County Offices
Newland
Lincoln
LN1 1YL

14 May 2019

Adults and Community Wellbeing Scrutiny Committee

A meeting of the Adults and Community Wellbeing Scrutiny Committee will be held on **Wednesday, 22 May 2019 at 10.00 am in Committee Room One, County Offices, Newland, Lincoln LN1 1YL** for the transaction of the business set out on the attached Agenda.

Yours sincerely

Debbie Barnes OBE
Head of Paid Service

Membership of the Adults and Community Wellbeing Scrutiny Committee (11 Members of the Council)

Councillors C E H Marfleet (Chairman), Mrs E J Sneath (Vice-Chairman), B Adams, Mrs P Cooper, R J Kendrick, Mrs J E Killey, Mrs C J Lawton, Mrs M J Overton MBE, C E Reid, C L Strange and M A Whittington

ADULTS AND COMMUNITY WELLBEING SCRUTINY COMMITTEE AGENDA
WEDNESDAY, 22 MAY 2019

Item	Title	Pages
1	**Apologies for Absence/Replacement Members**	
2	**Declaration of Members Interest**	
3	**Minutes of the meeting held on 10 April 2019**	5 - 16
4	**Announcements by the Executive Councillor and Lead Officers**	
5	**Government Green Paper and Future Funding** *(To receive an update from Glen Garrod, Executive Director of Adult Care and Community Wellbeing, who will provide the Committee with information on the latest position regarding the Government Green Paper and the future funding of Adult Social Care)*	Verbal Report
6	**Winter Funding Update Report** *(To receive a report by Tracy Perrett, County Manager – Hospitals and Special Projects, which provides a summary to members on Winter Funding for Adult Social Care Services to alleviate winter pressures on the NHS)*	17 - 48
7	**The Commercial Team Annual Report 2018/19** *(To consider a report on the Commercial Team Annual Report 2018/19, which will provide information to the Committee on the activities of the Team supporting the delivery of services in Adult Care and Community Wellbeing)*	To Follow
8	**Adults and Community Wellbeing Scrutiny Committee Work Programme** *(To receive a report from Simon Evans, Health Scrutiny Officer, which provides the Committee with an opportunity to consider its work programme for the coming year)*	49 - 56

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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

ADULTS AND COMMUNITY WELLBEING SCRUTINY COMMITTEE
10 APRIL 2019

PRESENT: COUNCILLOR C E H MARFLEET (CHAIRMAN)

Councillors Mrs E J Sneath (Vice-Chairman), R J Kendrick, Mrs J E Killey, Mrs M J Overton MBE, C E Reid, C L Strange and B Adams

Councillors: Mrs P A Bradwell OBE attended the meeting as observers

Officers in attendance:-

Glen Garrod (Executive Director of Adult Care and Community Wellbeing), Simon Evans (Health Scrutiny Officer), Alina Hackney (Senior Strategic Commercial and Procurement Manager - People Services), Justin Hackney (Assistant Director, Specialist Adult Services), Carl Miller (Commercial and Procurement Manager - People Services), Sarah-Jane Mills (Chief Operating Officer, Lincolnshire West CCG), Carolyn Nice (Assistant Director, Adult Frailty & Long Term Conditions) and Rachel Wilson (Democratic Services Officer)

66 APOLOGIES FOR ABSENCE/REPLACEMENT MEMBERS

Apologies for absence were received from Councillors Mrs C J Lawton and M A Whittington.

The Chief Executive reported that having received a notice under Regulation 13 of the Local Government (Committees and Political Groups) Regulations 1990, she had appointed Councillor B Adams as a replacement member of the Committee in place of Councillor M A Whittington for this meeting only.

67 DECLARATIONS OF MEMBERS INTERESTS

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

68 MINUTES OF THE MEETING HELD ON 27 FEBRUARY 2019

RESOLVED

That the minutes of the meeting held on 27 February 2019 be signed as a correct record by the Chairman, subject to it being noted that Councillor Mrs M J Overton MBE submitted her apologies.

69 ANNOUNCEMENTS BY THE EXECUTIVE COUNCILLOR AND LEAD OFFICERS

There were no announcements by the Executive Councillor and Lead Officers.

70 INTEGRATED COMMUNITY CARE PORTFOLIO

Consideration was given to a report by Sarah-Jane Mills, Chief Operating Officer, Lincolnshire West Clinical Commissioning Group, on behalf of the Lincolnshire Sustainability and Transformation Partnership in relation to the Integrated Community Care Portfolio. It was reported that the Lincolnshire health and care community had all committed to working in partnership to realise the ambition that the default position was that care would be provided in the community unless there was a clinical need or value for money reason that care and treatment should be provided in an acute hospital setting.

The Committee was advised that neighbourhood working was the foundation for making this happen and across Lincolnshire, twelve neighbourhood areas had been identified. In these neighbourhoods colleagues from all agencies, statutory and voluntary, would come together to support the needs of the local population. The term neighbourhood team was used to describe how professionals worked together to support the needs of an individual. It was a way of working that was similar to the 'team around the child' framework, not as single team rather than teams of professionals providing co-ordinated, person centred care to an adult with complex needs.

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

- It was noted that 14% of the population of the Skegness area had been diagnosed with type 2 diabetes. However, it should also be remembered that a lot of people had moved into this area after retiring.
- Resilient communities were about building relationships within a community to support people to manage their own conditions.
- Neighbourhood teams had consistently been one of the key developments recognised to improve integration since Lincolnshire Health and Care was initiated six years ago.
- It was queried what feedback from GP's had been like, and members were advised that this had been very positive, and the more they engaged then the more they saw benefits in terms of serving the local population.
- It was commented that liaison was very important, including with the third sector and smaller community groups, and it was queried how this was being addressed. Social prescribing played an important part in the NHS Long Term Plan, particularly around identifying those smaller local groups in an area so that teams could understand the smaller but valuable things that were taking place. It was noted that there was a lot of work taking place with staff, and if they were out in the community and noticed information about a community group they would pass on that information.

- It was noted that 'micro-commissioning' was taking place in other rural locations so that people could make the best use of services.
- It was noted that communication was critical. If a health and care professional, had access to all the relevant information their decision making for a patient would be improved.
- It was also highlighted that councillors knew their communities well and if they became aware of any small community groups or events to pass on this information.
- It was highlighted that work had been taking place around prevention for a long time, and it was queried how the current work was different from work which had been done before. There was a need for caution that major problems were not being overlooked.
- Assurances were sought that the move towards neighbourhood teams would not be a replacement for proper care provided by GP's. Members were advised that this was not the intention, and there was a need to need create local services so that if people needed to see a GP or other health professional that they were able to quickly get an appointment. The neighbourhood teams would not replace that, they would identify those individuals that had more complex needs and required a more personalised care plan.
- It was emphasised that these teams would not replace urgent health care services, but would complement those services already in existence and would help people in those situations where there was more of a social care need rather than a health need, and services would be designed around the individual rather than their disease.
- It was noted that GP's and health professionals spent a lot of time seeing people who did not have an actual health need at that time.
- It was commented that the north of Lincolnshire, particularly around Caistor was not served well medically, and it had been hoped that a new medical centre would be built in the next two to three years and that this would encourage more doctors to come to the area. It was also reported that many carers in this area worked from Market Rasen, and this highlighted the difficulties that those living in the more isolated hamlets faced, as they may only have access to call connect or rely on neighbours to access services.
- It was suggested whether services could be made better use of if they were clustered.
- It was noted that cross boundary working was not just an issue in the north of the county. People tended to cluster around primary care networks rather than the county or district boundaries. Health colleagues were working with partners over the borders, and work was underway to try and resolve these complexities with CCG partners.
- In relation to the map provided in Appendix 1 to the report, concerns were raised that there was a large disparity in the figures when looking at population numbers for each neighbourhood. Members were advised that the Primary Care Network (PCN) would help to address some of the issues as a PCN should serve between 30,000 – 50,000 people. For example, one network would cover Gainsborough, and in the Grantham and Stamford area there would be at least two.

- The services provided in a particular area would be shaped and influenced by demographic need. For example, in Skegness and Mablethorpe there was a higher need for diabetes services. The complexity was in terms of community assets. It was possible that there could be one area with a lot of community groups and another with very few. There was a need to look at how these areas could work together so these assets could be built up in other areas.
- It was queried how this would work for rural areas, as it could take between 30-45 minutes to get to the person. It was noted that capacity and demand would be important. From a management perspective, there was a need for a culture shift to think about the needs of an individual rather than what the organisation could do. To work in a way that was focused around the person, and not just their medical condition.
- Capacity would be released by managing staff more efficiently, for example, by having one person travelling to see all patients in one area rather than three travelling separately to the same area.
- It was noted that neighbourhood teams were made up of those people that already worked in those areas.
- It was commented that this was a good initiative and needed to gather more momentum.
- Digital technology would be a big part of supporting integrated community care.
- The work by KPMG would provide the basis for a vision where the details could be developed further. It was the staff on the ground that understood the detail, and the critical issue was how this detail could be included in the process and understanding what it would mean for people using the service.
- It was noted that KPMG had brought technical skills in terms of modelling and analysing data and providing that expertise that was needed. There had been a lot of engagement with the people involved in delivering services.
- It was commented that this had been a long time coming, but was not quite there yet. Neighbourhood teams would not work unless there were health services there to back them up.
- It was confirmed that there were no changes planned to the services that GP's provided, however, there may be changes to the number of outlets.

RESOLVED

That the comments made in relation to the Lincolnshire Sustainability and Transformation Partnership's Integrated Community Care Portfolio be noted.

71 HOME BASED REABLEMENT SERVICE

Consideration was given to a report which provided the Committee with an overview of the Home Based Reablement Service. Members were advised that the aim of this service was to maximise a person's independence whilst enhancing their quality of life, with the intention of reducing the need for care and support in the future. An effective reablement service was vital in supporting people to gain or regain the skills necessary for daily living, which had been lost through illness, deterioration of health and/or increased support needs.

Additionally, at time of market failure within the homecare market Lincolnshire County Council could request the Home Based Reablement Service provider to act as 'the provider of last resort' and use their capacity to support people with long term needs in their own homes on a short term basis.

Members were advised that the contract for the Reablement Service had been awarded to Allied Healthcare in 2015 for a period of three years with the opportunity for a further two year extension. However, at the beginning of November 2018, the Care Quality Commission (CQC) had written to 84 affected local authorities to make them aware of significant and immediate concerns regarding Allied Healthcare's financial viability. Lincolnshire's contract was the fourth largest in the country. Following extensive discussions with a number of organisations, including Allied Healthcare, the contract was successfully transferred to Libertas. It was noted that one of the immediate actions taken was to reach out to the workforce across the county to keep then updated of the situation. The transfer of staff from Allied to Libertas was undertaken within 10 days.

