

Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund planning template. Both parts must be completed as part of your Better Care Fund Submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	North East Lincolnshire Council
Clinical Commissioning Groups	North East Lincolnshire CCG
Boundary Differences	None identified
Date agreed at Health and Well-Being Board:	15th September 2014
Date submitted:	28th November 2014
Minimum required value of BCF pooled budget: 2014/15	nil
2015/16	£11.246m
Total agreed value of pooled budget: 2014/15	£0.650m
2015/16	£12.828m

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	North East Lincolnshire CCG
By	Dr Peter Melton
Position	Accountable Officer
Date	28/11/14

Signed on behalf of the Council	North East Lincolnshire Council
By	Rob Walsh
Position	Chief Executive
Date	28/11/14

Signed on behalf of the Health and Wellbeing Board	North East Lincolnshire
By Chair of Health and Wellbeing Board	Cllr Peter Wheatley
Date	28/11/14

2) VISION FOR HEALTH AND CARE SERVICES

a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20

In North East Lincolnshire we are adopting a system wide approach to deliver integrated and sustainable services that deliver better quality outcomes for our local population within the available health and social care budgets. We have based our plans on the joint strategic needs assessment which highlights a growing elderly and increasingly frail population. The JSNA reflects analysis from our Public Health analysts on local demographics and need according to specific population groups. The proportion of older adults in North East Lincolnshire is set to increase in the next five years, placing additional demands on services. North East Lincolnshire also contains specific pockets of deprivation which have remained static over the last few years but continue to present challenges for service design and provision. In particular we are facing challenges related to health inequalities and variations in life expectancy for men and women and between different wards in our locality.

To ensure that the local health and social care system is sustainable we have to find ways of ensuring that people's needs are identified early and that we ensure that wider population is supported to keep well. We have enabled this by ensuring that all citizens eligible for social care can access the advice, information and help they need and by directing clients to preventative services wherever possible. We are working to strengthen the public health offer, by ensuring that this is focused on preventative wellbeing, rather than the current service offer which has largely focused on treatment.

To support our transformative journey we have aligned the adult social care approach to

the wider vision for health and wellbeing locally, promoting solutions that focus on prevention, putting the community at the centre of service re-design, and supporting people to take greater responsibility for their own health and wellbeing.

Significant engagement and consultation with the public has taken place across Northern Lincolnshire as part of the Healthy Lives, Healthy Futures transformation programme involving a range of engagement and feedback mechanisms, all of which are published on the Healthy Lives, Healthy Futures website.

Comprehensive details of the engagement and consultation on our vision can be found at <http://www.healthyliveshealthyfutures.nhs.uk/>

We have been on this transformative journey since the creation of the Care Trust Plus in 2007. The Better Care fund will allow us to protect and invest further in a second phase of integration. It will help us to develop our integration approach more quickly and to greater depth, shifting the emphasis and activity away from hospital settings by investing further in a tier of intermediate and community care pathways.

Our vision is to deliver the right care, in the right place delivered by the right people, as close to home as possible, releasing the capacity and innovation which exists within our community to promote healthy living, self-care and prevention.

Our comprehensive whole system model

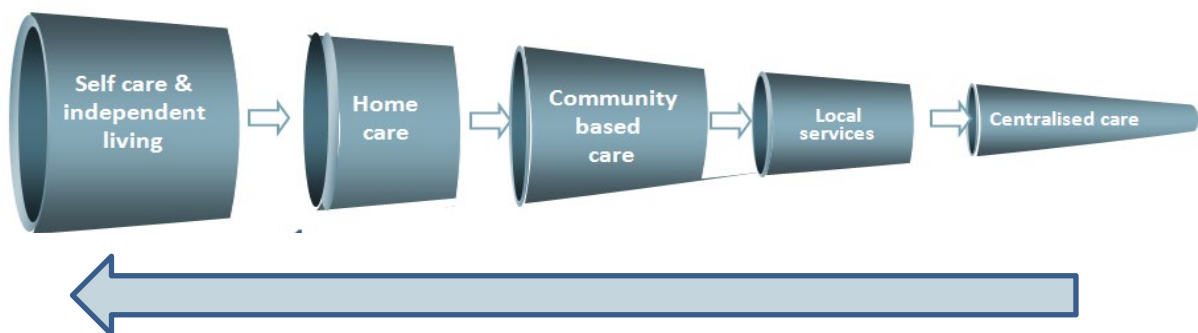


Figure 1. HLHF funnel of transformation

We want people to live independent, healthy lives, supporting one another and taking control of their own health. When they do need care however, they should have access to it by;

- Provision of services in the community, closer to the person, with reduced demand for hospital-based acute care;
- Provision of specialist and tertiary acute care, of sufficient scale to ensure safe, quality services.
- Access to Services 24/7 through the implementation of seven day working at a 24/7 single point of access.

Intrinsic to our vision therefore is the fact that people should be enabled to get back to

managing their own health as quickly as possible and the Better Care fund will enable us to boost re-enablement opportunities, invest further in intermediate tier services and develop our outcome evaluation capability.

This means that services which support people with their long term recovery to health are just as important as those which manage urgent health issues. This is critically important to the realisation of our vision as it embeds a whole system approach where every component, service, pathway and support element is of equal value.

Critical to this vision, and part of our BCF plan will be the ability of individuals to access professional support and advice through our integrated single point of access. We have started work on this, but the BCF will enable us to progress this at a faster pace and enable us to learn lessons essential to our on-going improvement.

Additionally, to enable people to access the support they need when they need it, BCF will enable us to deliver extended services throughout the week through our 7 day working initiative. This will support the shift from traditional patterns of care within the hospital setting towards a community based model.

Our work on developing the community based equipment service will enable more people to access equipment and technology which supports them to live safely at home and to seek re-assurance and help when and where needed.

b) What difference will this make to patient and service user outcomes?

The approach outlined in this vision will enable patients and services users to take a more active role in their own health and care management. The initiatives will also ensure that people are linked to the right services, as close to home as possible at the right time, reducing the risk of problems escalating and leading to unplanned hospital admissions.

Evidence shows that when people are given autonomy over their own condition, outcomes improve, for example COPD patients who are enabled to recognise triggers and deterioration in their condition and are equipped with relevant information and coping mechanisms, acute admissions drop and patient confidence increases.

Patient and service user outcomes will be specific to each scheme and are articulated in the project initiation documents appended at section 1 c) and e-mailed separately.

In terms of the Patient Experience metric we have chosen to apply, (87.9) – the trajectory is flat due to performance already being within the 20th best of 152 LAs. Therefore the plan is to maintain this high level of performance for an area the HWB believe to be a high priority and likely to be a significant challenge in itself.'

One example of the difference these interventions will make is described below:

“Just Checking” Programme

As an integrated health and social care commissioning organisation, the CCG has been working extremely closely with its commissioning domiciliary care agencies to find new ways of working flexibly to support people better in their own homes, minimise the risk of hospital admission / entry to long term care. Traditionally as domiciliary care is a defined

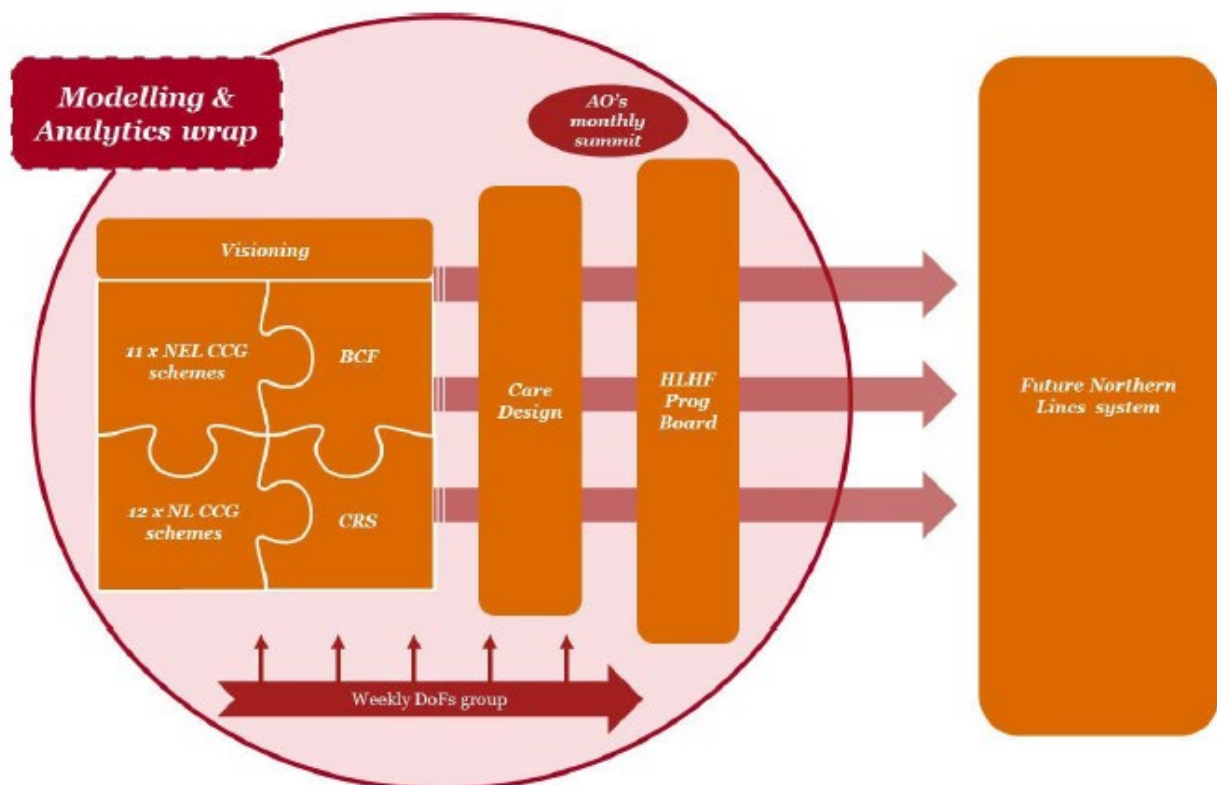
adult social care responsibility that is chargeable under Fairer Charging regulations, commissioned packages of care have been inflexible and traditionally, time and task orientated, summed up by the infamous 15 minute rigid calls model that has drawn such criticism from carer groups. Whilst in NEL we do still commission some 15 minute calls where circumstances allow (such as medication prompts) we have used pooled health and social care funding to create a recurrent fund that allows domiciliary care agencies to react to presenting situations without having to go through a bureaucratic process of seeking agreement from a care manager to re-commission a package of care. Agencies now have the ability to stay, resolve and stabilise the situation drawing on the “just checking” budget. This extra input is non-chargeable to the service user and is delivering results in terms of reduced care home placement and respite episodes.

