by 163. Approximately 80% of the new admissions are from new clients, with the remaining transferring from long term community services.
Operational comments:
The low number of admissions may be due to delays in processing financial assessments and this will be better understood by quarter 2.

Prior Year

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

Current Year

		2018/19 BCF (Financial Year)											
		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Placements per month													
Cumulative YTD				125									
Denominator				172,133									
Rate per 100,000				72.6									
Target (admissions)				**288**									
Target (per 100k)				167									
Performance				Achieved									

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

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

Observations from the data:

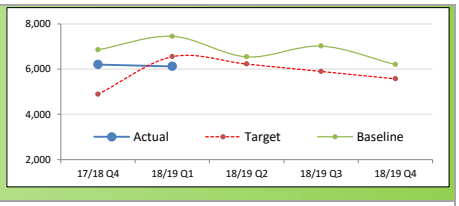
18/19 data is not available until Q4. Data for 17/18 shows 80.5% of hospital discharges into reablement were still at home 91 days after discharge, against a target of 80%. This in an improvement on 16/17 where the outturn was 75.4%. in 17/18 there was also an increase in number of episodes of reablement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

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

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

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

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



Performance observations from the data:
The Q1 total of 6,117 delayed days, exceeded the target of 6,547 by a 6.6% difference. The number of delays is lower (1,329 days) compared to the same period in 17/18. The proportion of social care delays has increased from 9% in Q4 17/18 to 13% however the proportion of NHS delays has fallen from 72% to 68% in Q1 while proportion of joint delays has remained fairly consistent at 19%. From April 18 to June 18 there has been a 3.2 decrease on the average number of delays per day.

Prior Year

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

Current Year

		2018/19 BCF (Financial Year)										
	Qtr 4 1718	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Average Per Day	74.5	67.9	68.9	64.7									
In month	2396	2,039	2,136	1,942									
In Quarter (cumulative)	6198	2,039	4,175	6,117									
Denominator	606565	602,877	602,877	602,877									
Rate per 100,000 population	1022	338.2	692.5	1,014.6									
Target (days) -based on revised HWB plan	**4,883**	**2,219**	**4,401**	**6,547**									
Target (per 100k)	805.0	368.0	730.0	1,086.0									
Performance		Achieved	Achieved	Achieved									

by Type of Care

	2017/18 Q4	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Acute	5,423	1,816	3,788	5,537									
Non Acute	775	223	387	580									
Total	**6,198**	**2,039**	**4,175**	**6,117**									
	2017/18 Q4	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**
Acute	87%	89%	91%	91%									
Non Acute	13%	11%	9%	9%									

by Responsible Organisation

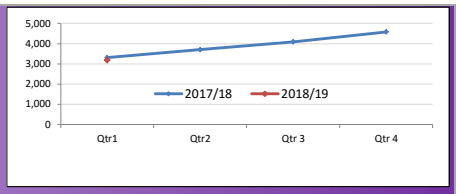
	2017/18 Q4	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
NHS	4,437	1,296	2,824	4,140									
Target (days)	**3,020**	1,670	3,304	4,901									
Target (per 100k)	497.9	277.0	548.0	812.9									
Performance		Achieved	Achieved	Achieved									
Social Care (SSD)	548	325	575	792									
Target (days)	1,403	131	263	394									
Target (per 100k)	231	21.8	43.6	65.4									
Performance		Not achieved	Not achieved	Not achieved									
Joint	1,213	418	776	1,185									
Target (days)	460	417	834	1,251									
Target (per 100k)	76	69.2	138.4	207.6									
Performance		Achieved	Achieved	Achieved									
Total	**6,198**	**2,039**	**4,175**	**6,117**	-	-	-	-	-	-	-	-	-
	2017/18 Q4	**Apr-18**	**May-18**	**Jun-18**	**Jul-18**	**Aug-18**	**Sep-18**	**Oct-18**	**Nov-18**	**Dec-18**	**Jan-19**	**Feb-19**	**Mar-19**
NHS	72%	64%	68%	68%									
Social Care (SSD)	9%	16%	14%	13%									
Both	20%	21%	19%	19%									

iBCF Measures

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

Definition: Cumulative YTD number of all clients who have received a permanent

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



Observations from the data: In 1718 the number of clients that received home care in Q1 was 3308 and by the Q4 it had increased to 4581 which was an 38.5% increase of clients that had received homecare in that year. If 1819 follows a similar sort of trend than the estimated Q4 figure will be 4402.

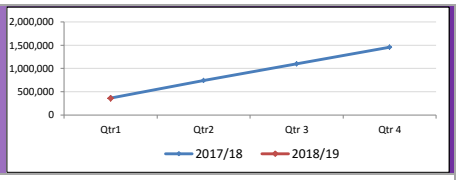
Prior Year		2017/18 (Financial Year)											
		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Clients in receipt of homecare (YTD)				3,308			3,703			4,090			4,581

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

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

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

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



Observations from the data:
In 1718 the number of paid hours home care delivered in Q1 365,067 and by Q4 the hours delivered had increased to 1,456,769 for the year which was a 299.04% increase. If 1819 follows a similar pattern than by Q4 the hours delivered will be an estimated 1,068,368.

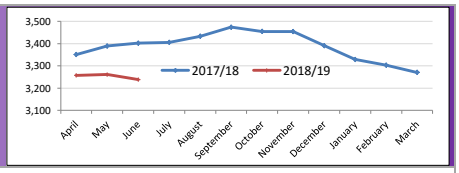
Prior Year		2017/18 (Financial Year)											
		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Hours Delivered				365067			740314			1100642			1456769

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

7: Total number of care home placements in year

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

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



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

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

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

Local Schemes

8. Reablement

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

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

Observations from the data:
Allied on average delivers 10,463 hours per month of face to face contact time, if this stays the average for the rest of the months by March 19 the approx. hours delivered will be 125,556.

Current Year		2018/19 (Financial Year)											
	Mar-18 YTD	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Cumilative Hours	128,272	10,730	21,228	31,389									
Hours Delivered		10,730	10,498	10,161									

9. Reablement

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

Observations from the data:
The target for this new measure has been achieved in Q1. Allied continue to work closely with Adult Care and health colleagues to facilitate timely discharge from hospital across the area. The target achieved demonstrates the skills of the team to reable service users to the full potential.

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

10. 7 Day Services

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

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

Observations from the data:
Hospital discharges on the weekend has increased by 0.5% in Qtr 1 of this year compared to Qtr 4 of the previous year however there was a 2.7% decrease of the number of clients discharged on the weekend (362 to 352) and a 6.8% decrease in the total number of clients discharged from hospital.

Current Year		2018/19 (Financial Year)											
	2017/18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
	Q4			Q1 1819			Q2 1819			Q3 1819			Q4 1819
Numerator	362			352									
Denominator	2,923			2,722									
Actual	12..4%			12.9%									
Target													
Performance													

11. Hospital Discharges With Social Care Team Involvement

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

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

Observations from the data:
The number of discharges with social team involvement in Q1 was 2,722 with 90.2% being in the age range of 65+. In Q4 of 1718 there were 2,923 discharges with social team involvement which was 6.88% more than the current Q1 figure.

Current Year		2018/19 (Financial Year)											
	2017/18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Age at Contact	Q4			Q1 1819			Q2 1819			Q3 1819			Q4 1819
18-64	217			256									
65+	2,696			2,455									
Unknown	10			11									
Denominator	2,923			2,722									
% of 65+	92.2%			90.2%									
Target													
Performance													

12. Carers Supported by Carers Service and Adult Care

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

Frequency / Reporting Basis: Quarterly
Source: Council Business Plan

Observations from the data:
In the 12 month period up to 30 June 2018 over ten thousand (10006) carers have been supported by the Carers Service and Adult Care. This is an increase of 317 carers compared to the 2017/2018 end of year figure.
1108 (11.1%) carers have received a Personal Budget as a Direct Payment.
642 (6.4%) cared-for adults have been provided with short term respite services to allow their carer to take a break.
8256 (82.5%) carers have received information and advice, including those supported by Carers FIRST's universal offer.
Note - the target for this financial year has been increased to 1730 carers supported per 100,000 over 18 population. This equates to a target of approximately 500 additional carers supported by the end of the year.
The denominator for this target has increased to 6.1. This is based on the latest over 18 population estimate for 2018 (606,565 - source: Office of National Statistics). The 6.1 relates to 'one hundred thousands

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

13. Making every contact count

Narrative:

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

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

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

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

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Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**25 September 2018**
Subject:	**Lincolnshire Joint Strategy for Dementia 2018 - 2021**

Summary:

The Joint Strategy for Dementia 2018 - 2021 is a refresh of the existing Joint Strategy for Dementia Care 2014 – 2017 and has been developed and co-produced with our strategic partners, people who live with Dementia, their families and carers to provide a strategic framework around Dementia for the next three years.

The Strategy refresh sets out our vision and details our achievements since the implementation of the Lincolnshire Joint Strategy for Dementia 2014 - 2017.

There is an event that is planned for 14 November 2018 that will be to Launch the refreshed Strategy, it is intended that this will be an interactive event for professionals, people living with Dementia, their families and carers.

Actions Required:

The Lincolnshire Health and Wellbeing Board is asked to:

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

1. Background

The Lincolnshire Joint Strategy for Dementia 2014 - 2017 was produced by the Council in partnership with the four Clinical Commissioning Groups (CCGs), NHS Trusts and voluntary sector agencies.

The Dementia Officers group has provided governance for the 2014-2017 Strategy to ensure that progress has been made on the priorities set; this governance will continue and will form a sub group that reports to the Health and Wellbeing Board.

The Council has, with support and engagement from the CCGs and other partners, refreshed and updated the Strategy for the period 2018 - 2021.

The refreshed Joint Strategy sets out the partnership's priorities for the next three years and what they will do to be able to achieve these, with the aim to improve services for people with Dementia, and their families, at all stages of the dementia journey.

The Strategy contains:

- The national and local policy context
- Lincolnshire's achievements since 2014
- The aims for the next three years and how we intend to achieve these.

Design and Publication

The Council's Communications Team will manage the process of graphic design, publication, and publicity to ensure corporate standards and processes are adhered to.

The text of the Joint Strategy must be agreed by all relevant partners before graphic design can be concluded. Subsequent publication will be in electronic and printed form.

A summary version of the Joint Strategy will also be produced, taking into account best practice guidance, and with people who live with Dementia, their families and carers' involvement.

2. Conclusion

Dementia is one of the most pressing national and local challenges for health and social care services.

Dementia continues to be a priority for health and social care commissioners.

The Association of Directors of Adult Social Services (ADASS) and the Local Government Association (LGA) have endorsed the Prime Minister's Challenge on Dementia 2020.

The Strategy supports the Joint Health and Wellbeing Strategy for Lincolnshire, Lincolnshire STP, and the NHS Five Year Forward View.

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

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

Evidence from the JSNA, in particular the Dementia Topic, has been used to inform the development of this Strategy.

Dementia is a priority area in the Joint Health and Wellbeing Strategy (JHWS) agreed by the Board in June 2018. The Lincolnshire Joint Dementia Strategy underpins the delivery plan for this priority area. The Dementia Officers Group is the lead group for the dementia priority in the JHWS and will be accountable to the Board for ensuring the objectives of the JHWS are being delivered.

4. Consultation

Engagement Activity

The Council has worked with strategic partners, particularly CCGs and NHS England to ensure the Joint Strategy accurately reflects current national and local priorities.

The Council was represented at a joint CCG Dementia Workshop in September 2017 which focused on dementia diagnosis, clinical services, and action planning.

The CCG workshop (led by South-West Lincolnshire CCG, with support from NHS England), recommended the setting up of a sub-group of the Lincolnshire Health and Wellbeing Board to ensure delivery of the objectives and actions of the Joint Strategy.

South-West Lincolnshire CCG and NHS England, have nominated managers with delegated authority to agree the refreshed Joint Strategy.

The Council has engaged with local groups of people with personal experience of Dementia. Their comments on living with Dementia have supported and been recognised when developing the refreshed Strategy.

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Lincolnshire Joint Strategy for Dementia 2018 - 2021

6. Background Papers

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

This report was written by Gina Thompson who can be contacted on 01522 554094 or gina.thompson@lincolnshire.gov.uk

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Lincolnshire Joint Strategy for Dementia
2018-2021
Draft V4.9
Lincolnshire
COUNTY COUNCIL
Working for a better future
NHS

Contents

Foreword

We are pleased to launch our strategy refresh which sets out our vison and details our progress and achievements since the implementation of the Lincolnshire Joint Strategy for Dementia 2014 - 2017 and also provides information on our priorities for Dementia services in Lincolnshire over the next three years. This work has been led by Lincolnshire County Council, and the Lincolnshire Clinical Commissioning Groups which are the agencies responsible for delivery of the Strategy.

Good progress has been made since 2014 but there is scope for more to be done to support people following a Dementia diagnosis**. We remain committed to the vision to support people to live healthy lives in order to reduce the risk of developing dementia, improve identification and early diagnosis to ensure that people can be better enabled to live well with Dementia through provision of meaningful support and services. By continuing to pursue our objectives and priority areas we will be able to support more people following a diagnosis and in turn support them to live at home, independently, for longer.**

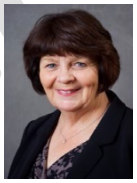
Carers of people with Dementia, most often family members, are at risk of isolation, and those providing high levels of care are more likely to experience ill-health, according to the Carers' Trust report A Road Less Rocky (2013). This strategy refresh continues to advocate priorities that will help ensure both people with Dementia, and their carers, are offered support, information and advice that supports them and those around them throughout their Dementia journey.

The summary of key aims in this strategy provides the framework by which we will set, monitor and report on further improvements.

Dementia is one of our most significant health and social care priorities, both nationally and in Lincolnshire, as it has far reaching effects on people who live with the condition, their carers, family, friends, communities, businesses, health, social care and voluntary services. NHS England has reported there is also a considerable economic cost associated with the disease, estimated at £23 billion a year nationally, a figure predicted to triple by 2040. This is more than the cost of cancer, heart disease and stroke combined.

We will continue to raise awareness and develop and commission services that support people with Dementia to live well by accessing activities and services which help their physical and emotional wellbeing as well as the wellbeing of their family, friends and carers. We will also continue to promote the benefits of a healthy lifestyle, recognising that what is good for the heart is good for the brain, and can in some instances slow the progression of the disease.

The impact of Dementia can be far-reaching, but by increasing awareness and understanding of Dementia among both the public and among professionals we can make a real difference to improving the lives of people living with Dementia and also support those who care for them. Our commitment to the people of Lincolnshire is to do all we can to ensure access to care and support for those who need it.



Cllr Mrs Patricia Bradwell OBE

Deputy Leader of Lincolnshire County Council, Executive Councillor for Adult Care and Health Services, Children's Services

Glen Garrod

Executive Director of Adult Care and Community Wellbeing Lincolnshire County Council

John Turner

Interim Chief Officer, South West Lincolnshire Clinical Commissioning Group (for Lincolnshire CCGs)

1. Introduction

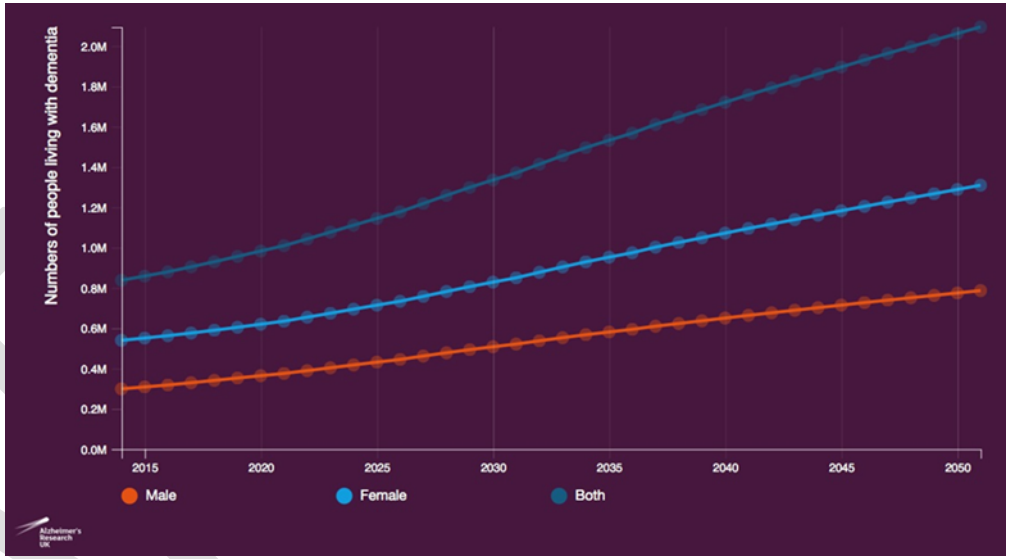
The purpose of this Strategy is to:

- Acknowledge the achievements of the Lincolnshire Joint Strategy for Dementia 2014 -2017.
- Update the Joint Strategy and set out Lincolnshire's vision for 2020.
- Identify key actions which will be undertaken to improve support and care for people with Dementia and their carers to realise our vision for 2020.
- Emphasise the need for a whole system approach across the NHS, Adult Social Care, Public Health, the independent and voluntary sector, and beyond, in order to identify the needs of people with Dementia, and those at risk of Dementia, and their families from diagnosis to the end of life.
- Promote the objective of a "Dementia-friendly" Lincolnshire by supporting the Dementia Action Alliance.

National View

Dementia is a progressive condition, and at present there is no cure or practicable means for screening people before symptoms emerge. Dementia continues to represent a public health challenge. Projections have calculated there were 850,000 people with Dementia in the UK in 2015 (Alzheimer's Society, 2014) and an estimated 46.8 million worldwide in 2015 (Alzheimer's Disease International, 2017). These numbers are set to rise, with it anticipated there will be over one million people with Dementia in the UK by 2021 and over two million by 2051 if no action is taken and current trends continue (Alzheimer's Society, 2014).

The graph below shows projections of dementia prevalence in the UK:



(Source: Alzheimer's Research UK)

Dementia can have a profound impact on people's sense of identity, behaviour, mood, and wellbeing, as well as all aspects of their relationships with others and their ability to manage everyday activities. The impact of dementia is not confined to people who directly experience the condition. It also has a major effect on their families and friends, and ultimately dementia has implication for everyone in society. As awareness and understanding of the personal and social impact of dementia has increased, a psychosocial approach has helped move from a narrow focus on disease alone to thinking about dementia in terms of disability. By highlighting the person rather than the disease leads to an emphasis on what helps people to live well with Dementia.

In 2015, Dementia replaced ischaemic heart diseases as the leading cause of death in England and Wales, accounting for 11.6% of all deaths registered in 2015 (Source: Office of National Statistics). It remains the leading cause of death for men and women over 80.

It is estimated that Mild Cognitive Impairment (MCI) affects between 5% and 20% of people aged over 65. Research suggests that 10% to 15% of people who had MCI with gradual memory loss went on to develop Dementia – usually Alzheimer's disease. Early work with people with MCI on improving their lifestyle can help to reduce the risk of MCI progressing to Dementia and may also provide them with wider health benefits. (Source: Alzheimer's Society)

The Lancet Commission has reported a range of potentially modifiable risk factors for Dementia that may account for approximately 35% of the risk of getting Dementia. (Source: The Lancet). These risk factors are:

- Low levels of education
- Midlife hearing loss
- Physical inactivity
- High blood pressure (hypertension)
- Type 2 diabetes
- Obesity
- Smoking
- Depression
- Social isolation

National Strategy

The NHS Mandate 2017-2018 states the ambition to:

- Deliver the actions as outlined in the Challenge on Dementia 2020 Implementation Plan
- Maintain a minimum of two-thirds diagnosis rates for people with Dementia.
- Continue to develop evidence based framework for a national treatment and care pathway and agree an affordable implementation plan for the 2020 Dementia Challenge, including improving the quality of post-diagnosis treatment and support.

In 2016, the new government re-committed to the policy as the Prime Minister's Challenge on Dementia 2020.

The Government's vision for 2020 and key aspirations are:

- **High quality, meaningful care** following diagnosis through to end of life care.
- **Public awareness and understanding** of the risk of developing Dementia is improved, and how people can **reduce risk by living more healthily**.
- GPs will play a leading role in ensuring **coordination and continuity** of care. Training will also need to be provided for all NHS staff on Dementia.
- National and local government will support the **Dementia Action Alliance** to help create a dementia-friendly community. Funding for Dementia research being **doubled by 2025**

The new national changes will help people plan for the future and put

people more in control of the care they receive. Listed below is further information and guidance in relation to Dementia.

NICE has released specific guidance relating to mid-life approaches to delaying the onset of Dementia.

NICE Dementia Guidance on assessment, management and support for people living with dementia and their carers.

Supporting NICE guidance, the National Collaborating Centre for Mental Health (NCCMH) has published:

- The Dementia Care Pathway (2018) which gives improvements in the delivery and quality of care and support for people living with Dementia and their families.

Dementia: Applying All Our Health) which sets out key prevention messages at a population, community, family and individual level which may help reduce the risk of Dementia (Source: Public Health England)

2. Key Facts

Dementia is now one of the top **5** underlying causes of death in the UK

2 in 3 people with **Dementia** are female

1 in 3 people born in the UK in **2015** will develop **Dementia** in their lifetime

850,000 people are estimated to be living with **Dementia** in the UK

Dementia is the leading cause of death for men and women over **80** years old

1 in 14 people over **65** have **Dementia** in the UK and **1 in 79** of the whole population

Dementia is estimated to cost **£26.3** billion per year

In **2014** the number of people **65+** with **Dementia** in Lincolnshire was estimated at over **11,000**

By **2020** the projected number of people living with **Dementia** in Lincolnshire is estimated at over **13,000**

1 in 4 adults in Lincolnshire are **physically inactive** compared to 1 in 5 across England

In 2016/17, **16.4%** of the population in Lincolnshire was recorded as having Hypertension (high blood pressure) compared to **13.8%** across England

Number of people in Lincolnshire estimated to have **Dementia** before **65** is **200** people

64% of adults in Lincolnshire are **overweight or obese**

6.7% of people over 65 in Lincolnshire were living with **Dementia** in 2015, **1.5%** of the population

Older people who are lonely are **1.63** times more likely to have **Dementia**

In 2015-16, **£4.18M** was spent by LCC on short term and long term care for people with memory or cognition problems

In 2015-16, **£350,000** was also allocated to the Dementia Family Support Service and included a contribution of **£50,000** to the Dementia Support Network

62,000 adults are registered with **depression** in Lincolnshire

3. Lincolnshire Context

Lincolnshire's Health and Wellbeing Board brings together key people from health and social care to work together to reduce inequalities and improve the health and wellbeing of the people of Lincolnshire. The Board has recently undertaken extensive engagement regarding its Joint Health and Wellbeing Strategy (JHWS) for Lincolnshire. Dementia has been identified as a priority area and this Joint Strategy reflects that fact with a number of priorities and actions which are directly related to the JHWS. The JHWS is available here.

The Lincolnshire Joint Strategy for Dementia 2014 – 2017 set out a plan to improve and to support people with Dementia their families and carers. Much has been achieved, and we will continue to address how we improve these things in our refreshed strategy.

In Lincolnshire, our achievements have included:

- The Dementia Family Support Service (DFSS) was developed and commissioned in October 2015 by Lincolnshire County Council. This service has helped over 3,200 people with Dementia and their Carers in Lincolnshire.
- There are now eight local Dementia Action Alliances in Lincolnshire covering all districts of the county. All those signed up to the DAA are working towards becoming Dementia friendly by actively contributing to raising awareness and understanding of Dementia. Developing Dementia-friendly environments, reducing stigma and developing positive attitudes towards the delivery of services.
- The Dementia Action Alliance acts as the formal partnership to progress the Dementia Friendly Communities. An accreditation process administered by the national DFC programme has to date recognised Lincoln, Boston, Skegness, Grantham, and Bourne under the scheme.
- Work has been undertaken on improving elements of the pathway, specifically on diagnosis.
- There are over two million Dementia Friends nationally with just over **19,000 in Lincolnshire,** alongside 140 active Dementia Friends Champions. Lincolnshire County Council and Lincolnshire CCGs have led a number of awareness campaigns and targeted promotional work to help increase the number of Dementia Friends in Lincolnshire and will continue to do so across the lifetime of this strategy.
- United Lincolnshire Hospitals NHS Trust (ULHT) is a member of the Dementia Action Alliance and is committed to supporting the Dementia Friendly Hospital Charter.
- ULHT has also developed a tool that will support emergency and admissions to ensure a tailored stay in hospital. This has been undertaken in partnership with the Alzheimer's Society, Carers FIRST Lincolnshire, and Commissioners.
- In Lincolnshire organisations have developed a Frailty Pathway which includes tools to identify and support dependency across services.
- Lincolnshire Partnership NHS Foundation Trust (LPFT) provides a Dementia and Specialist Older Adult Mental Health Service for people needing help with suspected or diagnosed Dementia, as well as adults aged 65 years with complex mental health problems and other specialist needs.
- LPFT was the first NHS trust in England to sign up as a Dementia research 'Champion'.
- The Managed Care Network is an alliance of mental health groups and organisations that provide activities and services to give people support, structure and choice in their lives, and which includes dementia in its

terms of reference. At present MCN supports local Dementia projects in the Boston, Spalding, Stamford, and Gainsborough localities.

- We have engaged with people with Dementia their families and Carers, in developing this Strategy, and will continue to do so to ensure we listen and take account of their experience and what they feel is needed to improve care and support.

The Picture for Lincolnshire

Dementia Profiles for Lincolnshire evidence that a number of risk factors are worse than the both national and regional levels. These include inactive adults (doing less than 30 minutes of moderate intensity exercise each week) and adults who are overweight and obese. Prevalence of a number of conditions which are risk factors for Dementia are also higher in Lincolnshire including hypertension, stroke, diabetes, CHD and depression (Source: Public Health England, Dementia Profiles).