Tom Carter, Managing Director and Claire Lee, Head of Operations at Libertas were in attendance for this item and provided updates to the Committee and the following points were noted:

- It was a joint approach between the County Council and Libertas in offering reassurance to the workforce, and there were some significant practical changes which had to be overcome, such as the loss of IT systems. The aim was to achieve stability for the service, and the organisation was able to deliver that stability. Work had continued over the previous three months, and work was now underway to think about the development of the service and what could be delivered in the future.
- The primary focus had been to connect with everyone in the service and inform them of what was going to happen and the expected timeline. New systems were brought in and the staff undertook training on the new systems. All staff were supported through this change so that reassurance could be given to service users that the only changes they would see would be the uniform and name. It was important that the workforce was behind Libertas, and therefore there was normal working from day one of the contract.
- It was highlighted that the work which had taken place to make this happen could not be underestimated, and despite the changes in provider Delayed Transfers of Care (DToC) continued to reduce. Members were also reminded that this had happened at one of the most difficult times of the year.

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

- It was commented that reablement was a very important service for people and it needed to be in place for when they came out of hospital and it was highlighted that it was not thought that there had been any complaints during this time.
- The Executive Councillor for Adult Care, Health and Children's Services thanked all those involved for their work during this time.

- The Executive Director for Adult Care and Community Wellbeing summarised for members the process undertaken when it became clear that there were questions regarding the financial viability of a provider such as Allied Healthcare.
- It was noted that Libertas had increased the percentage of people reabled to no service from 71.7% service users to 91.3% in February 2019. It was queried what Libertas were doing differently to Allied and members were advised that they were working with the reablement service closely and each referral was being looked at individually, and each one which was declined was also looked at.
- Officers were congratulated for the work they had carried out in ensuring the service had continued uninterrupted.
- It was queried whether there had been an increase in costs and members were advised that the contract had transferred to the new provider at the same cost. It was noted that Libertas had stretch targets in place for monitoring performance.
- It was queried what happened when something that needed changing was observed, it was confirmed that this feedback would be passed on and there was a good working relationship with this provider. It was also noted that Libertas was a prime provider for home care in two zones (Louth and Gainsborough).
- It was commented that it was thought that the service had got back into a good state in a relatively short space of time. There was a need for stability in order to grow and develop the service. In the future it was hoped that there would be an integrated reablement service, which would be similar to what is set up a few other areas of the country.
- It was suggested that the Committee may want to think about where this service should go in the future and what did 'good' look like.
- At this time it was not clear what the timescales would be for integrating the reablement service, as it was the NHS' intention to invest more in primary care. However, there was a question of whether more should be invested into reablement as the Council had evidence to show that it commissioned well and had a good commercial offer. It was acknowledged that it could sometimes take some time to persuade partners that this was the path to follow.

RESOLVED

That the information presented within the report be noted.

72 COMMUNITY BASED SUPPORT SERVICE FOR PEOPLE WITH DEMENTIA AND THEIR FAMILIES

The Committee received a report which invited members to consider the a report on the re-commissioning of a community based Dementia Support Service, which was due to be considered by the Executive Councillor between 15 – 29 April 2019.

Members were advised that the Council currently commissioned a dementia Family Support Service, which was provided by the Alzheimer's Society and the contract was due to end on 30 September 2019. It was reported that the aim of the service was to offer support and guidance for people with dementia to live at home independently for longer and to ensure that people were better enabled to live well with dementia through provision of meaningful support and services, in turn preventing crises, unscheduled hospital admissions and premature transition in long term residential care. The current service provided support to only those people who had a diagnosis of dementia. The service also provided support and guidance to family and carers of people with dementia so that they could support the person with dementia to continue in their caring role and maintain their own health and wellbeing.

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

- It was queried whether it was correct that people who had a diagnosis of dementia or were caring for someone with dementia were eligible for an exemption from council tax. It was confirmed that this was true, and it was the sort of information that the service would help people to find out.
- When people were diagnosed early, they would be sign posted to this service, as there was a lot that could be done to help people live well with dementia.
- This service would allow flexibility, and assurance was sought that both the elements proposed would not exceed the budget allowance. It was noted that there would be a need for a conversation with health colleagues if there was a spike in the diagnosis rates, and an increase in funding would be requested. However, there was capacity within the existing budget. Early diagnosis was stressed.
- It was queried why the cost per person was so much lower in east Sussex, and it was noted that they were achieving better value through delivering to more people. East Sussex was used as an example as it was the most comparable to Lincolnshire in terms of the service to be commissioned. There were particular challenges in relation to Lincolnshire's Rurality.
- It was hoped that this service would also benefit those people with a mild cognitive impairment as well as those with a diagnosis of dementia.
- Members were advised that it was a complex process to get a diagnosis of dementia and involved a series of scans, and often by the time that people got diagnosed it was too late to get the support that could prevent the serious complications. There was a lot that could be done in the early stages, such as advice and planning and the patient being able to make decisions for their future.
- It was queried whether people with dementia were able to access grants for improving their home, however, members were advised that this sat outside of the budget for this service but they could be signposted to relevant services.
- It was important that the service was measured by robust performance indicators.
- It was commented that there seemed to be an increasing number of people needing the service, but not an increasing budget. It was noted that the challenge was that the Council did not make the diagnosis, and NHS

colleagues were relied on for this. There was a national focus on dementia and CCG's were under pressure to perform and meet targets for dementia diagnoses. However, it was believed that there was enough capacity within the contract to manage an increase of 2% to match the national targets. The important of integrated working with the NHS and others was stressed.

- It was confirmed that the service was free at the point of delivery.
- The figure of 11,000 people living with dementia in Lincolnshire came from a number of sources, including the historical trends, projections and hospital records etc.

RESOLVED

1. That the Committee supports the recommendations to the Executive Councillor as set out in the report, including a suggestion that the proposed service be called the 'Dementia Support Service' rather than 'Dementia Community Support Service'.
2. That the Committee's comments be passed to the Executive Councillor in relation to this item, including the importance of early diagnosis; the effect of rurality on service delivery; the importance of performance information; and the importance of integration with health and other commissioned care services.

73 MEMORANDUM OF UNDERSTANDING

It was reported that the role of housing in achieving and maintaining good health, and the need to connect Housing services with Health and Social Care was well recognised nationally and locally. The Lincolnshire Health and Wellbeing Board had included Housing as one of its seven priorities in its Joint Health and Wellbeing Strategy (JHWS) and established the Housing, Health and Care Delivery Group (HHCDG) to oversee the Housing Delivery Plan.

The HHCDG had identified the need to agree a strategic vision with principles and core values for a Lincolnshire approach to working across the Housing, Health and Care sectors. The Memorandum of Understanding (MoU) attached as Appendix A to the report articulated the benefits of collaborative working and created an opportunity for better understanding of the preventative role that housing could play in achieving good health outcomes and sustaining independence.

The Committee was advised that the MoU had been supported by the Health and Wellbeing Board on 11 December 2018. A number of partners had already formally signed up to this and others were following due process in order to do so.

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

- A quarter of the population in any given area could have a disability currently or within the next 5 – 10 years, and currently houses were not designed to take account of this.

- If health and wellbeing was to be tackled, there was a need for open space so people could go for a walk or enjoy other activities. How modern estates were built needed to be considered so that they could include space for people to walk, play and exercise.
- It was thought essential that open space should be included within new developments and they should also include cycle paths.
- It was commented that the housing sector moved more slowly than both the NHS and social care sectors, and that it always took a number of years to implement changes. Health colleagues had engaged with the Place directorate. It was noted that open space had wellbeing value not just in terms of physical health but also benefitted mental health. The existing system, if it was left for 20 years would still not meet the needs of those people that needed it. The authority had been working with a number of districts to look at provision of extra care developments through partnerships, as there would be extra funds available which could be applied.
- It was commented that the Sincil Bank area in Lincoln was being regenerated as the need to create open space had been recognised and a pocket park was being developed, as there was very little green space in the city generally.
- It was commented that there was a need for greater emphasis on cycle routes, and it was commented that by way of example North Kesteven District Council had a condition that any larger developments must also include housing that was suitable for older people, for example have wider doorways, and this seemed to work well.
- It was also noted that there was a need to ensure that there was the right percentage of single person dwellings, as more people were living alone.
- It was commented that there were already a lot of bungalows in Lincolnshire, on the face of it this was in many instances appropriate housing for older people, and this could also be a factor in why a lot of older people moved to the county. However, whether all the bungalows were actually fit for purpose was another matter for consideration as some may be in need of modernisation.

RESOLVED

1. That the comments made in relation to the Memorandum of Understanding be noted.
2. That the actions within the Delivery Plan which was currently being refreshed by the Housing, Health and care Delivery Group be noted.
3. That the principles of the memorandum of understanding be embedded within Lincolnshire County Council's activities when scrutinising other topics.

74 SAFEGUARDING "SOURCES OF RISK" AND REPLACEMENT BUSINESS PLAN INDICATOR

Consideration was given to a report which provided the Committee with an information briefing regarding the proposed changes to the Council Business plan measure M114 '% Enquiries Where Service Provider is the Source of Risk'.

Members were advised that the proposed measure would identify the proportion of Adult Safeguarding concerns received in the year that lead to a Section 42 (Care Act 2014) safeguarding enquiry. It was noted that in 2017/18, the number of enquiries where risk was identified and the 'source of risk' was a service provider was 337, the number of these enquiries which were upheld because abuse or neglect was likely to have occurred, on the balance of probabilities, was 132. This represented approximately 39% of enquiries which related to service providers.

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

- There was support for the change of indicator and it was suggested that the longer version of the definition rather than the shorter version should be used.
- There was an assumption that partners had an understanding of safeguarding and there would always be referrals from them. There was an expectation that providers would understand what was a safeguarding concern and what was a concern around poor quality care.
- As the authority could identify trends and the source of concerns, it could do some work with the provider, if required.
- It was noted that there would be as much concern with a provider who did not make any reports as one who reported a high number.
- Once a concern was raised there would be an assessment of whether a safeguarding risk existed or not, and there would be support put in place even if there not found to be a safeguarding risk, as officers would want to ascertain why risks were not being assessed properly.
- It was suggested that it might be useful for the Committee to have a training session on this, and it was proposed that this took place at the end of the next meeting. It was also discussed whether this subject could be a topic for a councillor development group session at a later date.
- It was highlighted that safeguarding was everyone's responsibility and there was a need to use capacity to best effect.
- It was clarified that if the number of reports had reduced, but the number converted to safeguarding enquiries had increased, this would mean that more appropriate reporting was taking place.

RESOLVED

1. That the Committee note the change to the Council Business Plan measure and support the use of the long description of the definition "The proportion of adult safeguarding concerns received in the year that lead to a Safeguarding enquiry".
2. That consideration be given to holding a safeguarding briefing session at the conclusion of the Committee's next meeting on 22 May 2019.

75 BRIEFING ON AUTISM

The Committee received a report which provided a summary on Autism including specific information relating to autistic people presenting to Adult Social Care as well as an update in relation to Lincolnshire's All-Age Autism Strategy.