As the pilot proceeds, we intend to analyse the effect on A&E admission, GP out of hours and ambulance calls outs and should there be robust evidence of clear return on investment, the BCF board would look to channel additional resources into Just checking to expand the reach and flexibility further.

Through the integration and redeployment of health and social care resource into different service offerings, the emphasis on intervention will shift towards prevention and maintenance of wellbeing, resulting in reduction in exacerbation of debilitating conditions therefore service users will require less intervention and will remain well for longer within their homes and communities.

c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?

In partnership with our Northern Lincolnshire provider and commissioner partners as part of the HLHF programme, we are developing a description of future service delivery that provides a framework to sit between the current high level funnel ‘vision’ and the individual initiatives and service models. This work draws together the modelling for Commissioner Requested Services, BCF and individual projects describe in detail how services will look and where they will be located in 3-5 years’ time that is owned by the clinical and professional community. This will include a description of hospital and community facilities, and will be supported by activity, quality and financial modelling to show the reduction in bed usage and hospital attendances/admissions.



Integrated responses and support solutions

Services and pathways will be further integrated across providers, with all patients receiving an appropriate response to their needs regardless of the time of day.

- The development of our integrated Single Point of Access (SPA) will encourage multi-professional working while respecting professional difference and the unique contributions that different skill sets and approaches make to delivering positive outcomes.
- Attached to the SPA will be an integrated triage and response function that will co-locate rapid response nursing, mental health, social work and domiciliary care.
- The creation and development of the integrated SPA will enable the integration of long term case management to ensure that the most vulnerable and frequent users of health and social care system are easily identifiable through integrated case record systems. Named lead professionals will be responsible for their care, maintenance of independence and wellbeing using an asset-based approach.

Higher quality

The approach will improve overall quality and outcomes across all care services by ensuring that individuals are signposted to, and receive the right service. This has been reflected in the performance matrices attached.

Delivering sustainability through upstream prevention and substitution

We know that overall funding for health and social care services will not increase so the approach will have to deliver sustainable services that optimise all of the available

resources within the borough. We are doing this through:

- The creation of a preventative services market development board and a releasing community capacity board. This is enabling the identification of gaps in community resilience. We are actively stimulating the development of wellbeing and prevention services, for example befriending, through start-up funding and infrastructure support. This new tier of provision will offer a real alternative to statutory and traditional, formal social care services.
- Reviewing the way we commission the voluntary and community sector (VCS) with the intention of providing a clear and well-resourced infrastructure support service that will support all VCS organisations whether they be small luncheon clubs to larger social enterprises. This work has now been completed and the findings of the review are being developed into a clear set of actions to support the sector in meeting our local needs.
- Refocusing and accelerating our efforts to deliver 300 units of extra care housing across North East Lincolnshire. This forms a key part of the residential sector's market management and reduction, and, as well as providing a as a real alternative to residential care will also reduce the number of unnecessary A&E attendances leading to unnecessary admission.
- The creation of new, and expansion of existing community collaborative initiatives such as the falls collaborative and the COPD collaborative. These community-led models involve patients and service users in the management and co-ordination of their on-going care, retain patients and interested individuals as subject "experts" in particular conditions, and work to develop preventative messages and approaches that are cascaded through networks in the community. This model has proved to be effective in increasing community awareness of early signs and symptoms of disease and developing individuals' responsibility for their health, reducing unnecessary admissions to hospital.

3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

In 2007, the former NEL Primary Care Trust and NELC collaborated to form a Care Trust Plus partnership under S75 of the NHS Act, with the intention of securing better integration between adult social care and health services. At the same time it was recognised that further benefits could be derived by linking children's health provision to pre-existing council services for children. We also recognised that benefits could be gained from the integration of certain health improvement functions within the council, to ensure that there was a focus on the wider determinants of health. Due to the continued success of these arrangements, at the time of the recent NHS reform, the council and now CCG sought to maintain this work through the establishment of a successor section 75 agreement between the council and the CCG. In addition the council entered into a co-commissioning arrangement with the NHSE for the continuance of the children's

health commissioning arrangements. We have sought to align the CCG and council priorities by focusing on prevention, early intervention and the need to support people to take responsibility for their own health. Both organisations have collaborated in the development of the health and wellbeing strategy, which is helping to drive the prevention agenda locally.

The council and CCG have benefitted from the establishment of a mature and positive relationship which has enabled the delivery of integrated services and there are already robust governance arrangements in place which will enable a sound foundation for future working under the Better Care Fund plan.

This joint working has established a successful track record of delivering integrated solutions for health and social care and has demonstrated innovative quality outcomes for the end users.

A changing environment – the case for change.

The next three years will be highly challenging as the impact of three factors combine to place ever increasing pressure on adult social care resources.

The number of older people in North East Lincolnshire has been increasing and has already been a factor in strategic commissioning plans. It is anticipated that during the period of this strategy there will be a 5.9% increase in the number of people expected to be frail over the age of 65. This increase will potentially place increased demand on adult social care unless enhanced approaches to managing demand are adopted.

Central government financial support to local authorities is being cut. Over the period 2014/15 – 2017/18 NEL council will need to make real savings in adult social care of c£9m on a budget of c£49.5m an 18% reduction.

The Care Act 2014 places additional responsibilities and legal requirements on adult social care, which come into force in April 2015 and 2016. These national requirements will bring increased workloads and increased costs at a time when financial support from central government is being reduced.

Levels of need and eligibility

Underlying demographics

Since the production of the current joint Adult Social Care Strategy, analysis from the 2011 census has become available. This has been used to underpin the projections of need reflected in this section. The information from the analysis indicates a marginal increase in the expected number of people over the age of 65 in North East Lincolnshire when compared with previous estimates, for example in 2015 there are now expected to be 31,500 people over the age of 65 compared to 31,100 based on the 2001 census. The increase in 2015 is, however, accounted for entirely from the 65-74 age group with no increase in the over 75's. Indeed, from 2016 to 2019 it is now expected that there will be marginally fewer people over the age of 75 when compared with the 2001 census forecasts, for example 15,000 instead of 15,200 in 2016.

However, the growth from 2015 to 2018 in this older population is still in line with previous estimates. The following demographic pressures illustrate the extent of this challenge during the period of this strategy:

A 3.6% increase in the total population over the age of 65;

- A 7.1% increase in the total population over the age of 85;
- A 5.9% increase in the number of people expected to be frail over the age of 65;
- A 7.9% increase in the number of people with dementia;
- A 9.2% increase in the number of people with severe dementia.

The longer term trends underpinning these figures is given in Figures 1 and 2 where the total expected number of frail older people and the number of people with dementia are illustrated.