According to estimates, there were 11,289 people aged 65 and over with Dementia living in Lincolnshire in 2015, with 62% of people experiencing Dementia were estimated to be females. This gender inequality is caused by two factors: late onset of Dementia is estimated to be higher in females than males, plus women live longer than men which increases their risk of developing Dementia in older age (Source: Projecting Older People Population Information).

This table demonstrates the projected increase in the number of people with Dementia aged 65+ by district:

(Source: POPPI)

District	2017	2035
Boston	1017	1607
East Lindsey	2643	4378
Lincoln	1077	1798
North Kesteven	1797	3227
South Holland	1590	2656
South Kesteven	2184	4164
West Lindsey	1434	2555
Lincolnshire	11688	20427

The number of people aged 65 and older experiencing Dementia in Lincolnshire is projected to increase, at the same time the rates of Dementia prevalence are projected to increase to 8.2% of people aged 65+ or 2.3% of the total Lincolnshire population (Source POPPI).

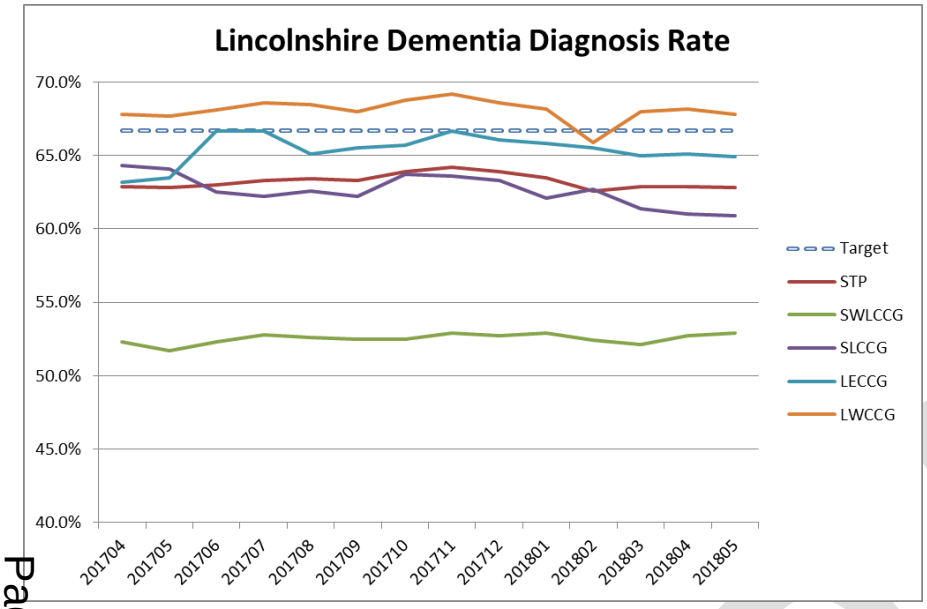
Applying national prevalence rates to the total number of patients registered at each Clinical Commissioning Group (CCG), Lincolnshire East CCG has the highest estimated rate at 4,104 (1.68%), which reflects the older age profile of its population (Source: Public Health).

From April 2017 the way NHS England calculates Dementia diagnosis rates has changed. Formerly, prevalence estimates were applied to Office of National Statistics population estimates. Instead they will be applied to registered populations from GP lists. Because of these changes it is not always useful to draw direct comparison between Dementia data published by NHS England in 2017/18 and earlier data sets, or those from other sources.

The growing proportion of people with Dementia will continue to represent a challenge to all aspects of health and social care provision. Therefore it is important that we work together in local communities to develop and ensure new and innovative ways to support people with dementia and their Carers

Fully addressing diagnosis aims requires a strategic approach. A self-assessment by the Lincolnshire CCGs in 2017 has identified areas of variation across clinical pathways which suggest an opportunity to share learning and pathways across CCGs. Work has been undertaken on improving elements of the pathway, specifically on diagnosis; however an integrated countywide pathway for Dementia care has yet to be developed.

The graph below compares diagnosis rates from April 2017 to May 2018:



(Source: Lincolnshire STP)

Dementia Research

All three of Lincolnshire's NHS Trusts and Lincolnshire County Council have pledged to be Join Dementia Research champions – the first time a whole county has promised to get behind the national campaign.

Join Dementia Research (JDR) is a nationwide online and telephone service that makes it easier for people to register their interest in volunteering for vital Dementia research.

County	JDR Registration numbers
Lincolnshire	290
Nottinghamshire	841
Derbyshire	650
Leicestershire	503
Northamptonshire	364

Nationally, there are more than 7,500 Join Dementia Research participants, and 165 studies have used the service as a way to find suitable volunteers. In Lincolnshire, 290 volunteers have signed up to JDR. The table below compares this figure with other authorities in the East Midlands. (Source: Research, Innovation and Effectiveness Department, LPFT)

A new recommendation from the National Institute for Clinical Excellence included in the NICE dementia guidelines June 2018 makes clear that health and care professionals should help people living with dementia and their carers find out about opportunities to take part in research, and empower them to make their own decisions about getting involved. One straightforward way to do this is to provide information about Join Dementia Research.

NICE evidence-based guidance remains central to improving awareness, prevention, early diagnosis and dementia care and support in Lincolnshire.

Enabling Research in Care Homes (ENRICH)

Improving the lives and health of older people living in care homes is a major UK government priority. ENRICH is a key part of the Government's Challenge on Dementia 2020 and LPFT help make this happen by improving the consistency of support for research outside the NHS. LPFT have worked with Lincolnshire Care Association (LinCA) and directly with homes to promote ENRICH, and now have the largest number of homes registered in the East Midlands.

LPFT have also completed one national research study, Agitation and Quality of Life in Care Homes (University College London), which involved three Lincolnshire care homes. The results of this large programme are currently awaiting publication.

4. Where we want to be in 2020: Our Vision

Over the next three years, to meet the aspirations of **National Dementia Policy**, and achieve our **Joint Strategy's Key Priorities** we commit to working with **Strategic Partners** across Lincolnshire and **National Partners**. We will adopt NICE Dementia Guidance (NG97).

"Next Steps on the NHS Five Year Forward View", published in March 2017, states that Sustainability and Transformation Partnerships (STPs) will be the main vehicle for health, social care and local government leaders to plan integrated service provision. The Lincolnshire Sustainability and Transformation Partnership have published its plans.

The refreshed Lincolnshire Joint Strategy for Dementia will be aligned to national policy. We will have robust processes to ensure monitoring and reporting of policy compliance. The Prime Minister's Challenge highlighted risk reduction as there is a growing evidence to reduce an individual's risk of dementia by supporting them to live healthier lives. Around a third of Alzheimer's disease diagnoses worldwide might be attributed to potentially modifiable risk factors.

We will deliver our prevention commitments as per the Joint Health and Wellbeing Strategy for Lincolnshire 2018. This will include:

- Improving timely identification and diagnosis
- Developing a prevention programme for vascular dementia increasing awareness of dementia across the population.
- We want to improve the experiences of people with dementia.
- Every person with dementia will have meaningful care from diagnosis to the end of life.
- We will ensure that people with dementia and their family carers are supported to live well no matter what stage of their illness.
- We will commit to extending support for and engagement with, Third Sector organisations working with people and families affected by Dementia.
- We will continue to work with NHS England, Alzheimer's Society and partners to ensure as many people affected by dementia as possible benefit from personalised support following diagnosis.

- We will use the National Dementia Statements, ensuring that we listen to people affected by dementia and gather evidence to better understand their experiences at every stage of the dementia journey. The new Dementia Statements reflect the things people with dementia say are essential to their quality of life:

  - ✓ *We have the right to be recognised as who we are, to make choices about our lives including taking risks, and to contribute to society. Our diagnosis should not define us, nor should we be ashamed of it.*
  - ✓ *We have the right to continue with day-to-day and family life, without discrimination or unfair cost, to be accepted and included in our communities and not live in isolation or loneliness.*
  - ✓ *We have the right to an early and accurate diagnosis, and to receive evidence based, appropriate, compassionate and properly funded care and treatment, from trained people who understand us and how dementia affects us. This must meet our needs, wherever we live.*
  - ✓ *We have the right to be respected, and recognised as partners in care, provided with education, support, services, and training which enables us to plan and make decisions about the future.*
  - ✓ *We have the right to know about and decide if we want to be involved in research that looks at cause, cure and care for dementia and be supported to take part.*

(Source: National Dementia Declaration: Dementia Statements, 2017)

Integrated Personal Commissioning (IPC)

Lincolnshire is an Integrated Personal Commissioning demonstrator site, with Dementia being an identified cohort for IPC delivery.

IPC is a nationally led, locally delivered programme that is supporting healthcare empowerment and the better integration of services across health, social care and the voluntary and community sector.

Through IPC, people, carers and families with a range of long-term conditions and disabilities are supported to take greater control over what services support them and who provide them.

Lincolnshire local authority and NHS partners have worked with the Alzheimer's Society, and other experts to focus on effective personalised care and support planning for people with dementia, incorporating a trial of a pioneering approach to individual asset mapping called Dementia Capital Networks. LCC and partners have also worked with Community Catalysts CIC to understand what is available to people and how a diverse local care market can be supported to thrive.

Alison's Story

Alison lives with dementia and participated in the IPC Dementia Capital Networks pilot project (DCN).

Alison had hobbies and interests but health issues were affecting her wellbeing. She took part in a DCN conversation to improve care and support planning by maximising the role of the person with dementia alongside family, social, and community resources.

Alison found the conversation a relaxed friendly experience, allowing time to talk about the things that really mattered to her: "*I felt listened to - a lovely, friendly, caring person, easy to talk to. What she said she would do was done… and no complicated words! I prefer this type of conversation and having this done in your own home feels relaxed and safe."*

Alison's family also found the DCN conversation made more things seem possible than before: "*Really good you came out and did the map as it is not until it's laid out in front of you do you really see things, the different areas, and access some areas we did not realise. It's good to talk something through and see things from a different perspective, it's a huge thing."*

DCN allowed Alison time and opportunity to share what was really important to her with family and friends and the Alzheimer's Society Dementia Support Worker. As a result of this person centred approach a four day holiday with the family was booked and the family worked to overcome the things that were getting in the way of Alison going shopping. Additional benefits entitlement was identified and a referral to Occupational Therapy Service made, all combining to provide Alison with a range of adaptions to her home, support and mobility. Most changes were delivered for low cost and brought her social network closer to find solutions for themselves.

Despite the conversation acknowledging concerns, Alison felt DCN helped her turn these into practical actions that were both reassuring and empowering: "*There are lots of vulnerable people out there, but I'm not one of them!"*

(Source: Alzheimer's Society)

5. Key Aims

The following key aims summarize the priorities and outcomes necessary to meet our objectives:

- Raise awareness and prevention by promoting healthy living among the public and professionals
- Improve diagnosis rates
- Following diagnosis to support more people to live at home independently for longer
- Enable people to live well with Dementia

Aim 1 – Raise awareness and prevention by promoting healthy living among the public and professionals

Priorities

1. We want to improve awareness of how healthy lifestyle choices can reduce personal risk of developing dementia.
2. Reduce the risk factors for Dementia across the county by actively promoting healthy lifestyle services focused on key risk factors.
3. Improve awareness and skills needed to support people with Dementia and their carers in all areas of health and social care.
4. Identify opportunities for improved integrated Neighbourhood Team working.
5. Active involvement in, and support for, the Lincolnshire Dementia Action Alliance and the national Join Dementia Research programme.
6. Support the Sustainability and Transformation Partnership (STP) and Lincolnshire Health and Wellbeing Board (LHWBB) governance frameworks which ensure clear accountability for the delivery of the Joint Dementia Strategy.

We will

- The Lincolnshire Health and Wellbeing Board, through its new Joint Health and Wellbeing Strategy 2018, will develop a prevention programme focused on Dementia
- Create a Dementia sub-group that reports to the Lincolnshire Health and Wellbeing Board on implementation of the strategy action plan.
- Develop a strategy action plan with designated tasks and timescales.
- Promote healthy living to 40-74 year olds.
- Include Dementia awareness and signposting for 65+ in the NHS Health Check programme.
- Reduce psychosocial risk factors such as loneliness and depression.
- Incorporate dementia risk reduction and brain health promotion measures in other policy work streams for pre-disposing conditions such as cardiovascular disease and diabetes.
- Ensure appropriate Dementia training continues to be made available to health and social care staff on a sustainable basis.
- Promote '*Join Dementia Research*' among professionals and the public.
- Promote work undertaken by the Dementia Action Alliances.
- Promote the police-led Herbert Protocol to help keep vulnerable people safe.
- Hold an event to publicise and promote Lincolnshire's Joint Dementia Strategy.
- Promote Dementia Friends Campaign and support communities to become dementia - friendly including businesses, and health and care settings.

Outcome Measures

- Increased numbers of Dementia Friends in Lincolnshire.
- Greater awareness of Dementia strategy among the public and professionals reflected through surveys, feedback, and public events.
- Increased participation in Dementia research.
- Health & Wellbeing Board reporting requirements
- Annual reports – Dementia Strategy action plan

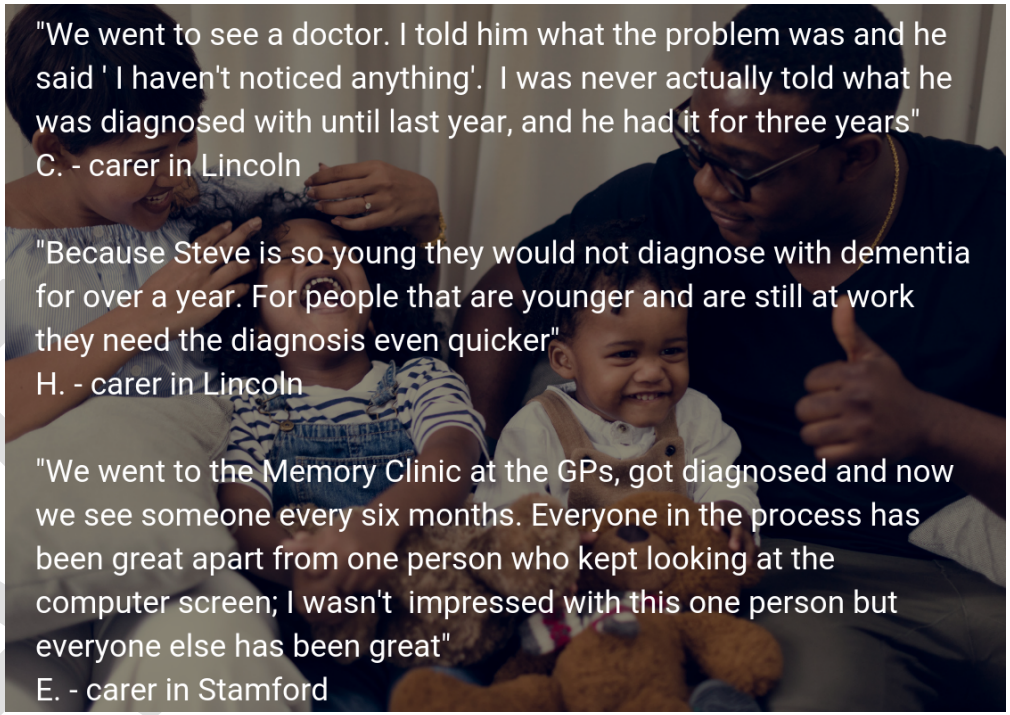
Aim 2 – Improve diagnosis rates

Priorities

1. We want to improve care by increasing Dementia diagnosis rates in line with national targets. We also want to ensure that we increase the number of people being diagnosed, and starting treatment or accessing interventions within six weeks of referral.
2. Achieve equity of access to diagnostic services by examining variations in waiting times and capacity.

We will

- Implement a countywide pathway for identification, referral, and timely diagnosis.
- Identify opportunities for jointly commissioning post-diagnostic support.
- Develop pathways to ensure people have access to appropriate post-diagnostic care and support.
- Focus on Mild Cognitive Impairment (MCI) as this represents a high-risk cohort who could potentially benefit through life-style education and social prescribing.



Outcome Measures

- Diagnosis rates meeting national targets in line with the NHS Mandate, Five Year Forward View, and the objectives of 'The Prime Minister's Challenge on Dementia 2020.
- Waiting time data.

Aim 3 – Following diagnosis to support more people to live at home independently for longer

Priorities

1. Improve the quality of post-diagnostic treatment, intervention and support available for people with Dementia and their carers to enable them to optimise independence and quality of life.
2. Ensure that people diagnosed with Dementia access timely intervention, social support and signposting.
3. Greater integration with the Frailty pathway and awareness of Dementia in multi-agency Neighbourhood Teams.
4. Agree and implement palliative care pathways for people with Dementia.

We will

- Develop service specifications for an integrated countywide Dementia pathway, taking into account NICE and NCCMH guidance.
- Design pathways around people with Dementia, taking into account, emergency hospital admission and Advance Care Planning.
- Pilot an Admiral Nursing service for people diagnosed with Dementia in Lincolnshire.
- Work with health and care professionals to ensure carers are listened to from the outset, and involved in the care of the person they support.
- Address unique palliative care aspects of people with Dementia when commissioning of end of life care.
- Embrace Neighbourhood Working.

Outcome Measures

- Published countywide Dementia pathway.
- Numbers of people accessing post-diagnosis support.
- Increased number of people with dementia having an integrated care and support plan

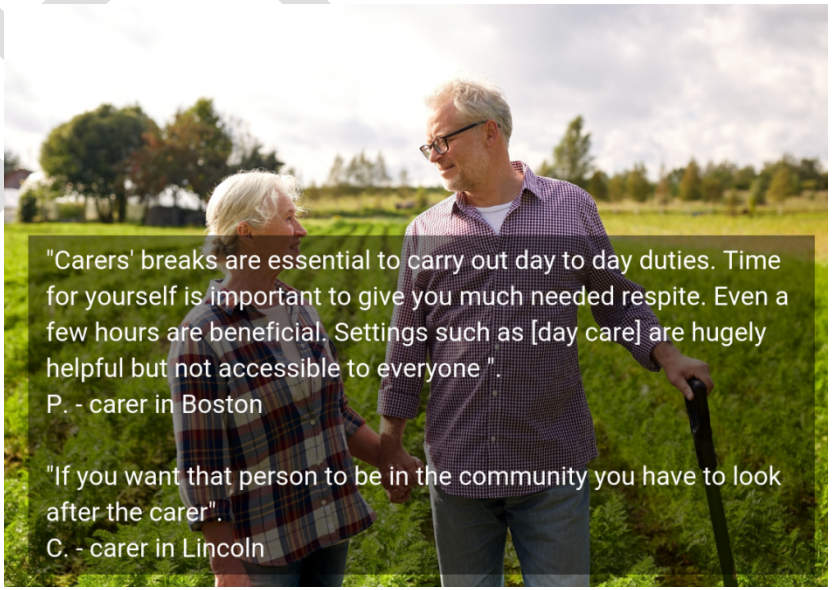
Aim 4 – Enable people to live well with Dementia

Priorities

1. Commission community based social support services for people with Dementia to live well and to support the wellbeing of families and carers. Ensure that people with lived experience of dementia are consistently involved in the governance and oversight of the Joint Dementia Strategy and its associated plans.
2. Standardise the Memory Assessment and Management Service (MAMS) model across the county to improve patient outcomes.
3. Reduce the amount of antipsychotic medication prescribed to people with dementia, reassessing a person prescribed antipsychotic medication every six weeks (NICE Guidelines June 2018, Dementia: assessment, management and support for people living with dementia and their carers).
4. Ensure people living with dementia who have sleep problems have access to a personalised multicomponent sleep management approach. (NICE 2018).
5. Ensure the sustainability of future support provision for people with Dementia and their families. Develop resilience and build community capacity.

We will

- Work with partners to provide an integrated and seamless carers journey that allows for the whole family approach.
- Work together to ensure a fully coordinated approach and deliver an agreed strategy action plan.
- Commission a post-diagnosis family support service to succeed the current DFSS agreement which will help promote resilience, healthy lifestyles, and physical and mental wellbeing.
- Promote and deliver the Joint Health and Wellbeing Strategy which acknowledges Dementia as a priority and emphasises prevention and early intervention.
- We will support the Integration agenda for people in Lincolnshire who access social care to have a joint health and social care assessment but critically to have a joint health and care plan where needed.



Outcome Measures

- Jointly Commission Services by CCGs and LCC.
- Evaluation of the MAMS service and outcomes.
- Improved outcomes for people with Dementia and their carers through data gathered from the Adult Social Care User Survey, Carers Survey and Commissioned Services.
- Number of people supported with dementia at home by integrated Neighbourhood Teams.
- Reduction in the amount of antipsychotic medication prescribed to people with dementia.
- Number of people with dementia dying at their usual place of residence.
- Number of people with dementia having an annual health check.
- Number of people with dementia that have a joint health and care plan.

6. Partnerships

The Dementia Officers Group is a special interest group of commissioners and providers which promotes good practice in Dementia care and support. Membership consists of staff from the statutory health and social care agencies as well as representatives from voluntary sector organisations. The group is chaired by an officer with responsibility for commissioning or providing Dementia services either for the NHS or local authority.

The group has drawn attention to the commitment in the Lincolnshire Joint Strategy for Dementia 2014 - 2017 to set up a Dementia Sub-Committee to be responsible for strategy implementation and governance. The Dementia Officers Group considers itself to be in a strong position to assume a more formal governance role towards this Dementia strategy.

The Alzheimer's Society

We have welcomed and worked with The Alzheimer's Society in Lincolnshire; they have been involved and supported in the following ways:

- The Sustainability and Transformation Plan for Lincolnshire (STP) to ensure it reflects sufficient Dementia commitment, and to continue to support and develop activity around local Dementia Action Alliances to encourage greater Dementia awareness.
- The Alzheimer's Society is represented on the CCG Dementia sub-group with representation from GP leads, NHS England and LPFT.
- Dementia leads in ULHT hospitals to develop a Dementia Care Bundle to improve patient outcomes.
- Primary Care teams across Lincolnshire to offer free training on Dementia.
- The Lincolnshire Integrated Personal Commissioning (IPC) demonstrator project to support people affected by Dementia at the centre of health and social care.
- Neighbourhood Teams and Memory Assessment clinics with the aim, over the next three years, of having a specialist Dementia support worker holding their own caseload as an integral member of the team.

The Alzheimer's Society has also invested in a range of support services in Lincolnshire future plans include promoting the 10 point plan for integrated dementia care and scoping a partnership project with NHS England's national Personalised Care Group team:

- End of Life Care Providers Group which is made up of seven health and social care organisations make up membership of the Lincs and Borders
- St Barnabas Hospice host the Lincolnshire Palliative Care Co-ordination Centre (PCCC) which is an administrative centre which matches care needs with care providers for patients needing palliative care.

7. Acknowledgements

This Joint Strategy acknowledges the contributions of:

- Lincolnshire County Council
- Lincolnshire Clinical Commissioning Groups
- NHS England
- Service users, patients, and carers
- Alzheimer's Society
- Lincolnshire Partnership NHS Foundation Trust
- United Lincolnshire Hospitals NHS Trust
- Lincolnshire Community Health Services NHS Trust

8. Sources & Useful Links

Alzheimer's Society
www.alzheimers.org.uk

Carers Survey (2017), Adult Social Care, Lincolnshire County Council
Internal Lincolnshire County Council Report

Dementia Action Alliance
www.dementiaaction.org.uk

Dementia Family Support Service
https://www.alzheimers.org.uk/homepage/168/dementia_connect#!/detail/a0z7000001gcTcWAAU?lng=-0.5456245999999965&lat=53.2315311

Dementia Friends
www.dementiafriends.org.uk

Herbert Protocol
www.lincs.police.uk/reporting-advice/missing-person

Join Dementia Research
www.joindementiaresearch.nihr.ac.uk

Joint Health & Wellbeing Strategy, Public Health, Lincolnshire County Council
https://www.lincolnshire.gov.uk/health-and-wellbeing/information-for-professionals/health-data-policies-and-publications/joint-health-and-wellbeing-strategy/115339.article

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

Lincolnshire Community Health Services NHS Trust
www.lincolnshirecommunityhealthservices.nhs.uk

Lincolnshire County Council
www.lincolnshire.gov.uk/

Lincolnshire County Council – Market Position Statement
https://www.lincolnshire.gov.uk/residents/adult-social-care/for-providers/key-documents/market-position-statement/127863.article

Lincolnshire County Council – Local Account
https://www.lincolnshire.gov.uk/residents/adult-social-care/strategies-policies-and-plans/adult-care-local-account/114719.article

Lincolnshire Partnership NHS Foundation Trust
www.lpft.nhs.u/

Lincolnshire Research Observatory
www.research-lincs.org.uk/Home.aspx

NHS Digital
https://digital.nhs.uk

NHS Lincolnshire East Clinical Commissioning Group
https://lincolnshireeastccg.nhs.uk

NHS South Lincolnshire Clinical Commissioning Group
https://southlincolnshireccg.nhs.uk

NHS Lincolnshire West Clinical Commissioning Group
http://www.lincolnshirewestccg.nhs.uk

NHS South West Lincolnshire Clinical Commissioning Group
http://southwestlincolnshireccg.nhs.uk

National Collaborating Centre for Mental Health (NCCMH)
https://www.rcpsych.ac.uk/members/nccmh.aspx

Prime Minister's Challenge on Dementia 2020
https://www.gov.uk/government/publications/prime-ministers-challenge-on-dementia-2020

Projecting Older People Population Information
http://www.poppi.org.uk

Social Care Institute of Excellence: building social capital
https://www.scie.org.uk/publications/windowsofopportunity/interventions/buildingsocialcapital.asp

United Lincolnshire Hospitals NHS Foundation Trust
https://www.ulh.nhs.uk

Public Health England Dementia Profile
https://fingertips.phe.org.uk/profile-group/mental-health/profile/dementia/data#page/1/gid/1938133052/pat/15/par/E92000001/ati/120/are/E54000013

Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of the Multiagency Review Steering Group

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**25 September 2018**
Subject:	**Multiagency Review of Mental Health Crisis Services in Lincolnshire**

Summary:

The Multiagency Review of Mental Health Services in Lincolnshire was completed in May 2018 and outlines ten key recommendations to be implemented in order to improve mental health and maximise the provision of mental health crisis services for the local population.