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

- There was a need for information about the number of people with autism who were in work and the type of work they were employed in. It was acknowledged that not everyone with autism could work and would require adult care, but there was a significant percentage who could work.
- A key question was the extent of support given by Children's Services to prepare children with autism for adult life.
- It was noted that the 15th priority within the Strategy was to support people with autism to get a job and also support to enable them to stay employed.
- It was noted that there were also other elements being covered by the Strategy, such as the criminal justice system.
- A supported employment project was planned. The Department for Work and Pensions was also carrying out work through the healthy work programme.
- A scrutiny review had been carried out regarding the transition to adult services from children's services, and this would be circulated to committee members once it was finalised.
- It was hoped that the Strategy would raise awareness and highlight the adjustments that could be made to support people. There was due to be a councillor development session on the refreshed strategy.
- There was a need to make sure that every day services were accessible to all. There had been a scheme of local accreditation for businesses, and people with autism had been involved in developing this.
- Concerns were raised that there were a number of children with autism that were home schooled as some schools were not able to meet their needs. Members were advised that there was an autism education training programme and all schools were currently participating in this. It was also noted that as part of the SEND strategy there were to be all needs special schools.
- For some older people, autism would never have been diagnosed or considered as a condition.
- The National Autism Strategy was being reviewed, and would now be all-age and would contain key areas and themes to be addressed. Employment would be one of these.

RESOLVED

That the report be noted.

76 ADULTS AND COMMUNITY WELLBEING SCRUTINY COMMITTEE WORK PROGRAMME

Consideration was given to the Committee's work programme and the following was noted:

- A short briefing session on Safeguarding would be arranged to take place after the meeting on 22 May 2019.
- There would be some changes to the items on the agenda for 22 May 2019 depending on whether the green papers were published.

RESOLVED

That the work programme and the points highlighted above be noted.

The meeting closed at 1.10 pm

Lincolnshire COUNTY COUNCIL Working for a better future

Policy and Scrutiny

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

Report to:	**Adults and Community Wellbeing Scrutiny Committee**
Date:	**22 May 2019**
Subject:	**Winter Funding Update Report**

Summary:

The purpose of this report is to provide a summary to Members on Winter Funding for Adult Social Care Services to alleviate winter pressures on the NHS.

Actions Required:

Committee to note and consider the report.

1. Background

In October 2018 the Secretary of State for Health and Social Care announced £240m of additional funding for Councils to spend on Adult Social Care services to help Councils alleviate winter pressures on the NHS, getting patients home quicker and freeing up hospital beds across England. The government recognised the significant progress that Councils had already made in tackling delayed transfers of care (DTOC), achieving a 39% reduction in DTOC attributable to Adult Social Care since February 2017, as well as recognising the good relationships between colleagues across the Health and Social Care system which meant that local systems worked together towards common aims.

The expectation was that this money would be spent with a focus on further reducing DTOC, helping to reduce extended lengths of stay, improving weekend discharge arrangements so that patients are assessed and discharged earlier and speeding up the process of assessing and agreeing what Social Care is needed for patients in hospitals. The expectation was that health providers and local authorities would monitor improvements in these measures through local jointly agreed monitoring, comparing improvements in each of these areas of impact. The total additional funding awarded in total was £240 million divided between local authority areas in the UK. Lincolnshire County Council received £3,367,950 of this funding.

The key areas we focused on fell broadly into the following two categories:

Supporting Hospital Discharges with a focus on flow through the hospitals

- Ensuring we had enough capacity in a struggling Home Care sector to meet the demand.
- Ensuring we had alternative care pathways available for when home support was not available.
- Ensuring we had the resources available to assess people earlier to enable a discharge home when a person was ready to leave hospital.
- Ensuring that we could provide a service over 7 days for the completion of assessments, the procurement of care and any equipment a person may need to return home.

Admission Avoidance

- Providing support at the Emergency Departments across the hospital sites to support a person to be returned home.
- Investment in services that would reduce the number of service users who required hospital treatment and admission, for example, falls prevention.
- Development of digitalisation and technology to support people in their own home and to support care homes.
- To support care homes so that the people who live there remain doing so even at the end of their life, so they are not taken to a hospital where they are frightened but supported to live at the care home.

See Appendices for a full list of schemes supported.

This report is to provide an update of the schemes and the successes of these and learning which we will take forward for winter planning for 2019/2020, which has already commenced.

Summary of Individual Schemes

Winter Room Scheme

The purpose of this scheme was to provide funding and a process to approve low level spend on an ad-hoc basis to remove blocks to discharge. The money allocated to this scheme has not been fully utilised to date and will continue to support complex discharges over coming months.

Case study 1– Mrs A was unable to return home when she was medically fit as she was unable to access her bedroom upstairs. This scheme enabled the home to be made safe by providing downstairs living at home ready for discharge and avoiding a delay.

Step Up/Discharge to Assess (D2A) Residential Beds

The purpose of this scheme was to provide intensive reablement / D2A care beds on a block basis for six months. The scheme enabled a multi-agency, community response for people who had ongoing complex needs to be discharged from hospital.

Initially eight beds were procured and due to feedback and concern from NHS partners an additional four beds were commissioned to support acute flow. Whilst all of the money has been committed the usage of the beds has been less than expected. Based on usage eight beds will be extended until 14 May to support the Easter and May Bank Holiday period and the remaining four beds have been decommissioned

To date the scheme has provided 70 additional bed days within the acute trust delivering £28k in avoided acute costs. The D2A beds have also delivered improved outcomes for individuals.

Case Study 2 – Mr J was unable to be discharged from hospital when medically fit because of concerns raised with regards to the poor condition of the property, due to hoarding. Assessments and tasks completed while in D2A bed:

- *Deep clean of the property prior to returning home. (Environmental Health)*
- *Full Continuing Health Care assessment (CHC) with regards to eligibility for healthcare funding. Environmental Health were involved. Checklist completed and agreed Decision Support Tool (DST) required as potentially eligible for full funding from CHC.*
- *Safeguarding investigation – due to concerns raised with regards to partner.*
- *Occupational Therapy home assessment*

Mr J was admitted to D2A bed on 24.1.19 and discharged on 07.02.2019.

Case Study 3 – Mrs S was unable to be discharged home due to level of confusion and concerns regarding Mental Health. There were concerns that Mrs S may require a long term residential placement. During the stay in the D2A bed an assessment of night-time needs was established, assessments were completed by the Older Adult Mental Health Services and additional Social Care assessments undertaken with regards to longer term care needed. Mrs S was successfully discharged to her own home.

Mrs S was admitted to a D2A bed on 7.2.19 and discharged home 21.2.19 with Reablement support. Following this period of support longer term services were not required.

Case Study 4 – Mr T was assessed as not having capacity due to a lack of insight into care needs, but had expressed a strong wish to return to his own home. A further period of assessment, and possible best interest meeting, was required to assess long term care needs and establish if a return home was achievable. Adult Care assessed in D2A bed and determined that Mr T needs could be supported in his own home, and he was successfully discharged home with a package of Home Support.

Mr T was admitted to D2A bed 20.2.19 and discharged home on the 3.3.19.

The purpose of this scheme was to test the model of an integrated out of hours co-located offer for CAS to support admission avoidance and discharge through winter. Social work posts to support this went out to advert twice. Unfortunately due to the temporary short term nature of these posts there has been little to no interest. However, as this money is committed to staffing the programme we will be utilising the underspend to advertise these for a 12 month period.

Homecare Trusted Assessors (Domiciliary)

The care home trusted assessor model is already well embedded in Lincolnshire. This scheme was to roll out a proof of concept for domiciliary care mirroring the programme we have in situ for care homes.

All monies have been committed and staff are in place across the acute sector.

Case Study 5 – Mrs B was initially deemed to require a homecare package of 2 carers, 4 times a day. The assessor observed Mrs B walk independently and get in and out of bed independently. The assessment was revised to require only one carer and enabled a timely discharge from hospital.

Extend Hospital Avoidance Response Team (HART) provision from 72 hours to 5 days

The funding was passed to Lincolnshire Community Health Services NHS Trust (LCHS) as the lead commissioners for this service to bolster and improve available capacity. HART were commissioned to increase their capacity by 25% initially and then to 50% by the end of winter.

Between January and March 2019 the HART service has accepted on average 164 cases per month, saving the NHS £54,000 in admission avoidance and £88,800 in hospital discharges (hospital discharge savings have been based on each case being open for 3 days). Case studies are available in Appendix A.

Homecare Restart Extension.

The purpose of this scheme was to enable home care providers to keep complex packages of care open following hospital admission. This would ensure that large packages of support, where a short hospital stay was expected, would remain open from the contracted 48 hours to a maximum of seven days. Where this was applicable it enabled people to return home quickly with a restart of the existing package of support rather than having to commission a new one.

98% of cases restarted within 0-1 day of request received by brokerage. As a result 1100 additional hours of homecare were delivered by the Council. It is estimated that this reduced the length of stay in hospital by two days per client at a saving of £72k to the acute sector.

Winter Induction Bursary plus 6 month bonus/DBS

The purpose of this scheme was to support and develop additional market capacity. The scheme was developed in conjunction with LinCA to maximise the number of new employees to the Care Sector.

Providers were able to access an induction bursary for new starters, new to the care sector, for a maximum of five employees per month over the winter period. Eligible employees would be guaranteed 25 hours full pay in the first two weeks of employment and a £250 bonus if they remain employed after 6 months.

The funding for this scheme is fully committed. All providers have recruited the maximum number of staff to be eligible for the initial payment. The end date for the bursary is six months and therefore the numbers of new starters will not be fully available until later in the year.

The waiting list for homecare across the county has reduced by 37% over the winter period. This is currently estimated to have provided an additional 1500 hours homecare per week and can be confirmed once the six month period is finished.

Investment in Technology

The purpose of this scheme was to invest in technology to support discharge and avoid admissions to hospital

£15k has been committed to LCHS to support Home First principles via enabling video conferencing to avoid admissions. Lincolnshire County Council has supported 62 care homes to meet the NHS Digital Toolkit standards and apply for access to NHS mail. From the 1 April it became possible to bid for additional funds from NHS Digital to support technology in social care. Lincolnshire County Council will be bidding to continue the roll out of the toolkit to all providers in Lincolnshire. The remaining funds will be used to match fund the bid to continue the roll out and support implementation of digital technology for monitoring residents across care homes.