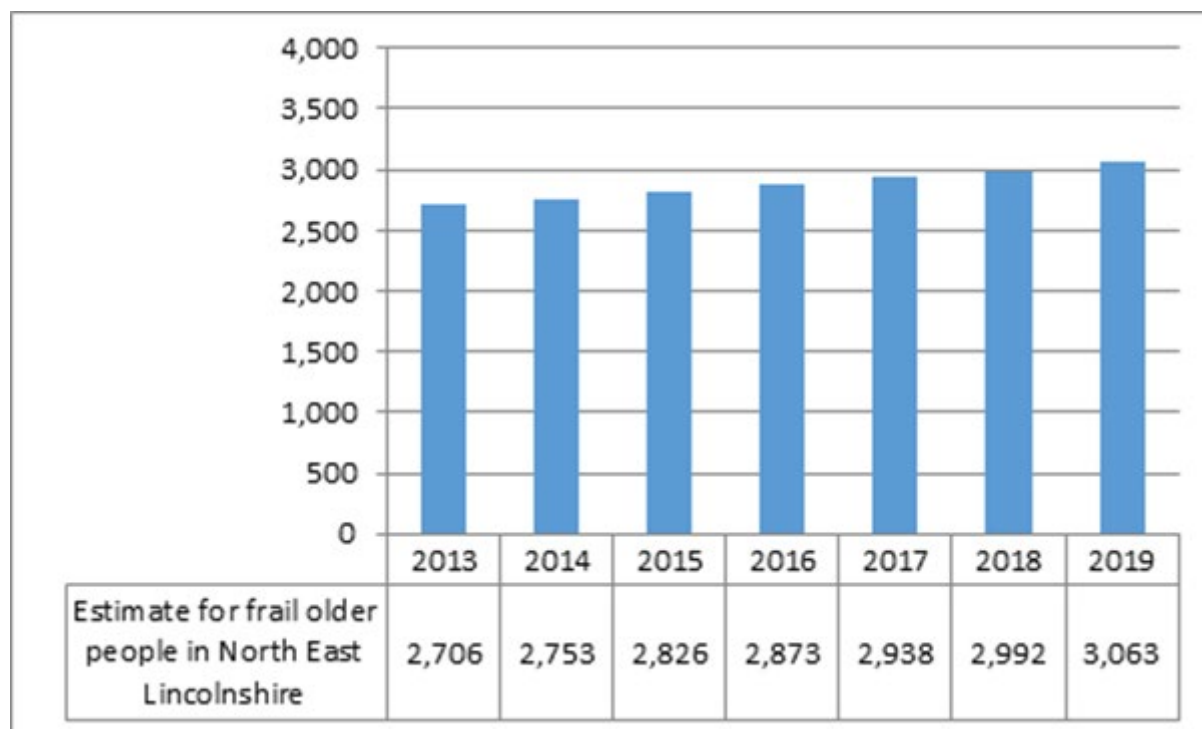


Figure 1 Expected numbers of people who are frail

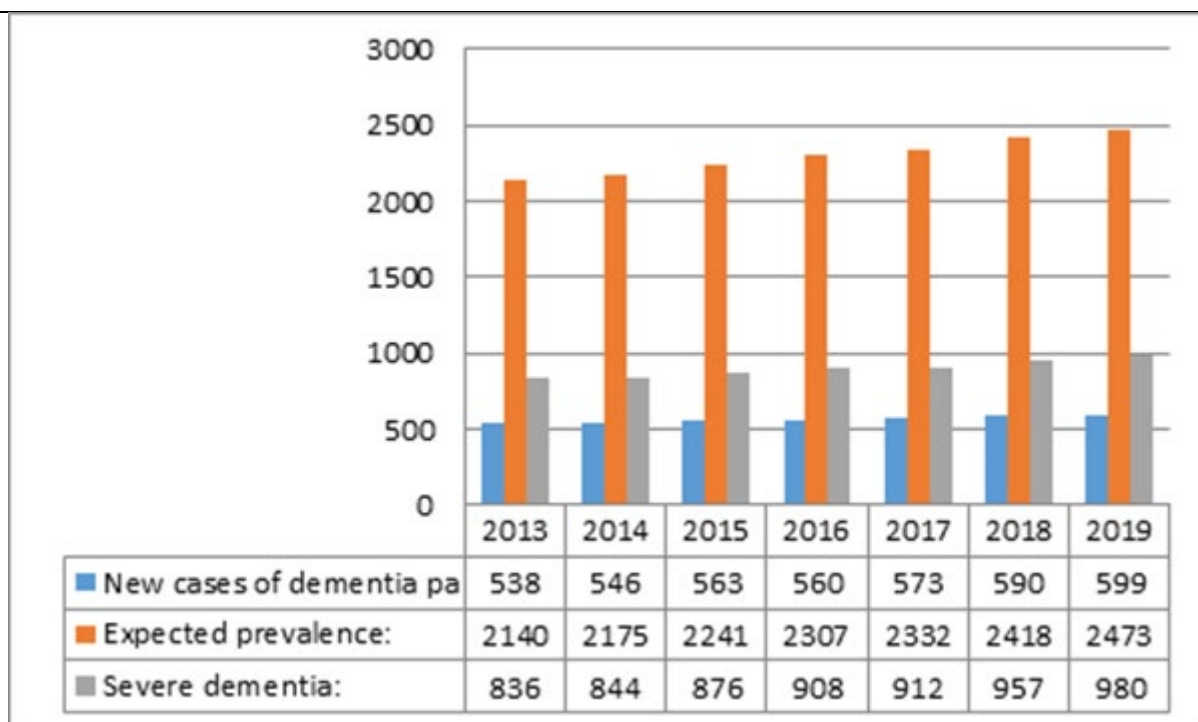


Figure 2 Expected numbers of people with dementia

How well does North East Lincolnshire currently meet this need?

At the start of any strategic review it is important to assess how well we are doing over time and in comparison with other locations. The journey that Adult Social Care commissioning has been taking is already well under way. The priorities of integration, developing the intermediate tier and the implementation of the priorities framework have been combined with a market management approach to ensure good quality services at affordable prices. These initiatives, described in detail elsewhere in this strategy, provide the backcloth for improved performance.

The latest year for which comprehensive and comparative data is available is 2013/14. During this year significant changes in both information systems and service configuration, particularly at the initial point of contact with services, have occurred. During that year^[1]:

- 2,564 separate individuals contacted our services for the first time;
- The vast majority of these were provided with advice or were signposted to appropriate support from voluntary or independent sector providers;
- 234 new clients had an assessment completed;
- 112 people started to receive a new service.

The figures above represent a significant reduction in the numbers progressing to receive a service during 2013/14. This pattern is expected to continue into the current period as the changes have been due to significant improvements in the triage of new requests and the development of alternatives, as outlined elsewhere in this strategy.

The figures above meant that on the 1st April 2014 there were:

- 1,743 people being supported with one or more services in the community;
- 932 of these were in receipt of home care, a reduction of 34% on the previous

^[1] Source: RAP 13/14 returns.

year, of whom 570 were receiving a package of more than 10 hours a week, which was a reduction of 13%.

The important contribution that carers make to supporting vulnerable people has long been recognised, which our strategy responds to. During 2013/14 437 carers received their own support from Adult Social Care services and 1,228 carers had their needs assessed alongside those of the people they cared for.

Comparative performance

How well we perform at the moment compared with other council areas can provide an important way of prioritising our efforts at further improvement. When using the Adult Social Care Outcomes Framework for 2013/14 North East Lincolnshire performs relatively well, out of 18 performance targets North East Lincolnshire achieved:

An improvement in performance in 13 measures;

10 measures in the top quartile compared to national performance, and none in the bottom quartile;

7 areas where we overachieved against our stated goal for the year.

Some examples of our successes include:

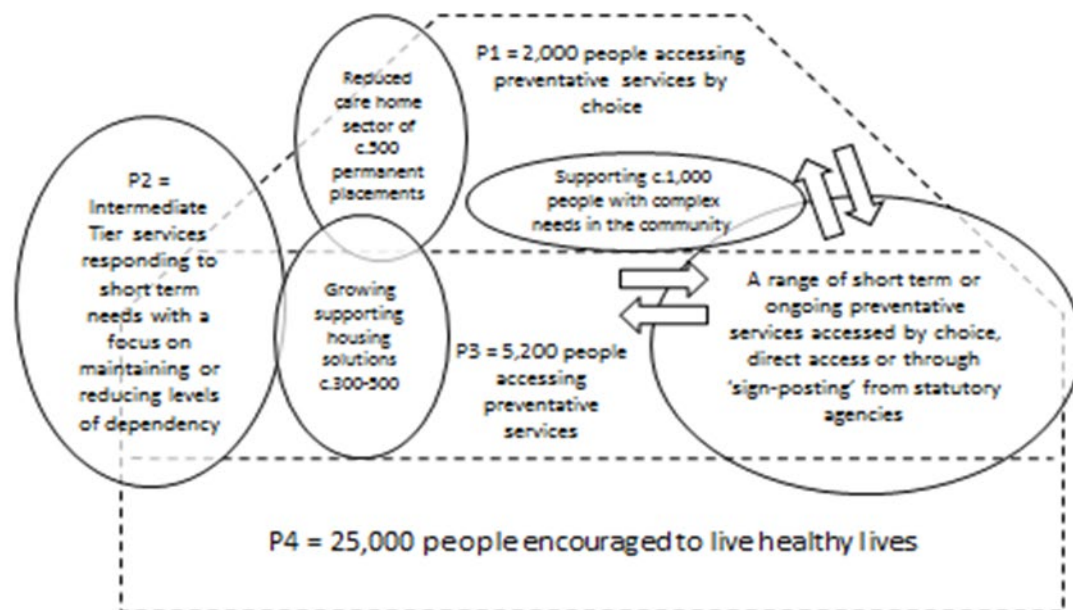
- The proportion of people using social care who receive self-directed support, where we achieve 78.8% compared to a target of 75% and were 25th out of 154 Local Authorities;
- The proportion of adults in contact with secondary mental health services who live independently at 88% compared to a target of 80%, which is the 8th best in England;
- The proportion of older people who were still at home 91 days after discharge from hospital into reablement and rehabilitation services at 94.4% compared to a target of 92.5%, which is the 10th best in England;
- The percentage of carers receiving needs assessment or review and a specific carer's service, advice or information at 50% compared to a target of 40%, being 23rd in England.
- Areas for improvement, where performance was in the lower quartile of English Authorities, and/or where performance had slipped included permanent admissions to care homes for over 65 year olds, delayed transfers of care from hospital and clients receiving a review.