Actions Required:

The Health and Wellbeing Board are asked to note the recommendations of the review and oversee implementation of those recommendations which are agreed by lead commissioners.

1. Background

The review of mental health crisis services was initiated due to an increase in the number and associated costs of patients being transferred to hospitals outside of Lincolnshire, revised legislation around section 136 detentions in a health based place of safety, and excessive use of police resources in dealing with mental health crisis. Intelligence suggested that mental health crisis services were not configured to meet the needs of local people experiencing crisis, and senior representatives from key stakeholder organisations came together to lead this multiagency review, with the shared aim of improving the experience of service users, making best use of the existing funding and resources available, and ensuring sufficient capacity of mental health crisis services across Lincolnshire.

The purpose of the review was to obtain a clear picture of currently commissioned mental health crisis services across Lincolnshire. The review covers the whole population of Lincolnshire, including all ages and geographical locations, and therefore looks at provision of services for children and young people, working age adults and older adults

across the county. These services include Crisis Resolution and Home Treatment Teams (CRHTTs), Approved Mental Health Professionals (AMHPs), mental health liaison service, triage car, crisis housing, section 136 suite and other health-base places of safety, Child and Adolescent Mental Health Services (CAMHS) and the Single Point of Access (SPA), and acute inpatient services are also included for the purposes of mapping the crisis pathway following assessment and identifying the impact of current crisis services on acute bed usage, both within Lincolnshire and in out of area placements.

Additional focus is also placed on those services not commissioned for mental health crisis response but who play an important part in the pathway, specifically Lincolnshire Police, Accident and emergency departments at United Lincolnshire Hospitals NHS Trust and General Practitioners.

The information presented within this review was compiled from three sources:

- Service information - gathered from relevant service specifications, operational documents and/or discussions with service leads, to obtain a full and current picture of service provision;
- User feedback - collected from a range of individuals and groups, including service users, carers and professionals, to understand views and experiences of current service provision;
- Data - activity and demand data has been collected from all local providers, and benchmarking against regional and national figures has also been undertaken, where relevant.

The Multi-Agency Steering Group, established to oversee the review of Mental Health Crisis Services in Lincolnshire, endorsed the following recommendations to be considered by lead commissioners and other key stakeholders, and wholeheartedly hope that these recommendations will lead to further positive outcomes in the development of Mental Health provision and improved outcomes for the people of Lincolnshire.

The recommendations are as follows:

1. ***Future ownership of the review and associated recommendations*** - To ensure that the review has the best chance to influence the future development of crisis support provision in Lincolnshire, it is recommended that the report is shared with responsible lead commissioners and associated key stakeholders.

2. ***Prevention, early intervention and recovery*** - While services to support people at the point of mental health crisis are essential, the priority should be to prevent people reaching the point of crisis in the first instance and aid the recovery of people who have experienced crisis wherever possible.

3. ***Mental health awareness*** - Providing training for all staff who may come into contact with those experiencing mental ill health, including mental health staff and all initial points of contact such as reception and admin staff, A&E and primary care, would help to raise awareness and improve attitudes, thereby reducing the stigma and discrimination associated with mental ill health.
4. ***Pre-referral support*** - There is a clear need for services to provide an all-age, 24/7 urgent response where those who simply need to speak to someone to prevent crisis escalating should be able to do so, and those who need additional support can be signposted or directed to the most appropriate and least restrictive source, including crisis teams where necessary.

5. ***Review and update the existing Crisis Resolution and Home Treatment Teams specification*** - While it is clearly important to provide a prevention and early intervention offer for people with lower level needs, the Crisis and Home Treatment services need to be more appropriately targeted at those in greatest need.

6. ***Review of wider community-based mental health services*** - While Community Mental Health Teams were outside the scope of the Mental Health Crisis Review, there is a link between Community Mental Health Teams and Crisis Services and it is recommended that key stakeholders should commission a multi-agency review of non-crisis community mental health provision aligned to Integrated Neighbourhood Team working.

7. ***Mental health transport services*** - There are often delays in commissioned transport responding to mental health crisis in a timely fashion, sometimes leaving other professionals at risk. It is recommended that there is an urgent review of the existing commissioning and provider arrangements for mental health transport services, to ensure that these services are effective, economic and appropriate.

8. ***Collaborative working between services*** - No single service can meet all of a user's needs, and additional focus should be placed on providing integrated team working as part of a wider health, emergency and social care system which supports the service user based on their individual needs.

9. ***Investment in mental health services*** - It is clear that the recommendations made in this report will require some level of investment and in this respect it is recommended that key stakeholders review the current expenditure on mental health services in comparison to the investment standard requirements. Equally, key stakeholders should review the proportion of overall existing expenditure on inpatient provision with a view to targeting a greater proportion of expenditure on community based and preventative provision in the future.

10. ***Priorities for Lincolnshire's Mental Health Crisis Care Concordat*** - It is recommended that, following receipt and consideration of this Review, Lincolnshire's Mental Health Crisis Care Concordat should consider a review of current priorities to ensure that the areas within this report are appropriately represented and to avoid duplication.

2. Conclusion

The multiagency steering group acted as the delivery vehicle for completion of the review and has now been disbanded. While it will be the commissioners for mental health who need to accept and agree the recommendations, the steering group's expectation was that the Lincolnshire Health and Wellbeing Board would provide oversight to the Sustainability and Transformation Partnership (STP) Mental Health and Learning Disability Group in implementing those recommendations which are agreed by commissioners, and review the plan for implementation regularly, as part of the Joint Health and Wellbeing Strategy delivery mechanism.

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

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

The evidence in the JSNA suggests that mental ill health for children and young people and adults has a significant financial impact on the economy and can result in negative outcomes in relation to education, employment, housing, substance abuse and the criminal justice system. This Review supports the evidence that supporting families and carers, building resilience through childhood to adulthood, and supporting self-care reduces the burden of mental and physical ill health over the whole life course, reducing the cost of future interventions, improving economic growth and reducing health inequalities.

In relation to the Joint Health and Wellbeing Strategy, this report contributes to the furtherance of the two priority areas of mental health and emotional wellbeing (children and young people) and mental health (adults), and the recommendations of the Review support the four aims of the Strategy, namely:

- Have a strong focus on prevention and early intervention
- Take collective action on health and wellbeing across a range of organisations
- Tackle inequalities and equity of service provision to meet the population needs
- Deliver transformational change in order to improve health and wellbeing

4. Consultation

The majority of the information contained within the report was gathered from engagement with a range of groups and individuals. Six engagement events were held across the county and an online survey was developed to gather the views and experiences of service users and carers. A combination of online surveys and focus groups was also used to gather the views and experiences of a range of professionals, including frontline police officers, A&E staff, GPs, AMHPs and representatives from third sector organisations.

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Executive Summary: Multiagency Review of Mental Health Crisis Services in Lincolnshire

6. Background Papers

Document	Where it can be accessed
Review of Mental Health Crisis Services in Lincolnshire – full report	https://www.lincolnshire.gov.uk/health-and-wellbeing/mental-health/

This report was written by Beth Rhodes, who can be contacted on 07368 212408 or beth.rhodes@lincolnshire.gov.uk

MULTIAGENCY REVIEW OF MENTAL HEALTH CRISIS SERVICES IN LINCOLNSHIRE

EXECUTIVE SUMMARY

BETH RHODES, PROJECT MANAGER

On behalf of the multiagency steering group representing

Lincolnshire Partnership NHS Foundation Trust, NHS South West Lincolnshire Clinical Commissioning Group, NHS Lincolnshire West Clinical Commissioning Group, NHS Lincolnshire East Clinical Commissioning Group, NHS South Lincolnshire Clinical Commissioning Group, Lincolnshire Police, Lincolnshire County Council

Date of Final Report: 14 May 2018

CONTENTS

EXECUTIVE SUMMARY

1. Introduction

Mental ill health is widespread and can affect people from all walks of life. Conditions vary in nature and severity, but all can have a significant impact on the lives of people who experience them. There is also a significant impact on society and the economy, with mental health problems being linked to homelessness, unemployment, poor physical health, and risky behaviour in young people. People can recover from mental illness if they receive timely and appropriate treatment and support, but many people struggle to access mental health services when they need them.

Lincolnshire is a large and sparsely populated county, which can make it difficult to deliver services which are accessible by those in rural areas, particularly by older adults. Within Lincolnshire, it is estimated that around 14% of the population suffers from a common mental health condition. Mental health services are provided primarily by Lincolnshire Partnership NHS Foundation Trust, as commissioned by the four Clinical Commissioning groups in Lincolnshire, with additional services commissioned and/or provided by Lincolnshire County Council, in conjunction with LPFT as part of a section 75 agreement and with the third sector to provide crisis housing (Richmond Fellowship).

This review of mental health crisis services was initiated due to an increase in the number and associated costs of patients being transferred to hospitals outside of Lincolnshire, revised legislation around section 136 detentions in a health based place of safety, and excessive use of police resources in dealing with mental health crisis. Intelligence suggested that mental health crisis services were not configured to meet the needs of local people experiencing crisis, and senior representatives from key stakeholder organisations came together to lead this multiagency review, with the shared aim of improving the experience of service users, making best use of the existing funding and resources available, and ensuring sufficient capacity of mental health crisis services across Lincolnshire.

The purpose of the review is to obtain a clear picture of currently commissioned mental health crisis services across Lincolnshire. The review covers the whole population of Lincolnshire, including all ages and geographical locations, and therefore looks at provision of services for children and young people, working age adults and older adults across the county. These services include Crisis Resolution and Home Treatment Teams (CRHTTs), Approved Mental Health Professionals (AMHPs), mental health liaison service, triage car, crisis housing, section 136 suite and other health-base places of safety, Child and Adolescent Mental Health Services (CAMHS) and the Single Point of Access (SPA), and acute inpatient services are also included for the purposes of mapping the crisis pathway following assessment and identifying the impact of current crisis services on acute bed usage, both within Lincolnshire and in out of area placements. Additional focus is also placed on those services not commissioned for mental health crisis response but who play an important part in the pathway, specifically Lincolnshire Police, Accident and emergency departments at United Lincolnshire Hospitals NHS Trust and General Practitioners.

There is a continuous pathway of mental health services, and the crisis response forms only a small part of this. Within crisis services, it is acknowledged that there is a continuum of services and interventions, from early intervention and prevention through to recovery and preventing future

crises, with the focus of this review being on urgent and emergency access to crisis care and flow through the crisis pathway, from referral to discharge, rather than on the quality of care provided.

The information presented within this review has been compiled from three sources:

- Service information - gathered from relevant service specifications, operational documents and/or discussions with service leads, to obtain a full and current picture of service provision;
- User feedback - collected from a range of individuals and groups, including service users, carers and professionals, to understand views and experiences of current service provision;
- Data - activity and demand data has been collected from all local providers, and benchmarking against regional and national figures has also been undertaken, where relevant.

2. Current Provision

There are a number of services commissioned to provide differing levels of mental health crisis response for people of all ages across Lincolnshire. However, it is noted that the number and range of services available for working age adults are greater than those available for children and young people and older adults. These gaps in provision were highlighted in the views and experiences of both service users and professionals, along with a number of other issues. It is noted that the information in this section is made up of the view s and experiences of a range of individuals and should not be read as fact.

Accessing Services

Younger adults transitioning from CAMHS to adults services can fall between services, and there is no crisis response for adults aged 65 years and over. There are also gaps in provision for those with personality disorder.

It can be difficult to access the adults' crisis teams, and there is a perception that the crisis teams don't do crisis. Service users can feel dismissed or ignored, and often feel that the only way to access services is to say the 'magic words' – suicide. Other professionals also report difficulties in contacting crisis services.

People need access to services at the point of crisis and the first point of contact is crucial. Having someone to talk to and a safe place to go can often be enough to prevent crisis, but phones can go unanswered and it can seem like there is no support available which leads to deterioration in mental health and escalation of crisis. Having to see a GP in order to be referred to crisis teams can be difficult logistically and can create additional delays.

There is geographical variation in provision across Lincolnshire, given the size of the county. There is some good practice but this is isolated in a small number of areas. There is a lack of knowledge and information around what services are available locally, what they do and how to access them. Definitions and expectations can be misaligned, and some services are funded on a short-term basis, meaning that they can disappear quickly. There is also a gap in services provided outside of normal hours, at evening and weekends.

A&E and the police are seen by many as the ultimate crisis response, but this adds additional pressure to already stretched resources, and is often not the best response for someone experiencing mental health crisis.

Whole System Approach

Across Lincolnshire, there is a lack of communication and collaboration between services, both within and between organisations, particularly with the third sector, and a lack of person-centred care. All services are working towards a common goal but no single agency can address everything in isolation, and providers need to work together to prevent escalation and potential admission.

For children and young people, there should be more joined up working between CAMHS and children's services to identify mental health or behavioural issues and agree the most appropriate response. Service users with a dual diagnosis of mental health and substance misuse issues also require a joined up approach between services, as presenting problems can be complex and require multiagency skills. However, this has been difficult to implement in practice.

The AMHP function in Lincolnshire is currently made up of two different services, which has led to disparity, friction and poor communication between professionals.

Police officers dealing with mental health are often subject to later criticism and redress, so it is important that they are able to access support from mental health professionals.

Attitudes and Experience

Service users and professionals report negative attitudes from crisis team staff, and emphasise that people should be treated with compassion, empathy and kindness. People would like to come away feeling more positive, but it can be difficult to relate to someone who has no experience of mental health.

Lived experience of mental health can help to build trust and understanding, and people are more likely to open up to someone who understands what it is like. Mental health awareness/customer service training should be provided for mental health staff and all initial points of contact, and the benefits of utilising peer support workers and volunteers was also noted.

Carers are key in supporting service users outside of hospital, but they report a lack of support and information, and would like to be more involved in decisions regarding care provided.

Service users feel that professionals sometimes don't know what is wrong, and that treatment often revolves around medication without addressing the root cause. Other treatments and activities should also be available.

Local Resource

There is widespread recognition that services are doing their best despite finite resources, but there is a lack of funding and resource across the system. This can mean that people are not seen in the right part of the system, which adds additional pressure onto other services. There is recognition

that additional resource is required in community settings, which could prevent people needing to access secondary care or inpatient services.

There are currently some staffing and recruitment issues across CAMHS and adults crisis teams and AMHPs, and there is also a shortage of section 12 approved doctors who are willing to attend to undertake Mental Health Act assessments which can lead to additional delays.

Staffing issues within EMAS also impacts on the crisis response, with AMHPs, police and service users having to wait several hours for ambulance transport. These issues also impact on the operation of the mental health triage car, which is sometimes not available due to staff shortages, and at other times is requested to attend non-mental health calls.

There has also been some historical underutilisation of resource with regard to the crisis houses, but occupancy has increased significantly over recent months.

Demand on Mental Health Crisis Services

Referrals into crisis teams are made via the Single Point of Access (SPA), but there are some misperceptions around the purpose of the SPA since the triage element was removed. The referrals process can be problematic for both the SPA, with incomplete and/or ambiguous referrals being received, and for referrers, with the process being time consuming and referrals often being returned.

The services provided currently are commissioned for individuals experiencing mental health crisis, but there is a suggestion that most of the demand presenting to the crisis teams is related to social or emotional distress, rather than mental illness. There is a lack of services available for those people who require lower level, practical or emotional support, which has a massive impact on other services, and this additional demand on the crisis teams affects capacity and prevents them from providing a responsive service for those patients who really need them.

Demand on the police and A&E departments from mental health concerns is great, although it is suggested that most people experiencing crisis come away from A&E with nothing. Many frequent attenders go to A&E as a result of social isolation rather than mental health issues. Similarly, the police deal with a number of frequent callers who just want to see someone. People experiencing mental health crisis can be dangerous and unpredictable and require expert help as soon as possible, but A&E or police contact is often not the best response.

Lincolnshire has a high number of section 136 detentions, and it is noted that this facility may be used inappropriately to deal with people who are drunk. People without a mental health problem should not be drawn into mental health services and police officers are now required to explore alternative options before detaining under section 136. However, AMHPs also report a greater number of inappropriate referrals which may be a sign of the system not working correctly.

The majority of detentions for young people under section 136 are due to behavioural issues rather than mental illness. There is a concern that young people are being referred into mental health

services when they don't need it, and that young people and their families need to learn to manage normal angst and distress.

Hospital Admission

LPFT is the only provider of inpatient mental health beds in Lincolnshire, and has one of the lowest levels of acute beds in the country. This can lead to delays in finding a bed, and higher numbers of patients being transferred to hospitals outside of the county. Beds for children and young people are commissioned nationally, and the small number of beds can also lead to delays in accommodating a young person.

Inpatient wards can be scary, with acutely ill people and the potential to learn negative behaviours, and people should be there for as short a time as possible. Service users report a lack of activity and talking therapy as an inpatient, with treatment based around medication and observation. Being placed in a hospital away from home and support networks can be particularly detrimental, having a negative effect on a patient's recovery and making it difficult for professionals in Lincolnshire to remain involved in their care.

There is also a feeling that some people may be admitted inappropriately, or stay in a bed for too long, due to a lack of alternative services available, or the inability of the crisis teams to discharge once care becomes consultant-led.

Avoiding Crisis

It is widely acknowledged that prevention and early intervention are key to managing mental health crisis, and that ongoing support following discharge is also required to support people to stay well. Providing support for prisoners upon release is particularly important, as they may struggle to manage on their own and require support with practical issues such as housing and benefits. Similarly, those who do not attend for appointments are likely to need more support and should not be automatically discharged.

There are many people who access mental health crisis services without a mental illness, and a focus should be on building resilience to minimize, understand or cope with normal feelings. Helping people to understand their mental health issues and seek support at the right time can prevent them reaching crisis or relapsing. Similarly, there is a high rate of self-harm in young people who find it hard to manage adolescence, and provision of services in schools and the early stages of life to facilitate mental health literacy can help young people to cope with their own feelings, and to raise awareness of mental health issues with their parents and ultimately their own children.

3. Best Practice

A number of documents have been published in recent years which outline the direction of travel for mental health, and mental health crisis care in particular, and provide guidance on the services which should be provided. These have been considered in the outcomes of this review.

The *Positive Practice Mental Health Directory* (2018) provides a directory of examples of positive practice in mental health services across the country and was searched to identify case studies which were relevant to the scope of this review. Many of the case studies relate to the implementation of

initial points of contact for service users, using telephone helplines, safe spaces, first response teams and single points of access. Other examples relate to system-wide reorganisation, crisis assessment and home treatment, mental health liaison services, street triage, crisis houses, older adults, transport and dual diagnosis, which could all be applied to the mental health crisis pathway in Lincolnshire.

In exploring best practice, a visit was also made to Northumberland Tyne & Wear NHS Foundation Trust to meet with the service leads for the Initial Response Team, Crisis Team and Together in a Crisis (TiaC) pilot to understand more about the services they have developed, and how this has impacted on capacity, demand and flow across the wider healthcare system.

Within Lincolnshire, there are a number of non-commissioned initiatives which have been identified by service users, carers and professionals as examples of good practice in preventing and/or diverting mental health crisis, outside of commissioned services. In Gainsborough, there are three projects that have been initiated and led by an ex-service user and crusader for mental health and wellbeing. The focus is on wellness rather than illness, and the approach is based on supporting people to identify and resolve their underlying problems, rather than doing it for them, with plans developed in collaboration with the service user.

4. Discussion

In general, commissioned crisis services in Lincolnshire perform well, with some going above and beyond to see people who sit outside of their remit but who would otherwise be at risk. However, service user, carer and professional opinions are not always favourable and a number of potential areas for improvement were identified, both within individual services and across the system as a whole. Few of the issues raised in Lincolnshire are unique, with many having been identified within other reviews and guidance documents.

Service Availability

Mental health services have been historically underfunded, and increasing demand has led to additional pressure on services. Investment in mental health promotion, prevention, care and recovery is of benefit to individuals, their friends and families and society but it is likely that the pressure on health services will continue, and organisations will need to work together to ensure the best use of existing resources. Ensuring that patients are cared for in the right part of the system can help to eliminate wasted resources.

Within Lincolnshire, it is acknowledged that services are doing their best despite limited resources, but the lack of funding available makes it difficult to provide the right level of service to everyone who needs it. Some clear gaps in service have been identified, such as a crisis response for older adults and dedicated services for personality disorder and assertive outreach, and there are some concerns around the level of service provided outside of normal working hours. Mental health services are not well known about within the health and care system, and outdated information can reduce the chances of accessing timely support, and can lead to inappropriate use of frontline services such as A&E.

There is a feeling locally that funding should be directed towards community services to allow people to be treated at home, in a less restrictive setting, with the support of their family, and at a lower cost to the economy. Increased pressure on beds means that it is more difficult to find inpatient beds for those people who do need them, and patients are increasingly being transferred to inpatient units outside of their local area which can make it difficult to stay in touch with family and friends and for professionals to visit, affecting a person's recovery and leading to increased lengths of stay.

Where required, it is vital that someone experiencing mental health crisis is transported in a safe, appropriate and timely manner, and that their dignity and privacy are preserved. The current unavailability of support services, such as ambulance transport to convey patients to hospital or to a place of safety and section 12-approved doctors to undertake Mental Health Act assessments, also impacts on the ability of mental health services to respond in a safe, timely and effective way.

Accessing Support

Services perform well once a service user is accepted, but access to services is an issue for both service users and professionals. Phones go unanswered, messages are not returned, and people are passed between services and asked to repeat the same information. These obstacles and delays can lead to crisis worsening, while more timely access could help to prevent crisis, reducing costs and improving quality of life. People experiencing mental health crisis should be able to access help quickly whenever they need it, even out of hours. When people do manage to speak to someone, the advice given can be patronising and unhelpful, and compassion, empathy and understanding are often lacking.

Many of the examples in the Positive Practice Mental Health Directory (2018) relate to initial points of contact for people experiencing mental health crisis, designed to ensure that there is someone to speak to, 24 hours a day. Some of the common themes include an element of peer support and lived experience, third sector involvement, the ability for anyone to refer, including service users and members of the public, and a safe, non-clinical environment.

Capacity and Demand

It is widely acknowledged that much of the demand on crisis teams may not be due to mental health issues, but that the distress experienced may impact on a person's mental health if not addressed. Due to a lack of services for this group, additional demand is put on frontline services such as crisis teams, police and A&E. However, police and A&E responses can be distressing and may not be the most appropriate for someone with mental health concerns. There is also an additional drive to reduce demand on these services.

The crisis teams estimate that as much as 75% of demand on their service is inappropriate, and much of this demand could be managed by lower level support such as through safe places, helplines, single points of access and first response functions, which have demonstrated improved quality of care and reduced demand on other services in other areas of the country.

Having a sufficiently staffed and skilled workforce with the right values and behaviours is crucial to the effective delivery of healthcare services. However, providing support to those experiencing

mental distress is demanding and difficult and mental health services face particular difficulties in terms of staffing levels and recruitment.

Attitudes and Experience

One of the main issues raised by people in Lincolnshire was the negative attitudes of staff in dealing with people experiencing mental health crisis, and this has also been found in a number of national studies. There should be a greater focus on mental health awareness for staff across the system, including mental health staff, GPs, receptionists and non-clinical staff to equip them to understand mental health, identify mental ill health at the first point of contact, and treat people with dignity and respect.

People in Lincolnshire also promoted the importance of lived experience of mental health, and the ability to understand what someone is going through when experiencing mental health crisis. The benefits of utilising peer support are becoming clearer, and many mental health services are utilising this resource to improve outcomes, reduce stigma and discrimination, and bring a focus which is different from that of mental health professionals.

Carer support is also extremely important to service users in Lincolnshire, but carers don't feel that they are supported by services, or as involved in the planning and provision of care as they would like to be. Carers are not healthcare professionals but they play an important role in prevention, as they are often aware of the triggers and signs of impending crisis and know what to do to avert or de-escalate it.

Collaboration and Communication

The needs of people with mental ill health are varied, and encompass much more than just clinical input. There is no single service that can meet all of a patient's needs, and services need to work together to manage all the issues which can impact on an individual. Care should be holistic and centred around the needs of the individual, rather than the remit of services, but there is a lack of integration and communication both within and between services and organisations, which leads to a disjointed approach, unnecessary boundaries, and an ineffective pathway for patients.

It is vital that a person's needs are recognised by the first person they come into contact with, in order to reduce the number of unnecessary contacts and the distress and frustration of being 'bounced' between services. It is important that services and care teams are able to communicate clearly and share 'need to know' information to identify risks and avoid the individual having to repeat information unnecessarily. The importance of collaboration with the third sector is also noted within the review, since these services are often viewed as less formal and judgemental by service users which can help them to open up, revealing more about their background and needs.

Prevention and Early Intervention

The most effective way to reduce demand on mental health crisis services is to prevent people reaching crisis point, but local mental health services are not currently designed or commissioned with this in mind. There should be a focus on recognising and promoting good mental health, for example through good parenting and support for schools in the early years, and helping people to live fulfilled, productive lives through housing, employment and community support.

Investment in lower level services to allow for intervention earlier in the pathway and prevent crisis can improve quality of life and aid recovery, and will also lead to reduced demand on acute services and ultimately admission to inpatient beds. The provision of ongoing care and support following discharge from services is also important, since discharged does not always mean cured and people often need help to stay well.

