HM Government

NHS England

BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 25 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 strategically and operationally in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils).

In Lincolnshire the BCF represents a mature programme with engagement and coproduction throughout either on an individual scheme basis or at programme level. The following bodies have been involved in the production of the plan:

- NHS Provider Organisations: Lincolnshire Community Health Services (LCHS); Lincolnshire Partnership Mental Health Foundation Trust (LPFT); the Primary Care Network Alliance (PCN), and United Lincolnshire Hospitals Trust (ULHT).

- Commissioning organisations: Lincolnshire NHS Integrated Care Board (ICB) and Lincolnshire County Council (LCC).

- Lincolnshire Health and Wellbeing Board and Housing, Housing, Health and Care Delivery Group (HWB Sub Group). Including Social Housing Providers (Lincolnshire Housing Forum), NHS organisations, 7 District Councils (City of Lincoln, West Lindsey, East Lindsey, Boston, South Holland, North Kesteven and South Kesteven), Adult Social Care, the Third Sector and the Private Rental Sector.

- Voluntary Engagement Team (VET) . Collaboration of Voluntary and Charitable organisations in Lincolnshire. VET are represented at the HWB, Lincolnshire Health and Care Provider Collaborative (LHCC) and the ICS Board. Representation includes St Barnabas (Hospice) and Age UK.

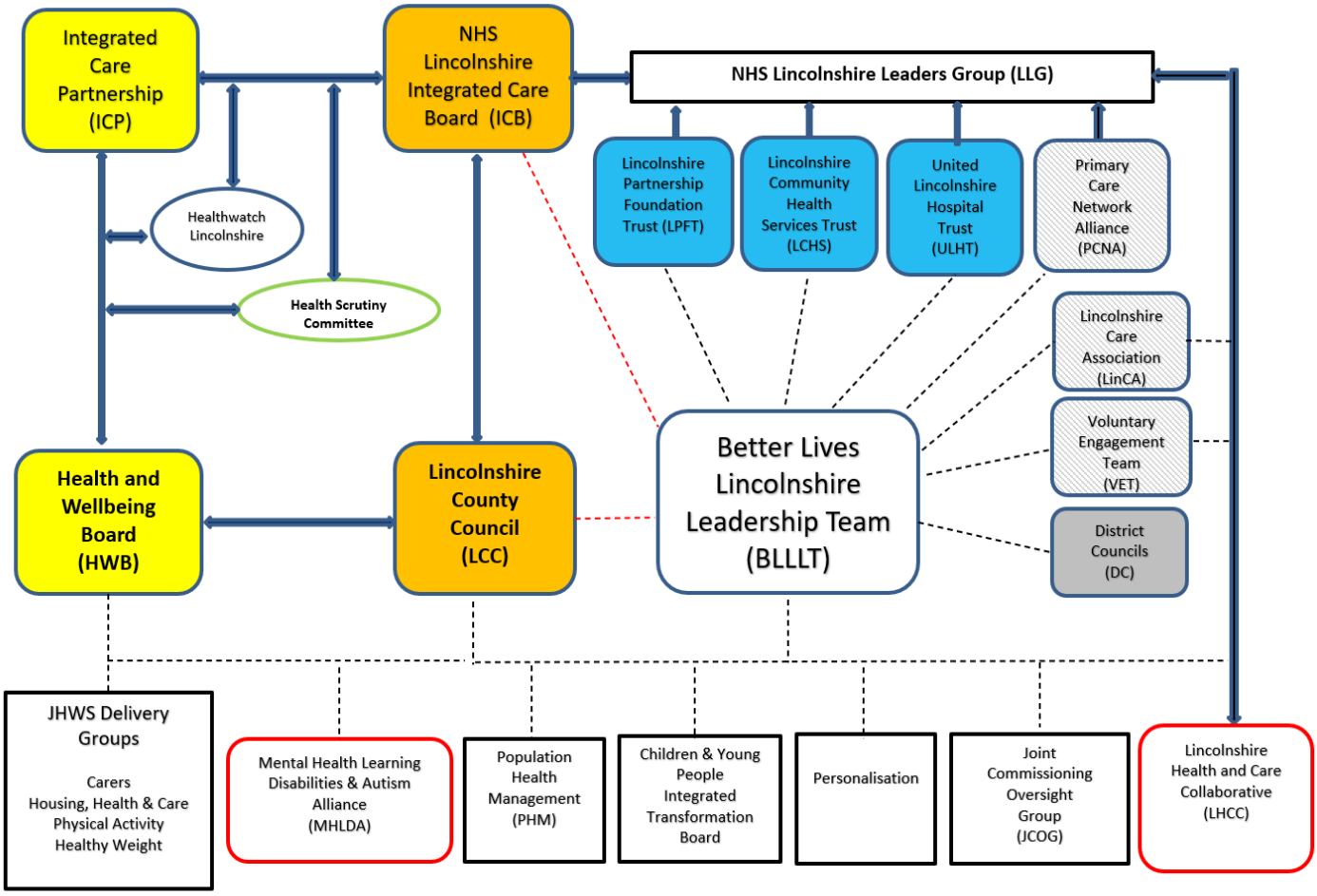
- Lincolnshire Care Association (LinCA). LinCA represents the social care providers in the County and has representation at the LHCC and ICS Board.