Through the development of an integrated "asset based" social work practice, we are aiming to ensure earlier intervention to delay or reduce the onset of care needs and to ensure that alternatives to traditional forms of on-going long term care are available via the community and voluntary sector and by building individual resilience. In this way, resources can be preserved to meet increased demographic demand and ensure continued provision for the complex needs of a more frail elderly population within the borough.

It is helpful therefore to look at the NEL "use of resources policy" as a way of explaining the methodology that has been adopted by the Better Care programme board. This model allows us to quantify and describe the type of services needed in each "category". In brief, while some health and social care economies have decided to rigidly limit social care eligibility to those with the most critical needs (which has a direct impact on health systems and provision), NEL has taken a different approach to ensure we have a collective whole system and integrated methodology. Central to promoting a "whole

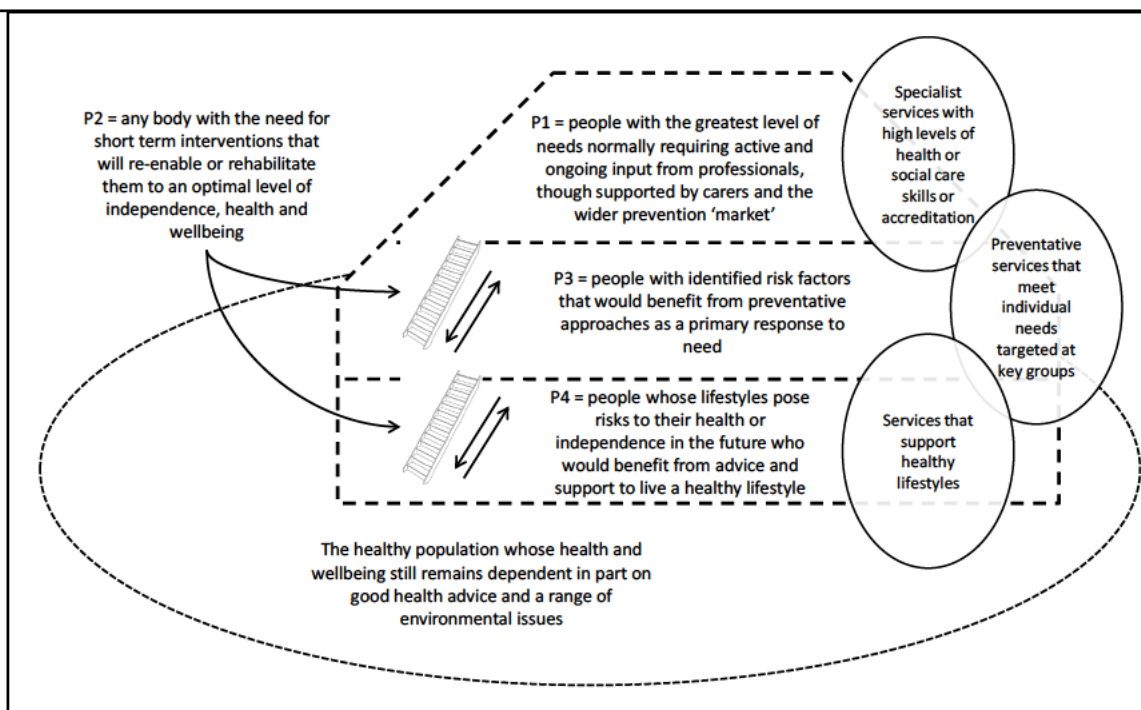
system” of integrated and affordable care, the local “use of resources” priorities framework (*April 2011*) introduced four categories of support which ensures the system as a whole is able to offer something to everybody - corresponding with need (see Table 1 later). This also allows us to deploy our professionals appropriately, concentrating our resources at the most vulnerable and complex.

The local market for care and support for older people in NE Lincolnshire (2017/18).....



The ‘priorities’ approach enables us to quantify the number of people likely to have similar needs and therefore consider the size of the market that might be needed to respond to these needs. It is important to note, however, that whilst there will be a relationship between each group of people and the market sector that responds to this need it is not necessarily the case that specific services will only meet the needs of one group of people. For example, someone with ‘P1’ needs, i.e. the most complex, might access support from a service predominantly set up to provide preventative support, which might, for example, be facilitated by a personal budget.

This is illustrated in Figure 2 where needs and service responses can be seen to have a strong relationship but are not totally equivalent. It is also important to note the ‘transitory’ nature of ‘P2’ needs. This means that intermediate tier services can and will be accessed by people whose on-going needs might be best described as P1, P3 or P4. Therefore, on an on-going basis the local population can be comprehensively described as needing either encouragement to adopt healthy lifestyles and live within a healthy environment or be in need of targeted health and wellbeing advice, specific preventative support; or support for significant and complex needs.



a) Figure 1 A generic framework for identifying needs and market responses

Table 1 describes the priorities framework as it might be applied to people from either a health or social care perspective, alongside the type of services that will make up the market for care and support. It is likely that on occasion, due in part to different statutory responsibilities and policy positions, an individual or groups of individuals might fall into different categories under the health and social care schema. Attempts to minimise this as far as possible have, however, been made.

In addition to the priorities framework, a comprehensive “Case for Change” exercise was undertaken in early 2013 to support the Healthy Lives, Healthy Futures programme and our BCF work is also supported by this analysis.

The Joint Strategic Needs Assessment also sets out the basis upon which our BCF plans have been founded and this in turn supports our Health and Wellbeing Strategy, our Adult social care strategy and the Healthy Lives, Healthy Futures programme. All of this work is inextricably linked.

Then most recent JSNA produced evidence of overall improvement in the health of our population, but little evidence of improvement in the areas where health is poorest and where social and economic challenges are greatest.

To build healthier communities, it is essential for the local authority and health organisations to work together in an integrated way to challenge and address these health inequalities.

To achieve sustainable improvements to health and wellbeing we will focus on improving the:

- Places people inhabit – by reducing poverty and impacting on wider determinants of health
- Services people access – by commissioning more “joined up” and aligned equitable

services and solutions

□ Lifestyles, people live – so we can impact more effectively on life expectancy and healthy life expectancy through greater focus on prevention and earlier detection.