Availability of information to service users, carers and the general public is important in signposting oneself or someone else to the right source of support, and should be made available publicly. There is also a perception that much of the demand on formal mental health services is due to the inability to cope with normal feelings of sadness or teenage angst, which are then medicalised and people are seeking support from formal mental health services.

Conclusions

A number of the specific issues identified within this review are already being addressed by existing improvement initiatives outlined above; however, there is still room for improvement in some areas. Many of the recommendations made will require additional resource and investment to come to fruition, while others will require cultural change which will be challenging in its own ways. In designing and commissioning services based on best practice, the size and profile of the local area and population should also be considered.

Limitations

The information contained within this review has been obtained from a range of sources. While the methods used to collect this information were designed to be as robust as possible, it is also recognised that there were a number of limitations to this:

- Relatively low numbers of people participated in engagement activities, although there were common themes which provide some reassurance that an accurate picture of views and experiences has been gathered.
- A number of anomalies were identified in LPFT and EMAS data which made it difficult to draw firm conclusions.

5. Recommendations

The recommendations of the review are as follows:

Recommendation 1 – Future ownership of the review and associated recommendations
Recommendation 2 – Prevention, early intervention and recovery
Recommendation 3 – Mental health awareness
Recommendation 4 – Pre-referral support
Recommendation 5 – Review and update the existing Crisis and Home Treatment Teams specification
Recommendation 6 – Review of wider community-based mental health services
Recommendation 7 – Mental health transport services
Recommendation 8 – Collaborative working between services
Recommendation 9 – Investment in mental health services
Recommendation 10 – Priorities for Lincolnshire's Mental Health Crisis Care Concordat

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Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of the Office of the Police and Crime Commissioner

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**25 September 2018**
Subject:	**Working Together to Create Safe, Well Communities – Policing and Mental Health Development Plan**

Summary:
This report (presented in summary format) was commissioned by the Police and Crime Commissioner to establish opportunities for collaboration between mental health and policing. It highlights opportunities for effective use of system resources; collegiate decision making and sustainable effective actions to reduce the demand on policing from mental health; with benefits for the entire health and social care system.

All actions within the report have been considered against system impact, inclusive of public health and policing outcome measures. The report was produced prior to the crisis care concordat multi-agency review; it is advised that both documents are reviewed together, as they are mutually supportive.

Actions Required:

The Board is asked to demonstrate support for the proposed opportunities; and to specifically consider the role of the Health and Wellbeing Board in strategic oversight.

1. Background

Mental health is a growing national issue. 20-40% of demand on police activity is attributed to mental health related incidents each year (House of Commons Home Affairs Committee, 2015). In Lincolnshire, 87% of 2800 recorded mental health related police call outs involved people already known to mental health services. Our commissioning response has included two adult Section 136 suites, a mental health triage car and mental health nurses in the force control room to divert these calls for police intervention to appropriate health-led support.

Whilst Lincolnshire organisations have grasped opportunities to create some innovative and successful solutions, more needs to be done to bring those existing initiatives together to create a coherent, integrated and measurable programme of work.

Working together to tackle some of our most complex challenges will improve community safety through crime reduction, improve mental well-being and contribute significantly to the de-escalation of acuity in the health environment.

Health and Justice Commissioners will benefit from the associated cost reductions. The longitudinal quality impact on our communities will include increased feelings of safety and experience associated with co-ordinated public sector response.

As a County, we have a long history of working together to improve services. Local commissioning has included 2 adult Section 136 suites, a mental health triage car and Mental Health Nurses in the Force Control Room to support crisis response.
Our health sector has already identified and commenced transformation in pathways which focus on treating people, rather than conditions, and stepping away from fragmented health services, favouring a commissioning approach which considers the persons journey through the health and social care environment.

In October 2016, Professor Sir Bruce Keogh described the relationship between health and social influences on offending and re-offending behaviour as “complex”. He suggested that [health and criminal justice systems] together should “grasp opportunities” for integrated working to prevent both offending and re-offending. In June this year, the Independent Commission on Mental Health and Policing (Adebowale, 2017) recommended greater integration in operational working between the NHS and policing.

Lincolnshire Police and Crime Commissioner has engaged with local partners to establish opportunities for cohesive working, and achieve high impact outcomes for Lincolnshire; including the reduction of mental health demand on policing. In collaboration we have produced a development plan which will provide some high impact interventions, to springboard our continuous development of this work programme with our stakeholders

2. Conclusion

The report supports a community collaborative approach to:

- Increased focus on crime prevention activity through use of intelligence and early intervention;
- Working with partners to help resolve the issues of individuals who cause recurring problems and crime in the communities they live in;
- Supporting multi-agency neighbourhood projects that build more cohesive communities and solve local problems (where police do not play a central role);
- Working with partners to establish joint technological solutions, enabling the transfer of learning between agencies Moving to a place-based approach to commissioning services in response to threat, harm, risk and vulnerability.

- The Office of the Police and Crime Commissioner has engaged with partners to identify and develop opportunities for collaborative, high impact actions. The

proposed detailed opportunities in the report are presented as a result of those interactions.

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

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

The proposed activity within the development plan has been based upon the Joint Strategic Needs Assessment for Lincolnshire as a key reference, cross referenced with national best practice guidance for working collaboratively as a system in targeting both crime and health issues, where objectives meet. The plan will support our health and policing communities to work together in addressing the issues highlighted in the JSNA, and in collaboration with the Joint Health and Wellbeing Strategy priority on Mental Health (Adults). A workshop on the 6th September between all strategic partners will result in a work programme which aligns initiatives with existing workstreams to enable effective utilisation of skills and system resources; this includes our JSNA development and public health leaders.

4. Consultation
5.

The document has been developed through active engagement with all partners listed within. It has since been shared with Clinical Commissioning Groups; the STP Mental Health and LD Board; LPFT Board; Lincolnshire Police; the Mental Health Crisis Care Concordat, and externally appraised by MP Nick Hurd and Inspector Michael Brown – National College of Policing lead for Mental Health.

6. Appendices

These are listed below and attached at the back of the report	
Appendix A	Working together to create safe, well communities – Policing and Mental Health Development Plan

7. Background Papers

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

This report was written by Claire Darbyshire, Deputy Director of Strategy, LPFT who can be contacted on 07815 495621 or Claire.darbyshire@lpft.nhs.uk

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Marc Jones
POLICE & CRIME COMMISSIONER
LINCOLNSHIRE – SAFER TOGETHER

Working together to create safe, well communities

Developing a partnership approach to mental health challenges in Lincolnshire

CONTENTS

INTRODUCTION

Mental health is a growing national issue. 20-40% of demand on police activity is attributed to mental health related incidents each year (House of Commons Home Affairs Committee, 2015). In Lincolnshire, 87% of 2800 recorded mental health related police call outs involved people already known to mental health services. Our commissioning response has included two adult Section 136 suites, a mental health triage car and mental health nurses in the force control room to divert these calls for police intervention to appropriate health-led support.

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Working together to tackle some of our most complex challenges will improve community safety through crime reduction, improve mental well-being and contribute significantly to the de-escalation of acuity in the health environment. Health and Justice Commissioners will benefit from the associated cost reductions. The longitudinal quality impact on our communities will include increased feelings of safety and experience associated with co-ordinated public sector response.

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In October 2016, Professor Sir Bruce Keogh described the relationship between health and social influences on offending and re-offending behaviour as “complex”. He suggested that [health and criminal justice systems] together should “grasp opportunities” for integrated working to prevent both offending and re-offending. In June this year, the Independent Commission on Mental Health and Policing (Adebowale, 2017) recommended greater integration in operational working between the NHS and policing.

Lincolnshire Police and Crime Commissioner has engaged with local partners to establish opportunities for cohesive working, and achieve high impact outcomes for Lincolnshire; including the reduction of mental health demand on policing. In collaboration we have produced a development plan which will provide some high impact interventions, to springboard our continuous development of this work programme with our stakeholders.

WORKING IN PARTNERSHIP

This piece of work has been undertaken through engagement with strategic and operational teams in our partner organisations. It has been an exercise in listening, to set the scene for our future development opportunities. We wish to thank our partners for the time they have committed to speaking openly about their challenges and those of their service users.

The Lincolnshire Police & Crime Commissioner
Lincolnshire Police
Lincolnshire Fire & Rescue
Lincolnshire County Council
    Inc. Public Health, Community Safety, Housing Health & Homelessness, Trading Standards
Lincolnshire District Councils
HMP Lincoln & North Sea Camp
Purple Futures
National Probation Service
Intraserve (Local Probation Service)
P3 Lincolnshire
Addaction Lincolnshire

Lincolnshire Health & Care Partners including:
    Lincolnshire Partnership NHS Foundation Trust
    United Lincolnshire Hospitals NHS Trust
    Lincolnshire Community Health Services
    East Midlands Ambulance Service
    Lincolnshire Clinical Commissioning Groups
    Lincolnshire Medical Committee

Healthwatch Lincolnshire
NHS England Health & Justice Team
Lincolnshire Crisis Care Concordat

Throughout the development of this work, our partners have spoken on behalf of their service users. Whilst we have engaged with a small number of service users as opportunities have arisen, we propose that in order to ensure our work programme remains person-focused that each programme will have its own approach to engagement and that our developments will incorporate some innovative 360^{o} feedback. This is addressed in our Development Plan (4.4).

SHARED SYSTEM CHALLENGES

The communities we collectively serve are becoming increasingly diverse and complex, necessitating different types of response from our public services.

Our partners are responding to challenges created by public funding constraints and rising demand, and are looking outwards to more system integrated ways of working to maximise resource, decrease wastage in public spending and optimise public service outcomes.

Police Forces are taking new approaches to address emerging types of crime, and working in partnership with justice, emergency response, health and social care and voluntary services to create ever more innovative approaches to the creation of safe communities.

Whilst police and justice leaders strive to create safe communities, health leaders strive to create well communities. The core human needs related to establishing feelings of "safe" and "well" are inter-related but our objectives to improve the lives of the people we serve, as a wider system collaboration are not always visibly aligned.

We have identified a need to look differently at our approach to community safety and well-being, focusing on the opportunities which most readily present themselves as shared challenges; and using the shared learning from these initial approaches to further our collaborative developments for the sustainable benefit of the public we serve.

KEY DEVELOPMENT OPPORTUNITIES

Whilst under pressure to meet the demands of a rising population and formidable budget constraints, public services face unprecedented new and evolving challenges, and with it, opportunities to look at our combined approaches

For policing, the emergence of new crime types demand a different approach to policing some of which are highly resource intensive. Crimes such as fraud target our vulnerable population and have a significant impact on victims. Serious and organised crime such as sexual exploitation, human trafficking, modern day slavery and terrorism are increasingly growing an online presence, threatening health and well-being behind the scenes in our communities.

The commonality between maintaining healthy communities and maintaining safe communities has helped us to identify shared objectives based on outcomes for our service users.

The Policing Vision 2025 supports a community collaborative approach to:

- Increased focus on crime prevention activity through use of intelligence and early intervention;
- Working with partners to help resolve the issues of individuals who cause recurring problems and crime in the communities they live in;
- Supporting multi-agency neighbourhood projects that build more cohesive communities and solve local problems (where police do not play a central role);
- Working with partners to establish joint technological solutions, enabling the transfer of learning between agencies
- Moving to a place-based approach to commissioning services in response to threat, harm, risk and vulnerability.

The Office of the Police and Crime Commissioner has engaged with partners to identify and develop opportunities for collaborative, high impact actions. The following proposed opportunities are presented as a result of those interactions:

1. REDUCE MENTAL HEALTH CRISIS PRESENTATION

Strengthening psychological resilience and creating stronger communities will help us to address the increasing demand for crisis support services.

We need to consider all factors leading to crisis regardless of place of presentation to ensure the right support and care continues, to help people sustain a good quality of life and associated mental health.

Multi-factorial social elements impact heavily on a person arriving at crisis point. We need to establish a method of addressing these elements collaboratively, using our existing resources.

The cost of crisis management is high: Lincolnshire spends over £1.9m per year responding to crisis reactively in blue light response for just 100 of our most frequent service users.

We have worked with partners in collaboration to commence deployment of a new way of working using the Hampshire Model (High Intensity Network). In Hampshire, the average cost per annum has reduced from £19,000 to under £3000 per service user, reducing incidents of suicide to zero and s136 detention to single figures.

Lincolnshire Crisis Care Concordat has commissioned a review of crisis pathways, due for publication in March 2018. It is important that as working groups and sub-committees develop from this collaboration, that we ensure central strategic oversight leads this complex and continually changing community system to avoid stifling progress by simply doing more, rather than working differently.

Lincolnshire does not have an evidence based single oversight of crisis demand which will make it difficult to make insightful decisions about allocation of resources. We have allowed our system to become reactive to crisis without addressing how people arrive at crisis and how we might work collaboratively to prevent it.

Improving our data sharing and strategic oversight will help us to look at system impact from our interventions in a way which exceeds two dimensional activity monitoring *(table below).* Working in partnership offers opportunities to shift our culture into one of whole-system budgeting, enabling a reduction in duplication and improving service experience through a collaborative approach to support.

2017 Crisis Response Service Activity	Episodes of Care
Community Crisis Team episodes of care	11,342
Mental health coded police interactions	2800
Ambulance conveyance for mental health crisis	1630
Admissions to acute mental health unit	937
Mental Health Triage Car call outs	448
S136 Detentions	366
Mental Health Rapid Response Car call outs	180
A&E	*Data not available
Hospital Liaison Team	*Data not available

To address these issues we propose to:

1.1 Lead, in collaboration with our partners, the development of a structured network to manage those people who place the most demand on emergency teams, creating effective multi-organisation support plans to de-escalate and prevent further crises.

1.1.2 Our network will consist of existing specialist resource from health, policing, fire and rescue services, criminal justice, mental and physical health resource in addition to housing support officers and support from our third sector and voluntary partners.

1.1.3 We will utilise shared learning and service user experience from this programme of work to develop wider understanding about the needs of our population and use this to inform future service developments. Particularly in relation to the development of community assets which support wellbeing and social inclusion.

1.1.4 We will ensure that our network aligns with the developing nationally represented high intensity network, contributing to local , regional and national continual learning and development.

1.1.5 We will implement digital technology in alignment with partners which will enable our multi-organisational teams to work effectively in their shared commitment to protect and care for these individuals.

2. DEVELOP A COLLABORATIVE APPROACH TO STRENGTHENING OUR VULNERABLE COMMUNITIES AGAINST CRIMINAL ACTIVITY.

The Policing Vision for 2025 supports work which improves understanding of vulnerability (physical and virtual) as a means to developing different methods of protection.

In Lincolnshire, specialised police units infiltrate crime intelligence, to attempt to identify which areas criminals are most likely to target. This intelligence is based on people who have already been victims and is therefore still a reactive approach. This type of crime can be committed online, or door-to-door, or by post. Reporting of crime/threat of crime is hampered by the stigma associated with being a victim.

Health professionals are regularly engaged with 80% of vulnerable individuals in communities, they will be aware of changing behaviours, and often vulnerability will be recorded in some way on the health record prior to the person becoming a victim of crime.

In times of system emergency, health records are accessed in order to identify any need for supported evacuation, and co-ordinate our emergency services to respond, for the purposes of community safety.

Whilst we must acknowledge the concerns regarding data sharing, we must remember our joint responsibility to protect and to care for our public. This responsibility extends to prevention of harm.

We must support new approaches to preventing harm by using intelligence we receive as part of our Joint Strategic Needs Assessment, and care records to co-ordinate meaningful early interventions to support our most vulnerable community members.

We will lead and support a programme of work which supports our specialist police teams in collaboration with our health partners to:

2.1 Strategically target crime prevention support to our most vulnerable and complex communities.

2.1.1 We will lead on a joint programme of work which enables key leaders in health to work with trading standards, our specialist public protection unit (leading Operation REPEAT and Operation REVIVE) and Friends Against Scams to find innovative solutions to targeting critical prevention work to our most vulnerable communities. This work programme will include:

2.2 Creation of accessible information and guidance to support people who might be more vulnerable to criminal activity, before offences take place.

2.2.1 Frail elderly

2.2.2 People with learning disabilities

2.2.3 People with severe and enduring mental health issues

2.3 Empowering health and social care professionals through a joint approach to safeguarding training, to identify those at risk from emerging new crime types and increase signposting to early support:

2.3.1 Police leadership in the development of safeguarding training packages, both online and face-to-face, which help our public services to identify any vulnerability to emerging crime types and also of the symptoms associated with being a victim of these crimes.

2.3.2 We will more frequently align our approach to communicating crime prevention to our vulnerable people, through existing community engagement initiatives planned through healthcare engagement.

3. ALIGNING LOCAL APPROACHES TO THE MANAGEMENT OF COMPLEX SOCIAL DETERMINANT FACTORS

Police Teams report difficulties in accessing health and social care solutions around a person or a family. Officers working directly within the management of complex and chaotic lifestyles, troubled families, anti-social behaviour, domestic abuse, prolific offender behaviours and substance misuse provide a voice for those who find it hard to access health and social support services. This feedback will provide some important insight for Health Commissioners, who regularly consider the impact of deprivation on health needs.

The Equality Act (UK Government, 2010) empowers those with a public duty to remove or minimise disadvantages suffered by people due to their protected characteristics. Barriers arise for individuals when their conditions are not recognised as a protected characteristic. Being homeless, misusing substances, offending and risky behaviours are not categorised as a condition and are therefore not routinely considered during the design of health services; recognition of local issues in Lincolnshire is apparent through the many local initiatives designed to find resolution to these wicked system problems (Grint, 2008).

Planning our services collaboratively in consideration of complex and chaotic lifestyles, would reduce complexity; reduce the impact on family, friends, neighbours and the general public through incidents of crime and community safety, which further impact on health system activity, capacity and quality.

Local Commissioners and public service providers must consider their responsibilities in alignment with “Hard to Reach” Groups (Department of Health, 2002) in addition to the Equality Act (UK Government, 2010) and;

- Take steps to meet the needs of people with certain protected characteristics where these are different from the needs of other people.
- Encourage people with certain protected characteristics to participate in public life or in other activities where their participation is disproportionately low.

As different organisations and third sector groups converge to fill the gaps between services without singe strategic oversight, our efforts are not effectively maximised. The benefits of any one programme cannot be easily determined.

Equally, creating a list of projects to align would present us with an “accurate for now” operational plan. We would benefit from different way of working across our structures to enable strategic leadership to benefit from oversight and shared decision making, and operational community policing and health teams to work efficiently in collaboration with partners.

Whilst being cautious not to risk policing resource, and specialist team capabilities being drawn into health objectives, there are opportunities to support community policing to recognise common objectives between health and social care partners, perhaps initially focusing on the key areas that we know to be determinant factors in protecting safety and

protecting health. Joint guidance for community integrated working may include:

- Substance misuse
- High intensity/high frequency users
- Community safety (Hoarding/Persons who create regular cause for concern through risky behaviours)
- Domestic abuse
- Crime reduction (Integrated Offender Management Team)
- Crime prevention - vulnerable community members
- Offender resettlement and community rehabilitation
- Victim support

Lincolnshire Health & Care are already working hard to align a variety of health practitioner teams to Neighbourhoods, dividing Lincolnshire into 12 areas, to enable health and social care practitioners work together as real teams. These teams are already demonstrating the value of operational relationships outside of their normal working practices, as part of a whole-person approach.

Some examples of opportunistic joint working in Lincolnshire include:

- A reduction of high frequency fire service calls in Gainsborough by addressing the persons rationale for taking safety risks to manage an unreported health condition. No further call outs following health team intervention to remedy the root cause.
- Referral to a mental health team to address the root cause of anxieties has resulted significant reduction in the number of calls for police support made by an individual who required continuous assurance of safety on a daily basis via emergency services.
- Victimisation of a known offender returning to a community resulted in continual crisis management through all services. A combined approach has enabled a multi-agency care plan, and has reduced the number of safe and well checks being undertaken by four organisations, regularly throughout the day, to just one check on a rota basis, increasing system productivity by 75%.

Social Determinant Factors of offending (Revolving Doors, 2013)
Poor Health & Social Equality
Social Exclusion
Substance Misuse
Housing problems & Homelessness
Associated social determinants (family history, environment, exposure to chaotic lifestyles)
Lack of clear lead in health & social care pathway
Difficulties in adhering to rigid appointment systems or attending during regular office hours
Distrust of statutory services – barrier in accessing health services
Disintegrated patient pathways
Stigma/ Health Professionals
Transition (Young person to Adult Services)
Fragmented data between prison & care

Our specialist police teams engage with partners through Local Authority led strategic management boards (SMBs):

- Anti-social behaviour
- Domestic Abuse
- Substance Misuse
- Offence Reduction

- Organised Crime
- Sexual Violence and;
- Safer Lincolnshire Partnership *(former Lincolnshire Community Safety Partnership)*

To make a sustainable impact on both health improvement and crime/ harm reduction, we need a collaborative approach to system projects which seek to improve the lives of our most complex service users.

The Police & Crime Commissioner proposes central co-ordination of existing Strategic Management Boards and the associated intelligence to support their decision making, co-ordinated by the PCC Office.

We propose a revision of the current strategic oversight of all of these groups, to enable a single committee to remain accountable for organisational alignment to a system co-ordinated programme of shared priorities:

4. DEVELOP A STRATEGIC OVERSIGHT COMMITTEE TO LEAD EFFECTIVE OPERATIONAL COLLABORATION AND ONGOING LEARNING AND DEVELOPMENT.

The health and social care system is held to account locally by the Lincolnshire Health and Wellbeing Board. It would therefore seem sensible that a single report in respect of the impact of partnership collaboration should be presented there, representing a joined community safety and wellbeing position.

19 key organisations in Lincolnshire have individual legal responsibilities, strategic aims and operational delivery plans relating to our shared key objectives. We collectively support representation at an array of committees and meetings often duplicating effort.

To support this new way of working we will:

4.1 Deliver in collaboration with our partners; a single strategic committee to lead and hold our collaborative organisational efforts to account. It is proposed that this structure will be supported by the work of a programme co-ordinating hub, based in the Office of the Police and Crime Commissioner.

4.2 Lead the development of a Lincolnshire Health & Justice Quality and Innovation Network, to create a sustainable platform to embed lessons learned from effective integrated working, applying best practice locally, regionally and nationally.

4.3 Support the removal of barriers to cross-organisational working by creating information sharing arrangements which support our teams to collaborate to keep our communities safe within the confines of our legal obligations in relation to the Data Protection Act (1998) and Human Rights Conventions (Art.8), and the forthcoming General Data Protection Regulation (GDPR).

4.4 Create a central platform for continuous stakeholder engagement and feedback to ensure those using our services, their carers and those working with them, are able to inform the design of new approaches, and tell us how our approaches have impacted them.

5. IMPROVE UNDERSTANDING AND INCREASE ACCESS TO TIMELY MENTAL HEALTH SUPPORT

In 2017, 51% of the total recorded police sickness absence in Lincolnshire was associated with psychological illness. Our officers are frequently exposed to highly distressing situations. Their commitment to public service sometimes leads them to manage their own mental health, which means that when help is sought, it has often already caused damage to their own wellbeing. Talk therapy services are often not accessible because of real or perceived vulnerabilities or compromise caused by unintended public recognition in the mental health environment.

Improving police officers understanding of mental health also helps to develop their application of it in the community. Better understanding

helps management of risk to safety. For example: An officer might suspect

that mental health is prevalent but knowing that a person escalates rapidly to violent behaviours when afraid provides an opportunity for officers to assess more accurately and take more informed actions. 66% of mental health related Force Control Room calls were associated with concerns for a person's safety and wellbeing which necessitated officer attendance.

In 2017, 2726 police call outs were associated with mental ill health. This is felt to be a low representation due to data recording. In order to look accurately at demand, we need to understand more detail about these calls and the subsequent potential for reducing them.

We will therefore lead a multi-faceted approach to improving mental health in our communities by:

5.1 Developing a tailored police officer mental health programme to improve psychological resilience.

5.1.1 Outreach Talk Therapy (IAPT) Services at no cost to officers who live in Lincolnshire

5.1.2 Development of a tailored psychological resilience programme in alignment with police and police staff training. Supporting new recruits prior to deployment, active officers and officers preparing for retirement.

5.2 Supporting existing police mental health liaison officers and leads in the force to deliver mental health training and local insight to officers.

5.2.1 Creating a reciprocal arrangement for training, which enables policing staff to provide support for safeguarding training in light of new and emerging crime types, and mental health staff to provide operational insight into mental health conditions and awareness of current local approaches to care.

5.3 Creation of a cross-organisational review of mental health demand through the force control room, in order to inform service design considerations, through critical appraisal of experiences through our collective services.

5.4 Alignment of operational policing and health pathways, exploring mobile device technology and the use of community mental health liaison roles to create responsive and proactive solutions to emerging mental health concerns in the community.

MEASURING SUCCESS & SUPPORTING CONTINUOUS INTEGRATED DEVELOPMENT

Integrated outcome measures will provide us with shared intelligence about the impact of our decisions and actions on the whole system. Through this we will create a culture of evidence based developments.

