BCF narrative plan template

This is an optional template for local areas to use to submit narrative plans for the Better Care Fund (BCF). These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover the headings and topics in this narrative template.

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover

Health and Wellbeing Board(s)

Lincolnshire

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, district councils)

How have you gone about involving these stakeholders?

NHS Lincolnshire CCG (LCCG), Lincolnshire County Council (LCC), Lincolnshire Community Health Services (LCHS), Lincolnshire Partnership Foundation Trust (LPFT), Lincolnshire Care Association (LinCa), The Voluntary and community sector Engagement Team (VET) and District Councils. Lincolnshire has a history of successful BCF planning and delivery with oversight from the health and wellbeing board. Throughout 2020/21 and so far this year, there has been continuous involvement with the above stakeholders to guide the development and ongoing iteration of the BCF plan for 2021/22. VET has developed into a community interest company who have member organisations to represent the wider heath and social care voluntary, community and social enterprise sector. The Lincolnshire BCF manager is a member of the VET board and uses this forum to engage with the sector. All stakeholders listed are represented at the Lincolnshire health and wellbeing board and receive regular updates on the development of the BCF plan.

Executive Summary

This should include:

- Priorities for 2021-22
- key changes since previous BCF plan

The Lincolnshire Health and Care system has a history of close collaboration and integrated working. There are a range of priorities for 2021-22 however these all coalesce around the plans to embrace the opportunities for further integration with the introduction of the ICS.

Governance and Structure: The Lincolnshire system has already agreed that the ICS Partnership Board will be a further iteration of the HWB. Membership of the ICSPB has been extended to include the VSCE sector. Plans for 2021/22 include appointing to a Managing Director to lead the development of a Lincolnshire Health & Care Collaborative.

Sustainable Independent Provider Market: A new home care prime provider service mobilised 1 October 2021, which has seen additional investment from the BCF to assist workforce recruitment and retention issues. LinCa as the strategic partner is leading an external workforce strategy to support the sector.

Discharge to Assess: All system partners are working in collaboration around the "home first partnership" and a workstream to deliver care closer to home. This priority is delivering workstreams to affect change such as bringing together the main occupational therapy services into a single service with a focus on home first. The system is exploring the adoption of a "somerset" type model for discharge to assess to further embed the principles that people need to return home rather than into residential bed based provision. The system has appointed a System Flow Director to lead this work.

There may appear to be a disconnect between the BCF schemes/expenditure plans with a relatively low proportion of schemes identified with the "domiciliary care" category and the plans to improve discharge outcomes in relation to national condition 4. However the nature of historical funding settlements has meant that schemes have evolved and it is difficult to disaggregate larger schemes into sub categories that do provide domiciliary home care services in addition to residential and other community support e.g. scheme 10, 18, 25, 26, 34.

Proactive Care: Working with PCNs around PHM to identify cohorts of individuals who may benefit from a personalised approach to care and support planning. Working with individuals to prevent or delay a crisis and potential hospital admission. The PCNs are developing structures and services to operate in a more proactive way. This includes increased community pharmacy and social prescribing.

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

The Lincolnshire system has 1 upper tier local authority, 1 CCG, 7 district councils and NHS providers who operate within the Lincolnshire geographical boundaries. There is cross border activity with secondary care use in neighbouring counties, but generally the system activity is contained within the Lincolnshire health and wellbeing board (HWB) area. Overarching governance of the BCF is via the HWB; however there is a wider governance structure in place.

Housing: Lincolnshire has a Housing, Health and Care Delivery Group (HHCDG). This is a subgroup of the HWB and brings together partners across the system around the housing agenda. DFG elements of the BCF are considered at this group, alongside wider issues such as housing elements of the transforming care agenda, housing standards, accessible design, and energy.

Joint Commissioning: The Joint Commissioning Oversight Group (JCOG) is a joint commissioning committee with executive representation from LCCG and LCC. Strategic intentions around joint commissioning is established in this group which inform the BCF development.

Finance: Officers from LCCG and LCC meet regularly to monitor the delivery of the BCF and financial allocations.