4) PLAN OF ACTION

a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

Please see embedded programme plan



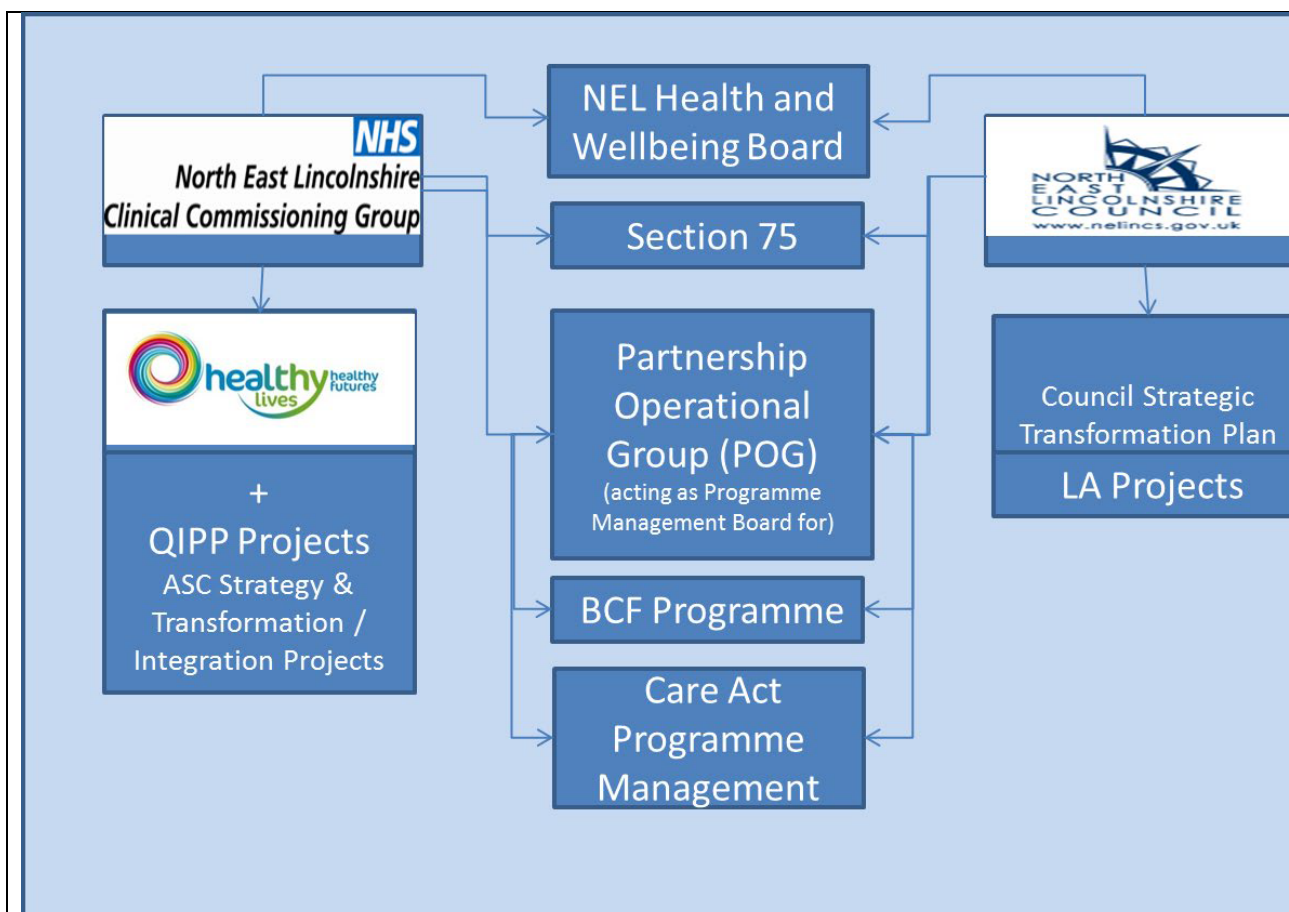
BCF programme
Plan.doc

:

b) Please articulate the overarching governance arrangements for integrated care locally

NEL CCG and NEL council are committed to ensuring specific oversight and governance arrangements are in place to monitor action and delivery against this plan. The Better Care programme board has been created as part of the existing partnership arrangements to provide oversight to the delivery of the action plan. The board will meet bi-monthly and receive a performance report, escalating pertinent issues to the Health and Wellbeing board as well as through each organisation's governance structures, i.e. NEL council cabinet and CCG Partnership board.

Figure 2 – BCF Governance Organogram



Current arrangements are in place for the management of the section 75 partnership agreement and the partnership operational group will provide further opportunity for the development and oversight of the programme of work associated with BCF.

c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track

Please see above and programme board diagram

Overall programme co-ordination/office

The programme co-ordination will be undertaken by the NEL CCG using its programme management tool Covalent to ensure that all of the actions required to deliver the BCF are undertaken in accordance with the programme plan.

Progress will be tracked routinely by the council and CCG at the partnership operational group, acting as the BCF programme board. This group will escalate issues to the health and wellbeing board where necessary and the council or CCG will ensure that the necessary corrective action is taken.

d) List of planned BCF schemes

Please list below the individual projects or changes which you are planning as part of the Better Care Fund.

Ref no.	Scheme
NEL BCF 1	<p><u>Single point of access</u></p> <p>NEL will use the better care fund to invest in the infrastructure required to set up and run the enhanced and integrated SPA, offering all citizens and professionals in NEL a single destination, telephone number and website for all community health and social care services including intermediate tier, prevention services, assessment, information and advice. This will deliver;</p> <ul style="list-style-type: none"> • <i>Improved user experience, allow easier access to ready information and advice</i> • <i>The most appropriate response through a multi-disciplinary approach</i> • <i>Reduced delays and duplication in the system</i> • <i>Promote self-care and independence</i> • <i>The ability for providers to co-operate rather than simply competing</i> • <i>Efficiencies in the wider system</i> • <i>Smarter hospital discharge through earlier and more rigorous planning</i> • <i>Better co-ordination and integrated case management of the most vulnerable and frequent users of emergency services.</i>
NEL BCF 2	<p><u>Extra care housing</u></p> <p>We will deliver 300 extra care housing units by 2018, targeted to meet projected demand, across NEL in 5 brand new schemes. Health and social care staff will help set the criteria for entry and case finding based on local modelling. We will also re-shape the learning/physical disability supported living market to deliver new bespoke independent living solutions</p>
NEL BCF 3	<p><u>Preventative services market development</u></p> <p>We will stimulate the local voluntary and community sector (VCS) to produce and provide bespoke local “substitute” support solutions to meet identified gaps which will take pressure off traditional social care services.</p>
NEL BCF 4	<p><u>Community equipment services</u></p> <p>We will commission and deliver a more accessible and integrated community equipment and wheelchair service that promotes independent living through the provision of advice, information and signposting and where necessary an assessment of need. In addition, aids to daily living may be deployed via a care plan or through self-funding.</p>
NEL BCF	<u>Nursing Support to Care Homes</u>

5	<p>Building on the success of implementing a Quality Framework earlier this year within the care homes which identifies good practice through setting out the standards of care expected and then rewarding with a Gold, Silver or Bronze award, this proposal picks up the areas of weakness in health care and education to:-</p> <ul style="list-style-type: none"> • improve support to care homes and nursing homes, to increase the skills of the staff • improve the quality of life and health and wellbeing of care home and nursing home residents • reduce and prevent admissions to hospital and attendance at A & E • expand and eventually provide to home care agencies, to support vulnerable and frail elderly people living at home and receiving a service
NEL BCF 6	<p><u>7-day working/7-day services</u></p> <p>Ensuring more timely assessments and seven day working facilitate the reduction in the number of delayed discharges from hospital.</p>
NEL BCF 7	<p><u>Just Checking</u></p> <p>Commission new flexible care at home arrangements to complement and enhance current arrangements.</p>

5) RISKS AND CONTINGENCY

a) Risk log

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers and any financial risks for both the NHS and local government.

There is a risk that:	How likely is the risk to materialise?	Potential impact	Overall risk factor	Mitigating Actions
We are unable to reduce acute admission as planned and therefore unable to release	3	5	15	A combination of the 7 new BCF projects and existing demand management projects have been designed to ensure we have the best opportunity to reduce activity and divert resources to our BCF projects. The relationship is symbiotic in that success allows further investment which in turn should lead to greater activity reductions.

£0.5m into BCF				<p>Funding will be released on a phased basis and is subject to achievement of relevant levels of reduction in avoidable admissions.</p> <p>If reductions are not achieved, monies will not be released. The CCG has earmarked a contingency outside of the BCF in this eventuality.</p> <p>The level of avoidable admissions is in line with national figures of 14% of all admissions and this cohort is the strategically important group to be targeted where specialist acute care is not required and where a safe and effective alternative in the community is to be developed further. Rapid Response service is being developed further in capacity, in further integration with social care and mental health crisis response approaches and the step-up hospital avoidance pathway is being supported with the use of community nursing beds. Extended home based services, joint provider 7 day working developments and the closer inspection and planning of high volume service users and the frail elderly (including GP input) will all further support the early identification and community support of many of those in the avoidable admissions category.</p> <p>Work also continues to expand the scope and scale of the GP in A&E service “stream” to provide an effective and appropriate service for those attending A&E who do not require accident and emergency services and this will further support A&E to deal with the remainder in a timely and effective manner.</p>
Effectiveness of re-ablement a. We are unable to offer sufficient re-ablement capacity to meet demand	3	4	12	<p>The performance of re-ablement services is closely monitored through contract performance and KPIs, including measures of occupancy levels and length of stay (bed based services), achievement of re-ablement goals and service user satisfaction. Along with data on Delayed Transfers of Care for those in hospital and assessed as appropriate for re-ablement services and national comparative data there is an on-going</p>

b. We are unable to identify those with sufficient re-ablement capacity Our current top quartile performance worsens.				commissioner/provider analysis of the demand versus capacity and adjustment made in conjunction with providers. Historically DTOC figures are higher in Q1 and Q2 then fall in Q3 and Q4 and therefore the BCF target has been set based on a detailed analysis of this historical trend
	3	3	9	
We are unable to reduce delayed transfers of care a. Current performance worsens. b. We are unable to reach the target we have set.	3	4	12	The Unplanned Care Board has established a monthly detailed analysis of Delayed Transfers of Care in order to monitor the different cause/reasons and the professional groups responsible for assessment and service readiness delays. Where capacity is identified then adjustments have been and can be made and process improvements have been identified in the liaison with hospital Operations centre and the disparate community services that enable timely discharges. Under joint working developments and winter planning considerations, providers have been incentivised to make performance improvements and the NEL SPA identified as being a focus for community coordination.
	2	3	6	
Risk to Commissioners of non-achievement of financial plan within agreed timescales	3	5	15	Increased pressure due to implications of the Care Act combined with a significant Adult Social Care funding efficiency requirement presents a significant risk to project delivery – close monitoring and review will mitigate this risk.