Our single strategic oversight committee for Lincolnshire we direct change based on information from our partners co-ordinated in the PCC hub to create a multi-system strategic impact report. The data supporting our shared objectives, will align Public Health Outcomes; NHS Outcomes; Marmot Indicators; Public Health Profiles; Police & Crime Statistics; Local Deprivation Indices; CQUINS and contractual key performance indicators. Measurable impact will include:

Key High Impact Outcomes	**Development Dependencies**				
Year One	**1**	**2**	**3**	**4**	**5**
Decreased blue light activity associated with highest frequency users	x		x		x
Decrease in s136 detentions	x		x		
Continued decrease in criminal activity reported from our communities' most prolific offenders	x		x		
Increased reporting of crime/attempted crime amongst vulnerable communities including; cybercrime, fraud and exploitation and domestic abuse Decreased impact of crime amongst vulnerable communities		x			
A reduction in police sickness absence associated with psychological illness & associated increased capacity in police operational workforce					x
Demonstrable shared learning and innovation between policing and mental health at community level			x		x
Equity in service provision across system public services leading to improved service user satisfaction and engagement	x	x	x	x	x
A visible, high impact, co-ordinated Lincolnshire Health, Justice and Community Safety work programme				x	
Improved risk assessment and subsequent safety of public service teams who respond to calls for assistance	x		x		x
Year two					
Decreased mental health related police activity *(measured through time on scene)*	x	x	x	x	x
Increase in early referrals to mental health liaison and health neighbourhood teams, from operational policing for mental health support *(i.e hoarding behaviours, police call outs with a root cause of anxiety, depression or lack of effective social support networks in community)*			x		x
Increased police confidence in identifying and responding to mental health challenges in the community/ increasing police reporting of low level concerns into health led neighbourhood teams/ community mental health services					x
Strong operational working relationships, measurable through cross-organisational 360° feedback					
Increasing level of commissioned wellbeing activity in communities associated with justice pathways in community (third sector growth in commissioning)			x		
Decrease in Lincolnshire suicide rate	x		x		
Cost efficiencies identifiable through strategic alignment and maximisation of resource impact (reducing duplication of effort, using capacity to improve impact on key challenges)	x	x	x	x	x

NEXT STEPS

1. PARTNERSHIP COMMITTMENT

Our partners will be invited to discuss our Key Developments at an interactive event, where we will look to align organisations and named project leads to work programmes and offer further opportunity for system engagement.

At the event we will ask senior decision in all our partner organisations to make a public commitment to support the development of the programme as part of a Lincolnshire concern.

2. CO-ORDINATION OF OUR DEVELOPMENT PROGRAMME, LEADERSHIP & SYSTEM STRATEGIC OVERSIGHT

Programme co-ordination & leadership

Leading effective work programmes across health, justice and related services involve working across complex commissioning and funding streams. Experiences from the Health Inequalities National Support Team identified the need for an 'organising hub' to provide a strategic focused approach to tackling these complex issues and achieve population level outcomes.
It is proposed the co-ordination of this programme of work will be based in the Office of the Police & Crime Commissioner. The appointed lead will need to understand the nature of local and national policies and organisational contexts; encouraging and shaping new ways of tackling problems in partnership. Strong leadership and effective systemic engagement are needed to drive this agenda to ensure system level impact and sustainability.

System Strategic Oversight

It is proposed that a new committee be devised with representation from all partners at senior decision making level. The committee will receive reports from the PCC organising hub, consolidating outcome data and intelligence, to support system-wide oversight. This report pack will include the outputs and decisions from existing Strategic Management Boards, the Crisis Care Concordat and our Integrated Outcomes Framework as a starting point.

3. PUBLIC ENGAGEMENT & COMMUNICATION

Whilst the work programme describes innovative approaches and opportunities, we need to acknowledge our partnership approach publically and address the concerns that the public will inevitably have, about data sharing to make clear the parameters of our work and offer jointly devised messages of assurance. Partners are asked within their commitment to different ways of working to enable their public engagement and communication teams to work collaboratively in the delivery of these messages.

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Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Derek Ward, Director of Public Health

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**25 September 2018**
Subject:	**Consultation on the contracting arrangements for Integrated Care Providers (ICPs)**

Summary:
On 3 August 2018, NHS England launched a 12 week consultation on the contracting arrangements for Integrated Care Providers (ICPs). The consultation documentation details how the proposed ICP Contract would underpin integration between services, how it differs from existing NHS contracts, how ICPs fit into the broader commissioning system, and which organisations could hold an ICP contract. The deadline for submitting responses to the consultation in 26 October 2018.

This report provides a brief overview of the key proposals and the potential implications for Lincolnshire.

Actions Required:
The Lincolnshire Health and Wellbeing Board is asked to:

1. discuss the implications of the ICP consultation;
2. consider if the Board should respond to the consultation, and if so,
3. establish a small working group to draft a response on behalf of the Board for approval by the Chairman prior to submission by 26 October 2018.

1. Background

NHS England is currently consulting on proposals for an Integrated Care Provider (ICP) Contract (12 week consultation running from 3 August to 26 October 2018). The consultation document is provided in Appendix A. It provides details on how the ICP Contract would underpin integration between services, how it differs from existing NHS contracts, how ICPs fit into the broader commissioning system, and which organisations

could hold an ICP contract. The document also includes a series of questions which NHS England is seeking feedback on.

The proposals describe a new model of contract that NHS England is developing to support the commissioning of Integrated Care Providers for the NHS and (potentially) social care and public health services. As the document states:

"Despite the longstanding aim of improving integration there has never before been a commissioning contract designed specifically to promote an integrated service model including primary care, wider NHS and some local authority services. Commissioners want the opportunity to use a contract of this type to ensure that contracting, funding and organisational structures all help rather than hinder staff to do the right thing and to define more clearly who has overall responsibility for integrating and co-ordinating care." (Para 16 p7)

The ambition to integrate is not new, and was originally signalled in the NHS Five Year Forward View (FYFV) in 2014. However, this consultation document provides a series of proposals that give a much clearer policy view on how to achieve integration. Key points include:

- In some parts of the country NHS, LA & voluntary sector organisations are coming together to form Integrated Care Systems (ICSs). There are already 8 pilot areas and Government is looking to learn from these quickly and roll out learning
- The ICP contract will be based on population based care with an outcomes drive approach. The ICP will use a population based payment approach rather than individual contracting for individual services or procedures. An ICP contract may be awarded for a term of up to 10 years
- Providers would receive a "whole population annual payment" WPAP in monthly instalments. The WPAP will provide flexibility for the ICP to manage care more effectively across different settings and invest in services designed to improve the longer term health outcomes of the population
- Due to WPAPs and outcome focussed commissioning, the ICP will have to manage any increases in the demand for services it delivers over the duration of the contract
- ICPs are not new types of legal entities or organisations, they are providers (new or existing) that have been awarded ICP contracts
- GPs will be part of the ICP contract and model, and may be employed by the provider organisation (a community trust, acute trust or even local authority or voluntary sector organisation). They will be a key part of wider multi-speciality teams
- The ICP contract required providers to address health inequalities, to conduct risk stratification (to target services) & is aimed at improving the health and wellbeing of the population – not simply treating new and existing disease.

The consultation suggests changes to regulations that would support a fundamental shift in NHS (and potentially social care and public health) provision. Although still an early consultation, the document provides a level of detail about how ICPs will develop that has been lacking previously.

In Lincolnshire the implications of the ICP contract could be profound and far reaching on the local NHS. However, the future role of the Health and Wellbeing Board within the context of an ICP contract is not as clear as the document also makes reference (para 15, page 7) to the setting up of a joint forum *'for the discussion of what is best for the*

population and for the achievement of the defined goals, and how budgets and resources can best be used to those ends. In these collaborations there can be a sense of shared, system accountability for managing separate organisation's resources, quality improvement and population health in a more aligned way.'

2. Conclusion

The ICP consultation proposes a new model of working which could have fundamental implications for the NHS (and potentially care and public health) service in Lincolnshire. The Board is therefore asked to discuss the proposals set out in Appendix A and consider establishing a small working group to draft a response to the consultation on behalf of the Board and subject to approval by the Chairman.

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

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

The draft consultation includes a requirement for the provider to provide analysis of population health needs and to develop strategies to improve health and wellbeing of the population, supporting the CCG's discharge of its own duties in this respect. This requirement will need to be consider alongside current requirements under the Health and Care Act (2012) which places a duty on the local authority and clinical commissioning groups, through the Health and Wellbeing Board, to produce a Joint Strategic Needs Assessment (JSNA) and to use the evidence from the JSNA to inform the priorities in the Joint Health and Wellbeing Strategy (JHWS).

4. Consultation

Not applicable

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Draft Integrated Care Provider Contract: a consultation

6. Background Papers

Document details	Where it can be accessed
Draft Integrated Care Provider Contract – full consultation resources	https://www.engage.england.nhs.uk/consultation/proposed-contracting-arrangements-for-icps/

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NHS England

Draft ICP Contract: a Consultation

Draft Integrated Care Provider (ICP) Contract - consultation package

August 2018

Draft ICP Contract: a Consultation

Draft Integrated Care Provider (ICP) Contract - consultation package

Version number: 1

First published: August 2018

NHS England Publications Gateway Reference: 07883

Equality and health inequalities statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Contents

Our consultation - purpose of this document

1 This document has been published in support of NHS England's consultation on the proposed Integrated Care Provider (ICP) Contract.[1] It provides detail about how the ICP Contract would underpin integration between services, how it differs from existing NHS contracts, how ICPs fit into the broader commissioning system, and which organisations could hold the ICP Contract.

2 This consultation includes a series of questions on which NHS England welcomes feedback. A summary of these questions, next steps, and details of how to respond are set out at the end of this document. Further documents have also been published as part of the consultation package. The package includes:

- The draft ICP Contract and explanatory notes
- Frequently asked questions
- An overview of integrated budgets
- A document describing the incentives framework for ICPs
- A draft template Integration Agreement and frequently asked questions
- Guidance on CCG roles where ICPs are established
- A draft equality and health inequalities analysis

3 Our initial intention had been to consult formally on the draft ICP Contract in accordance with NHS England's legal duties,[2] but to do so once it had been tested and further developed, working with commissioners in the context of their local procurements.

4 Earlier this year we committed to bringing our consultation forward to take the opportunity to explain what the ICP Contract is for and when it might be used, and to dispel misconceptions about what integrated care models might mean for the NHS and people's care.

5 The High Court has now decided the two recent judicial reviews in NHS England's favour.[3] The Health and Social Care Committee has also published its report on integrated care, in which it expressed some support for ICP development.[4] Following these developments, we are now consulting on lead provider integrated care models and on the draft ICP Contract. Following the consultation, we will decide whether to issue the ICP Contract as a formal alternative to the NHS Standard Contract. If we do, it would then be available for use by commissioners wishing to commission an integrated model of care for their population, subject to their proposals being reviewed by NHS England and NHS Improvement through the Integrated Support and Assurance Process (ISAP) and enabling Directions being made the Secretary of State.

1 The previous iteration of this draft ICP Contract was referred to as the draft Accountable Care Organisation (ACO) Contract. At that point in time, we described ICPs as accountable care organisations or ACOs. We have changed our terminology in recognition that, as reported by the House of Commons Health and Social Care Committee, use of the term 'accountable care' has generated unwarranted misunderstanding about what is being proposed. We believe that the terms 'Integrated Care Provider' and 'Integrated Care Model' better describe our proposals – to promote integrated service provision through a contract to be held by a single lead provider.

2 Legal duties under Regulation 18 of the Standing Rules Regulations can be found on the Government website: http://www.legislation.gov.uk/uksi/2012/2996/regulation/18/made (Information accessed 25 July 2018)

3 R (on the application of Hutchinson & Anor) v Secretary of State for Health and Social Care and NHS England [2018] EWHC 1698 (Admin); and R (on the application of Jennifer Shepherd (On behalf of 999 Call for the NHS) v NHS England [2018] EWHC 1067 (Admin), [2018] WLR(D) 295.

4 The House of Commons Health and Social Care Committee Integrated care: organisations, partnerships and systems Seventh Report of Session 2017-19 [p39] can be found on the Government website: https://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2017/inquiry4/

6 Regardless of the outcome of this consultation, NHS England has no plans to replace existing contract forms (the generic NHS Standard Contract, and GMS, PMS and APMS contracts for primary medical services), which we anticipate will remain appropriate in most circumstances. It will be for local commissioners to determine which form of contract would best suit their particular population's health needs.

The ambition to integrate care

7 The NHS in England comprises a series of local organisations, bound by a common philosophy and set of standards. These organisations are either 'commissioning' (purchasing) healthcare (NHS England and local Clinical Commissioning Groups (CCGs)), or providing it. There are, for example, 229 NHS trusts and foundation trusts providing a variety of services and approximately 7400 GP practices, as well as numerous other independent and third sector provider organisations. Social care is bought separately by local authorities, usually from another set of providers. Between the providers and commissioners contracts are agreed, setting the services required by commissioners and the terms on which they are to be provided.

8 A person with complex needs may have contact with their GP, their local hospital, a community services provider, a mental health services provider, as well as the care home in which they live. Accordingly, there is a (long-recognised) need for health and social care services to be better integrated,[5] improving people's experience of the care they receive and offering opportunities to improve outcomes and efficiency. As the Care Quality Commission put it in its 2016/17 State of Care report:

'People should be able to expect good, safe care when they need it, regardless of how this care is delivered... It's clear that where care providers, professionals and local stakeholders have been able to do this – where they have stopped thinking in terms of 'health care' and 'social care' (or specialities within these) and instead focused their combined efforts around the needs of people – there is improvement in the quality of care that people receive. To deliver good, safe care that is sustainable into the future, providers will have to think beyond their traditional boundaries to reflect the experience of the people they support.'[6]

9 The most recent mandate given by the Government to NHS England includes increasing integration with social care so that care is more joined up to meet physical health, mental health and social care needs. This aim is also reflected in previous versions of the mandate.[7]

10 More recently, the House of Commons Health and Social Care Committee has expressed its support for improving integration of care, highlighting its potential to improve patient experience.[8]

5 An example of this, the Integrated Care and Support: Our Shared Commitment (2013) report, can be found on the Government website: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198748/DEFINITIVE_FINAL_VERSION_ Integrated_Care_and_Support_-_Our_Shared_Commitment_2013-05-13.pdf (Information accessed 25 July2018).

6 The CQC State of Care report 2016/17 [p36],can be found on the CQC website: https://www.cqc.org.uk/sites/default/files/20171123_stateofcare1617_report.pdf (Information accessed 25 July 2018)

7 See for example, NHS mandate 2018 to 2019 which can be found on the Government website: https://www.gov.uk/government/publications/nhs-mandate-2018-to-2019 (Information accessed 24 July 2018)

8 The House of Commons Health and Social Care Committee Integrated care: organisations, partnerships and systems Seventh Report of Session 2017-19 [p17] can be found on the Government website: https://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2017/inquiry4/ (Information accessed 25 July 2018)

11 NHS England's policy goals in relation to this area have been clear for some time. NHS England's ambition to transform the delivery of care in this spirit was first described in 2014's Five Year Forward View (FYFV):

'The traditional divide between primary care, community services, and hospitals – largely unaltered since the birth of the NHS – is increasingly a barrier to the personalised and coordinated health services patients need. And just as GPs and hospitals tend to be rigidly demarcated, so too are social care and mental health services even though people increasingly need all three.'

12 The FYFV proposed two 'new care models' through which collaborative care redesign could deliver integration of services for whole populations. These were referred to as the Multispecialty Community Provider (MCP) and the Integrated Primary and Acute Care System (PACS).[9] Since then, the Next Steps on the Five Year Forward View further articulated the ambition 'to make the biggest national move to integrated care of any major western country'.[10]

13 To achieve this, across England, steps are already being taken to improve collaboration between commissioners and providers and to deliver better care for patients. In some parts of the country, organisations are coming together to form 'integrated care systems' (ICSs), where commissioners and providers of NHS services, in partnership with local authorities and others, voluntarily take collective responsibility for managing resources, delivering NHS standards and improving the health of the population they serve. The first wave of 'shadow ICSs' were announced in June 2017 with four more announced in 2018. Other collaborations will take place at a number of different levels in the system, including through provider partnerships, such as networks of primary care providers.

Why do contracts matter?

14 Care redesign and integration are the absolute priority in order to improve patient services; any wider changes should only serve to support that. However, as Appendix A describes in more detail, the health and care services provided to an individual or population are currently bought via a series of different contracts, with different providers. For example, each GP practice holds a contract of one sort for primary medical services, whilst hospital, mental health or community NHS services are bought on another type of contract, often separately from each other. A complex set of separate contracts, organisations and funding streams can lead to duplication and lack of coordination, make communication between providers, clinicians and patients more difficult, and risk loss of focus on the overall needs of the person. This affects how people receive their care from the various health and care services across the system.

15 For this reason, in some areas, commissioners and providers have found it helpful to put in place an overlaying agreement (which can be known as an 'alliance

9 The Multispecialty Community Provider (MCP) emerging care model and contract framework can be found on the NHS England website: https://www.england.nhs.uk/wp-content/uploads/2016/07/mcp-care-model-frmwrk.pdf (Information accessed 25 July 2018). The Primary and Acute Care Systems (PACS) – describing the care model and the business model can be found on the NHS England website: https://www.england.nhs.uk/wp-content/uploads/2016/09/pacs-framework.pdf (Information accessed 26 July 2018).

10 The Next Steps on the Five Year Forward View [p.31] can be found on the NHS England website: https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf (information accessed 28 July 2018)

agreement'), supplementing the providers' individual contracts with the commissioner and formalising their collaboration. This agreement can describe shared processes, goals and incentives, and set up a joint forum for discussion of what is best for the population and for the achievement of the defined goals, and how budgets and resources can best be used to those ends. In these collaborations there can be a sense of shared, system accountability for managing separate organisations' resources, quality improvement and population health in a more aligned way.

16 Despite the longstanding aim of improving integration there has never before been a commissioning contract designed specifically to promote an integrated service model including primary care, wider NHS and some local authority services. Commissioners want the opportunity to use a contract of this type to ensure that contracting, funding and organisational structures all help rather than hinder staff to do the right thing and to define more clearly who has overall responsibility for integrating and co-ordinating care.

What is the draft ICP Contract?

17 The development of the draft ICP Contract responds to the demand in some areas for a single contract through which general practice, wider NHS and in some cases, some local authority services can be commissioned from a 'lead' provider organisation, responsible for delivering integration of services. Such a provider can be known as an 'Integrated Care Provider' (ICP). The draft ICP Contract provides for:

- a consistent objective to deliver integrated, population based care
- as far as possible, consistency in terms and conditions in relation to different services, reducing the risk of conflicting priorities or requirements getting in the way of clinicians and care workers doing the right thing for people in their care
- a population based payment approach, allowing flexible redeployment of resources to best meet needs and encourages a stronger focus on overall health, rather than simply paying for tightly defined activities
- aligned incentives across all teams and services.

18 The ICP Contract is intended to promote an environment in which different teams and services can come together in a coordinated way, incentivising organisations to focus on delivering better patient care and improving the health of the population as a whole. The contract is designed to allow this to be achieved in a transparent way, ensuring consistency with all national NHS standards and requirements, whilst establishing clear accountability through a lead provider. The long term health and care outcomes for the population are the priority, and the prevention of ill health which the contract seeks to incentivise is vital to achieving improvement in those outcomes.

19 This form of commissioning, in the way that we understand clinicians and staff want to see it, can ensure the sustainability of care redesign that can in the first instance usually be established through collaboration. It can ensure that these benefits are not lost over time. In particular, the new contract is designed to facilitate a stronger role for providers of primary medical services, allowing GPs to work at the heart of the system and with colleagues to take an operational, clinical leadership role in co-ordinating the care that is delivered to their patients, treating them in the most appropriate setting, close to home.

20 In this context, it is important to understand that ICPs are not new types of legal entity, but rather provider organisations which have been awarded ICP contracts. The area that is at the forefront and may choose to use the draft ICP Contract (subject to the outcome of this consultation exercise) is Dudley. The bid for this proposal is led by an NHS body, and has the support of local GPs.

Question 1:
Should local commissioners and providers have the option of a contract that promotes the integration of the full range of health, and where appropriate, care services?
Yes/No/unsure; and please explain your response.

Case study: Dudley CCG

Dudley is a large metropolitan borough in the Black Country, nine miles west of Birmingham. The borough has a population of 316,000, with great variation of affluence and poverty and health outcomes. The gap in life expectancy between the least and most deprived areas of Dudley is 9.6 years for men and 7.3 years for women, and the proportion of Dudley residents aged 65 and over is 18.6%, higher than the national average of 16.3%. The proportion of older people in the area is increasing, and age brings with it a range of physical and mental ailments. The structure of the NHS and related local authority services, in which organisations are designed around types of treatment rather than around people, is not optimal for managing the increasingly complex health and social care needs of people living longer with multiple conditions.

In 2015, health and care organisations from across Dudley gave new energy to improving how they work together to meet people's changing needs, as explained in this public video here. This resulted in (amongst other things) different staff groups from a range of health care and voluntary sector organisations joining with GPs to establish multi-disciplinary teams that work in the community with more vulnerable patients with multiple complex needs, to take a shared responsibility for better co-ordinating their care – giving people clear credible alternatives to hospital.

In addition, better continuity of care is achieved for individuals with long-term conditions by bringing together specialists with GPs to work to the same shared outcome objectives which are often co-produced with their patients.

Dudley CCG considers that the new more integrated model has been a success; people in Dudley now enjoy services that cover their medical and social needs in one place, link more closely with the voluntary sector and empower them to stay healthier for longer at home. They report that this 'has made a huge difference to [their] life'; 'has given [their] confidence back'; and that 'the service is fantastic'. In addition, staff involved in this work report that this 'provides easier access to a variety of professionals'; that it 'has improved efficiency greatly and led to a service improvement for people who use services and their carers' and that 'integration has re-energised team members and the enthusiasm of key professionals in the service has encouraged more staff to want to become involved'.

Dudley CCG undertook a public consultation in 2016 on making the new care model a permanent feature of the local care landscape. Three themes emerged from the consultation in terms of the public's expectations of services – access to a service, continuity of care from a service and co-ordination and communication between services. A video from the consultation explaining the proposals can be found here.

It is theoretically possible to deliver such a model by establishing and maintaining the synchronisation of all existing contracts, but Dudley CCG believes that practically, this would be extremely difficult. Health and care organisations in Dudley are managed under 170 contracts and agreements, with each covering different types of care and resulting in each organisation having its own focus. This is a typical situation.

Dudley CCG believes that putting in place a new single ICP Contract instead for the integrated care model will make it easier to bring services together and also help Dudley commissioners and residents hold the new lead organisation to account for improving the health of the local population as measured by a single set of population health outcomes, described here, and some of its income will be linked to these measures. Through this, Dudley would ensure that the system has an incentive to improve the health of the local population, rather than simply treat its illnesses. A ten-year contract would be awarded to support this, allowing providers to invest in changes to improve long-term population health.

How have we created the draft ICP Contract?

21 We have developed the draft ICP Contract from existing NHS contracts, further informed by joint working with stakeholders within and outside the NHS.

Collaborative development of the draft ICP Contract

22 Engagement on what is now the draft ICP Contract began with six 'vanguard' areas working towards implementation of the Multispecialty Community Provider (MCP) care model. A contract development group was established in 2015 which brought together interested CCGs with wider stakeholders such as the Royal College of General Practice, the BMA, and the National Association of Primary Care (NAPC). This early co-development period led to a publication of a draft 'MCP Contract Package' in December 2016, which began an engagement period in which feedback was invited on the draft.

23 Following its publication, it became clear to NHS England that the draft MCP Contract could in fact have a broader application. The next version of the draft contract was re-named to reflect this and published in August 2017 as the draft NHS Standard Contract (Accountable Care Models) ('the draft ACO Contract'). We published alongside it a summary of the engagement received earlier in the year on its first iteration as the draft MCP Contract.[11] As part of our engagement process, we have continued to develop the draft Contract with CCGs intending to use an ICP model in their local areas. We have also had discussions with a group of local authorities, facilitated by the Local Government Association. The purpose of these discussions was to ensure that the draft ICP Contract is fit for purpose for commissioning social care and public health services as an integrated package with health care services where commissioners locally wish to adopt this approach. These discussions have been productive and have resulted in a number of changes to the draft Contract. This contract, as further developed, is now known as the draft NHS Standard Contract (Integrated Care Provider) ('the draft ICP Contract').

Structure of draft ICP Contract and inclusion of requirements relating to primary medical services

24 The structure of the draft ICP Contract follows that of the generic NHS Standard Contract with which most NHS services are commissioned. It is in three parts:

i. **Particulars**, which the parties to the contract sign, and which record the signature of the contract and contain all the locally-agreed details and requirements – i.e. what is 'particular' to the specific arrangement between the parties to each local contract

ii. **Service Conditions**, setting out the core national requirements in clinical and service terms which any ICP will be required to deliver

iii. **General Conditions**, setting out the necessary contract management processes and standard, legal 'boilerplate' requirements.

11 The full draft Contract package published in August 2017, including a summary of the feedback previously received, can be found on the NHS England website: https://www.england.nhs.uk/new-business-models/publications/. This package of documents may be further updated subject to the outcomes of the consultation. (Information accessed 25 July 2018)

25 As with the structure, much of the content of the draft ICP Contract is identical to that of the generic NHS Standard Contract. This is because although the draft ICP Contract aims to support a new approach to service delivery, the regulatory and policy requirements which underpin and safeguard the delivery of NHS services – for example the fundamental standards of care and the NHS Constitution, along with contracting safeguards – remain the same. Any provider which holds an ICP Contract would therefore be subject to those same requirements.

26 However, additional requirements needed to be incorporated into the draft ICP Contract to allow integrated services, including primary medical services (such as care provided by GP practices), to be bought with the same contract rather than through different contracts.

27 People most commonly access health care through their GP, and integrated care models therefore rely on GP registered lists as the foundation of a population-based approach; GP participation is therefore essential to the success of the care and contractual models. The draft ICP Contract is specifically designed to aid the integration of primary medical services with other local health and care services – and along with improving people's care, this is also intended to ensure the sustainability of general practice, support a future of strengthened relationships between GPs and the rest of the system, and offer the scale and infrastructure with which to underpin the ongoing delivery of primary medical services.