How have you gone about involving these stakeholders?

Lincolnshire has a history of successfull BCF planning and delivery with oversight from the health and wellbeing board. The level of ambition to build integrated services utilsing the BCF is evident through the level of pooled budget, significantly above the minimum required. Throughout 22/23 there has been continuous involvement and joint working across the stakeholders and schemes and objectives have been co-produced. Throughout the winter of 22/23 in particular stakeholders have worked closely together across the system to support and deliver the discharge fund and objectives within. This has continued within the BCF planning for 23/25

Governance

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



Executive summary

This should include:

- Priorities for 2023-25
- Key changes since previous BCF plan.

A predominately rural county, Lincolnshire is the fourth largest county in England with a population of 768,364 residents (2021 census). With strong agriculture, manufacturing, food and tourism sectors, Lincolnshire has no motorways, little dual carriageway and 80km of North Sea coastline. Our population is on average older than the population of England. It also has a higher proportion of adults over the age of 75 and the number in this age range is expected to double over the next 20 years. Year-to-year increases in the size of this ageing population are one of the key planning assumptions for Lincolnshire's health and care system.

The combination of an ageing population, increasing complexity of needs, a rural geography and areas of high socioeconomic deprivation as indicated in the recent Director of Public Health Annual Report. This defines the specific challenge of commissioning and delivering high-quality and effective health, social care and preventative services in Lincolnshire.

Ethnicity

• The diversity of the population is gradually increasing as a result of new and emerging communities. From the latest ethnicity data from 2021, 89.2% of residents identify themselves as White British, with 6.1% identifying themselves as Other White and 4.7% identifying as Other Ethnic Groups. This is also shaped by the presence of Ukrainian guests (over 1,000) and other groups from the international community.

Deprivation

• Urban areas and particularly the coast suffer higher deprivation, although there are pockets of deprivation across the county, including in rural areas which frequently suffer from issues of accessibility.

• Lincolnshire has 335,550 households. 21% of private housing stock is estimated to have a serious hazard likely to cause illness or harm. Improving the availability of housing for people with particular needs is a form of collective endeavour.

• There are around 200 caravan sites, and nearly 25,000 static caravans on the Lincolnshire coast (the largest concentration in Europe) with a permanent population of over 6,000 people. There are also smaller static caravan sites across other areas of the county; A report by Centre for Regional Economic and Social Research suggested 40% of caravan dwellers were in effect full-time residents in East Lindsey and that some others spent 40-50% of the year in their caravan. The report also suggested that 31% of local caravan residents were living with long-standing illness, disability or infirmity and nearly a quarter surveyed had health issues affecting mobility. 11% stated that they accessed local GPs as a 'temporary resident'.

Economy & Employment

• Lincolnshire has strong agriculture, manufacturing, food and tourism sectors, however these tend to provide lower paid and lower skilled employment than the national average. Lincolnshire as a whole is the largest single contributor to agricultural production in England, providing nearly 30% of the field vegetable crops in the country from its arable land.