Scheme related risks are detailed for each piece of work in the associated project plans

b) Contingency plan and risk sharing

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place

i) between commissioners across health and social care and ii) between providers and commissioners

NEL CCG already has a relatively low rate (second lowest of its peer group) of non-elective activity and has stemmed growth to a greater extent than its peers over the last six years (1.7% compared to 9%). The CCG plans assume a 1% pressure from demographic growth in 2015/16, so taking this demographic growth into account the planned reduction in activity in 2015/16 equates to 2.9% real terms. The planned 1% reduction in 2014/15 activity equates to £561k and an amount equivalent to this has been ring-fenced within the Better Care Fund.

Risk sharing arrangements

i) The existing risk sharing arrangements already in place as part of the s75 agreement between NELC & the NEL CCG in relation to Adult Social Care will be used for Better Care Fund

ii) The risk sharing arrangements established between the CCG and the local providers (NLAG, LINCS, focus, NAViGO, Care Plus Group & Core Care Links Ltd) as part of the Healthy Lives Healthy Futures Programme will be used to support the risks associated with non-delivery of the target. This includes the establishment of a sustainability fund, alongside a transformation fund to support the changes that need to be made to make the local care system sustainable in the longer term.

6) ALIGNMENT

a) Please describe how these plans align with other initiatives related to care and support underway in your area

These plans are fully integrated in the overall programme of commissioning and delivery of services in North East Lincolnshire

As part of developing initiatives for the Better Care Fund, we have triangulated a number of existing strategies and programmes including:

- The ambitions set out as part of Healthy Lives Healthy Futures

The Healthy Lives, Healthy Futures ambitions and specific aims under each part of the funnel represent the golden thread which stitches together each of the local strategies into an overarching vision for service delivery in North East Lincolnshire

- The Health and Wellbeing Strategy
- The CCG Five year strategic plan
- The Council's local strategic priorities
- Adult Social Care Strategy
- Local Strategic Housing plans (including ExtraCare Housing)
- Local strategies for implementation of change related to the Care Act

Programme arrangements for delivery of initiatives under each of these strategies are closely linked in order to share resources, minimise duplication and avoid working at crossed purposes.

In addition to the schemes detailed in this submission, further work is on-going in relation to stimulating community based activity and supporting community members to take responsibility for their own health and wellbeing. These joint initiatives represent a selection of key pieces of work aimed at knitting together local delivery into a seamless service offering supporting the Better Care Fund

Releasing community capacity As outlined earlier, through the health and wellbeing board, the council and CCG have commissioned work to stimulate preventative services within the voluntary and community sector, with the aim of enabling older and vulnerable people to remain supported within their local communities.

Information, advice and guidance

Building on the work that has been developed through the Services4me portal, a web based product which enables services professionals and clients to access information about the availability of services in their local areas, the council and CCG have embarked upon some early discussions to explore the further potential for joining up information, advice and guidance to support clients in accessing the information they need to help manage their conditions and continue to live independently.

Community hubs initiative

The council and its partners are exploring the potential to develop a number of community based service hubs within 4 localities in NEL. The intention of the hubs will be to place services closer to the communities and to ensure better engagement and involvement of communities in designing prevention and wellbeing solutions that best meet local need.

Voluntary and community sector (VCS) support review

In addition to the initiatives promoting self-care and independent living for individuals, work is underway to review the current provision and position of local voluntary sector organisations and the contribution of their service provision to the overall strategic objectives of NELCCG and NELC

The review finished at the end of September 2014, and the recommendations are now being formulated into an action plan shared with VCS stakeholders.

One of the possible outcomes is that further income generation support will be commissioned in order to maximise income into the borough for service provision delivered through the VCS which supports the “shift to the left” as described in relation to our joint vision.

b) Please describe how your BCF plan of action aligns with existing 2 year operating and 5 year strategic plans, as well as local government planning documents

The BCF plan of action has been developed alongside the CCG 2 year operating plans and 5 year strategic plan, with a joint vision as described in the funnel diagram depicted earlier in this document.

All of the interventions described as part of the Better Care Fund action plan contribute to the strategic direction of the “shift to the left” – reducing reliance on secondary care provision, appropriately sizing intermediate and community based care and promoting self-care and independent living

Activity and performance data have been integrated to ensure a joint overview on transformational change for the next two years.

The Council plan outlines a series of ambitions to place NEL on a more sustainable footing and articulates two key themes for the area of stronger economy and stronger communities. Within this there is a strong emphasis on building community resilience and independence with a focus on preventative action.

These themes are further developed within the joint health and wellbeing strategy. There is alignment with the adult social care strategy in terms of a desire for preventative health and wellbeing approaches that promote individuals to maintain or regain their independence, thus managing the demand for formal statutory services, and in turn reducing the need for hospital based services.

c) Please describe how your BCF plans align with your plans for primary co-commissioning

- For those areas which have not applied for primary co-commissioning status, please confirm that you have discussed the plan with primary care leads.

Intended Partners

The CCG is currently in a unique position as an integrated commissioner of local health services and adult social care services.

An expression of interest has been submitted which proposes that NEL CCG, NEL council and Yorkshire & Humber NHS England area team bring together their commissioning of services from the 30 local general practices, and to co-ordinate the planning and commissioning of wider primary care services.

The strategic intention is aligned with the ambition for the area that is built upon increasing the independence of individuals and communities to support themselves, a greater proportion of service delivery within integrated community and primary care services, and reduced reliance on residential and hospital based services. Where a person does need public funded services, their return to independence is to be as rapid and complete as possible.

This is entirely congruent with the council’s strategic direction, and taken together the overall impact will be greatly increased community resilience and capability with less reliance on publically funded services, which will enable a concentration of public resource on the most vulnerable in our population who will be supported by services provided as close to home as possible.

The Council and CCG are already working closely together to enhance service user and public involvement in developing services, for instance through asset-based community development and the development of 4 ‘community hubs’; and through a review and (likely) joint commissioning of a new approach to support for voluntary, community & social enterprise organisations in the borough. This co-commissioning proposal would

enable and promote stronger linkages between this work and the development of future plans for primary care services.

This strategic direction requires general practice (and wider primary care) to be able to respond by delivering services that maximise individual's independent living through their role in prevention and health improvement, signposting self-support/education, and supporting effective management of long term conditions. Where services are required, they will need to be increasing their capacity to meet urgent access demands, supporting increasing numbers of vulnerable individuals and signposting/gatekeeping access to other services. This requires a significant shift in working patterns, pathways and integration to assure that services are accessible at consistent standards on a 24/7 basis.

The current arrangements for commissioning of general practice services has separated the planning and contracting of service into three separate organisations and processes:

- PMS/GMS commissioning by the NHSE area team
- Preventative, public health, health improvement and substance misuse services by the council
- Local additional services and practice development by the CCG

Whilst efforts have been made to co-ordinate across the three, it is clear that this fragmentation has had an adverse impact on progress towards the requirements of the strategic plan, and has been confusing and potentially destabilising for individual providers.

Also it is clear that despite many areas of improvement being achieved in recent years, there remain some unacceptable inconsistencies in quality and patient experience between primary care providers which require consistent and co-ordinated targeted improvement and support for practices from all three partners which has not been easy to achieve in all instances. There has also been a missed opportunity to use the levers available within local PMS contract arrangements for improving quality and driving service change. This has been partly due to the impact of organisation change, but looking forward it is clear that a formal mechanism such as co-commissioning is an essential vehicle for ensuring that the planning, contracting, delivery and assurance of these services is seamless and integrated across agencies.

Co-commissioning across the three partners in this proposal would also enable coherent planning and commissioning of services across:

- local health and social care providers, led by the CCG. This will enable cohesive systems of out-of-hospital care that bring together general practice, community health services, mental health services and social care – and alignment with plans for hospital services.
- the wellbeing and health inequalities agenda, led by the Council. Their involvement will also enable even stronger alignment with the wider partnership working in NEL
- wider primary care and specialist services, led by the Area Team

Taken together, this will enable cohesive systems of care and wellbeing that bring together general practice with all other elements to provide more joined-up services, better patient/client experience and improve outcomes for our population.

7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

b) Protecting social care services

- i) Please outline your agreed local definition of protecting adult social care services (not spending)

The CCG and the Council have been jointly developing plans to protect ASC services as a result of the current substantial financial restrictions and from the pressures of increasing demand. The BCF projects will further strengthen this overall approach and complement the existing strategies and cultures we have in place and that are described here.