28 For primary medical services to be commissioned as part of an integrated package we have ensured that the draft ICP Contract complies with statutory requirements already applicable to primary medical services. However, we also wanted to ensure that the contract is as streamlined as possible. We have therefore worked with the Department of Health and Social Care (DHSC) to develop a set of new 'Directions', a type of legislation which will underpin the specific primary medical services requirements within the ICP Contract, and are designed specifically for a contract for integrated services. We are not inviting specific comments on the draft Directions at this stage, and they remain subject to change, but the Department of Health and Social Care will be undertaking a separate consultation that asks for specific views on the Directions themselves. If NHS England introduces the ICP Contract for use following this consultation, then (subject to the outcome of the Department's own consultation on the Directions), the Directions will initially only be made available on a case by case basis for specific areas after they are signed off through the Integrated Support and Assurance Process, satisfying Government scrutiny requirements.

Inclusion of core requirements of an integrated whole population care model

29 The draft ICP Contract includes core requirements of a provider delivering an integrated care model, developed through work with commissioners and providers participating in the vanguard programme (2015 onwards).

30 For example, the draft ICP Contract:

a. requires providers to consider how they can address health inequalities, supporting the CCG's discharge of its own statutory duties in this respect

b. adds a requirement for the provider to conduct risk stratification to identify people who are more likely to require care in the future

c. includes a requirement for the provider to provide analysis of population health needs and to develop strategies to improve the health and wellbeing of the population, supporting the CCG's discharge of its own duties in this respect

d. includes an obligation to develop shared electronic patient records.

Amendments to regulations

- In developing the draft ICP Contract NHS England and DHSC have identified the need for various changes to existing Regulations. The most significant of these changes are to allow GPs to suspend their General Medical Services (GMS) or Personal Medical Services (PMS) Contracts should they decide to become 'fully integrated' with the ICP (see further details at paragraph 73): essentially, to allow primary medical services to be commissioned via the ICP Contract while maintaining for GPs the security of their General Medical Services or Personal Medical Services contracts. In addition there are a number of smaller technical changes which are generally designed to ensure current rules will apply to holders of the ICP Contract in the same way as to other providers of similar services. These regulations, if and when laid before Parliament, will not require the creation of ICPs, nor mandate what form they will take.
- Between 11th September and 3rd November 2017 the Department of Health and Social Care ran a public consultation on the proposed amendments to the identified regulations. This consultation Accountable Care Organisations: Consultation on changes to regulations required to facilitate the operation of an NHS Standard Contract (Accountable Care Models), specifically asked consultees to consider whether the draft regulations delivered the policy objective of the introduction of a model contract for an integrated care model. The Department of Health and Social Care has published its response to that consultation which can be found here.
- The Department of Health and Social Care has also separately previously consulted on proposed amendments to pensions scheme rules so that work which is currently pensionable under the NHS Pension Scheme remains so for those delivering NHS services under a contract for an integrated care model or a subcontract to it.

Using the draft ICP Contract

31 While the draft ICP Contract provides a framework for commissioning integrated care, and dictates some core national requirements and processes, it does not dictate matters for specification locally, by commissioners, on the basis of their assessment of what is required to best meet the needs of their local population in accordance with their statutory duties.

32 The duration of any ICP Contract, as for current local arrangements under the generic NHS Standard Contract, is not determined nationally, but is for local commissioners to decide, based on the model that they think would work best for their population. Where commissioners use the ICP Contract, they may consider it appropriate to award a contract for a term of up to 10 years (as could in principle occur with existing contracts) – recognising that the details of the contract will need to be monitored by commissioners and revisited regularly by commissioners and providers to ensure the contract continues to reflect changing circumstances. An important idea behind the draft ICP Contract is that by giving one organisation responsibility for providing health and care services for the whole local population, it will be able to shape services around what really works best. A longer-term contract offers the stability needed to incentivise the provider to improve longer-term outcomes by investing in services to manage and improve people's health and conditions, rather than being focused solely on meeting short-term targets. It will inevitably take some time for the impact of any new care model to emerge and for the new provider to be able to show improvements in population health outcomes.

33 The following paragraphs set out details about how the ICP Contract would be used. Further details are available in the draft ICP Contract and explanatory notes.

The service specification

34 As far as healthcare services are concerned, the area served by an ICP will be defined by commissioners, usually by reference to the practice areas of the GP practices integrated with it. For any public health services and adult social care services, the area served by the ICP is likely to be the area of the relevant local authority. Where the ICP is commissioned to provide core GP services, all permanent and temporary residents of its area will have the right to register with it. The ICP may also accept people onto its list of registered patients people who are not permanently or temporarily resident in that area. The ICP will then be required to provide those core GP services for everyone who has registered with it. The ICP must provide all other healthcare services specified by its commissioners for everyone registered as a patient with the ICP or with one of the practices integrated with it, and for everyone permanently or temporarily resident in its area and not registered with a GP practice elsewhere, as required to meet their individual needs. For everyone for whom the ICP is to provide services, it will be responsible for delivering on the proposed core national requirements set out in paragraph 30 above. But although these go some way to describing how services are to be delivered in a generic sense, they do not describe:

a. the range of services for which any specific ICP will be responsible
b. how, where, and by whom those services are to be delivered
c. with which other services those ICP services are to be integrated, and how.

35 The population health management, outcomes-driven approach envisaged by the draft ICP Contract differs from the service/activity-based model on which most existing commissioning contracts are based. Existing contracts are often prescriptive as to the types of services to be delivered and how they are to be delivered.

36 In an ICP context, a focus on the broader needs of the population and on improving health and care outcomes demands a different approach. While it is for local commissioners to decide what and how to commission services, if commissioners are overly prescriptive the ICP will not have the flexibility and discretion to allocate resources, deploy health and care professionals and alter the provision of services on an ongoing basis to best meet the changing needs of local people, reflecting up-to-date best practice and a focus on prevention. But – understandably – commissioners will be concerned to ensure that a full range of high quality services is maintained in accordance with their commissioning strategies, and that any changes to the way in which services are delivered are well managed, and appropriately consulted upon. The key is to achieve the right balance between prescription and a more outcomes-based approach to service specifications. Finding this balance is consistent with the CCG's duty to arrange for the provision of health care services.

37 Given the ICP's focus on population health management, prevention and improvement of health and care outcomes, it is inevitable that over the course of an ICP contract it will consider altering the way in which it provides services to best meet these objectives. However, it will be for local commissioners to determine (by how prescriptive or otherwise they are in specifying the services in their Contract) the scope the ICP will have to do this without the commissioners' consent. And, in any event, the ICP would be subject to the same rules and requirements as any other provider of NHS services when considering service change. Further details are outlined at paragraph 91.

The integrated budget

38 Providers of NHS services are paid in a number of different ways. For NHS services other than most primary care, payment is subject to the National Tariff Payment System (NTPS). For some services, such as community services or mental health services, commissioners and providers can choose their local payment arrangements, subject to the national tariff's rules, and will usually be paid via a fixed payment. This payment method is typically known as a 'block contract' and is reported by the National Audit Office,[12] to account for over a third of all NHS contracts in 2017/18. Block contracts are normally paid in advance of the service being undertaken and the value of the contract is usually separate to the actual number of patients treated or the amount of activity undertaken. For primary care services, GPs are generally paid on the basis of a capitated payment related to the number of registered patients on a practice list, alongside a range of other payment streams. For many hospital based services, the tariff's national currencies[13] and prices apply, so providers are paid on the basis of the amount of activity provided. The fragmented nature and misaligned financial incentives of the current payment system can inhibit the delivery of more integrated and better co-ordinated care centred around the patient.

39 The draft ICP Contract envisages commissioners paying for the entire bundle of in-scope services as a package by way of an integrated budget, rather than on a service-by-service basis. The draft ICP Contract thus accommodates this by providing for a

12 The National Audit Office's publication Sustainability and transformation in the NHS (2018) [section 3.17], can be found on the National Audit Office's website: https://www.nao.org.uk/wp-content/uploads/2018/01/Sustainability-and-transformation-in-the-NHS.pdf (Information accessed 25 July 2018)

13 A currency is a unit of healthcare for which payment is made. Under the national tariff system, a currency is a specification of a particular service or activity which may then be used as the basis for specific price to be paid for that activity.

Whole Population Annual Payment (WPAP), paid in monthly instalments, which will represent the majority of the funding available to the ICP under the contract. The initial baseline budget by reference to which the commissioners will determine the WPAP (and other payments to which the ICP may be entitled under the ICP Contract) is likely to be set by commissioners by reference to their current spend on the in-scope services. It is intended that the WPAP will provide flexibility for the ICP to manage care more effectively across different settings and invest in services designed to improve the longer term health outcomes of the population. The integrated budget approach has been developed to encourage the promotion of whole population management, prevention, self-care and a focus on outcomes rather than inputs or units of activity delivered.

40 Although most of the money available to the ICP will be through the WPAP, there will additionally be an incentive scheme for ICPs (see paragraphs 44-46) and may be additional payments to the provider for the small number of services where rules still require the payment to be made following delivery of specific activities. For example, this may apply in relation to the provision of vaccinations and immunisations. The WPAP applicable to any ICP Contract will need to be adjusted periodically to reflect changes to the size and profile of the population served by the ICP. It may also need to be adjusted from time to time to reflect agreement between the commissioners and the ICP as to the scope of services to be delivered. These adjustments will ensure that the ICP's funding can change in a controlled way over the lifetime of the contract, and will for example be required where an ICP budget is no longer sufficient to provide the full range of in-scope services to its population. Separately, periodic adjustments may be required to ensure that payments will continue to be affordable within CCGs' allocations.

41 The WPAP approach would be implemented using the existing flexibilities available to commissioners and providers of NHS services pursuant to the NTPS. A WPAP is entirely consistent with the statutory framework.[14] Block payments of this nature may be agreed under the national tariff. In particular, if the WPAP includes nationally priced services, the commissioner and provider would agree 'local variations' to the specifications and prices of the relevant services, in accordance with NTPS rules, so as to combine them into a single package of services (along with other locally priced services) for which a single price is paid.

42 The commissioning of an ICP Contract on the basis of a WPAP will mean that the ICP becomes responsible for managing changes in the demand for services that are within scope of the ICP's contract. There are significant benefits of this approach, as the ICP is incentivised to focus on the causes of ill health and the management of conditions across its population; however the draft ICP Contract also introduces a number of additional safeguards to ensure that the ICP's budget is managed appropriately. These are set out at paragraphs 54-58. The CCG retains statutory responsibility to arrange the provision of services for people for whom it has responsibility.

43 For more information on the integrated whole population payment approach please see the Integrated Budget Overview, published alongside this consultation.

14 See the judgment of the Court in R (on the application of Jennifer Shepherd (On behalf of 999 Call for the NHS) v NHS England [2018] EWHC 1067 (Admin), [2018] WLR(D) 295.

The incentives framework for ICPs

44 The draft ICP Contract, like all other NHS contracts, is designed to accommodate an incentive payment scheme. This means that a proportion of the contract value will be paid to the ICP only on achievement of certain goals. This is intended to improve the quality of service provision. There are two existing national incentive schemes, which will be reflected in the draft ICP Contract depending on the scope of services included, as follows:

- **Commissioning for Quality and Innovation (CQUIN) scheme** which contains a number of different indicators, chosen from a nationally developed set and currently constituting 2.5% of the available budget for most NHS services (except primary care)
- **Quality and Outcomes Framework (QOF)**: QOF sets out an entitlement for holders of primary medical services contracts to additional funding on achievement of a range of different process and clinical indicators. Where GPs have decided to join the ICP in a fully integrated way (see paragraph 73) core primary medical services will be included in the ICP Contract for that portion of the population. In this case the associated QOF payments for the relevant registered list will be available to the ICP on achievement of the national requirements, as they are to practices. We are currently exploring how there might be changes to future QOF arrangements to better support collaborative working in an integrated care environment as part of the QOF review. NHS England has recently published a review of QOF, and discussions about its implementation are proceeding in parallel.

45 When using the ICP Contract, as with the generic NHS Standard Contract, commissioners would have the option to add additional indicators to the existing national schemes. This could for example change the balance of funding available through the WPAP and incentive scheme respectively. Any additional money at risk in this way would however be subject to a national assurance process before the contract was awarded, to ensure the balance of financial risk for the provider was sustainable.

46 For more information on the Incentives Framework for ICPs, please see the guidance published alongside this consultation.

Role of subcontractors

47 Subcontracting by providers of NHS services is common; indeed many NHS and independent providers use subcontractors in support of fulfilling their obligations under their commissioning contract. Subcontracting can enable patient choice and diversity of provision, and allow ICP models to accommodate the invaluable contributions of smaller providers, such as those from the voluntary sector and social enterprises.

48 It is anticipated that at the outset, subcontracting elements of the package of services commissioned under an ICP Contract may be required to enable delivery of the desired care model. This is because it is unlikely that any one single provider will initially have all the staff, skills, capabilities, and/or assets to deliver the full range of services and obligations required under the ICP Contract.

49 It is important to note that subcontracting does not in any way relieve the ICP of its responsibility to the commissioner for the delivery and quality of any subcontracted service. The ICP, as lead provider, remains accountable to the commissioner for the delivery and integration and management of its 'supply chain' of subcontractors.

50 The draft ICP Contract therefore includes a range of provisions which set out obligations on the ICP and the commissioners as to the extent to which they may transfer, assign or subcontract to other bodies their rights and obligations under the contract. This includes:

- requiring that the decision by the ICP to let a subcontract is subject to commissioner approval
- setting out that, as a condition of approval, the subcontractor may be required to sign a Direct Agreement with the commissioners (under which the commissioners can automatically become the direct commissioners of the subcontracted services, thus protecting service continuity)
- allowing the commissioners to require a subcontractor to be appointed, removed or replaced in specific circumstances.

Question 2:
The draft ICP Contract contains new content aimed at promoting integration, including:

- **Incorporation of proposed regulatory requirements applicable to primary medical services, included in a streamlined way within the draft ICP Contract**
- **Descriptions of important features of a whole population care model, as summarised in paragraph 30**

a) **Should these specific elements be amended and if so how exactly?** Yes/no/unsure; and please explain your response.

b) **Are there any additional requirements which should be included in the national content of the draft ICP Contract to promote integration of services?** Yes/no/unsure; and please explain your response.

Question 3:
The draft ICP Contract is designed to be used as a national framework, incorporating core requirements and processes. It is for local commissioners to determine matters such as:

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

Have we struck the right balance in the draft ICP Contract between the national content setting out requirements for providers, and the content about providers' obligations to be determined by local commissioners? Yes/no/unsure; and please explain your response.

Question 4:
Does the bringing together of different funding streams into a single budget provide a useful flexibility for providers? Yes/No/unsure; and please explain your response.

Safeguards included in the draft ICP Contract

51 Alongside incorporating existing safeguards from the generic NHS Standard Contract, we have included a number of new safeguards into the draft ICP Contract, with the aim of ensuring that the contract is used as intended to improve the overall health and care of the relevant local population. These are set out below.

52 In addition we have included safeguards to prevent any unlawful delegation of CCG functions to an ICP.

53 These are outlined at paragraph 83.

Ensuring the ICP is financially resilient, and its budget is used appropriately to deliver service continuity

54 Many of the services which may be included in ICP models will already, under existing commissioning arrangements, be paid for on a 'block' basis. But the scale of an ICP model and the ICP's systemic importance makes it particularly important that commissioners will have assurance that the ICP budget is used appropriately, for the maximum short and longer-term benefit to all local people, that necessary services will continue to be delivered, and that the ICP will remain on a sound financial footing. It will be crucially important that providers do not avoid potentially more complex and costly treatments where these are clinically indicated. Commissioners will always need to ensure that the way the contract is used locally provides for a full range of services to be available to the entire population, and ensures quality or safety of care is protected. It may, for example, wish to specify certain services which must always be available to particular patient groups, or impose additional quality standards (supplementing those imposed by the mandatory elements of the Contract) which must always be maintained.

55 An ICP will have to manage any increases in the demand for services it delivers by the population, as the ICP itself would be responsible for delivering the extra services required. Commissioners would therefore require the ICP to think through how best to improve the health and care of its population as a whole to manage demand by keeping people well. This requires an ICP to ensure it manages its budget appropriately over the duration of the contract and to demonstrate transparently how it is doing so.

56 We have included a range of new provisions in the draft ICP Contract, to ensure financial accountability, transparency and service continuity. These include requirements on the ICP:

- to provide an independently audited financial business plan to the commissioner before the start of each contract year for review and comment
- to operate "open book" accounting
- to submit annual audited accounts
- to be transparent about remuneration of senior staff.

57 Safeguards have been incorporated into the draft ICP Contract replicating and in some cases strengthening, those that exist under the generic NHS Standard Contract. These safeguards envisage an active and substantial continuing role for commissioners in contract management and oversight throughout the life of the contract:

- rights to terminate the ICP Contract, or the provision of individual services to some or all of the population, for a range of defaults on the part of the ICP, including in relation to service quality, or when there are concerns as to the ICP's financial viability concerns
- rights to suspend individual services
- rights to require the ICP to terminate subcontracts, and/or appoint new subcontractors
- a requirement for key subcontractors to enter into direct agreements with the commissioners, giving the commissioners assurance of service continuity in the event that the ICP contract, or any service under it, is terminated or suspended, pending recommissioning of services
- the ability for the commissioners to set periods of notice for termination by the ICP – whether of the whole ICP Contract or of specific services – of sufficient length to enable managed recommissioning and transition planning
- the expectation that the commissioners and the ICP will agree and include in their Contract detailed exit arrangements, to take effect pending and on termination and covering both a managed transition of services to new providers and financial consequences of termination
- a requirement that, regardless of any other agreed financial consequences, where termination of the ICP Contract or a service is as a result of the ICP's default, the ICP will compensate the commissioners for the costs they incur as a result, including the cost of recommissioning.

58 The ICP Contract is presented in a form which best demonstrates how it will look (subject to the outcome of this consultation and to population of Particulars locally) if and when used by the proposed early adopter site, where an NHS provider is expected to be the ICP. In the event that an ICP Contract is awarded other than to a statutory body, we believe that it would be appropriate to include additional provisions (at General Conditions 18 – 20 and 23, and associated definitions) to provide further assurance to commissioners and the population they serve (these are set out in the Appendix to the Explanatory Notes to the draft ICP Contract). These include requirements on the ICP:

- to ensure that it maintains an agreed minimum net worth and current assets to current liabilities ratio
- not to carry out any business other than as contemplated by the ICP Contract (in other words, the ICP must be a 'single purpose entity')
- not to use the assets used for delivery of services as collateral without the prior approval of the commissioner
- not to distribute funds unless a range of quality standards and financial conditions have been met
- (where required by the commissioners) to secure a guarantee from its parent organisation or a third party, providing financial security for the ICP's performance of the Contract.

Protecting patient choice

59 We have been conscious to make sure that the bringing together of services into a single contract does not restrict the choices available to people about how and where they receive care. NHS England and CCGs are under a legal duty to promote patient choice and to give effect to the legal rights to choice patients have under the NHS Constitution, and these legal requirements will continue to apply.[15,16] Accordingly, the draft ICP Contract contains requirements to ensure that existing patient rights are protected. It includes, for example, the requirements that:

- local people are offered choice in where, how and by whom services are delivered to them, wherever possible
- the ICP adheres to the rights of patient choice in respect of secondary and tertiary care services, as set out in the NHS Constitution
- NHS users are offered a choice of GP from those employed or engaged by the ICP
- NHS users have a choice of readily-accessible locations at which to receive GP services
- the ICP offers sufficient pre-bookable and same-day GP appointments to meet the needs of the population, including during evenings and at weekends.

These requirements may be supplemented by local requirements as commissioners think appropriate for their local needs.

Question 5:

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

- **guarantee service quality and continuity**
- **safeguard existing patient rights to choice**
- **ensure transparency**
- **ensure good financial management by the ICP of its resources.**

a) Do you agree or disagree with our proposal that these specific safeguards should be included? Agree/ Disagree/unsure; and please explain your response.

b) Do you have any specific suggestions for additional requirements, consistent with the current legal framework, and if so what are they? Yes/No/unsure; and please explain your response.

15 The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 (PART 8) can be found on the Government website: http://www.legislation.gov.uk/uksi/2012/2996/part/8/made (Information accessed 25 July 2018)

16 The National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 can be found on the Government website: https://www.legislation.gov.uk/uksi/2013/500/contents/made (Information accessed 25 July 2018)

What kind of organisations could hold ICP Contracts, and how would they be selected?

60 Commissioners would select an ICP based on their assessment of the most capable organisation to hold the contract. This section explains how they would be selected, the assurance process that they would go through and the types of organisations that may hold an ICP Contract.

How would an organisation be chosen to hold an ICP Contract?

61 Commissioners of health and social care in England (i.e. NHS England, CCGs and local authorities) are public bodies. This means that they must comply with certain legal requirements before awarding contracts for goods and services. In the context of health and social care services, they must usually advertise their intention to award a contract and must run a clear, transparent and fair process for selection of an appropriate organisation to hold that contract.[17]

62 Before embarking on any procurement exercise, and throughout the procurement process, commissioners must comply with their legal duties to engage with the public. This means talking to local service users, staff, providers, local authorities and other representative bodies to decide on the right care model to address local health and care needs.

63 As part of an open and transparent process, we would expect them to test, amongst other things:

- how they will improve the quality and efficiency of services, and meet the needs of the population
- how much experience any bidding organisation has in delivering the full range of services in scope of the contract
- whether the bidder has a proven track record of providing the type of services in the scope of the contract
- the robustness of delivery model proposed by the bidder
- the bidder's ability to work effectively with local GPs to provider integrated services to people and deliver the proposed model of care, and clarity around how GPs will relate to the ICP (e.g. whether GPs have committed to full or partial integration with the proposed ICP)
- whether they will be able to deliver value for money and have the financial standing required to hold the contract
- whether they have sufficient capability and capacity, for example through use of technology, workforce and estates, to deliver the long term improvements in outcomes which are required by the commissioner.

64 Although commissioners are required to advertise their intention to award a new contract, this does not necessarily mean that there will be a competitive procurement involving multiple bidders. In some local areas, the response to the advertisement may result in the commissioners engaging in dialogue with a single bidder.

17 The Public Contracts Regulations 2015 can be found on the Government website: http://www.legislation.gov.uk/uksi/2015/102/contents/made (Information accessed 25 July 2018)

National assurance over the award of an ICP Contract

65 The award of ICP Contracts will be subject to an assurance process known as the Integrated Support and Assurance Process (ISAP). ISAP is designed to operate as an additional safeguard over the award of ICP Contracts, recognising that ICPs could be of greater systemic importance than existing providers in the system holding contracts with a longer duration.

66 Under ISAP, NHS England and NHS Improvement conduct a coordinated review of the proposals, at specific key critical points of the procurement process. ISAP's objectives are to:

- ensure the proposals are in the interests of service users and the public
- take a system view of the potential consequences of the proposal, potential contract award and implementation
- ensure potential risks presented by the approach and the contract are identified and understood and that appropriate measures are in place to mitigate
- improve efficiency and reduce duplication in the work of NHS England and NHS Improvement, increasing the speed of the national assurance for complex contracts.[18]

67 Each CCG is accountable for its decisions when carrying out its statutory functions and the ISAP is not a substitute for their governance and assurance processes.

What type of organisations would hold an ICP Contract?

68 As noted previously, ICPs are not new types of legal entity. An ICP would be simply an organisation which has entered into an ICP Contract with commissioners. Nothing about the ICP Contract inherently alters who may offer to provide NHS-funded services.

69 Statutory organisations are likely to hold the ICP Contract, but for example ICPs based on primary and community services (similar to the multispecialty community provider concept) could be led by a GP federation. It is for would-be providers to decide the organisational form which they believe will be best suited to deliver the ICP Contract which the commissioner wishes to award, and for the commissioner to assess the suitability of that organisation against its advertised criteria.

70 The draft ICP Contract is not intended to, and does not, promote or encourage privatisation of NHS services or outsourcing of NHS services to private sector organisations. Indeed to do so would be unlawful.[19]

71 In local procurement processes to date, NHS statutory providers have been able to demonstrate relevant experience and the ability to convene key partners, particularly GPs, to integrate care as the ICP Contract envisages. The area that is at the forefront and may choose to use the draft ICP Contract (subject to the outcome of this consultation exercise) is Dudley. The bid for this proposal is led by an NHS body, and has the support of local GPs.

18 Further details can be found in the ISAP documents on the NHS England website: https://www.england.nhs.uk/publication/integrated-support-and-assurance-process/ (Information accessed 25 July 2018)

19 See section 13P of the National Health Service Act 2006 (NHS Act 2006). This is available at http://www.legislation.gov.uk/ukpga/2012/7/section/23/enacted (Information accessed 25 July 2018)

How could GPs participate in an ICP?

72 The active participation of GPs is critical to the successful delivery of integrated care models. But the participation of any individual practice or GP is entirely voluntary, and the manner in which they integrate with an ICP will be for them to decide.

73 In addition to the possibility of a GP-led organisation holding the contract itself, the draft ICP Contract envisages two alternative approaches to GP involvement and integration with an ICP:

- Under what we have called a partially-integrated approach GP practices would continue to deliver usual GP services to their patients under their existing GMS or PMS arrangements.[20] The ICP would be responsible for delivery of a package of other services. The ICP will be required by the ICP Contract to ensure integration of its services with the primary medical services delivered by the practices, in pursuit of locally-defined 'integration goals'. The main difference for each GP practice is that they will enter into an Integration Agreement with the ICP,[21] setting out how they will work more closely together, for example through establishing common approaches to multi-disciplinary teams, agreeing to share information in line with information governance rules, and establishing joint decision making structures across the system. The Integration Agreement may provide for GP practices to be remunerated for playing their part in closer integration by sharing in incentive payments flowed through from the ICP Contract.
- Full integration involves usual GP services being commissioned with other services under a single ICP Contract. The draft contract has been created to enable this, by including terms and conditions applicable to primary medical services (see paragraphs 24-28 above). But in order that usual services can be commissioned under such a contract, existing GMS and PMS arrangements in relation to those services must be set aside, whether permanently (by ending their existing contract) or for the life of the ICP Contract. As noted earlier in this document, changes to secondary legislation have been proposed by the Department of Health and Social Care which would provide that, where a GP practice decides that it wishes to become fully integrated with an ICP, it may suspend its current contract, allowing the primary medical services to be commissioned through the ICP Contract. GPs would then become either salaried GPs of the ICP or subcontractors. Practices would have the option to reactivate their suspended GMS and PMS contracts at different points throughout the lifetime of the ICP Contract, and this reactivation would otherwise happen by default following the expiry or termination of the ICP Contract.