Section 75 boards. Each section 75 agreement which underpins the BCF (mandatory and additional schemes) have a Section 75 oversight group. This includes a Learning Disabilities Partnership Board, Community Equipment Partnership Board, Mental Health Partnership Board and Unplanned Care Partnership Board.

Appendix A shows the governance diagram for the Lincolnshire Health and Wellbeing board and the different subgroups with the lead organisation for each.

Overall approach to integration

Brief outline of approach to embedding integrated, person centred health, social care and housing services including

- Joint priorities for 2021-22
- Approaches to joint/collaborative commissioning
- Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.
- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21.

Lincolnshire has established a Joint Commissioning Oversight Group JCOG with the strategic intention of ensuring joint commissioning delivers outcomes for the people of Lincolnshire. A current priority being the procurement of a new fully integrated community equipment service with a pooled budget. Technology and the design of joint approaches to technology enabled care is also a live issue.

Lincolnshire has a system personalisation board which drives the growth of personalised approaches with a focus on integration:

Workforce: A 2 year programme is underway with a focus on embedding strengths based approaches across the system. This has started at the adult care customer service centre with new tools developed for a strengths based initial conversation. This has been extended into the wellbeing service delivered by the District Councils, Carers service, Cardiac rehab service, learning disability team, mental health team and locality adult care teams. 360 practitioners have been part of the health and wellbeing coaching programme with 8 practitioners progressing onto becoming accredited coaches. The ultimate aim of this work being to develop a workforce across health and care that understand the benefits of personalised care and have the skills to deliver this. In the medium term this work will increase capacity within the system to influence others and provide a champions network of early adopters.

Social Prescribing: The voluntary sector engagement team have been commissioned to provide strategic support to the development of social prescribing across Lincolnshire. This includes hosting a new electronic recording system which is integrated into primary care data systems. The aim of this work being to bring together a disparate group of practitioners who operate under the banner of “social prescribing”. The funding of designated posts through PCN created a risk of silo approaches. Funding a coordination and development role within the VCSE sector has enabled a more consistent approach to be developed. This includes the reporting of outcomes through a shared social value engine to demonstrate return on investment.

Care and support planning: Lincolnshire has a care portal, which is a system for accessing shared data sources. Within the care portal we have developed a personalised care and support planning module for sharing plans with system partners. This supports the idea of people only telling their story once and the personalised plan following them through the system

Supporting Discharge (national condition four)

What is the approach in your area to improving outcomes for people being discharged from hospital?

How is BCF funded activity supporting safe, timely and effective discharge?

Lincolnshire system partners have recognised that further work is required to ensure that the national hospital discharge policy and the adoption of a true home first discharge to assess way of working is fully implemented and embedded. The work is being taken forward by the home first partnership D2A delivery group reporting to the patient flow programme and the Urgent care partnership board. Data is used for improvement and key metrics shared across the system with an emphasis on continually improving patient outcomes.

The system has received a peer review from the LGA and ECIST and although the observations and recommendations were varied, the key message was around the scarcity of reablement and domiciliary care leads to unnecessary short and long term placements in residential care and community health beds, which result in poor outcomes for people and patients.

We are agreeing how to rapidly work together to deliver the recommendations of the report, prioritising the creation of increased pathway 1 capacity to increase the reablement, rehabilitation and recovery offer for patients leaving bedded care. This is reflected in the planned BCF schemes with an investment in out of hospital services, reablement, and domiciliary care services.

We will be aiming to consistently achieve the following:

- 95% of patients discharged to their own home/usual place of residence via pathway 0 and 1. Supported by the HART (Hospital Avoidance Response Team) service, integrated pathway 1 offer, 2 hour urgent care response and admission avoidance services. Emphasis on reducing hospital acquired functional decline by focussing on effective pre-hospital intervention, reducing acute length of stay if admitted, use of criteria to reside, expected dates of discharge, and daily monitoring of 7, 14 and 21 day stranded and super stranded.

- 98% of patients who no longer meet the criteria to reside to be pulled into community capacity (health & social care services) within 24 hours. We will monitor:

1. Flow out of hospital – demand for pathways, capacity on pathways, actual discharges and wait times
2. Activity on pathways – LOS, outcomes (as patients move from pathways), demand for long term care and readmissions. Number of people who remain in their own home 91 days after discharge.