• Unemployment in Lincolnshire is below national rates, however there is significant seasonal employment in relation to the strong horticulture and tourism sectors, particularly in the east and south of the county. Lincolnshire has one of the fastest growing rates of carers in the UK. Between 2001 and 2015, the county experienced a 27.5% increase in the number of carers, compared to the general rate of population growth of 6.2%.There are estimated to be over 84,000 unpaid carers in the county

Education

• Lincolnshire's school level attainment is broadly in line with national figures, and above regional figures, at GCSE level , and above both national and regional figures at A' level; The proportion of the working age population in the county qualified to NVQ level 3 and higher is below regional and national averages.

Priorities for 2023 – 2025

- Intermediate Care Ambitions – as defined by the recently agreed business case (see later)

- Housing – for both working age adults and older people and includes equipment and adaptations (DFGs)

- Home First – supporting Discharge. Which remains work in progress but overlaps significantly with the other priorities. These represent a composite mutually reinforcing agenda.

- Further utilisation of the opportunities provided by digital technology – notably Techology Enabled Care (or TEC) which is led by the Director of Public Health as part of a wider digital roadmap which includes shared records.

National Condition 1: Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person centred health, social care and housing services including:

- Joint priorities for 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

Priorities for 2023 – 2025 (see also above)

- Intermediate Care Ambitions

- Housing

- Home First – supporting Discharge

- Further utilisation of the opportunities provided by digital technology

Reduce the pressures on urgent & emergency care by building capacity across the system – providing the right care, at the right time, in the right place.

The above priorities will help us use our collective resources more effectively and equitably – thinking increasingly system not service. They will be further supported through a number of underpinning developments which includes:

- More Personalised care and services though strengths based practice and co-production – in both home based, specialist and acute settings.

- Housing, Occupational Therapy (increasingly aligned across employing bodies) and improved use of equipment and adaptations

- Population health management to help define the optimum configuration of services and levels of provision in better meeting inequalities.

National Condition 2

Use this section to describe how your area will meet BCF objective 1: **Enabling people to stay well, safe and independent at home for longer.**

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- how work to support unpaid carers and deliver housing adaptations will support this objective.

Personalised care and Strengths Based Approaches- Maximising independence through changing culture, behaviour and practice

Having been influenced by the work of both Think Local Act Personal and Social Care Futures our vision is that 'people stay as healthy, safe and independent as possible during all stages of their life'. We have progressed an ambitious Improvement Programme which extends beyond Adult Care. Co-produced with and delivered by our workforce, partners, people with lived experience it is embedding personalised, strengths-based approaches which are based on applied behavioural science and are empowering frontline practitioners and those they support.

Our Initial Conversation Model has resulted in people having the right conversation at the right time, being supported earlier in their journey and this has freed up practitioners to provide support where it is needed most. We have applied Strengths Based and Behavioural Approaches in over 55 teams across Adult Care, the Wellbeing Service, the Acute Trust, LPFT, Occupational Therapy Services, and will be a core part of our developing Intermediate Care Layer and Trusted Reviewer model.

First workshops have also been delivered to over 500 practitioners across 55 teams including our system partners. Using these approaches Practitioners report a positive impact in over 90% of cases. TEC Practitioners report improved independence, an increase in the number of people having conversations about TEC with 60% of conversations exploring how TEC can promote independence with 30% of people planning to use TEC. Adult Care and our partners are delivering better outcomes for people, with a more empowered workforce which has resulted in quicker, more proportionate assessments, improved use of community assets, TEC and a reduced reliance on state funded provision.

Adult Care has funded a 6-month programme In the Acute Trust on a ‘proof of concept’ basis which the Trust has agreed to extend. This work involved a behavioural programme supported by IMPOWER consultants developing a set of 6 interventions to apply Strengths Based Approaches and collaborative working across Lincoln County Hospital, Boston Pilgrim and Community Hospital Therapy Teams and Discharge Coordinators. Clinicians have reported a positive impact and it has supported improved inter-ward transfers and discharges, unblocking delays. There has been an increase in patients discharged from MAEU, regular flow focused rounds across assessment units and greater ward leadership and collaboration.