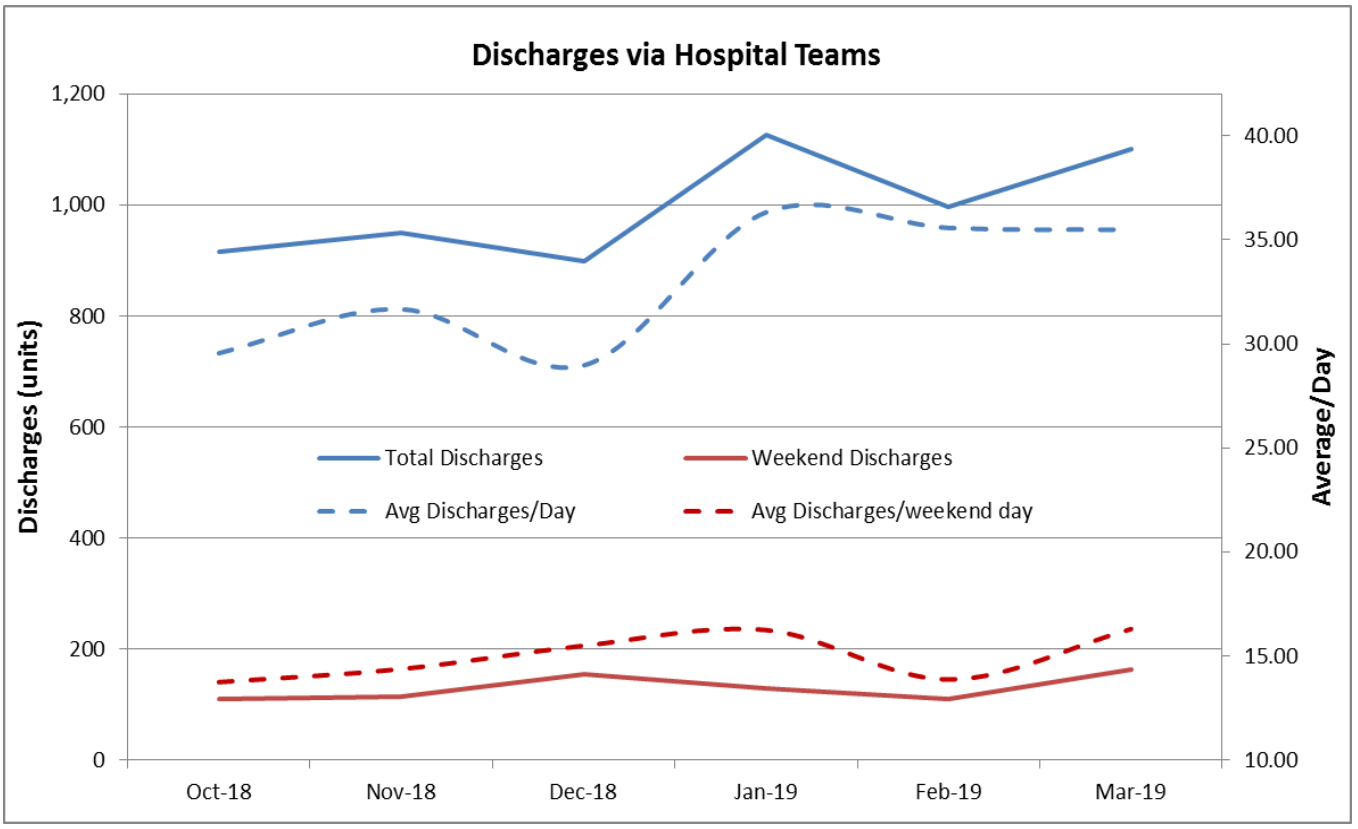
Assessment Staffing for Hospital Teams/ Housing Link Worker

The purpose of this scheme was to minimise delays in discharges and implement good practice on discharge and discharge planning.

- Assessment Staffing for Hospital Teams

The additional agency staff undertook 244 episodes of work to facilitate 97 people to be discharged. The table and chart below show increased discharges completed via hospital teams over the winter period.

	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Total
Total Discharges	916	950	898	1,126	996	1,100	5,986
Avg Discharges/Day	29.55	31.67	28.97	36.32	35.57	35.48	32.89
Weekend Discharges	110	115	155	130	111	163	784
Avg Discharges/weekend day	13.75	14.38	15.50	16.25	13.88	16.30	15.08



Data based on Hospital Case Monitoring Forms, where confirmed discharged date entered.

Housing link worker for 12 months

This post will support patients in Lincoln County Hospital whose housing needs could cause a DTOC. The increase in this resource was to mirror the scheme already in place at Boston Pilgrim Hospital. The post holder will be employed by East Lindsey District Council as part of their housing support offer. Recruitment to this post was delayed due to the timing of the funding announcement and the needs for the District Council to seek the necessary agreement to host the role. The role was offered as a secondment, but was not appointed to and is in the process of being advertised externally. The plan is for them to be in post in the summer and be fully operational for the winter of 2019/2020.

Equipment ICES over 7 Days

This scheme was to enable equipment to be delivered seven days a week. All money has been committed to enable NRS (the provider for Lincolnshire Community Equipment Services) to open seven days a week to allow NHS therapists to order equipment over the weekend. Although this service was available no requests were made for deliveries on Sundays. The following have been identified as the most commonly identified barriers to discharging patients at the weekend:

- Decreased levels of staffing in hospitals over the weekend. Reduced provision at weekends naturally inhibit the ability of any of these services to care for patients during that time; whether to assess a new admission and implement a management plan, or to facilitate discharge for a patient who is otherwise ready to leave the hospital.

- Inadequate community support including General Practitioners, Community Nursing Teams, care packages, Multi-Disciplinary Teams and equipment provision.

(See Appendix D for additional information)

Prevention of Nursing De-registration

The purpose of this scheme was to maintain capacity and availability in nursing placements over the winter period. The funds were transferred to the CCGs as the responsible commissioners for nursing care.

No nursing homes have been deregistered over the winter period.

End of Life Care

The purpose of this scheme was to ensure that the end of life pathway was improved both in and out of hospital, with nurses acting as community / acute liaison, and support hospital and community staff to facilitate and promote end of

life pathways. The nurse would also support advanced planning and support to enable people to remain in preferred place of death.

The money for this scheme is fully committed to St Barnabas. Although recruitment was initially hoped to coincide with the recruitment of Admiral Nurses, this did not prove successful. We have extended this scheme to 2021, as it is felt that a longer term employment opportunity will attract nurses into the post. Work is currently underway with St Barnabas and the hospital social work teams to map out how we will work together for this project to be successful. (Please see Appendix B for details of the scheme.)

Lincolnshire Partnership NHS Foundation Trust

This additional funding was put in place to ensure continued performance of the Lincolnshire Partnership NHS Foundation Trust (LPFT) DTOC, and to ensure flow through the in-patient units supporting a timely discharge. DTOC attributable to LPFT has remained consistently low over the winter.

LPFT Delayed Transfers of Care

	Social Care	*Both*
Oct-18	*0*	*53*
Nov-18	*0*	*5*
Dec-18	*0*	*28*
Jan-18	*0*	*31*
Feb-18	*0*	*28*

Wellbeing Increased Capacity

This scheme was to increase the capacity of the Wellbeing Service over the winter period. The aim of the Wellbeing Service is to promote independence and support people to remain living independently in their own home.

The winter monies delivered additional assessment capacity.

Measure	*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***
Total number of Trusted Assessments	*344*	*387*	*339*	*393*	*337*	*291*	*496*	*497*	*376*	*597*	*491*	*329*

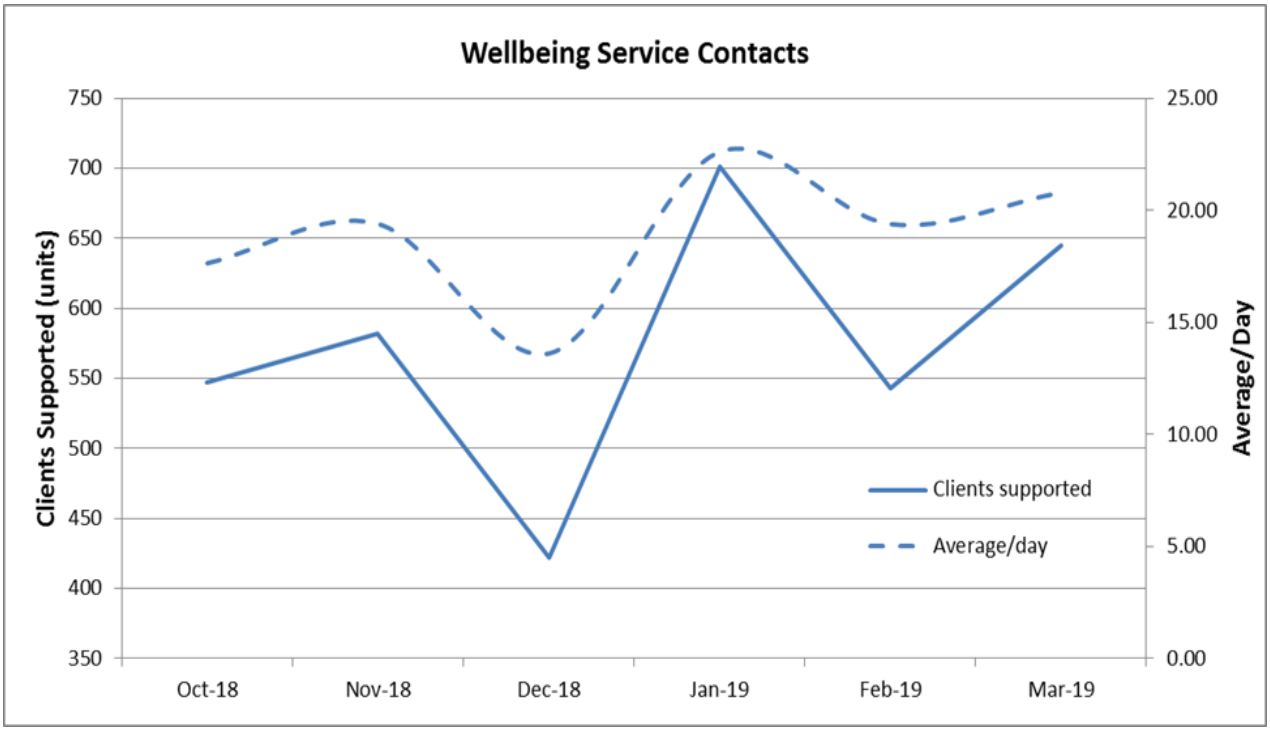
Work has already begun with the Wellbeing Service to determine how the service can support winter pressures for the forthcoming winter. Initial suggestions are for an urgent next day assessment to support DTOC and falls patients, and additional capacity being added to the urgent equipment provision part of the service.

Outcomes of the Wellbeing Service:

- 98% of customers beginning support within 10 days of assessment.
- 96% of customers have been successfully supported to achieve an overall improvement in their outcomes.
- 77% of all call outs in 2018-19 have been to support customers following a non-injury fall or to attend to a no-response activation of a telecare alarm.
- Non-injury falls accounted for 45% of all responses and are consistently the highest reason for dispatching a responder each month.
- To date responders have supported customers on over 330 occasions following a non-injury fall at home.
- Responders have also supported customers on over 60 occasions whilst awaiting an ambulance attendance providing updates on customer's condition and offering reassurance.