74 The opportunities for GPs to be involved in the direction and leadership of the ICP will be central to their engagement and to the success of the care model and contract. Any successful provider will have to demonstrate that it can work closely with general practice providers to offer a joined up set of services to their population. For their part, GPs will wish to take the opportunities presented by integrated care models to play a greater role in population-focused decision-making.

20 An explanation of primary medical services contracts, including GMS contracts and PMS agreements, is provided in the Glossary.

21 NHS England has also published a FAQ for the draft template Integration Agreement.

75 The options for GPs to become involved in the decision making of the ICP itself will depend on the organisational form chosen by the bidding providers. In particular, NHS trusts and foundation trusts are public sector organisations whose governance is subject to legislation. Within the current statutory framework, GPs could take up a variety of roles at executive and non-executive level alongside opportunities to become a salaried GP, subcontractor or local stakeholder. These flexibilities and options could enable governance and operational arrangements that fully align to delivering an integrated service model and enable GPs to exert strategic influence over decision making and operational delivery.

76 We have previously produced a series of videos about what it is like to be a GP working to develop an integrated care model and to support GPs to learn more about these models. These videos are based on real GPs' own views and site experiences, and are available at https://www.england.nhs.uk/new-business-models/ publications/gp-participation-in-a-multispecialty-community-provider-mcp/.

Question 6:

a) Should we create a means for GPs to integrate their services with ICPs, whilst continuing to operate under their existing primary care contracts? Yes/No/unsure; and please explain your response.

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

c) Are there any specific features of the proposed options for GP participation in ICPs that could be improved? Yes/No/unsure; and please explain your response.

How would ICPs fit into the NHS commissioning system and wider health care system?

77 The draft ICP Contract does not change the statutory duties of commissioners and supports better integration of care in the way which primary legislation currently allows.[22]

Commissioner duties, functions and activities

78 Commissioners of NHS services have duties and powers imposed on them by law. Statutory duties are the "must dos" that commissioners are responsible for delivering. Statutory powers are the things that commissioners may do (i.e. they have some discretion in deciding whether to do these things to help fulfil their statutory duties). In this section, we use the term 'function' to describe these statutory duties and powers.

22 In this context, it is important to note that the High Court has, in determining that the ICP model is lawful, held that the integration of health and social care via a single provider of care (an ICP) where that provider has a substantial degree of autonomy over health care choices and resource allocation:

- is within the statutory powers of a CCG;
- does not represent the unlawful delegation to ICPs of non-delegable functions or preclude CCGs from fulfilling their statutory functions; and
- is not contrary to the commissioner-provider split under the National Health Service Act 2006.

See R (on the application of Hutchinson & Anor) v Secretary of State for Health and Social Care and NHS England [2018] EWHC 1698 (Admin).

79 CCGs' functions[23] include:

- commissioning, i.e. making arrangements for the provision of services to meet the reasonable needs of people for whom the CCG has responsibility
- preparing joint strategic needs assessments and joint health and wellbeing strategies with local authorities
- promoting the NHS Constitution
- having regard to the need to reduce inequalities between patients with respect to the outcomes achieved for them
- promoting patient choice
- promoting integration, with a view to securing that health services are provided in an integrated way.

80 Within the existing legislative framework, CCGs have considerable flexibility to carry out their functions in collaboration with other CCGs, NHS England, and/or local authorities. Most CCGs also purchase external commissioning support (for example, from commissioning support units and/or private providers of commissioning support services).

81 CCGs may also, through the generic NHS Standard Contract, require providers to undertake activities to help them exercise their own functions, for example by requiring the provider to do things that have the aim of reducing inequalities or ensure patient choice. However, a CCG will always retain legal responsibility for their functions. This can never be delegated to a provider. The draft ICP Contract does not change this position: it maintains a statutory boundary between commissioners and providers of NHS services.

82 It would be for local commissioners to determine what they want to commission an ICP to do, and to specify that in the contract with that ICP. As they already do under existing NHS contracts, commissioners may through their ICP Contract give the ICP the scope to take decisions about resource allocation and the design of care, with the aim – among other things – of improving integration and service quality.

83 We are aware that the range of services which might be integrated under an ICP Contract is potentially extensive. To ensure that a commissioner cannot unlawfully delegate its statutory functions to an ICP, we have included the following safeguards in the draft ICP Contract:

- Service Condition 1.8 of the draft ICP Contract expressly prohibits an ICP from doing anything that would put the Commissioner in breach of its statutory duties or amount to an unlawful delegation. The full text is set out in the below footnote,[24] and further information is also included in the accompanying document Contract package: Questions and answers.

23 A list of CCG functions from 2013 can be found on the NHS England website: https://www.england.nhs.uk/wp-content/uploads/2013/03/a-functions-ccgs.pdf (Information accessed 25 July 2018)

24 The Provider may, within the scope provided by this Contract, use and allocate its resources and deliver the Services in such a manner as it determines will best service the needs of the Population, provided that it does not do or fail to do anything which would:

1.8.1 place any Commissioner in breach of any statutory duty in relation to the Population;

1.8.2 render any Commissioner liable to challenge under the Public Contracts Regulations 2015 or otherwise; or

1.8.3 constitute an unlawful delegation of any function by any Commissioner.

- Service Conditions 1.4 and 1.5 of the draft ICP Contract impose obligations on the ICP and the commissioner to perform all their obligations under the contract in accordance with, amongst other things, the terms of the contract and (within the meaning of the contract) "the Law".[25] This includes adhering to the division in commissioning responsibilities between commissioners and providers, under the NHS Act 2006.
- The draft ICP Contract includes provisions (see General Condition 17) to deal with breaches of the contract, including a breach of Service Condition 1.8 referred to above. These could be used as means of redress if a provider overstepped the statutory boundary between commissioning and provision of services. Commissioners could also vary the contract where an ICP has failed to meet its contractual obligations, or terminate, with immediate effect, the contract where the ICP has breached any of its obligations in any material respect or persistently.

84 As noted above, the draft ICP Contract is based on the generic NHS Standard Contract. In relation to the statutory division between commissioners and providers of NHS services, the draft ICP Contract is similar to the NHS Standard Contract in these ways:

- As under the NHS Standard Contract, the draft ICP Contract requires the commissioner to outline and define the scope of services which it requires the ICP to deliver. In both cases the contract provides a framework for decisions then made by the provider. Both the draft ICP Contract and the NHS Standard Contract therefore give a provider, within set contractual limits, discretion to make decisions and use its judgment about the allocation of resources. The draft ICP Contract is not therefore new in this respect.
- An NHS Standard Contract between a CCG and a provider for the delivery of acute and specialist health services to patients already requires the provider to allocate its clinical and management resources for those services in the way it determines will best meet the needs of its patients, as long as it is able to meet the core operational standards and quality requirements for the services in question. This is already expected of providers, which respond to normal pressures in the health care system. The draft ICP Contract will not change this.

85 Neither the existing NHS Standard Contract, nor the draft ICP Contract, require funds to be spent by the provider in any particular way on the services provided. The key requirement is to deliver the services in the contract, to the level of quality it requires. It is for the provider to decide how best to spend its funds to meet those requirements.

86 Commissioners of ICP Contracts must continue to assure themselves that they are fulfilling their statutory functions, even where the ICP is required by the contract to undertake activities in support of the commissioners' functions. Alongside the safeguards in the draft ICP Contract, which envisages a continuing and active role of a commissioner throughout the lifetime of an ICP contract, a thorough procurement process for the award of an ICP Contract will be important. Through ISAP, NHS England and NHS Improvement will seek assurance that (amongst other things) before the contract is awarded the CCG has taken legal advice on its ability to continue to carry out its statutory functions.

25 Meaning, in the language of the draft ICP Contract, "(i) any applicable statute or proclamation or any delegated or subordinate legislation or regulation; (ii) any enforceable EU right within the meaning of section 2(1) European Communities Act 1972; (iii) any applicable judgment of a relevant court of law which is a binding precedent in England and Wales; (iv) Guidance; and (v) any applicable code, in each case in force in England and Wales".

87 As for all other contracts commissioners will continue to be responsible for managing performance of the ICP. CCGs will continue to be responsible for the development of the service specification, desired outcomes, standards and outputs by which performance will be measured, contract management and quality monitoring, alongside oversight of risk and reward mechanisms. This would include holding the ICP to account for the performance of the entire ICP Contract, including those aspects subcontracted to other providers.

88 We have developed CCG roles where ICPs are established, which sets out more detailed guidance about the implications that commissioning an ICP may have for CCGs. It is available alongside this consultation document.

Public accountability and involvement

89 As leading systems testing new approaches to accelerated improvement, holders of ICP contracts will be held to a higher standard of transparency on value, quality, and reduction of inappropriate clinical variation. This will aid continuous improvement, monitoring and evaluation, and the spread of best practice across the NHS. We are using this consultation to engage on those proposals already included in the ICP Contract and to develop as necessary further measures for inclusion (see consultation Question 10). The incorporation of this suite of additional transparency requirements, included as a template within each ICP Contract would, once agreed, be a condition of using the contract, enforced through the ISAP approval process.

90 The draft ICP Contract does nothing to change the existing statutory obligations of both commissioners or providers of NHS services regarding public accountability. Commissioners are required to make arrangements to involve the public in commissioning, including consulting their local populations when proposing significant service change. This is explained in statutory guidance. Where use of the ICP Contract is currently being considered, activity has included engagement events and the involvement of people who use services and public groups.

91 We have previously noted that within the parameters of the contract an ICP would undertake some improvements to and redesign of the provision of services. Changes to service provision would need to be carefully considered, and would be a matter on which both commissioners and the ICP will need to engage with local people, staff and affected organisations. The ICP Contract requires the ICP to support commissioners in performing their duty to involve the public on such changes, and in some cases this engagement and involvement activity may actually be led by the provider, in line with current practice. For larger proposed changes, the existing rules on service reconfigurations will also apply. These are set out in guidance[26] published by NHS England, which sets out the steps that commissioners and providers should follow to give effect to major NHS service changes. In particular:

- CCGs have a legal duty to involve patients and the public in proposals for service reconfiguration, to have regard to the above guidance, and must necessarily work in partnership with other bodies in developing service change proposals

26 The guidance Planning, assurance and delivering service change for patients can be found on NHS England's website: https://www.england.nhs.uk/wp-content/uploads/2018/03/planning-assuring-delivering-service-change-v6-1.pdf (Information accessed 24 July 2018)

- Providers, whether or not subject to similar duties under statute, will be subject to a duty to involve the public in the planning, development, consideration of and decisions upon service change proposals through contractual obligations imposed on providers under both the existing NHS Standard Contract and (in stronger terms) the draft ICP Contract.

In addition to these requirements, the draft ICP Contract allows the commissioner to specify through the Service Specification specific premises from which key services must be delivered, as is the case under the existing generic NHS Standard Contract; the ICP would not be able to depart from this without commissioner consent.

92 The obligations for public involvement on the ICP mirror (and in certain respects go beyond) those obligations which are imposed on any other provider under the generic NHS Standard Contract. Alongside providing support and assistance as necessary to the CCG in order to meet the commissioner's obligations, these include requirements to involve local people, staff, and voluntary and community sector organisations in considering and implementing service redesign. In addition the ICP will be required to operate the Friends and Family Test, to carry out appropriate staff surveys and other surveys, and to provide assistance to commissioners in relation to the latter's statutory duty to carry out consultation on proposals for service reconfiguration. The commissioners' own statutory obligations around public involvement would remain unchanged. If the ICP is an NHS trust or foundation trust, its statutory duties in relation to public involvement will apply in addition to its obligations under the ICP Contract.

93 In addition to its contractual and statutory obligations as to public involvement, the ICP would be required by the ICP Contract to respond to complaints by service users, mirroring those in place for other providers holding existing NHS contracts. This includes publishing and operating appropriate complaints procedures. As with current providers under NHS Standard Contracts, the ICP must separately comply with the 'duty of candour' obligation to be open and transparent with service users and their families about any problems or incidents that arise with their care.

94 CQC is committed to working with and learning alongside new ICPs as they emerge. CQC is currently considering its approach to ICPs, and other new, integrated models of care. Within its existing legal powers, CQC will be able to register an organisation holding an ICP Contract where it is established as a separate legal entity. This will enable CQC to regulate the ICP overall, as well as its constituent regulated services.

Involvement of local authorities

95 Local authorities have statutory responsibilities for providing public health and social care services for relevant local populations. They do so through a combination of in-house provision and commissioning of services from provider organisations.

96 Earlier sections of this document (see paragraphs 7-13) describe the widely-recognised importance of integration between health and social care services. Indeed, across the country over recent years NHS commissioners and local authorities have worked together collaboratively on integration initiatives such as the Better Care Fund (BCF), pooling resources to jointly tackle the needs of their population.

97 The benefits to be derived from the whole population approach envisaged by the ICP Contract could potentially be greater if social care and public health services were to be commissioned under it, alongside NHS services, giving one single organisation responsibility for delivering genuinely integrated health and social care services. This would likely need to be supported by a 'section 75 agreement' between NHS and local authority commissioners. Section 75 agreements (i.e. agreements made in accordance with section 75 of the NHS Act 2006 and the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000), which are already in use, allow health bodies and local authorities to pool budgets in one or more pooled funds and to delegate the exercise of certain of their functions to the other party.

98 However, there are several models through which closer integration of healthcare, public health and social care services can be and is being pursued, and it will be for local health and council partners to decide the approach best suited to local circumstances. Where an ICP model is envisaged, integration between NHS and local authority services could also be achieved through separate arrangements, such as an integration agreement between the local authority (and/or the providers of services it has commissioned) and the provider holding the ICP Contract for healthcare services.

99 We have worked with a number of local authorities, and the Local Government Association (LGA), with a view to ensuring that the draft ICP Contract is a suitable vehicle for the commissioning of public health and/or social care services alongside NHS services, where local commissioners wish to adopt this model. In response to feedback from local authorities and the LGA to date, we have (amongst other things) ensured that the draft ICP Contract:

- allows for the population to be served by the ICP to be defined in a way which can accommodate the different statutory responsibilities of CCGs and local authorities
- makes explicit that some provisions apply only to healthcare services, some only to public health and/or social care services, and some to all services
- makes specific reference to regimes particular to local authorities and their staff: for example, the Local Government Pension Scheme.

100 When considering whether to commission social care and public health services via an ICP Contract, a local authority would of course need to consider:

- how it will design its budget for those services in scope, bearing in mind the size and demand-led nature of the adult social care budget
- how it will continue to discharge its core statutory duties in relation to social care and public health, including strategic commissioning and shaping the market in social care
- how the arrangements will allow elected members to continue to discharge their responsibilities to local people and for the council as an organisation
- how links between social care and public health with other council functions will be maintained.

101 As they are currently, NHS services would remain free at the point of use under an ICP Contract.

Question 7:

a) **Do you think that the draft ICP Contract adequately provides for the inclusion of local authority services (public health services and social care) within a broader set of integrated health and care services?** Yes/No/unsure; and please explain your response.

b) **If not, what specifically do you propose?** Please explain your response.

Question 8:

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

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

Are there any other specific safeguards we should include to help the parties to ensure commissioners' statutory duties are not unlawfully delegated to an ICP? Yes/No/unsure; and please explain your response.

Question 9:

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

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

a) **Should we include much the same obligations in the ICP Contract on these matters as under the generic NHS Standard Contract?** Yes/No/unsure; and please explain your response.

b) **Do you have any additional, specific suggestions to ensure current public accountability arrangements are maintained and enhanced through an ICP Contract?** Yes/No/unsure; and please explain your response.

Question 10:

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

a) **Do you think that the draft ICP Contract allows ICPs to be held to a higher standard of value, quality and effectiveness and to reduce inappropriate clinical variation?** Yes/No/unsure; and please explain your response.

b) **Do you have any additional, specific suggestions to secure improved value, quality and effectiveness, and reduce inappropriate clinical variation?** Yes/No/unsure; and please explain your response.

Question 11:
In addition to the areas covered above, do you have any other suggestions for specific changes to the draft ICP Contract, or for avoiding, reducing or compensating for any impacts that introducing this Contract may have? Yes/No/unsure; and please explain your response.

How might the ICP framework affect equality and health inequalities?

102 In developing the proposed contracting arrangements for ICPs, we have been mindful of considering any potential impact on equality and health inequalities.

103 Overall we anticipate that the proposed contracting approach for Integrated Care Providers provides a national framework to enable the integration of care, which could have a positive impact for people with protected characteristics and those that are more likely to experience health inequalities, such as health inclusion groups. Its focus is on ensuring that people receive integrated care that is focused on meeting their individual needs. At the whole population level, a key component of the new models of care such as PACS and MCPs (which the contracting framework would support) is that they are focused on addressing the wider determinants of health and tackle inequalities. This also complements the existing NHS England policies on equality and health inequalities, assisting in the compliance to the Public Sector Equality Duty.

104 We have set out in our accompanying draft Equality and Health Inequalities Analysis more details about how we anticipate that the proposed national framework for ICPs may affect people with protected characteristics and those that are more likely to experience health inequalities.

105 We note that, subject to the outcomes of this consultation, the practical impact of this national framework would be determined by the local decisions made by commissioners in determining a care model and selecting an appropriate provider. It will be important for local commissioners and providers to undertake their own equality and health inequalities analyses to inform their decision-making, in accordance with legal and contractual requirements.

Question 12:
Are there any specific equality and health inequalities impacts not covered by our assessment that arise from the provisions of the draft ICP Contract? Yes/No/unsure; and please explain your response.

How do we measure impact, and learn?

106 We do not yet have any ICPs in place in England. However, subject to the outcomes of this consultation, we plan to study the effects of the first ICP Contracts that come into being and share learning with others that may follow. Following its recent inquiry on integrated care, the House of Commons Health and Social Care Committee recommended that ICPs should be carefully evaluated before being implemented widely.[27]

107 Dudley, the first area that might use the draft ICP Contract, has a programme of evaluation underway. We will work with the first systems using the draft ICP Contract to ensure that:

- in the near term we capture the lessons around how to improve the local processes for designing and establishing an ICP under contract, including how amending national rules could aid this
- in the longer term there is ongoing evaluation of any improvement in population health outcomes and other measures of performance in areas served by an ICP relative to others and how these were achieved.

108 We would expect local areas that implement an ICP Contract to evaluate outcomes and impact against local measures.

Next steps

109 Following the conclusion of this consultation we will consider the feedback we receive. We plan to then publish a response to the consultation, and will decide whether to make the draft ICP Contract or an amended version of it available to CCGs as a model commissioning contract. If we decide to do so, we will:

- publish the model contract and guidance to CCGs about the circumstances in which we would allow it to be used (in line with ISAP and our powers under the Standing Rules)
- if we consider it necessary to do so, put in place a process, aligned to ISAP, under which we may consider amendments to the model contract proposed by early CCG users during their procurements, within our discretion under those Standing Rules. We may choose to do this in recognition that integrated care models are at an early stage of development in the NHS in England, and the terms of the model contract may need adjustment to reflect those models as they are developed locally. Any amendments we consider may then be incorporated in subsequent versions of the model contract, on which we would carry out further consultation.

27 The House of Commons Health and Social Care Committee's publication Integrated care: organisations, partnerships and systems inquiry Seventh Report of Session 2017-19 [p41] can be found on the House of Common's website: https://www.parliament.uk/business/committees/committees-a-z/commons-select/health-committee/inquiries/parliament-2017/inquiry4/ (Information accessed 25 July 2018)

Summary of consultation questions

Question 1:
Should local commissioners and providers have the option of a contract that promotes the integration of the full range of health, and where appropriate, care services? Yes/No/unsure; and please explain your response.

Question 2:
The draft ICP Contract contains new content aimed at promoting integration, including:

- **Incorporation of proposed regulatory requirements applicable to primary medical services, included in a streamlined way within the draft ICP Contract**
- **Descriptions of important features of a whole population care model, as summarised in paragraph 30**

a) **Should these specific elements be amended and if so how exactly?** Yes/no/unsure; and please explain your response.

b) **Are there any additional requirements which should be included in the national content of the draft ICP Contract to promote integration of services?** Yes/no/unsure; and please explain your response.

Question 3:
The draft ICP Contract is designed to be used as a national framework, incorporating core requirements and processes. It is for local commissioners to determine matters such as:

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

Have we struck the right balance in the draft ICP Contract between the national content setting out requirements for providers, and the content about providers' obligations to be determined by local commissioners? Yes/no/unsure; and please explain your response.

Question 4:
Does the bringing together of different funding streams into a single budget provide a useful flexibility for providers? Yes/No/unsure; and please explain your response

Question 5:
We have set out how the ICP Contract contains provisions to:

- **guarantee service quality and continuity**
- **safeguard existing patient rights to choice**
- **ensure transparency**
- **ensure good financial management by the ICP of its resources.**

a) **Do you agree or disagree with our proposal that these specific safeguards should be included?** Agree/ Disagree/unsure; and please explain your response

b) **Do you have any specific suggestions for additional requirements, consistent with the current legal framework, and if so what are they?** Yes/No/unsure; and please explain your response.

Question 6:

a) **Should we create a means for GPs to integrate their services with ICPs, whilst continuing to operate under their existing primary care contracts?** Yes/No/unsure; and please explain your response.

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

c) **Are there any specific features of the proposed options for GP participation in ICPs that could be improved?** Yes/No/unsure; and please explain your response.

Question 7:

a) **Do you think that the draft ICP Contract adequately provides for the inclusion of local authority services (public health services and social care) within a broader set of integrated health and care services?** Yes/No/unsure; and please explain your response.

b) **If not, what specifically do you propose?** Please explain your response.

Question 8:

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

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

Are there any other specific safeguards we should include to help the parties to ensure commissioners' statutory duties are not unlawfully delegated to an ICP? Yes/No/unsure; and please explain your response.

Question 9:

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

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

a) **Should we include much the same obligations in the ICP Contract on these matters as under the generic NHS Standard Contract?** Yes/No/unsure; and please explain your response.

b) **Do you have any additional, specific suggestions to ensure current public accountability arrangements are maintained and enhanced through an ICP Contract?** Yes/No/unsure; and please explain your response.

Question 10:
It is our intention to hold ICPs to a higher standard of transparency on value, quality and effectiveness, and to reduce inappropriate clinical variation. In order to achieve this the draft ICP Contract builds on existing NHS standards by incorporating additional provisions describing the core features of a whole population model of care and new requirements relating to financial control and transparency:

a) **Do you think that the draft ICP Contract allows ICPs to be held to a higher standard of value, quality and effectiveness and to reduce inappropriate clinical variation?** Yes/No/unsure; and please explain your response.

b) **Do you have any additional, specific suggestions to secure improved value, quality and effectiveness, and reduce inappropriate clinical variation?** Yes/No/unsure; and please explain your response.

Question 11:
In addition to the areas covered above, do you have any other suggestions for specific changes to the draft ICP Contract, or for avoiding, reducing or compensating for any impacts that introducing this Contract may have? Yes/No/unsure; and please explain your response.

Question 12:
Are there any specific equality and health inequalities impacts not covered by our assessment that arise from the national provisions within the draft ICP Contract? Yes/No/unsure; and please explain your response.

How to give feedback

110 NHS England is keen to receive feedback and answer your questions on proposed contracting arrangements for ICPs. Your views will help NHS England to further shape and refine our proposals. The consultation period runs from 3 August - 26 October. We encourage you to read the full consultation document before responding.

111 You can respond by:

- Online survey: the online survey can be accessed by clicking this link.
- Post: Alternatively, if you can't respond online you can post your response(s) to ICP Consultation Response team, NHS England, Skipton House, 80 London Road, London SE1 6LH.

112 NHS England is grateful to individuals and organisations who take the time to respond to this consultation. During the 12 week consultation period, we will work to gather views from a range of stakeholders. Following the close of the consultation period, NHS England will review, analyse and consider all responses received. A summary of the responses will be published on our website to provide an opportunity to reflect on what has been heard.

Appendix A –
How is health and social care currently commissioned and provided in England?

113 The NHS in England is actually comprised of a series of different organisations which between them deliver a comprehensive health service in England.

114 These organisations fall broadly into two categories:

- Providers of health care: these are the organisations that deliver free-at-the point- of-use NHS services to patients. These mostly include GP practices (which are typically independent contractors) and statutory bodies (such as NHS trusts or NHS foundation trusts). But other types of organisation, including voluntary and independent sector organisations, also provide some services.
- Commissioners, or purchasers, of health care: these are the bodies which have statutory duties to arrange for appropriate health care services to be provided to the people for whom they are responsible. The 195 local clinical commissioning groups (CCGs) are responsible for arranging (amongst other things) most acute services, mental health services, ambulance and community health services for local people. NHS England[28] has responsibility for commissioning primary medical services, dental, pharmacy, ophthalmic and certain specialised services.

115 CCGs have a duty to improve the health of the people for whom they hold responsibility. In doing so, they must ensure that they promote health and wellbeing, address health inequalities, and provide high quality services in line with the national standards which are set out in, for example, the NHS Constitution for England.