Adult Care is a key a stakeholder and joint funder of the ICS ‘It’s all about people’ programme board, which brings together and oversees the programme of work and projects that relate to embedding personalised strength-based approaches and ways of working across and into Lincolnshire ICS. Initial Conversation and Personalised Strengths Based Approaches have been identified as a system priority. The SRO is also the Chair of LVET (a collaboration of 3rd sector colleagues) and oversees key elements of the programme which include the co-production of ‘Our Shared Agreement’, which articulates what a new relationship between people and health care should feel like. The programme has provided accredited learning and development in Personalisation to over 2000 practitioners (mostly health professionals), and over 1000 practitioners have subscribed to Lincolnshire Person Centred Learning network. We have also upskilled 10 practitioners who have been trained to deliver Shared Decision Making and Personalised Care and Support Planning training to 500 practitioners.

Our co-production programme delivered with the ‘Everyone Co-production Network’ is in progress, embedding co-production at all levels of Adult Care. We are also developing the Lincolnshire ICS co-production Strategy as a co-sponsor alongside the CEO of the ICB, working with system leads to understand what it would take for Lincolnshire to become a national leader/exemplar in co-producing health and care. This includes using current good practice and evidence to identify what the system needs to do to embed co-production. Across the ICS over 400 people with lived experience and 70 clinicians / practitioners have been involved in co-production.

National Condition 2 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

An joint analysis of this service has been underway with the support of IMPOWER. The results have identifed significant opportunities for further improvements. There are 7 forms of service in Lincolnshire which constitute different elements of an Intermediate Care layer either commissioned by the County Council and/or the Integrated Care Board. 80% of the services are bed based and in total there are 279 intermediate care beds across the County. These beds are commissioned differently with variable prices, furthermore there is no consistency in the model for example the beds in community hospitals are nursing led whereby the reablement service is led by social care workers.

On average, 940 people receive a service from Intermediate Care services per month. 55% of people leave intermediate care services with no or some sort of package of care back to the community. As such some of the service elements are performing well.

National Condition 2 (cont)

As a system Lincolnshire spent £34m on Intermediate Care services in 2022/23 which represents a major investment. Following the recent review, a decision was made to start a transformation programme to move from the current bed based and fragmented model to a more integrated community based approach, led by therapists.

This is a three years programme (starting June 2023) looking at setting up multi disciplinary teams in the community to support step up and step down pathways under the banner of Home First ideology.

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- unplanned admissions to hospital for chronic ambulatory care sensitive conditions
- emergency hospital admissions following a fall for people over the age of 65
- the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

Within Falls Prevention we are making use of an evidence based programme, provided by ‘One You’ Lincolnshire, to improve balance, maintain independence and increase strength for those who have fallen or at risk of a fall and subsequent ambulance call outs etc,. This

pilot programme over the course of 15 months is aiming to work with 400 people with a 24 week programme with people over 65, in cohorts of 12-14 people.

People will be assessed by a health care professional and the offer is for an hour per week of face to face strengths training but also includes a social aspect. This social aspect not only gives people the opportunity to socialise but the trained instructor will provide elements of health promotion, for example digital literacy or healthy eating. People will also be supported to undertake an hour of activity in their own time as well, utilising printed materials where tasks are demonstrated, videos and digital resources.

The programme has had a soft launch recently ahead of a full launch in July when additional instructors are trained. The programme will be independently evaluated by the University of Bristol and this evaluation will include how this programme is rolled out within a rural area and the barriers faced but also are people keeping active after they have attended the programme.

A secondary evaluation is also planned alongside Population Health Management analysis. This evaluation will flag people who have been through the falls programme and measure this cohort of people against those who haven't; monitoring for falls admissions at the acutet for example.

Primary Care colleagues are providing support, for example the South Rural PCN have an OT working with the service. Across the PCN footprint analysis has been completd to map out across the 400 people/30 programmes where the programmes need to be targeted for example, on the Lincolnshire Coast we know people are at greater risk of a fall.

National Condition 3

Use this section to describe how your area will meet BCF objective 2: **Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge, including:

- ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.

- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.

- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

Active Recovery Beds - Active Recovery Beds describe a pathway for a facility where people are ready to be discharged from hospital but are not ready to return to their former home or level of independence. They may require time, support, care and potentially therapies to enable them to be re-abled to return home. Active Recovery Beds will focus on the rehabilitation and enablement of eligible patients for the duration of their stay with the aim of minimising their reliance on longer term funded care in their home environment on discharge.