Case Study 6 - In January 2019 the Wellbeing Hub received a Wellbeing referral for Mr Y who needed help and support to deal with his current situation at home. The referral stated in the referral document that the gentleman was increasingly stressed by his situation and he had expressed thoughts of suicide.

During a telephone call with Mr Y he disclosed that his daughter had died on the 9th December 2018 following a RTI and throughout the conversation Mr Y was increasingly distressed. After completing the triage questions and talking to Mr Y for approximately 40 – 45 minutes, the Wellbeing Officer was concerned about his welfare. The Wellbeing Officer requested a welfare check by the Police. The Police later confirmed that Mr Y had made an attempt on his life but was found and sent to hospital via ambulance and was being assessed by Mental Health professionals.



Data based on the number of Wellbeing contacts made; Clients supported/opened (or other similar).

Falls Prevention/ Co-responders Scheme

This scheme supported the introduction of falls advisory service in residential homes and additional investments for "LIVES" service to attend falls within 45 minutes of a call.

The overall aims of the project are to:

1. Reduce the length of time people are on the floor following a fall (typically this can be up to 4 hours normally and the longer someone is on the floor the worse their outcomes are likely to be); and

2. Reduce the numbers of people conveyed to hospital following a fall (through referring them into community based services that can help keep them safe and well at home).

The project is delivered through a partnership of core organisations including East Midlands Ambulance Service, LIVES, Lincolnshire County Council, Lincolnshire Community Health Services and Wellbeing Lincs. Between 19 December 2018 and as of 17 March 2019 the project has:

- supported 164 people who have experienced a fall.
- 73% of these were successfully discharged at the scene and not conveyed to hospital (this is compared to a baseline of approx. 50% conveyance rate).
- dispatched LIVES to attend a fall within 45 minutes in approximately 70% of cases.

Case Study 7 – Mrs T sustained a head injury following a fall and was attended to by the LIVES service. The LIVES responder noticed that Mrs T's walking frame was not suitable and as a result she has been measured for and received a new frame. Mrs T was also referred to an Occupational Therapist to assess her needs. Mrs T passed on her thanks for the prompt help and her appreciation of everything the project has done for her.

Quote from feedback provided via LIVES website:

LIVES attended today for my Mother who had had a fall. What a fantastic service they provide. They are such a caring, efficient and supportive incident response team. They were extremely thorough, empathetic and they took time with my Mother and explained every step of her care. We are so very lucky to have this service in our area. Simon and Debbie provided incredible care today. Thank you. Please can you make sure this is passed on in recognition to both Simon and Debbie so they are aware of the great work they are doing.

£300k has been committed to falls prevention and the co-responders scheme via LIVES over the winter period. The remaining £100k will be used to extend the existing LIVES scheme to allow for a full evaluation of impact to be completed by Lincoln University.

2. Conclusion

The schemes on the whole have been successful and supported the system through the winter with additional services to support timely discharge and reduce non-elective admissions. Some of the schemes that did not start or started very late were due to the lateness of the notification of the additional funding award. Lincolnshire County Council has been informed that the same level of additional funding has been awarded for 2019/20, which will enable us to ensure all of the additional winter pressure schemes are fully operational ready for winter. Lincolnshire County Council will work with the support of our system partners to ensure this funding supports the people of Lincolnshire going forward.

3. Consultation

a) Have Risks and Impact Analysis been carried out??

No

b) Risks and Impact Analysis

N/A

4. Appendices

These are listed below and attached at the back of the report	
Appendix A	Hospital Avoidance Response Team Increased Capacity Report November 2018 - March 2019
Appendix B	St Barnabas Hospice Anticipatory Care Nurses - Business Case
Appendix C	Falls Response Partnership - Progress Report 16.4.2019
Appendix D	NRS Seven Day Opening for Winter Discharge of Care 2.4.2019

5. Background Papers

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

This report was written by Tracy Perrett, who can be contacted on 01522 554375 or tracy.perrett@lincolnshire.gov.uk.

APPENDIX A

Reporting Month: November 2018 to March 2019

Hospital Avoidance Response Team Increased Capacity Report

Wendy Humphreys
FOR AGE UK LINCOLN & SOUTH LINCOLNSHIRE ON BEHALF OF THE LILP CONSORTIUM

Contents

1. Key Performance Indicators

In November 2018, the team were asked to increase capacity from 130 acceptances per month to 150. Following notification of additional funding, in order to increase capacity, we recruited the following additional staff;

- Temporary Recruitment Officer in our HR department to deal with increased recruitment activity
- Temporary Call Handler to free up capacity of Team Leaders to deliver care and support
- Temporary Responders within the HART Team to meet increased capacity

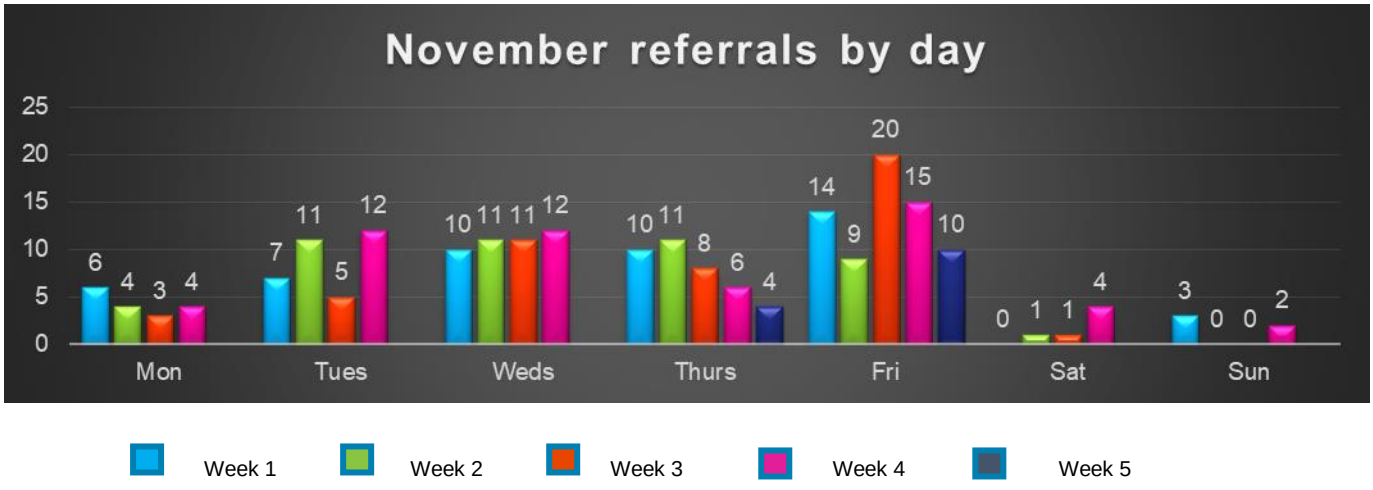
Recruitment takes up to 8 weeks. Following this, it is approximately 6-8 weeks before Responders can lone work. This enables us to have received a clear DBS and for the staff member to have undertaken the Care Certificate training, if required, along with any other mandatory training we provide.

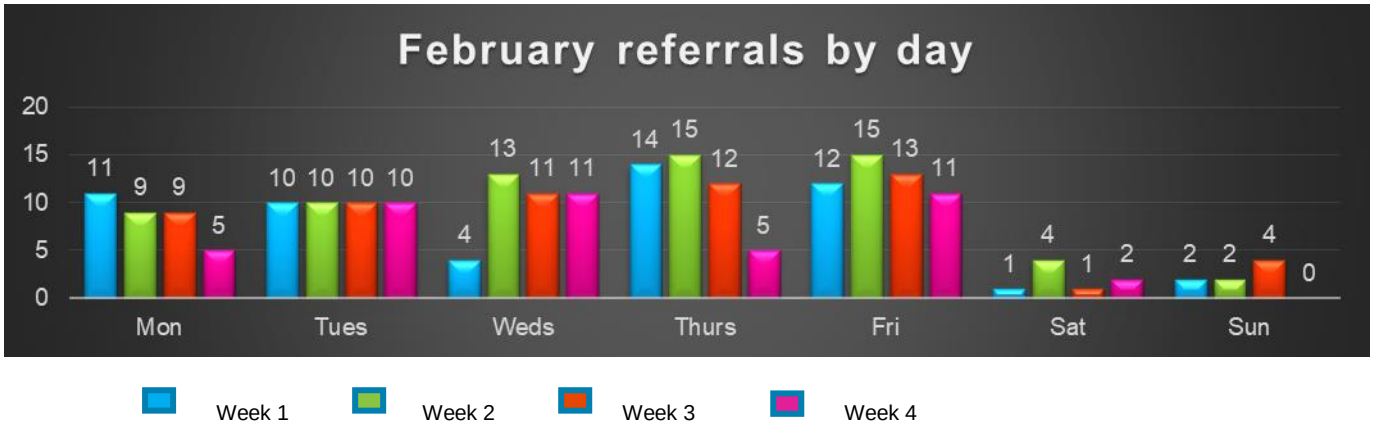
In the interim, whilst recruiting and training, we offered overtime at higher hourly rates of pay to existing staff, which resulted in immediate additional capacity and demonstrated the flexibility of the service to be reactive to increased demand.

Historically, there has been an influx of referrals towards the end of the week, with very few during weekends and the early part of the week.

Over more recent months, referrals have become more evenly spread throughout the week, allowing us to accept more and balance our capacity. The charts below demonstrates the change in referrals.

Weekend referrals remain low.





Number of HART referrals

Figures below show the number of referrals, acceptances and rejections.

	Actual Referrals	Total Acceptances	Rejections	Acceptance %	2017/2018 Comparison	
					Referrals	Acceptances
Nov 2018	**239**	**150**	**89**	**63%**	**127**	**106**
Dec 2018	**185**	**125**	**60**	**67%**	**129**	**109**
Jan 2019	**245**	**164**	**81**	**67%**	**180**	**127**
Feb 2019	**245**	**163**	**82**	**67%**	**156**	**116**
Mar 2019	**246**	**164**	**82**	**67%**	**182**	**126**
Years Total	**2454**	**1661**	**793**	**68%**	**1648**	**1260**

Our performance has achieved target number of referrals with the exception of December. This was due to the low number of referrals received – acceptance percentage of referrals was 67%, which was 3% higher than the previous month.

Reasons for Referral Rejections

	Actual Rejections November 2018	Rejections as a % of all referrals (239)	Actual Rejections December 2018	Rejections as a % of all referrals (185)	Actual Rejections January 2019	Rejections as a % of all referrals (245)	Actual Rejections February 2019	Rejections as a % of all referrals (245)	Actual Rejections March 2019	Rejections as a % of all referrals (246)	Actual Rejections Service Total	Service Total Rejections as a % of all referrals (2454)
No Capacity in the Area	70	29%	53	29%	68	28%	68	28%	69	28%	671	27%
No - Inappropriate	2	0.5%	1	0.5%	0	0%	0	0%	2	1%	15	0.5%
No - V2 Capacity	17	7%	6	3%	13	5%	14	6%	11	4%	107	4%
Yes but unable to make contact with referrer to confirm	2	0.5%	1	0.5%	2	1%	1	0.5%	1	0.5%	7	0.5%

A total of 401 referrals which were declined between November 2018 and March 2019.