A number of BCF schemes are highlighted within the plan which support safe, timely and effective discharge. These range from making increased funding available for home care providers, providing intermediate care (bed based and home based) to trusted care home assessors in the hospital.

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

Lincolnshire recognises the importance of having a safe, secure and warm home on people's health and wellbeing. The focus on this in the JSNA has been enhanced with 2 chapters on 'Housing Standards and Unsuitable Homes' and 'Insecure Homes and Homelessness'.

Several new posts shared across the System have been created: Strategic Lead – Healthy and Accessible Homes and housing intelligence officers. In addition the district councils are funding a County Housing [Homelessness] Partnerships Co-ordinator.

In 2021 the Housing, Health and Care Delivery Group reviewed its membership, terms of reference and delivery plan. It also published Lincolnshire Homes for Independence – a blueprint for helping people with care and support needs to live independently in a home of their own. Objectives in the blueprint are arranged in to four categories: Understanding needs and opportunities; Housing for people with care and support needs; Helping people remain in their current home; Helping people find and move to a new, suitable home

The delivery plan contains actions to help achieve the above objectives. Numerous actions are of relevance to the Better Care Fund plan, including updating the market position statement on homes for working-age adults with care and support needs; and updating the extra care housing delivery programme, continuing to progress this programme.

There has been a common Lincolnshire Discretionary Housing Assistance Policy developed with the intention that all district councils will adopt this under the Regulatory Reform Order. This supplements mandatory DFG making provision to top-up the maximum of £30,000 and for a range of aids, adaptations, and improvements to ensure people stay safe, warm and well. This can help to move to a suitable home (relocate) and help reduce delayed transfers of care (DTOC). District councils can also retain additional discretionary policies under the RRO, such as to waive the means test for mandatory DFG for works costing below a certain level; which some do. In addition, opportunities to deliver items such as stairlifts and modular ramps through the Integrated Community Equipment Service rather than through DFG are being explored.

Lincolnshire is a strategic partner with the national Centre for Ageing Better and has been involved in the Good Home Inquiry that it commissioned and published. Numerous workshops, focus groups and interviews have been held to better understand what residents want and need and to define and map 'housing' services.

In 2021/22 the DFG funding has been passed in its entirety to the District Councils.

Equality and health inequalities.

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan.
- How these inequalities are being addressed through the BCF plan and services funded through this.
- Inequality of outcomes related to the BCF national metrics.

Lincolnshire has a strong and comprehensive partnership approach to addressing health inequalities via the developing Integrated Care System. NHS Lincolnshire are working closely with the Director of Public Health – who has a statutory role in reducing health inequalities – to embed an agreed approach to addressing inequalities throughout the Health & Care System.

A Health Inequalities Governance Structure for the ICS has been created and has representation from across the system. A health inequalities plan will be developed by March 2022

The priority groups in Lincolnshire are the 'Core20' – the 20% most deprived communities – as well as those people with protected characteristics who experience inequitable outcomes. Primary, secondary and tertiary prevention will be addressed with a 'proportionate universalism' approach adopted, where universal services are offered with additional resource targeted at those who experience inequalities in health.

The One You Lincolnshire service – jointly funded by the CCG – remains a key means of addressing inequalities in health via primary prevention, with an expanded adult weight management offer in place designed to address inequalities.

The HEAT (Health Equity Assessment Template) Project has been established to pilot and roll out training and support to use the tool in 2021/22 across organisations and transformation programmes. 3 pilots identified – CVD, Smoking – Maternity and long COVID.

A Prevention work stream has been established to take forward NHS LTP priorities regarding health inequalities (Tobacco dependency, alcohol, healthy weight and TB). Smoking is the single biggest contributor to inequalities in life expectancy, and a Smoking steering group (multi agency) is in place with a focus on smoke free pregnancy and inpatient pathways.

Population Health Management is an approach that aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population. In Lincolnshire a Population Health Management Development Programme has started, which seeks to bring together opportunities through the BCF and a wider integrated system approach to reducing health inequalities.