116 In practice, commissioners arrange for the provision of services from health care providers by awarding contracts to them. For example, each GP practice will hold a contract awarded to it by NHS England (or the local CCG on its behalf if NHS England has delegated its commissioning responsibility to that CCG), and each NHS trust or foundation trust will hold contracts, awarded by a number of CCGs and/or by NHS England, for the delivery of health services. It is for commissioners to decide which providers they commission services from to meet their statutory duties, subject to the relevant procurement rules[29]. Contracts awarded by NHS commissioners to providers take different forms, depending on the nature of the services to be provided by the provider in question.

117 Most services delivered by GP practices are commissioned by NHS England under what are known as General Medical Services (GMS) contracts or Personal Medical Services (PMS) agreements. Some GP services are also commissioned under contracts known as Alternative Provider Medical Services (APMS) contracts. Most of the terms and conditions of these contracts or agreements (including payment terms and care quality standards) are set out in legislation and/or agreed following national negotiations between NHS England and GP representatives. Contracts awarded to GP

28 Since 1 April 2013, NHS England has been the operating name for the National Health Service Commissioning Board. NHS England was established as a body corporate by the Health and Social Care Act 2012, which made amendments to the National Health Service Act 2006.

29 The Public Contract Regulations 2015 (http://www.legislation.gov.uk/uksi/2015/102/contents/made) and the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 (https://www.legislation.gov.uk/uksi/2013/500/contents/made) apply to the procurement of health care services (Information accessed 25 July 2018)

practices vary in duration; GMS contracts are usually open-ended, PMS agreements may or may not be time-limited, while APMS contracts are typically for a fixed period of time.

118 NHS England (in accordance with powers given to it under its Standing Rules[30]) requires CCGs (and NHS England itself), when commissioning other health care services (except pharmaceutical services, and primary care ophthalmic and dentistry services), to use what is known as the NHS Standard Contract. This is a template contract published by NHS England in full length and shorter forms, and revised periodically. Because this template contract is used by all commissioners and providers of these services, a consistent set of rules, standards and contract management processes is applied nationally.

119 The NHS Standard Contract sets out mandatory terms and conditions governing (amongst other things):

- service quality
- compliance with the NHS Constitution and other legal requirements
- patient safety and safeguarding
- patient records
- patient choice
- how performance issues are to be managed
- how disputes are to be resolved
- when a contract may be terminated or suspended
- invoicing and payment arrangements.

120 The NHS Standard Contract is also a framework within which commissioners must specify, on a contract-by-contract basis, matters including:

- how long the contract is to last
- the services to be provided
- how those services are to be provided, and to whom
- prices for services (if there are not national prices for those services, determined by NHS Improvement, or those prices are agreed or determined not to apply), and how those prices might be varied periodically
- local policies and processes with which the provider must comply
- local quality standards.

121 These are, rightly, things to be decided locally and in respect of each individual contract, because CCGs will be best placed to determine what will best meet the needs of the people for whom they are responsible.

30 The Standing Rules are contained within the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012, which can be found on the Government website: http://www.legislation.gov.uk/uksi/2012/2996/contents/made (Information accessed 25 July 2018). These regulations are made by the Secretary of State for Health and Social Care under powers given to him under primary legislation, including the National Health Service Act 2006.

122 Meanwhile, local authorities[31] have statutory responsibility for arranging public health services and social care services for local people. Local authorities may provide services themselves, but they may also commission other organisations (private sector care homes, for example) to provide services for them. Although they are closely linked to NHS services, these services and the funding for them are not part of the NHS.

31 In this context, usually meaning: (a) a county council in England; (b) a county borough council in England; (c) a district council in England; (d) a London borough council; (e) the Council of the Isles of Scilly; (f) the Common Council of the City of London.

Glossary

Better Care Fund or BCF
The Better Care Fund (launched in April 2015) is a programme spanning both the NHS and local government which seeks to join-up health and care services. The BCF requires local health bodies and local authorities in each health and wellbeing board area to pool funding. In 2016/17, £5.9 billion was pooled in the BCF.

Clinical commissioning groups or CCGs
Clinical commissioning groups, established by the Health and Social Care Act 2012, are responsible for commissioning healthcare services within their geographical boundaries by assessing local needs and monitoring the quality of the care which is provided.

Commissioning
Commissioning is the term used to refer to the process of planning, purchasing and monitoring health services.

The draft ICP Contract
The draft NHS Standard Contract (Integrated Care Provider), first published under that name with this consultation package, (but based very closely on a draft contract published on 16 December 2016 as the draft NHS Standard Contract (Multi-speciality Community Services) Contract, or 'draft MCP Contract'), and on 4 August 2017 as the draft NHS Standard Contract (Accountable Care Models) is the subject of this consultation. The draft ICP Contract is made up of:

- Particulars
- Service Conditions
- General Conditions.

The draft ICP Contract is supplemented by guidance and explanatory documents. These include:

- guidance on integrated budgets
- Incentives framework for ICPs
- draft template Integration Agreement and associated overview
- guidance on CCG roles where ICPs are established.

See here for further details.

NHS Five Year Forward View or FYFV
The NHS Five Year Forward View was published in October 2014 by NHS England as a planning document. The FYFV proposed new care models, including the concepts of a Multispecialty Community Provider (MCP) and Primary and Acute Care System (PACS).

NHS Five Year Forward View Next Steps or FYFV Next Steps
In March 2017, NHS England published Next steps on the NHS Five Year Forward View. This document took stock of progress at the half way point of the Five Year Forward View and set out priorities for the two years following its publication.

Integrated Care Provider or ICP

An Integrated Care Provider (ICP) is a provider organisation that is contractually responsible for providing an integrated set of services to a defined population, under a NHS Standard Contract (Integrated Care Provider) Contract. The ICP can provide services itself and/or subcontract provision of services to other organisations (such as GP practices).

ICPs are not new legal entities, and there is no process by which an organisation would be 'designated' an ICP by NHS England or any other body: an organisation will be an ICP if it is awarded an ICP Contract under which it assumes that role.

Integrated Care Systems or ICSs

An ICS is an evolved version of an STP. In an ICS, commissioners and providers of NHS services, in partnership with local authorities and others, take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve.

The Integrated Support and Assurance Process or ISAP

The Integrated Support and Assurance Process provides a co-ordinated approach by NHS England and NHS Improvement to supporting and assuring the procurement and transactions related to complex contracts.

Multispecialty Community Providers or MCPs

Multispecialty Community Providers (MCPs) were first announced by NHS England in the FYFV. MCPs are whole population care models which integrate primary medical services with other community-based health and care services. Further details were provided by NHS England in the Multispecialty Community Provider Emerging Care Model and Contract Framework published in July 2016. The draft ICP Contract is an evolved version of the earlier draft MCP Contract and subsequent draft ACO Contract.

The NHS Act 2006

The National Health Service Act 2006 (the NHS Act 2006) is the principal legislation governing the health service in England. The NHS Act 2006 was substantially amended by the Health and Social Care Act 2012.

NHS Constitution

The NHS Constitution for England is published by the Secretary of State under section 1 of the Health Act 2009. The NHS Constitution describes itself as follows:

'This Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities, which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively.'

The Secretary of State, all NHS bodies, private and voluntary sector providers supplying NHS services, and local authorities in the exercise of their public health functions are required to take account of the NHS Constitution in their decisions and actions.

NHS Standard Contract

The NHS Standard Contract is the name given to the model commissioning contract currently mandated by NHS England (pursuant to its powers under the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996) for use by commissioners for all of their commissioning contracts for healthcare services other than primary care. The draft ICP Contract is largely based on the NHS Standard Contract and, subject to the outcome of this consultation, may in due course be adopted (in its current form or as further amended) as a model commissioning contract – a variant of the NHS Standard Contract for use by commissioners in circumstances to be defined by NHS England.

Primary and Acute Care Systems or PACSs

Primary and Acute Care Systems are whole population care models which integrate hospital care with services including primary medical services. PACS were first outlined in a framework document published in September 2016: Primary and Acute Care System (PACS) Integrated primary and acute care systems – Describing the care model and the business model.

Primary medical services contracts

NHS England commissions primary medical services through three types of contract: the General Medical Services (GMS) contract; the Personal Medical Services (PMS) agreement; and, the Alternative Provider Medical Services (APMS) contract. Currently, most GP practices operate under GMS contracts or PMS agreements. A small minority operate through APMS contracts.

The GMS contract is a nationally prescribed contract between NHS England and a practice. Statutory regulations require the GMS contract to contain certain contractual requirements. GMS contracts are underpinned by nationally agreed payment provisions. The duration of GMS contracts is usually open-ended.

The PMS agreement is also based on statutory regulations but enables greater local agreement on certain contractual provisions in particular the funding arrangements. PMS agreements may or may not be time-limited.

APMS contracts are typically for a fixed period of time and allow greater local tailoring of the contractual requirement.

Section 75 agreements

These are agreements made under section 75 of the National Health Service Act 2006 between a local authority and an NHS body in England. Section 75 agreements can include arrangements for pooling resources and delegating certain NHS and local authority health-related functions to the other partner(s) if it would lead to an improvement in the way those functions are exercised.

The Standing Rules or the 2012 Regulations

The National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012/2996, which (among other things) empower NHS England to draft model commissioning contracts and require NHS commissioners to use them when they commission certain services.

Vanguards

'Vanguard' areas are those areas selected by NHS England in 2015 to pilot new models for integrated care.

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Lincolnshire COUNTY COUNCIL
Working for a better future

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

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

Report to	**Lincolnshire Health and Wellbeing Board**
Date:	**25 September 2018**
Subject:	**Social Housing Green Paper Consultation**

Summary:

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

This report briefly sets out the key consultation points seeking to raise awareness of the Green Paper and asks the Board to consider whether the Housing, Health and Care Delivery Group (HHCDG) should be tasked with drafting a response to the consultation on behalf of the Board. The next meeting of the HHCDG is on 16 October and the deadline for responding is 6 November 2018.

Actions Required:

The Board is asked to consider if it wishes to respond to the Social Housing Green Paper consultation by formally tasking the Housing Health and Care Delivery Group with drafting a response. Final approval of the response will be made by the Chairman of the Health and Wellbeing Board, in conjunction with the Chairman of the Housing Health and Care Delivery Group, prior to submission by 6 November 2018 deadline.

1. Background

Following the Grenfell Tower tragedy a number of wide ranging reviews have been and are being undertaken nationally and locally to identify issues that need to be addressed in order to learn the lessons and minimise the risks of such an incident re-occurring. The tragedy has also raised other issues; in particular, it has put a spotlight on the policy, structure, provision and management of social housing.

This green paper sets out the government's vision for social housing and is issued alongside separate but connected consultations on proposed changes to the rules about using right to buy receipts and evidence in relation to the regulation of social housing.

The social housing vision focuses on five principles:

- A safe and decent home for residents;
- Improving and speeding up how complaints are resolved;
- Empowering residents and ensuring that their voices are heard so that landlords are held to account;
- Tackling stigma and celebrating thriving communities; and
- Building the social homes we need and ensuring that those homes are a springboard to home ownership

Housing has been identified as one of the key priorities in the new Joint Health and Wellbeing Strategy, the Board is therefore asked to consider if it wishes to formally respond to the consultation. The Housing, Health and Care Delivery Group are meeting on 16 October 2018 and can be tasked with drafting a response on behalf of the Board. The final Board response will be approved by Cllr Woolley, in conjunction with Cllr Bowkett, prior to submission by the 6 November 2018 deadline.

Individual organisations on the Board and HHCDG retain their right to also submit their own response to the consultation.

2. Conclusion

In Lincolnshire there is a growing recognition that the push to build houses to address the housing crisis is in danger of being about numbers of new homes at the expense of the quality of those homes and of the community environment in which they are built and the accessibility of appropriate services. It is therefore important that Lincolnshire's response covers not only the very specific proposals within the consultation document, but that it also provides examples of proposals that help to address the linkages with health and wellbeing, quality of the community environment and access to services.

The Green Paper could do more to recognise that social housing provision for those with additional needs and vulnerabilities requires specific planning, delivery and management to create better usage of limited resources within both housing and health and care related services.

This consultation is a good opportunity to demonstrate in a joint response, the linkages between housing, health and care services and a further opportunity to demonstrate that Lincolnshire is making those connections and planning accordingly.

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

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

The JSNA and JHWS for Lincolnshire both recognise the importance of housing provision and conditions. Given the ambition in Lincolnshire to deliver 100,000 new homes, expanding and creating new communities, we need to ensure that these homes

and others deliver the priorities of the housing and health agendas in a co-ordinated way. A Memorandum of Understanding is due to be signed shortly to underpin a work programme that will deliver the housing priority of the JHWS. The response to the consultation paper therefore is an opportunity to reflect and demonstrate this.

4. Consultation

Attached at Appendix A is the Local Government Association (LGA) briefing on the Social Housing Green Paper. This provides a good summary of the key messages and challenges that emerge from it.

5. Appendices

These are listed below and attached at the back of the report	
Appendix A	Social Housing Green paper – Local Government Association briefing 15 August 2018

6. Background Papers

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

This report was written by Kate Ellis, Major Development Director, City of Lincoln Council on behalf of the Housing, Health and Care Delivery Group who can be contacted on 01522 873824 or kate.ellis@lincoln.gov.uk in conjunction with Alison Christie, Programme Manager Health and Wellbeing who can be contacted on 01522 552322 or alison.christie@lincolnshire.gov.uk

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The social housing green paper – Local Government Association briefing

15 August 2018

The social housing green paper titled "A new deal for social housing" and published on 14 August 2018 is the Government's vision for social housing. It sets out proposals to rebalance the relationship between tenants and landlords, drawing on the Government's engagement with social tenants following the tragic events at Grenfell Tower. Consultation on the proposals in the Green Paper closes on 6 November 2018.

The paper is designed around five principles:

- a safe and decent home for residents
- improving and speeding up how complaints are resolved
- empowering residents and ensuring that their voices are heard so that landlords are held to account
- building the social homes we need and ensuring that those homes are a springboard to home ownership

The Government has also issued a consultation on changing the rules governing the use of right to buy receipts (deadline 9 October) and a call for evidence on the regulation of social housing (deadline 6 November) alongside the green paper.

Our press response on the day was widely covered in national and local media.

KEY MESSAGES

- The green paper is a step towards delivering more social homes but it is only a small step, compared with the huge and immediate need for more genuinely affordable homes.
- The Government must go beyond the limited measures announced so far, scrap the housing borrowing cap, and enable all councils, across the country, to borrow to build once more. This would trigger the renaissance in council house-building which will help people to access genuinely affordable housing.
- We have long called for reforms to Right to Buy in order to allow councils to build more homes, and there are some positive signs in the consultation. But we must go much further so that councils can deliver the affordable homes that our residents need and deserve, including allowing councils to set discounts locally and to keep 100 per cent of receipts from homes sold.
- It is good that the Government has listened to our concerns and dropped plans to force the sale of council homes. We have worked hard to demonstrate the need to scrap this policy which would have forced councils to sell off large numbers of the homes desperately needed by low-income families in our communities
- We look forward to engaging with the Government, councils and partners in responding to the green paper, building on the local good practice in tenant engagement and empowerment.

Briefing

18 Smith Square, London, SW1P 3HZ
Email info@local.gov.uk
Tel 020 7664 3000 Fax 020 7664 3030
www.local.gov.uk

CHAPTER 1: ENSURING HOMES ARE SAFE AND DECENT

- Ensuring resident safety: Government are seeking to bring forward implementation of the recommendations on tenant involvement from Dame Judith Hackitt's Review of Building Regulations and Fire Safety. This will include a programme of support for tenants to engage landlords in issues of building safety
- Decent Homes standard: Government will consider whether the Decent Homes standard provides adequate safety and standards for social tenants
- Government is asking for views on whether minimum standards recently introduced for privately rented housing should also apply to social homes

LGA view:

The LGA is working closely with Government on the implementation of the recommendations of the Hackitt Review. We also agree on the importance of taking swift and meaningful action to help social tenants feel safe in their homes. Building new relationships between landlords and tenants will take time. In the shorter term there are immediate steps Government could take to protect all occupants of high rise buildings.

The LGA is calling for combustible materials to be banned from external cladding systems and for the use of desktop studies to be prohibited in relation to external cladding systems. We are also calling for any new burdens on local authorities to be fully funded, including the need to facilitate whistleblowing

Significant progress has been made in bringing council owned housing up to the Decent Homes standard. Government can help support further improvement by providing the freedoms and flexibilities that will allow councils to invest in their housing stock over the longer term.

The LGA supports the ambition of greater safety of tenants in social housing, but any further regulatory approach should be proportionate and the Government must not lose sight of the fact that private rented property, where many vulnerable homeless families are housed due to a lack of social housing, will often be older and more likely to contain a health and safety hazard.

CHAPTER 2: EFFECTIVE REGULATION OF COMPLAINTS

- Removing barriers to redress: Government is seeking views on strengthening local mediation for disputes, and on the value of the requirement for a designated person (either a tenant panel, MP or councillor) to consider a case before it can be escalated to the Ombudsman
- Supporting resident to raise complaints: the paper seeks views on raising awareness of complaint processes and improving tenants' access to advice and support
- Speeding up the complaints process: the paper seeks views on speeding up landlords' complaints process, and how existing systems can be developed to give tenants an effective route for raising safety concerns

LGA view

The LGA will be working with Government, council landlords and the Tenant Participation Advisory Service to share good practice.

While in certain instances there are advantages to looking at the redress process with a view to making it clearer and accessible, it is important not to undermine existing good practice. In the majority of cases tenants will understand and have confidence in the existing redress process, and will not necessarily benefit from imposed reform.

Local politicians are well placed to support tenants through the complaints process and they should retain a formal role in resolving disputes, and integrate into wider local processes of governance and redress.

CHAPTER 3: EMPOWERING RESIDENTS AND STRENGTHENING THE REGULATOR

- Arming residents with information on landlord performance: the paper is seeking views on new performance indicators to help inform tenants, and proposals to make handling of complaints part of the overall reporting framework. There could also be a role for the Regulator in publishing comparative ratings for landlords
- Rewarding good performance: government funding for building programmes could be conditional on a new measure of tenant satisfaction
- Ensuring residents voices are heard: the paper seeks views on making tenant engagement more consistent, and providing a national platform for tenants
- Strengthening choice over services: the paper seeks views on a new stock transfer programme to promote the transfer of local authority owned housing to community based housing associations; setting up trailblazers for new models of resident led governance; the ability of TMOs to deliver good outcomes for tenants, and examples of other forms of innovative tenant involvement
- Value for money for leaseholders: the paper highlights tenants concerns over a lack of transparency on service charges and difficulties in buying properties in a shared block. Government will seek opportunities to reflect the needs of social tenants in existing work on leasehold reform
- A stronger regulator: the paper seeks views on the ability of the regulator to scrutinise the performance of social landlords and take action against them

LGA View

The regulatory frameworks for social housing covers both councils and housing association landlords. Council landlords are accountable to local politicians and are therefore not accountable to the regulator on the full regulatory framework. This is the right approach and it strikes a balance between national standards and local democracy. Treating all social landlords as the same would be bureaucratic and the costs would ultimately be paid by tenants through their rents.

Councils understand their tenants and local housing circumstances best, and how to improve performance through positive productive relationships locally. National performance regimes inevitably generate perverse incentives leading to unforeseen consequences, and so we would caution against over prescription

through national Key Performance Indicators and in linking them to Affordable Homes Programme grant.

The Green Paper proposes significant changes to the way council owned housing stock is run and expresses interest in further stock transfer. We believe that these decisions are best made at local level by councils and residents. There is no one size fits all model for council housing governance and there are many excellent examples of tenant led activity in council owned housing.

The LGA is already looking at good practice in tenant involvement working with the Tenant Participation Advisory Service, as noted in the Green Paper.

CHAPTER 4: TACKLING STIGMA AND CELEBRATING THRIVING COMMUNITIES

- Celebrating thriving communities - the paper seeks views on investing in community initiatives and events, like street parties, and on how to share positive stories of social housing residents and their neighbourhoods.
- Embedding good customer service and neighbourhood management – the paper seeks views on supporting the professionalisation of housing teams and to develop a performance indicator to understand service improvement and social value
- Promoting good design – the paper seeks views on how planning guidance can support good design in the social sector, and how to involve residents in design.

LGA view

Councils are proud of their housing stock, the tenure, and their tenants, and have had to rebut negative stories about what it means to be involved in council housing for many years. It is therefore positive to see some emphasis on this issue, which ultimately is complex and will take a long time to resolve.

However the green paper does not go nearly far enough in allowing councils to invest in existing and new housing and places, and in continuing to treat and refer to social housing as an option of last resort or ‘springboard’ into other tenures.

Ultimately there is a need for a huge expansion in the social housing stock for people from all walks of life, creating thriving mixed communities. And this must be a positive vision focused on quality units, new council housing is already offers among the most innovative and best designed estates around, councils just need to be allowed to develop more of it.

CHAPTER 5: EXPANDING SUPPLY AND SUPPORTING HOME OWNERSHIP

- Supporting councils to build more – the paper seeks views on the balance between investing in grant or borrowing, the proposals for reforming Right to Buy, enabling housing companies, and confirms the repealing the Higher Value Assets policy.
- Community-led housing – the paper seeks views on how to boost the community-led housing, developing new community owned homes, and enabling resident-led estate regeneration.

- Helping housing associations and others develop more affordable homes – the paper seeks views on what additional certainties are needed by housing associations to deliver more homes
- Ensure we are using existing social housing efficiently for those who need it most – the paper seeks views on a review to understand social housing allocations, and confirms council flexibility on fixed-term tenancies.
- Ensuring social housing is a springboard to homeownership – the paper seeks views on how to further support shared ownership products, confirms continuing of voluntary Right to Buy pilots

LGA view

A significant expansion in social housing is the single most important step the Government could take in solving the housing crisis. It would add new supply quickly, support home ownership, reduce homelessness, and generate huge public service savings. Given the scale of benefits, the green paper's ambition is disappointing, although some positive steps have been taken.

There are a number of valuable proposals set out in the RtB consultation, which we have argued for, such as:

- being able to reinvest great proportions of receipt into new homes
- matching receipts with Affordable Housing Programme grant
- having a longer period within which to deliver
- repealing the forced sale of higher value assets policy

Retained local flexibilities on fixed term tenancies, and support for delivery by local housing companies are also welcome.

The UK is suffering from a housing crisis and immediate action is required. Right now councils are housing 77,000 families and 125,000 homeless children in temporary accommodation, with a further million on waiting lists, and many more families struggling in expensive, less secure private rented housing. The last time the country built enough homes councils built 40 per cent of them. We need a renaissance in council building led by a removal of borrowing restrictions, local retention of all sales receipts and a flexibility to set RtB discounts.

Conclusion

The proposals in the green paper are not sufficient on their own to bring about a renaissance in social housing, which will only be achieved by enabling councils to build the homes their communities need. It should also be noted that the proposals set out in the green paper will need to be funded either by councils (i.e. by tenants themselves through rents) or the Government separately.

We look forward to discussing this further, and hope that it is a start of a more ambitious plan delivering change.

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Health and Wellbeing Board – Decisions from 5 June 2018

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

		Tuesday 26 March 2019 Tuesday 11 June 2019 Tuesday 24 September 2019 Tuesday 3 December 2019 (All the above meetings to commence at 2.00pm)

Lincolnshire Health and Wellbeing Board Forward Plan

The items listed for today's meeting are set out below:

25 September 2018, 2pm, Committee Room 1, County Offices		
Item & Rationale	**Presenter/Contributor**	**Purpose**
Better Care Fund *To receive a report on Lincolnshire's Better Care Fund plan for 2017/19 including a finance and performance update showing the current position.*	Glen Garrod (Executive Director, Adult Care & Community Wellbeing)	Decision
Multiagency Review of Mental Health Crisis Services *To receive a report on behalf of the Multiagency Review Steering Group on the review of Mental Health Crisis Service in Lincolnshire and recommendations for future service design and commissioning.*	Beth Rhodes (Programme Manager)	Discussion
Working Together to Create Safe, Well Communities – Policing and Mental Health Development Plan *To receive a report on the Policing and Mental Health Development Plan which highlights opportunities for effective use of system resources, collegiate decision making and sustainable actions to reduce the demand on policing from mental health, with benefits for the entire health and care system.*	Marc Jones (Police & Crime Commissioner) and Claire Darbyshire (Deputy Director of Strategy, Lincolnshire Partnership NHS Foundation Trust)	Discussion
Consultation on the contracting arrangements for Integrated Care Providers (ICPs) *To receive a report on the NHS England consultation on the contract arrangements for Integrated Care Providers.*	Derek Ward (Director of Public Health)	Discussion
Social Housing Green paper consultation *To receive a report from the Housing Health and Care Delivery Group on the social housing green paper consultation. The consultation outlines the government's proposals for addressing some of the issues raised by social housing tenants following the Grenfell Tower tragedy. The paper asks the Board if it wishes to respond to the consultation.*	Cllr Wendy Bowkett, Chairman of the Housing Health and Care Delivery Group	Discussion

Lincolnshire Health and Wellbeing Board Forward Plan

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

4 December 2018, 2pm, Committee Room 1, County Offices, Lincoln		
Item & Rationale	**Presenter/Contributor**	**Purpose**
LGA Facilitated Workshop – Improvement Plan To consider the outcome/improvement plan arising from the peer review work facilitated by the Local Government Association.	Alison Christie Programme Manager Health and Wellbeing	Discussion
HWB Grant Fund – six monthly update To receive a report on the HWB Grant fund projects	Alison Christie Programme Manager Health and Wellbeing	Information

26 March 2019, 2pm, Committee Room 1, County Offices, Lincoln		
Item & Rationale	**Presenter/Contributor**	**Purpose**

Items to be programmed:

- Green Paper on Older People
- Joint Health and Wellbeing Strategy update reports