328 of these referrals were declined, due to a lack of capacity in the area and 61 declined due to requests or for two person visits. Lack of capacity occurs when there is an influx of referrals, with support required on the same day as the referral is received. By the time the referral is received, staffing has already been organised. The solution to this would be to overstaff each day in order to allow for last minute referrals.

There is also a large proportion of instances where the referral is cancelled by the referrer at short notice. This has an impact on capacity as the calls have already been allocated at this stage. Only 5 of the referrals were classed as inappropriate and were declined for that reason.

Admission Avoidance

	Actual Acceptances	Percentage of Acceptances
November 2018 (150)	39	26%
December 2018 (125)	43	34%
January 2019 (164)	51	31%
February 2019 (160)	36	22%
March 2019 (164)	41	25%
Total YTD (1661) from April 2018	373	22%

Between November 2018 and March 2019, we have accepted a total of 210 admission avoidance referrals from GP's, clinicians in the community, Accident & Emergency departments or assessment wards. Whilst this makes up a 22% percentage of overall acceptances for the HART service, we continue to work on increasing this referral area by engaging more closely with neighbourhood teams.

Supported Discharge from Hospital

	Actual Acceptances	Percentage of Acceptances
November 2018 (150)	111	74%
December 2018 (125)	82	66%
January 2019 (164)	113	69%
February 2019 (160)	124	78%
March 2019 (164)	123	75%
Total YTD (1661) from April 2018	1288	78%

During this period, the HART service accepted 553 referrals for support so that people could be discharged from hospital. At present, the majority of referrals are received for this purpose with many hospital ward staff referring into the service to enable a safe discharge with onward support for the individual.

2. Funders Return on Investment

Bed Day Savings

On hospital discharge alone, based on an average of 3 days per case, a saving of **3,864** bed days has been made.

Admission Avoidance cannot be calculated in the same way but if we were to apply the same reasoning and an average of 3 days per case, a saving of **1,119** bed days has been made during the year.

Financial Savings

A £540,200 saving was made over the year by the service supporting clients to bridge the gap between hospital discharge and their package of care starting. We can prove this saving because without our support in place they would have not been discharged from hospital.

The service has also saved the NHS £44,100 through supporting customers to build their confidence leading to an independent pathway, however the person may have been discharged without our support. This is extra added value that the service brings to the NHS.

Savings based on calculations of £2,000 per Admission Avoidance and £400 per day of Hospital Discharge.

Service Cost April 2018 – March 2019	£480,000
Extra Funding for Winter Pressures November 2018 – March 2019	£50,000
Year proven savings to NHS	£1,048,200
Year unproven savings to NHS	£44,100
Return on investment	£562,300

The below table demonstrates the return on investment of the additional pressures funding. During the period of increased capacity, between November 2018 and March 2019, we accepted 121 additional referrals.

Month	Additional Referrals	% Admission Avoidance	Admission Avoidance	% Hospital Discharge	Hospital Discharge	Savings - Admission Avoidance	Savings – Hospital Discharge	Total
November 2018	20	26%	5	74%	15	£10,000	£18,000	
December 2018	0	34%	0	66%	0	0	0	
January 2019	34	31%	11	69%	23	£22,000	£27,600	
February 2019	33	22%	7	78%	26	£14,000	£31,200	
March 2019	34	25%	9	75%	25	£18,000	£30,000	
Total	**121**					**£64,000**	**£106,800**	**£170,800**

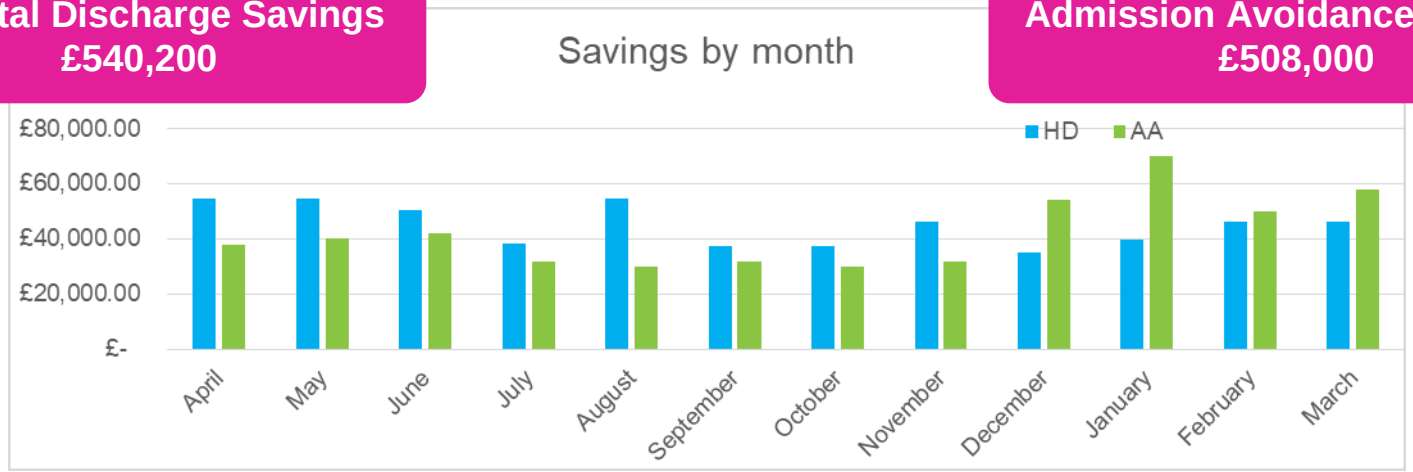
We have calculated this on the percentage split for each month.
Hospital discharge savings have been based on each case being open for an average of 3 days.
Based on the above calculation, there is a net return on investment of £120,800 in relation to the additional funding for winter pressures.

Hospital Discharge Bed Day Savings 3,864

Admission Avoidance Bed Day Savings 1,119

Hospital Discharge Savings £540,200

Admission Avoidance Savings £508,000



3.Case Study

Case Study 1

We were contacted by a GP from Market Rasen Surgery, requesting support for a lady who was recovering from shingles, to avoid hospital admission. The lady was an unpaid carer for her husband who is living with dementia.

The GP advised that the lady was weak and unsteady on her feet and her medication was 'in a mess'. The GP had arranged for the community nurse to attend to organise the medication so that we could support with prompting or administering if necessary.

We supported the lady over a period of 3 days, during which time the team made notes and provided thorough handovers, they liaised closely with other visiting professional such as the GP, as well as obtaining advice during visits from team leaders, and raising any concerns.

On the third day, the Responder in attendance having read the notes from the previous two days, and assessing the lady on arrival at the property, noticed a decline in her condition from the previous day. The lady was refusing food and drink, had become increasingly weak and was complaining of stomach pain.

Our team contacted the GP and highlighted their concerns. The GP arranged to visit that day and the Responder remained at the property until the visit had taken place, to ensure the safety of the lady and her husband.

On re-assessing the lady, the GP agreed that there had been a decline in her condition and stated that he would be organising a non-emergency ambulance to admit her to hospital. The staff member in attendance raised concerns about the husband being left home alone and respite care was arranged for him.

The Responder was at the lady's property for 4 hours ensuring that she received the support she needed. Telecare was left in place whilst the lady was awaiting the ambulance so that she could call for help if needed.

Support Provided

- Planned visits providing care and support
- Additional unscheduled visits
- Medication support
- Encouragement to eat and drink
- Monitoring of deterioration
- Liaising with GP to highlight concerns
- Support whilst waiting for GP
- Telecare equipment installed
- Alerting the GP that husband would need support if his wife was admitted to hospital

This is an example of well supported admission avoidance. Everything was put in place by the GP to use hospital admission as a last resort. Due to their extensive training, staff were

able to support, observe and highlight deterioration and escalate where necessary, on this occasion to the GP.

Case Study 2

A referral was received from Lincoln County Hospital for a gentleman who was being discharged. He had some severe respiratory problems and had a domiciliary care package due to commence the following day. Support from the team was required for that evening and the following morning.

Whilst agreeing a care plan with the gentleman, he told the Responder that his radiators were cold. Upon checking, the Responder found that there was no power to the control box. The Responder checked the fuse box and there seemed to be no problems. The gentleman advised that his neighbour was aware of how the heating system worked and asked the Responder to go and ask him to help.

The Responder remained at the property, getting the gentleman something to eat and drink, whilst the neighbour had a look at the heating.

Unfortunately they were unable to get the system working and the Responder offered to call British Gas to get some help. The gentleman and neighbour advised that they knew a plumber and would contact them.

The Responder arranged an unscheduled call later on that evening to check the gentleman was comfortable and to assist him with getting ready for bed.

Upon arrival for the second call of the evening, the neighbour was still there and had provided a heater, which was set up to make sure that the room was warm. The Responder also offered Telecare, which the gentleman accepted. This was installed the following morning, at his request.

The gentleman was also informed of the funding available for support around the home via the Winter Pressures fund and agreed to some support with his cleaning and shopping.

A plumber attended the following day to resolve the issue with the heating.

Support Provided

- Planned visits providing care and support
- Additional unscheduled visits
- Reactive support provided in relation to the heating
- Preparing food and drink
- Telecare installation
- Referral to Help in the Home funded support
- Liaising with the neighbour according to the client's request

This case demonstrates the commitment of the team to ensure individuals are safe and comfortable in their homes, including putting in additional calls and support, or referring on to additional services, if required. An holistic approach is taken, and support is tailored to the individual circumstances.

Case Study 3

During a visit to a gentleman, the team noticed that he was particularly distressed and seemed to be having difficulty in managing his home. Upon discussion, we found that he was previously provided with the support of a carer full time, which was funded by Adult Social Care. The care service had been withdrawn due to a breakdown in relationship with the carer and he was now not in receipt of any support from carers.

The gentleman disclosed that he had not been eating very much as he was unable to prepare food. He also said that he was unable to clean up and had no clean pots to use. The Responder noticed that the gentleman appeared to be feeling itchy and asked about this and was told that he was covered in bites and he thought it may be because his bed covers hadn't been changed in some time.

The Responder asked the gentleman for his consent to contact other professionals to obtain some more intensive support for him and he confirmed that he would like us to do this.