The Active Recovery Bed service aligns with the desired 'home first' approach to care for residents of Lincolnshire, supporting a person's transfer to the most appropriate setting and including an element of reablement that cannot be provided in a person's own home for a short period of time. The level of reablement service provided to each person during their Active Recovery Bed stay will be based on a detailed individual care plan with input from a Multi-Disciplinary Team including the care provider, social work practitioner and health professionals.

The core principle of the service is to maximise independence and enable the person to resume living at home safely in a time-efficient manner and where possible with a reduced package of care to what would have been required upon hospital discharge. The Active Recovery Bed service is not intended for all hospital discharges. The focus of the service is to support those with complex needs requiring an integrated response, and who can improve to enable them to live at home independently with a reduced package of statutory care.

The service will also be accessible to those in the community where a short period of stay in a bed-based reablement setting would prevent an unnecessary acute hospital admission.

National Condition 3 (cont)

This means the service will also be available for use by community services such as the Falls Response Service and East Midlands Ambulance Service. During the winter of 22/23 Active Recover Beds were procured as part of discharge monies and throughout that time 85% of referrals were accepted. Of those individuals discharged from the service, 18.3% were discharged home with no on-going care and 33% were discharged home with LCC home care or HBRS and within that 33%, 60% went home with reduced needs.

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
- planned changes to your BCF plan as a result of this work.
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?

- how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

The rational for the estimated demand is based on the number of referrals from step down pathway.

In average 940 people in Lincolnshire are receiving intermediate services per month of whom 51% are successfully moving back home with no or some home care support. The majority of Intermediate Care services are bed based and the utilization of these beds are between 75% to 80%.

In Lincolnshire, there are two community based intermediate care teams: Home First and D2A services. In order to improve the outcome for people needing Intermediate Care, a new initiative was set up in December 2022: Active Recovery Beds. This scheme provides a therapy led bridging service between hospital and home, currently 80% of people who received this service are discharged back home with no or less support.

There is a need for shifting the focus from bed based intermediate care service to community based to support both step up and step down pathways. The demand for Intermediate Care services is growing therefore a review was commissioned to ensure readiness for the future.

The outcome of this review has been summarized in the presentation. Attached.

National Condition 3 (cont)

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- Discharge to usual place of residence

It became apparent during October and November 2022 that a number of Older Adults were spending several hours in the Emergency Department (ED) which on occasions led to hospital admission. Lincolnshire Reablement Service, alongside Adult Social Care, Lincolnshire Community Health Service In-reach Team and ULHT therapists working together co-produced and supported the Reablement Team in identifying patients that could return home, once signed off from ED, with up to 48 hours support in their own home.

During this time independence would be promoted and the right equipment would be put in place. In the past 6 months, 156 patients have received this service, with 32 progressing to no service at all leading up to 48 hours and 44 continued with the reablement services for a few more days, then needing no further input. The remaining patients either declined the service once home or needed ongoing support but with reduced packages of care. The success of this service has led to further discussions with the reablement service with a view to further expansion.

National Condition 3 (cont)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

Following on from successful collaboration between partners during the Covid Pandemic and exploration of transfer of care hubs already in place in some parts of the country, Transfer of Care Hubs opened at Lincoln County Hospital and Pilgrim Hospital Boston on 28th June 2022. The hubs consist of staff from Adult Social Care (ASC), United Lincolnshire NHS Hospital Trust (ULHT), Lincolnshire Reablement Service (LRS) which is commissioned by Lincolnshire County Council and Lincolnshire Community Health Service (LCHS). Other partners such as Age UK, Lincolnshire Partnership Foundation Trust, Housing Team and Neighbourhood Teams join the hubs virtually.

Staff triage all referrals who are medically optimised and identify their discharge Pathway - 0 to 3. If one area is busier than another, then a trusted assessor model can be implemented for example, if the representative of LCHS requires more information, if necessary, the ASC rep can support by visiting the patient on their behalf.

Whilst cases have been triaged, utilizing a strengths-based approach, some patients have been identified as not requiring services or the request has been amended to ensure the appropriate services are put in place. For those receiving support from ASC, enough information is gathered to ensure a package of care is available on discharge from hospital but a review is undertaken in the customers own home to ensure the right services are in place, at the right time, in the right place, hence ‘Discharge to Assess’.