The working definition agreed between the partners of how and why we need to implement a strategy to tackle these dual challenges (which also will feature in the refreshed Adult Social Care Strategy) is;

“Protecting the most vulnerable through integration of services and pathways, effective management of demand and investment in prevention”

How do we intend to do this?

The critical and fundamental foundation to this approach is the development of an integrated “asset based” social work culture which will be equipped with the skills to work with local people in a manner that identifies and stimulates alternatives to traditional forms of on-going long term care. We took the decision in 2013 that this would be best achieved by allowing our social workers to embed these principles into the very articles of association that founded NEL’s independent social work community interest company. Sharing the responsibility for the variable budgets that fund packages of care in NEL will ensure that focus* and the CCG are constantly sighted on trends, spend and whether the new asset based approach is delivering real efficiencies and cost avoidance.

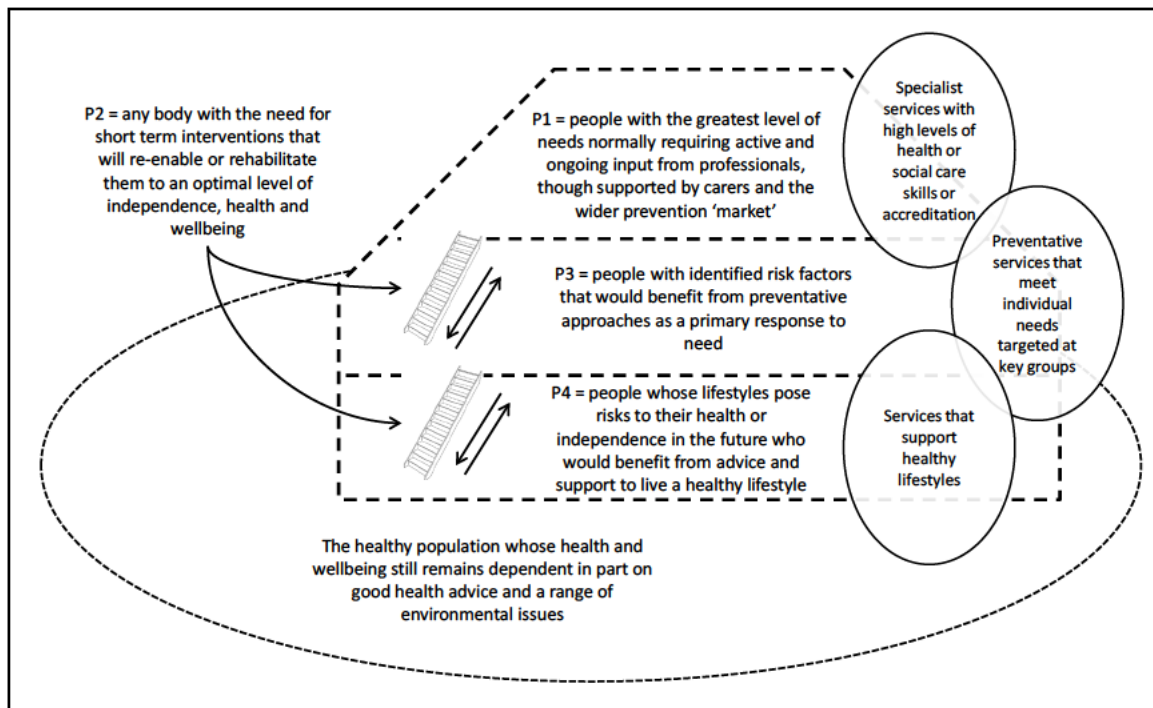
Underpinning this new approach to social work, NEL “use of resources policy” was introduced as a way of ensuring that unhelpful and rigid interpretations of eligibility would not hamper the new asset approach. It also allowed us an opportunity to reflect the nature of the integrated arrangements in NEL as the new policy (also referred to as the priorities framework) in that it applies equally to the approach to Continuing Health Care(CHC) Assessments and would allow for integrated assessments of need between CHC and ASC. Furthermore it also embedded the importance of the intermediate tier and re enablement to the model in NEL.

This new local priorities framework introduced four categories of support which ensures the system as a whole is able to offer something to everybody - corresponding with need (see Table 1 later). This also allows us to deploy our professionals appropriately, concentrating our resources at the most vulnerable and complex.

The ‘priorities’ approach enables us to quantify the number of people likely to have similar needs and therefore consider the size of the market that might be needed to

respond to these needs. It is important to note, however, that whilst there will be a relationship between each group of people and the market sector that responds to this need it is not necessarily the case that specific services will only meet the needs of one group of people. For example, someone with 'P1' needs, i.e. the most complex, might access support from a service predominantly set up to provide preventative support, which might, for example, be facilitated by a personal budget.

This is illustrated in Figure 2 where needs and service responses can be seen to have a strong relationship but are not totally equivalent. It is also important to note the 'transitory' nature of 'P2' needs. This means that intermediate tier services can and will be accessed by people whose on-going needs might be best described as P1, P3 or P4. Therefore, on an on-going basis the local population can be comprehensively described as needing either encouragement to adopt healthy lifestyles and live within a healthy environment or be in need of targeted health and wellbeing advice, specific preventative support; or support for significant and complex needs.



c) Figure 2 A generic framework for identifying needs and market responses

Table 1 describes the priorities framework as it might be applied to people from either a health or social care perspective, alongside the type of services that will make up the market for care and support. It is likely that on occasion, due in part to different statutory responsibilities and policy positions, an individual or groups of individuals might fall into different categories under the health and social care schema. Attempts to minimise this as far as possible have, however, been made.

In addition to the approach described above, we have reviewed and analysed two critical care markets to ensure they are as stable and robust as they can be given the financial situation and growth in demand. We have developed a strategy for each with the aims of creating optimal efficiency, quality and stability.

The residential care market will be more effectively market managed to shrink an oversupplied market that has led to instability over recent years. The introduction of a new quality standard will ensure that only the best, most stable and effective care homes will be contracted with in the future, delivering higher occupancy and higher quality.

We will also re-commission the domiciliary care market to ensure sufficient volume is offered in return for the most efficient and stable unit costs. With the development of the preventative tier of services that will offer substitute services in relation to interventions like befriending, shopping, escorting etc., domiciliary care will be targeted at the most complex and vulnerable cases.

It should be noted that the schemes identified within this paper are designed to protect adult social care services against increasing demand, however do not take into account the additional extra pressure associated with the Care Act, estimated locally at £6million per annum.

iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)

£5.090m has been allocated for the protection of adult social care services, comprising:

- 100% of the funding that went to NELC via the s256 agreement in 2014/15 (£3,440K)
- A share of the additional £1.9bn from NHS Allocations (Core CCG funding) (£1.65m)

iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met

The council and CCG have established a Care Act implementation board with an associated project plan, supported by a dedicated programme manager. A number of work streams are being developed to ensure that new systems will be in place, and that the policy implications are understood and can be met.

This work has highlighted the need for further investment in social work resource to meet the anticipated increase in demand for assessments. More detailed work is underway to identify the likely financial implications and profiling of increased expenditure that will result from the reforms.

Significant work has already been undertaken in anticipation of the reforms to safeguarding and it is anticipated that the council and CCG will be able to discharge their respective responsibilities once the act is in force.

Further work will be needed to understand how the council and CCG can ensure that the approaches currently used in NEL to manage resources can be refined and aligned to the new eligibility criteria.

The current direction of travel and work that has been established by the partners in relation to prevention and wellbeing, advice and information those wishing to access support is very much aligned to the aspirations within the act.

Now that the formal guidance has been issued we are in a better position to fully understand and meet the implications of the new duties.

v) Please specify the level of resource that will be dedicated to carer-specific support

£0.429m will be dedicated to carer specific support

Carers (to carers and carers centre)

We have established a contract with the Carers Support Centre (to promote, support and improve the mental, physical and emotional well-being of all carers in North East Lincolnshire, so they can continue in their caring role, look after their own health and wellbeing and have a life of their own in terms of opportunities for work, training, education, leisure and social interaction

The expected outcomes from the contract are:-

- Delivery of a high quality, culturally sensitive and inclusive carer led service that is delivered by appropriately trained staff & volunteers to meet individual and collective carers' needs.
- Carers of all ages, and the people who work with them, are well informed about the information, support and services available for carers.
- Effective partnership working with all local carers' forums and wider carer participation from all carer groups to gain a strong collective carer voice that informs the development & improvement of local services.
- Effective strategic partnership and working relationships with relevant organisations and agencies across the statutory, voluntary, community & independent sectors to improve the overall health and wellbeing of carers residing in North East Lincolnshire.
- Secured additional funding/ resources in the form of grants, subsidies and initiatives through the development of successful bids working in partnership with carers.
- Development of a carer aware and friendly community through robust publicity, promotion, outreach and engagement activities.
- Carers of all ages including those from hard to reach carer groups are identified and registered with the Carers Centre, carers' support service.
- Registered carers are able to access a range of information, specialist advice and carers support services which are responsive and sensitive to their individual needs.
- Overall the service will ensure all registered carers are seen as expert care partners, who are treated with dignity & respect and are supported to:
 - Feel recognised
 - Feel less isolated in their caring role and are appropriately supported.
 - Stay mentally and physically well.
 - Have a life of their own outside of their caring role.
 - Not be forced into financial hardship.
 - Access training and education opportunities and gain or maintain employment.
 - Feel they have learnt improved coping strategies and are better able to cope in their caring role.
 - Avert crisis situations.