The Responder fed back to the Team Leader at the office, who organised the following;

Support Provided

- Two Responders attended the property to prepare some food, wash the pots and change the bedding. They also had a general tidy up and moved the food to the front of the freezer so that the gentleman could reach it. One load of washing was completed
- Contact was made with the Complex Care Team who arranged to visit the next day to organise medication and assess for support needed
- Advice was given to contact GP in relation to the itching skin and possible bites
- Referral made to Help in the Home funded support

The HART Team supported this gentleman in order to avoid a potential hospital admission. He was close to the point of crisis and had it not been for our intervention, he would have at risk of falls, infection and becoming undernourished.

APPENDIX B

ST BARNABAS HOSPICE

ANTICIPATORY CARE NURSE

1. DESCRIPTION

Background

Palliative Care is now recognised as an enabler to facilitate high quality person centred care for people with complex needs (1, 2). Early access to palliative/supportive care promotes resilience, self-management and reduces unnecessary admissions to hospital (3) The Ambitions Document (2016) sets out very clearly a national frame work for local action. Indeed, locally in Lincolnshire, commissioners are keen to bench mark current services against these ambitions and influence future developments.

There is a requirement to develop a proactive palliative care approach which would be embedded as part of the Social Services Team within the acute multi-disciplinary team (MDT) to support front door services such as:

- Accident and Emergency
- Medical admissions Unit
- Surgical admissions Unit
- Frailty Unit

The innovation would also provide patient follow up onto the wards and subsequent case management as current practice is dependent on referrals from clinicians to the Specialist Palliative Care Team within ULHT – often leading to the late identification of need, subsequently resulting in the burden of non-beneficial interventions for the patient (1,2), and a limited window of opportunity to support the person and their family to achieve their preferred place of care/preferred place of death. There is evidence that this way of working reduces average length of stay by up to 8.4 days, due to earlier identification. While also reducing future unnecessary admissions to hospital through improved integrated working.

Demographics

- Lincolnshire has one of the most aged populations in England (5)
- 10% of the population in Lincolnshire is over the age of 75 (National Average 7.8%) (5)
- Number of people over the age of 75 is set to double over the next 30 years, Lincolnshire wide (5).
- High levels of deprivation is linked to the development of frailty 10 years earlier than the general population (Oliver et al 2014) and is evidenced in the high levels of admission rates of people under the age of 75 from the East Coast.
- Currently almost half of all deaths occur in hospital in Lincolnshire (5)
- At any one time 30% of hospital beds, nationally are occupied by someone in the last year of their life (2)
- Most deaths occur following a period of chronic illness (2)
- Many people will people will require to spend a proportion of their last months, weeks and days in hospital (2)
- 71 % of acute hospital costs are accrued in the last year of life (6)

Scoping work completed by the St Barnabas Hospice Matron for Palliative and End of Life Care in 2017 within ULHT, reflected national findings that there is lack of identification of people on or during acute admission who would benefit from generalist palliative/anticipatory care resulting in:

- Increased likelihood of inappropriate admissions.
- Increased likelihood of preferred place of care/Death not being achieved.
- Increased likelihood of delayed discharge to preferred place of care/death.

Through proactive working it was identified that 80-90% of the people being admitted to the MEAU acute trust wide has severe frailty and would have been eligible for palliative/ supportive care. That is not to say their admissions were not appropriate due to the acute presenting event, however, identification of palliative/supportive care need on previous admission may have negated the need for subsequent presentation to hospital as an acute event would have been assessed in the context of their chronic condition (7,8,9,10) The literature advises that with appropriate case management 20- 30% of unnecessary admissions could be avoided (7,8,9,10) – this concurs with the observations made: had presenting patients plans of care, prior to admission been optimised.

2. IMPACT (Tick those that apply)

Clinical	√	**Financial**	√	**Risk Management**	√	**IT**	

Describe Impact/Benefit

Benefits: For the people in our care

- Support earlier identification of person centred palliative care needs based on the four pillars of well-being.
- Collaboration with the Adult Social Care Social Service Team and St Barnabas Hospice will enable cross pollination of skills and knowledge resulting improved outcomes for the people we care for.
- Facilitate improved communication with the Adult Social Care Brokerage team brokerage to optimise use community care resource to facilitate preferred place of care/death.
- Opportunity to upskill social care and acute care clinicians regarding the importance of a timely psycho- social approach to palliative care to reduce avoidable admissions to hospital and facilitate person centred outcomes.
- Improve confidence and practice of social care team to recognise people with palliative care needs.
- Enable the people in our care to have access to best practice and high level of skill and competence.
- Enable staff in care and nursing homes to have their learning and support needs regarding caring for people with palliative and end of life care needs to be identified, to ensure ongoing support from St Barnabas Hospice and other community services to achieve person centred outcomes.
- Facilitation of direct communication with Neighbourhood Working, for people with complex needs in order to optimise opportunities for them to achieve their preferred place of care and death.
- Access to SystmOne documentation and communication to enable the people we care for to have their plans of care relayed to Community MDT in a timely manner.
- Enable people from hard to reach groups to access palliative care services: People in nursing residential and care; people the mental illness; people with learning disabilities; people from lesbian, gay, bisexual and transgender community; people from traveller community and people from black and ethnic minority groups.

Benefits continued :

- Increase in number of referrals through the Palliative Care Coordination Centre from across ULHT, reduces workload of the acute trust and promotes seamless care.
- Increase in the numbers of people accessing timely palliative and end of life care.
- Increase in number of carer assessments completed through working in collaboration with Carers First.
- Reduction in average length of stay acute trust.
- Increase in the numbers of people who achieve their preferred place of care.
- Increase in the numbers of people who achieve their preferred place of death.
- Increase in the numbers of people who have their advance care plan recorded within an EPaCCs template.
- Decrease in the numbers of people who experience a non-beneficial admission to hospital.

The project is anticipated to support:

- Up to an average 8.4 day reduction in length of stay in hospital
- Earlier identification of people with severe frailty entering their final stage of life, enabling earlier initiation of appropriate care planning.
- Person centred care planning that promotes quality of life.
- Improved support for people to develop Advance Care Plans based on their preferences.
- Improved support for carers and family.
- 20 - 30 % reduction in inappropriate admissions associated with appropriate care planning (ACP, DNACPR, EPaCCS Care plan)
- Improved access to palliative care for people in care and nursing homes.
- Communication with GPs advising that patient should be registered on their palliative care register.

Key Performance Indicators

KPI	Anticipated Data Source	Anticipated Baseline	Anticipated Outcomes
30% reduction in length of hospital stay	ULHT admissions/discharge data	12.2 days Average Geriatric Medicine 13.48 days	8.54 days 9.436
30% reduction in readmission rates post Advanced Care Planning and establishment and discharge to preferred place of care	ULHT emergency admissions data	Scoping required	
30% Increase in the numbers of people referred to the PCCC from Social Services Team based within ULHT	PCCC Referral Data		

Project Risks

Short term

Inability to recruit short term contract

Impact might not be as anticipated due to lack of capacity in community services.

Lack of willingness of acute staff to engage, (no current evidence of this)

Lack of uplift in roles to cover AL/training

Medium Term

Community Services do not have the skills, knowledge or resources to respond increased identification of need.

Long Term

Increase of 33% of people over the age 85 by 2024 – Any reduction in admissions to acute care absorbed by on-going increased demand on service

APPENDIX C

Report To: **Lincolnshire Urgent and Emergency Response Board**

Subject: **Falls Response Partnership – Progress Report**

Date: **16 April 2019**

From: **David Stacey, Lincolnshire County Council**
Ross Noble, East Midlands Ambulance Service
Nikki Silver, LIVES

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1. Purpose

This report provides an update to the Lincolnshire Urgent and Emergency Response Board on progress made with regards to the Falls Response Partnership project. Information is provided up to 11 March 2019.

2. Background Information

Falls constitute a large proportion of ambulance attendances with delays in attendance leading to worsening of patients conditions, a high rate (estimated to be approx. 50%) of transportation to hospital and a considerable risk of further falls, all of which adds to current pressures on emergency, acute hospital and social care.

Lincolnshire County Council has taken the decision to invest £300k in 2018/19 and 2019/20 to develop a Falls Response project for the county. At a recent meeting of Adult Care and Community Wellbeing Executive Directorate Management Team it was agreed to extend the current project to 30 June 2019. This will allow a further period of time to ensure sufficient numbers of people are supported to achieve a robust evaluation of the project.

3. Report

3.1 Project Performance

Progress to week commencing 11 March 2019 is as follows:

FRP Volumes	Total
Number of calls referred to LIVES	164
Stood down before arrival at scene	24
Number attended by LIVES	140
Number of responses which result in patient discharged at scene	102
Percentage discharged at scene	73%

FRP Volumes	Total
Number of responses which result in an EMAS vehicle being deployed	38
Number of patients conveyed to hospital	36
Time from receipt of 999 call to LIVES response dispatch (Average)	01:59:40
Time from LIVES response dispatch to discharge/conveyance to hospital (Average)	01:48:49

Average numbers are up to 18 per week (last 3 weeks) from 11 calls per week. Capacity is approx. 56 per week. It has recently been agreed to refer all falls calls to LIVES based on the patient's condition and the intensity of support required rather than on the category or code the 999 call is given. This should support increased referrals and also be within the capacity of LIVES to manage.

Percentage of people discharged at scene continues to be good compared to the baseline (73% compared to 50%). Although the time to dispatch is higher than the 45 minutes which the partnership want to achieve. Despite this, data suggests that approx. 70% of calls are dispatched within 45 minutes (67% within 30 minutes).

Prior to the formal evaluation the partnership continues to review cases which have been referred through to LCHS in an attempt to understand the community services which patients go on to receive following discharge at scene.

3.2 University of Lincoln Interim Progress Report

The evaluation has been submitted for ethical approval through University of Lincoln. For the initial data analysis at least 3 months of data is needed so an anonymised dataset for has been requested from EMAS Performance Management Information Team (PMIT) in March 2019 for the period January 2017 to March 2019 including:

- Persons aged 65 years and older with Advanced Medical Priority Dispatch System (AMPDS) coded as fall or Electronic Clinical Record (Patient Report Form) coded as fall
- Physiological measures (pulse, blood pressure, respiratory rate, temperature, AVPU, GCS etc.)
- Initial attendance (CFR vs ambulance or Rapid Response Vehicle)
- Disposition (home, community referral, transport to hospital)

Initial data from LIVES including records of patients attended with falls as part of the service are being collated and entered on a database and surveys are currently being developed or adapted in order to understand the experiences of patients, LIVES and ambulance staff.

The extension of the project to the end of June will help support further, more robust evaluation of the project.

4. Conclusion

The Falls Response Partnership continues to work closely to ensure the project is well-managed.

Work is ongoing to understand the outcomes for individual patients regarding the follow on support they receive in the community. Added to this, work is required to ensure capacity is fully utilised within the project.

The University of Lincoln evaluation has commenced now that we have three months of data which can be analysed.

5. Recommendations

Lincolnshire Urgent and Emergency Response Board is asked to note this report and the progress being made with the Falls Response Partnership project.