To progress the hub to the next stage of the model for Lincolnshire, an external organization, IMPOWER facilitated an away day to identify the next steps and workstreams required to move the hubs forward. The long-term goal of the Hub is that all discharges from acute and community hospitals within Lincolnshire and Lincolnshire residents in out of county hospitals will be triaged via the hub teams and transport will also be co-ordinated from the hubs. Next steps also include recruiting staff into integrated leadership roles within the transfer of care hub to provide oversight and quicker escalation of complex cases thus reducing any delayed discharges.

National Condition 3 (cont)

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

Lincolnshire has a strong track record of partnership working under section 75 arrangements. Working with partners across the spectrum of care enables the focus to be on the individual's journey, shaping the market to meet their needs and maximising the resources available.

The funding is being used to support initiatives that promote community-based care, enable people to live as independently as possible and invest in prevention and early intervention. Should they need to go into hospital, the funding is being used to support a prompt discharge with the appropriate package of care in place. Funding is being used to improve the information and advice provided to people in receipt of care with a focus on ease and timeliness of access.

Some of the initiatives, aligned to the duties under the Care Act, which best highlight how Lincolnshire is using BCF funding are detailed below.

- Learning Disability Services

The Community Learning Disability Team in Lincolnshire provides integrated health and social care provision. The BCF is the vehicle used to pool the funding for packages of care and provide one flow of funding into providers for both health and social care packages.

- Shaping the market (homecare and reablement)

Under the Care Act a local authority must promote the efficient and effective operation of a market in services for meeting care and support needs. Lincolnshire has utilised BCF funding to increase the rate paid for both non-residential and residential care to reflect providers cost of care, informed by the completion of a market assessment.

- Initial conversation

Strengths Based and Behavioural Approaches are being applied in over 55 teams across Adult Care, the Wellbeing Service, the Acute Trust, LPFT, Occupational Therapy Services, and will be a core part of our developing Intermediate Care Layer and Trusted Reviewer model. Our Initial Conversation Model has resulted in people having the right conversation at the right time, being supported earlier in their journey, provided information and advice and this has freed up practitioners to provide support where it is needed most.

Workshops have been delivered to over 500 practitioners across 55 teams including our system partners. Using these approaches Practitioners report a positive impact in over 90% of cases.

- Co-production

Our co-production programme delivered with the 'Everyone Co-production Network' is in progress, embedding co-production at all levels of Adult Care. We are also developing the Lincolnshire ICS co-production Strategy as a co-sponsor alongside the CEO of the ICB, working with system leads to understand what it would take for Lincolnshire to become a national leader/exemplar in co-producing health and care. This includes using current good

practice and evidence to identify what the system needs to do to embed co-production. Across the ICS over 400 people with lived experience and 70 clinicians / practitioners have been involved in co-production.

- Transfer of Care Hub and Discharge to Assess.

Following on from successful collaboration between partners during the Covid-19 pandemic and exploration of transfer of care hubs already in place in some parts of the country, Transfer of Care Hubs opened at Lincoln County Hospital and Pilgrim Hospital Boston on 28th June 2022. The hubs consist of staff from Adult Social Care (ASC), United Lincolnshire NHS Hospital Trust (ULHT), Lincolnshire Reablement Service (LRS) which is commissioned by Lincolnshire County Council and Lincolnshire Community Health Service (LCHS). Other partners such as Age UK, Lincolnshire Partnership Foundation Trust, Housing Team and Neighbourhood Teams join the hubs virtually.

- Active Recovery Beds

In December 2022 60 Active Recovery Beds were commissioned to meet an identified need for people being discharged from hospital. This service affords customers time, post discharge to recover and commence reablement to support them back to a level of independence, thus reducing the need for large packages of care and promoting self-support and independence.

- Hospital Discharge Reablement Service:

This Service involves customers being identified in the Emergency Department (ED) who, with additional support, could be discharged home from the ED with the reablement service. The service involves the reablement team taking customers home and supporting them for up to 48 hours, ensuring the right equipment is in place and actively encouraging customers to become independent.

As of 10th May 2023, 156 customers have received this service since it started 5 months ago, with 32 progressing to no service at all after 48 hours and 44 continued with the reablement services for a few more days.

- Pathway 1 Discharge to Assess

All customers that require support to remain living at home are initially reviewed in the transfer of care hub for a hybrid service provided by Lincolnshire Reablement Service and Lincolnshire Community Health Service. This joint service provides a mixture of both rehabilitation and reablement, with the goal of achieving identified outcomes and independence.

Supporting unpaid carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

There are a range of BCF schemes in Lincolnshire which support unpaid carers. Some are directly providing short breaks and identified within the plan, however all services are working to identify unpaid carers and provide appropriate support.

- BCF funded primarily the Health Team (including Hospital in Reach at Boston, Lincoln and Grantham)
- In addition, support was provided to increase the management team by one, to support the monitoring, evaluation and approval of personal budgets under £1000
- An additional Benefits Advisor was employed in order to manage demand and reduce waiting times

Health Community Support Advisors (CSAs)

From January 2018 to the 31st of March 2022 , the Carer's First Health team in Lincolnshire supported over 3,227 carers. These carers have been identified from the following health settings/organisations:

- United Lincolnshire Hospital Trust (ULHT Acute & Community Hospitals)
- General Practice/Primary Care Networks
- Neighbourhood Teams
- Voluntary Health Services
- Lincolnshire Community Health Services
- Palliative and End of Life Services
- Mental Health Services

Carers First Health CSA's are co-located within a range of Health settings in order to engage directly with informal carers.

During the pandemic lockdowns the team worked flexibly to support Hospital Discharge and remote and community based Carer Wellbeing Support to 940 Carers.

Benefits Advisors

Carers First has a well-developed Benefits Advice Service delivered by a team of three trained and experienced Welfare Benefits Advisers. They provide group/1-2-1 benefits workshops, benefits checks, form completions, appeals and income maximisation including applications for additional grants alongside website info/tools e.g. the Turn2us benefits calculator is embedded on Carers First website.

This dedicated team has helped Lincolnshire Carers gain an additional £5.8m in benefits since December 2017. Additionally, membership of Carers Trust has enabled Carers First to secure £66,942 for Lincolnshire Carers over the last three years to pay for items such as washing machines, cookers, beds, food, carers breaks and transport costs and Carers First is a District Council selected referrer to the Household Support Fund.

Carers Personal Budgets (Additional Manager supported by BCF)

Carers First is a strategic partner and highly experienced at assessing needs and has processed, monitored and evaluated £2.6m in Carers Personal Budgets to date in a timely manner.

A new Carers contract is in place from 2023 and BCF funding provides top-up support to this contract to achieve early identification of carers working alongside health and care partners. NHS providers will be supported to fulfil the NHS Long Term Commitment ro Carers within the ICS by supporting across the system to develop strategic and operational relationships, offering advice, guidance and securing system led support for Carers, this includes:

1. Primary Care: support and advice to develop and maintain systems and processes to identify and support adult Carers, such as: GP Carer registration; Carer Registers in Primary Care; preventative health promotion initiatives including vaccination campaign and health checks; pop up or drop-in Carer surgeries/ clinics

2. Secondary Care: support and advice to develop and maintain systems, processes and practice to identify adult Carers including provision of service information, Carer identification at admission, in-patient and out-patient settings and other support for Carers.

3. Health and Care Higher Education: influencing and supporting curriculum content to help influence and educate future professionals ahead of qualification (nursing, medicine, social work, therapies etc.), including Lincoln School of Health and Social Care and Lincoln Medical School. This also includes potential support for student placements or internships or contributing to research and student projects.

Collaboration with colleagues will also support initiatives to improve the identification and support of Young Carers and Young Adult Carers. Health partners will have their offer complemented with information and access to relevant resources, case studies and good practice, co-producing training and helping to implement good practice across the system.

Between 1 April 2022 and 31 March 2023, support was provided to 9582 carers including 2936 new carers. This support can include providing a direct payment or providing information and advice. In addition, 456 carers were supported with respite care or direct support for the cared-for-person. This highlights Lincolnshires penetration rates into the wider carer community which suggests Lincolnshire has a higher level than a number of other Councils eg. Derbyshire/Essex.