APPENDIX D

Report Title:	**NRS Seven day opening for Winter Discharge of Care**
Author:	**Prashant Agrawal**
Date of report:	**02/04/19**

Aim of service:

Following an options appraisal a seven day NRS (Provider for Lincolnshire community equipment Services) opening service was implemented with the aim that provision of equipment can aid in facilitating hospital discharge and potentially reduce delays in transfer of care over the weekend. It is proposed that the current Lincolnshire Community Equipment Service (LCES) contract is reviewed to consider the potential for an enhanced wrap around service. This entailed prescribers having access to NRS ordering seven days a week during winter pressure period (Mid Dec to end of March). Including NRS having adequate capacity required to provide bariatric equipment (two person delivery).

Duration of the trial: 23rd December through to the end of 31st of March 2019.

Cost of service: Any orders received were charged & delivered via the service level chosen but a contribution from LCC was agreed to cover NRS administration cost for providing this service which was charged at £250 for each Sunday worked.
Total Cost 15 x £250 = £3750

Opening times: Sunday between the hours of 10am to 4.00pm excluding bank Holidays
Utilisation of service: There were no orders placed on Sunday during the trial period.
Key stakeholders in respect of uptake of the service were identified as, Discharge Lead from Acute hospitals, Locality Lead and Lead Practitioners (Adult care LCC) for acute hospital, Therapy Leads from ULHT, AHP Lead from LCHS, Lead Practitioners and locality lead covering non acute/ community hospitals and District Nurses.

It is agreed that to increase utilisation of the service that better communication and raising awareness with key stakeholders would be vital. This was done prior, during and following implementation through:

- Internal communication via all key stakeholders;
- Bulletin board information on IRIS (NRS ordering system);
- Face to face meeting with key stakeholders individually or part of a group; and
- Raising awareness in Lincolnshire Partnership board meetings and transformation group meetings.

Possible barriers to Uptake
Most commonly identified barriers to discharging patients at the weekend comprise:

- Decreased levels of staffing in hospitals over weekend: Reduced provision at weekends naturally inhibit the ability of any of these services to care for patients during that time; whether to assess a new admission and implement a management plan, or to facilitate discharge for a patient who is otherwise ready to leave the hospital.
- Inadequate community support including General Practitioners, Community Nursing Teams, care packages, MDT and equipment provision.
- Role of Peripheral stores: Peripheral stores play a vital part in facilitating discharge and avoiding delay in discharges. As these stores allow prescribers to have instant access to above mentioned equipment to aid discharge and rehabilitation.

Lincolnshire COUNTY COUNCIL
Working for a better future

Policy and Scrutiny

Open Report on behalf of Andrew Crookham, Executive Director - Resources

Report to:	**Adults and Community Wellbeing Scrutiny Committee**
Date:	**22 May 2019**
Subject:	**Adults and Community Wellbeing Scrutiny Committee Work Programme**

Summary:

The Committee is requested to consider its work programme.

Actions Required:

To review, consider and comment on the work programme; and highlight any activity which could be considered for inclusion in the work programme.

1. Current Items

The Committee is due to consider the following items at this meeting: -

22 May 2019 – 10.00am	
Item	*Contributor(s)*
Government Green Paper and Future Funding	Glen Garrod, Executive Director of Adult Care and Community Wellbeing
Winter Funding Update Report	Carolyn Nice, Assistance Director, Adult Frailty and Long Term Conditions Tracy Perrett, County Manager – Hospitals and Special Projects, Adult Care and Community Wellbeing
12.15 – 1.00 pm – Safeguarding Briefing **Linda MacDonnell, Head of Safeguarding**	

2. Future Items

Set out below are the meeting dates for the remainder of 2019, with a list of items allocated or provisionally allocated to a particular date. The items in the published forward plan of executive decisions within the remit of this Committee are listed in Appendix A.

3 July 2019 – 10.00am	
Item	*Contributor(s)*
Rural and Coastal Communities in Lincolnshire	Derek Ward, Director of Public Health
Annual Report of the Director of Public Health	Derek Ward, Director of Public Health
Homes for Independence Strategy	Kevin Kendall, Assistant Director County Property Semantha Neal, Chief Commissioning Officer, Public Health Division, Adult Care and Community Wellbeing
Short Breaks Provision in Lincolnshire *(Executive Councillor Decision Between 4 and 5 July 2019)*	Carl Miller, Commercial and Procurement Manager – People Services
Adult Care and Community Wellbeing Quarter 4 2018-19 Performance	Katy Thomas, County Manager - Performance & Intelligence, Adult Care and Community Wellbeing
Policy under Section 117 of the Mental Health Act 1983 *(Executive Councillor Decision)*	Heston Hassett, Section 117 Specialist Project Manager, Specialist Adult Services

4 September 2019 – 10.00am	
Item	*Contributor(s)*
Adult Care and Community Wellbeing Quarter 1 2019-20 Performance	Katy Thomas, County Manager - Performance & Intelligence, Adult Care and Community Wellbeing
Adult Care and Community Wellbeing Budget Monitoring Report	Head of Finance, Adult Care and Community Wellbeing

4 September 2019 – 10.00am	
Item	*Contributor(s)*
Government Green Paper on Care and Support for Older People (to be confirmed)	Glen Garrod, Executive Director of Adult Care and Community Wellbeing
Government Green Paper on Prevention (to be confirmed)	Glen Garrod, Executive Director of Adult Care and Community Wellbeing Derek Ward, Director of Public Health

9 October 2019 – 10.00am	
Item	*Contributor(s)*

27 November 2019 – 10.00am	
Item	*Contributor(s)*
Adult Care and Community Wellbeing Quarter 2 2019-20 Performance	Katy Thomas, County Manager - Performance & Intelligence, Adult Care and Community Wellbeing
Adult Care and Community Wellbeing Budget 2019/20	Head of Finance, Adult Care and Community Wellbeing

The following list of items has been previously suggested by the Committee, or an update has been previously requested: -

- National Carers Strategy
- Joint Commissioning Arrangements
- Alcohol Harm and Substance Misuse Services
- Day Opportunities
- Managed Care Network for Mental Health (C*onsidered 11 April 2018)*
- Care Quality Commission Update (C*onsidered 29 November 2017)*
- Adult Safeguarding Commissioning Strategy – Refresh due in 2019 (C*onsidered 5 September 2018)*
- Adult Frailty and Long Term Conditions Commissioning Strategy – Refresh due in 2019 (C*onsidered 10 October 2018)*
- Wellbeing Commissioning Strategy – Refresh due in 2019
- All Commissioning Strategies – Annual Summary

3. Previously Considered Items

The items previously considered by the Committee are listed in Appendix B.

4. Conclusion

Members of the Committee are invited to review, consider and comment on the work programme and highlight for discussion any additional scrutiny activity which could be included for consideration in the work programme.

5. Consultation – Not applicable

6. Appendices – These are listed below and set out at the conclusion of this report.

Appendix A	Forward Plan – Items Relevant to the Remit of the Adults and Community Wellbeing Scrutiny Committee
Appendix B	Adults and Community Wellbeing Scrutiny Committee – Previously Considered Items

7. Background Papers - No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Simon Evans, Health Scrutiny Officer, who can be contacted on 01522 553607 or by e-mail at Simon.Evans@lincolnshire.gov.uk

APPENDIX A

FORWARD PLAN OF KEY DECISIONS WITHIN THE REMIT OF THE ADULTS AND COMMUNITY WELLBEING SCRUTINY COMMITTEE

From 1 June 2019

DEC REF	MATTERS FOR DECISION	DATE OF DECISION	DECISION MAKER	PEOPLE/GROUPS CONSULTED PRIOR TO DECISION	OFFICER(S) FROM WHOM FURTHER INFORMATION CAN BE OBTAINED AND REPRESENTATIONS MADE (All officers are based at County Offices, Newland, Lincoln LN1 1YL unless otherwise stated)	DIVISIONS AFFECTED
I017762	Extra Care Housing	4 Jun 2019	Executive	Adults and Community Wellbeing Scrutiny Committee	County Property Officer Tel: 01522 553726 Email: Kevin.Kendall@lincolnshire.gov.uk	All
I017423	Short Breaks Provision in Lincolnshire	Between 4 July 2019 and 5 July 2019	Executive Councillor: Adult Care, Health and Children's Services	Commercial Team - People Services; Adult and Community Wellbeing Departmental Management Team; Adults and Community Wellbeing Scrutiny Committee	Commercial and Procurement Manager Tel: 01522 553673 Email: Carl.Miller@lincolnshire	All

APPENDIX B

ADULTS AND COMMUNITY WELLBEING SCRUTINY COMMITTEE
PREVIOUSLY CONSIDERED ITEMS

KEY
✓ = Item Considered

	2017				2018								2019		
	15 June	26 July	6 Sept	29 Nov	10 Jan	14 Feb	11 Apr	30 May	4 July	5 Sept	10 Oct	28 Nov	16 Jan	27 Feb	10 Apr
Meeting Length - Minutes	135	170	146	150	245	120	200	185	135	135	210	185			
Adult Care and Community Wellbeing Corporate Items															
Autism Strategy															✓
Better Care Fund		✓													
Budget Items			✓		✓				✓		✓		✓	✓	
Care Quality Commission				✓											
Contract Management					✓										
Integrated Community Care															✓
Introduction	✓														
IT Updates					✓							✓			
Joint Strategic Needs Assessment	✓														
Local Account				✓											
NHS Long Term Plan														✓	
Quarterly Performance		✓	✓	✓			✓		✓	✓		✓		✓	
Strategic Market Support Partner			✓												
Winter Planning										✓					
Adult Frailty, Long Term Conditions and Physical Disability															
Assessment and Re-ablement															✓
Care and Support for Older People – Green Paper												✓			
Commissioning Strategy											✓				
Dementia Items											✓				✓
Homecare Customer Survey									✓						
Residential Care / Residential Care with Nursing - Fees						✓			✓						
Review Performance									✓						
Adult Safeguarding															
Commissioning Strategy										✓					
Safeguarding Scrutiny Sub Group				✓		✓		✓		✓					
Carers															
Commissioning Strategy											✓				
Community Wellbeing															
Director of Public Health Report								✓							
Director of Public Health Role								✓							
Domestic Abuse Services			✓												
Healthwatch Procurement								✓							
NHS Health Check Programme							✓								
Sexual Health Services													✓		
Stop Smoking Service					✓										
Wellbeing Commissioning Strategy											✓				
Wellbeing Service												✓			

KEY
✓ = Item Considered

	2017				2018								2019		
	15 June	26 July	6 Sept	29 Nov	10 Jan	14 Feb	11 Apr	30 May	4 July	5 Sept	10 Oct	28 Nov	16 Jan	27 Feb	10 Apr
Housing Related Activities															
Extra Care Housing						✓									
Memorandum of Understanding															✓
Supported Housing						✓									
Specialist Adult Services															
Commissioning Strategy										✓					
Managed Care Network Mental Health							✓								
Shared Lives							✓								

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