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

In partnership with the Good Home Alliance we are looking to implement a trusted assessment role to support a range of identified cohorts. The trusted assessment role would look to identify any issues with an individuals current home so they can be supported to live independently, safe, warm and well. Cohorts of people would include those with long term disabilities where homes require adaptions, mental health as well as supporting Core20plus cohorts such as travellor communities.

The aim of this partnership would be more than a signposting service, with trusted assessors keeping a casework style role for as long as necessary until an individual no longer requires support. For some individuals it will mean a more permanent support role but still with the aim of supporting a person to live independently by helping them to develop skills to do so.

Whilst there is a number of services available to support people with their independence at home, we recognise that navigating and identifying these services can be difficult. We therefore aim to set-up self-help within the Good Home Alliance via Connect2Support. This would include a healthy home assessment that people could complete for themselves, or via family members and friends, to help identify issues within the home or that there is a requirement for support from someone within the system e.g. district nurse or fire officer. A person could also be supported by these individuals to undertake the assessment or additionally a trusted assessor can support.

DFG delivery guidance for local authorities provides examples of good practice for local strategic collaboration. Lincolnshire's Health and Wellbeing Board created the Housing Health and Care Delivery Group (HHCDG) for this purpose. This forum brings together adult care, public health, district council housing leads and the NHS and considers DFG and discretionary housing assistance in the wider context of enabling people to live independently in a home of their own for as long as possible. HHCDG is supported in overseeing the DFG by the Lincolnshire Housing and Health Network and the Lincolnshire Healthy and Accessible Homes Group.

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

District councils have each adopted a policy for discretionary financial assistance under the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002. For the most part this is used to top-up the DFG and/or help applicants meet an assessed contribution. Discretionary assistance accounted for around thirteen per cent of total spend in 2022/23. However, increasing demand and costs for disabled adaptations has left none for discretionary assistance in one district's case. Some district councils offer grants or loans for other forms of discretionary housing assistance, e.g., warm homes grants. But there is currently disparity between districts and the Housing Health and Care Delivery Group (HHCDG) is seeking to achieve greater consistency. There is a common housing assistance policy in development with all district councils due to adopt it in 2023/24. This will still allow individual district councils flexibility to award assistance for other purposes and to avoid fettering discretion.

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- Changes from previous BCF plan
- How equality impacts of the local BCF plan have been considered
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Changes to local priorities related to health inequality and equality and how activities in the document will address these
- Any actions moving forward that can contribute to reducing these differences in outcomes
- How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

We have an obligation to take action to eliminate discrimination, advance equality of opportunity and foster good relations under the Equality Act 2010, public sector equality duty (2011) and reduce inequalities for the population it serves as part of the requirements of the Health and Social Care Act 2012.

Within the Health Inequalities Framework for Action we are continuining to see a year-on-year improvement in addressing health inequalities by narrowing the gap in healthcare outcomes within Lincolnshire.

We will achieve this through action to address:

• Wider determinants: Actions to improve ‘the causes of the causes’ such as increasing access to good work, improving skills, housing and the provision and quality of green space and other public spaces and best start initiatives.

• Prevention: Actions to reduce the causes, such as improving healthy lifestyles – for example stopping smoking, a healthy diet and reducing harmful alcohol use and increasing physical activity. This is supported by the re-commissioning of ‘One You Lincolnshire’ and the Child and Family Weight Programme which is into year two and is still performing well. The programme is getting good engagement and uptake and analysis can point to it being a positive preventative programme.

• Access to effective Treatment, Care and Support: Actions to improve the provision of and access to healthcare and the types of interventions planned for all

For 2023 we are introducing the concept of a health inequalities hub via the LA and ICB with the LA Public Health Team leading the way with developing some of this work the Hub. The early work of the Hub will look at demand management, particularly within CORE20PLUS groups who typically may not access preventative services and are not empowered to engage until they are attending at UEC. Looking at reducing demand across the system, from childrens to older age and understanding their barriers to access, the Hub will look to focus on service delivery and five things that can be done now to lower those barriers.

Population health management data, service level data, service user feedback and engagement and clinical perspectives will provide a wider evidence base to support the five things we can do now. The aim is to the support health equity assessments and use the evidence base to inform them to drive some deliverable, tangible system change.

This approach is joint across the system, looking to understand all data to help reduce the demand on UEC and inform system delivery.