- Provide feedback on the carers support service and wider carers services on an on-going basis through a variety of mechanisms.
- In addition adult and parent carers will be supported to:
- Have a low level carer's assessment of need by the provider and at least an annual review.
- Be referred where appropriate for a full carer's assessment of need.

Record how they are feeling using a locally agreed tool, at appropriate and agreed intervals so that any improvement in outcomes can be recorded.

Care Act Implementation £162k

Funding has been set aside for the estimated costs related to carers as a result of the care act, this covers:-

- Put carers on a par with users for assessment. £54k
- Introduce a new duty to provide support for carers £108k

vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?

There has been no change to the council's budget

c) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to prevent unnecessary admissions at weekends

North East Lincolnshire health and social care community is one of the national pilot sites working with the NHSIQ to deliver 7 day services where needed. There is a 7 day steering group that has been established which has representation on it from both Health and social care commissioners and the providers.

North East Lincolnshire's 7 day services programme will build on the range of existing 7 day services to make these comprehensive, of high quality and with consistent access across the population. This will reduce the dependency on in-hospital care as a catch all for the gaps and inconsistencies across 7 days of out of hospital services.

The programme's mission is to develop an environment where people can be supported to achieve their maximum health and wellbeing in their own home 7 days a week. The initial focus will be the elderly, including those who are frail. In North East Lincolnshire currently £77 million is spent on the over 85's health and social care for approximately 3,900 people. It is our belief is this can be delivered in a more comprehensive and consistent way across the 7-day week at a reduced cost. Often these people end up as admissions to hospital especially at weekends when there is a reduced level of health and care services and hospital placement is a safety net to prevent harm.

We aim to achieve the following across the 7-day week:

- Reduced isolation
- Immediate and consistent access to support through triage out of hospital

- An integrated team response to health and care issues as they arise to support maintenance of the individual in the home
- Technology enabled care wherever possible
- Access to relevant information for all through a shared care record
- Support to Carers as appropriate to maintain individual independence
- Devolved accountability and decision-making across organisations to the individual identified to deliver care
- Improvement against all 5 domains of the national outcomes framework
- Reduction in overall costs to commissioners from existing spend

The measurements we have identified for success will be:

- An individual improvement in self-reliance and wellbeing
 - Satisfaction surveys
 - Friends and family test
 - Patient/carer listening events
 - Reduction in the elderly (over 75) Average length of stay in hospital
- A reduction in institutional bed base across north east Lincolnshire
 - Baseline measurement with year on year target reductions
- An improvement in the overall SHMI score – especially where factors are affected by out of hospital care
 - Baseline measurement and quarterly score improvement targets
- An increase in patient centred co-ordinated response from a reduced number of interventions/organisations
 - Measurement of the number of interventions and the number of organisations involved in care
- A reduction in the duplication of information
 - Measurement of the number of times information requested from individuals
 - Measurement of the number of different organisational systems data is held on for individuals
- An increase in the use of centralised triage to provide a co-ordinated response
 - Reduction in A&E attendances measured on each day of the week
 - Reduction in emergency admissions measured on each day of the week
 - Reduction in A&E attendances and emergency admissions from care and nursing homes
 - Reduction in 999 calls measured by day of the week
 - Monitoring of the number of people who have bypassed the triage system
- Innovative commissioning to support integrated delivery
 - Development of commissioner outcome integrated contract across providers
- A reduction in commissioner spend
 - Baseline spend 12/13 on over 85's on health and social care and an agreed cost reduction each year for next 5 years.

The 7 day service programme has undertaken an assessment of the services that are currently working 7 days and what additionally needs to be provided. One of the key elements of success will be to have faster access to senior clinical decision-makers in the community to support rapid diagnosis and management of the elderly to improve their outcomes.

A range of workstreams have been established/are under development which will be

delivered over 2 years as described below:

Workstreams commencing in year 1(2014/15)

- Increased general practice opening from 8-8 across our primary care centres geographically located, which any resident can access
- Enhanced 8-8 community services
- Development of a primary care strategy and vision for the future
- Chronic disease management support including access to specialist nurses
- GP front ending of accident and emergency services with community and mental health support
- Re-ablement support following the intensive support using community nursing, community mental health team and therapies such as brief intervention, OT and physiotherapy
- Developing a 7-day home loan system to support people in their own home with a 4 hour response time

Workstreams commencing in Year 2 (2015/16)

- A 7-day clinically supported centralised triage phone service that builds on our existing arrangements with the single point of access. We will particularly target nursing and care homes to use this number instead of 999 and through vulnerable elderly checks in primary care ensure that their family and carers have the number. This will be managed by the social care and nursing teams of call handlers as now with additional GP support 7 days a week.
- 7-day support to the centralised triage by rapid response (health & social care), mental health crisis team, voluntary organisation support such as befriending, shopping and emergency home repairs to provide intensive support to maintain the individual in their place of residence.
- A shared care record to support the transfer of information and this is expected to be *Systemone*.
- Where possible support will be technology enabled, we already have access to tele-care/tele-health and this will be used to maintain people in their place of residence if necessary. Response time will be within 24 hours.

d) Data sharing

i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

We have previously invested significant time & resource in the provision of an integrated health and adult social care record.

An important element in this was the insurance that an accurate NHS number was provided on all service user\patient record.

This provided the backbone for being able to use the NHS number as the single guaranteed identifier for all records.

All the known population has an electronic record with NHS number, which allows for optimum data sharing across services and also the quick identification of citizens accessing the integrated North East Lincolnshire single point of access.

Having spent several years implementing an information management technology strategy focused on a minimum number of centralised electronic systems, NELCCG are in a strong position to use the NHS number as a primary identifier as both of the locally used Primary & Adult Social Care systems have the NHS number listed as a mandatory field, and with an integrated link to national patient lookup facilities the NHS number is embedded into the system.

There is no further work to be completed for the CCG systems to be NHS number compliant

In addition the North East Lincolnshire health community has a shared system for Primary care (70% GP coverage), Community care (100% Coverage) & Adult social care (100% Coverage) allowing for true interoperability and record sharing integrated into the system. This ensures a level of record and policy consistency across all systems.

- ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Our Primary Integrated Health & Adult Social Care Solution (SystmOne) provides a Client Side API which has been used to provide integration with specialist solutions. This API has previously been utilised to provide interoperability with Dermatology and Voice recognition solutions. SystmOne also supports the use of data synchronisation over the use of defined web interfaces allowing the real time data transfer between Care and finance systems.

As part of an integrated approach to data, we are committed to investigating the adoption of a uniform information architecture across the integrated services commissioned by NELCCG.

To support this all future Provider and Supplier contracts will specify the requirement to provide a compatible, well defined architecture to support data transfer across the entirety of the patient/service users journey or to support key KPI's.

It is the preferred approach for the North East Lincolnshire health community to utilise national recognised systems with proven API or interoperability backgrounds.

The North East Lincolnshire Health Community has already undertaken a programme of system rationalisation, where the majority of providers already have access to a single shared solution with a centralised record system.

However, where possible, continue to investigate options to reduce the number of bespoke non integrated systems replacing them with integrated, interoperable or interfaced systems, supported by Open API's, Portal Interfaces or shared data sources.

To support the intelligent use of the rich data available within our shared care records North East Lincolnshire will continue to support further development of Business Intelligence systems with Open APIs/Interfaces to provide key information to key people on demand.

ALL CCG trusted partners must be able to prove that they meet the nationally recommended level of IG Compliance, this is managed on behalf of the CCG by Y&H

CSU.

Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, and professional clinical practice and in particular requirements set out in Caldicott 2.

NHS NEL CCG employs the expert services of North Yorkshire and Humber Commissioning Support Unit to provide support, guidance and governance for all IG relevant issues.

All existing systems are frequently audited against the required NHS IG Standards and all new systems have to pass IG approval before purchased or implemented.

e) Joint assessment and accountable lead professional for high risk populations

- iii) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them

In 2013/14 4,700 individuals, 2.8% of the population, accounted for £53.7m, 56% of the CCG acute hospital spend.

The CCG and Adult Social Care working with the providers are implementing a number of approaches to deal with those who are at high risk of admission to hospital.

As part of the 7 day services initiative an Multi Disciplinary Team has been established For those individuals who are frequently attending A&E, which is working with those frequent attenders to understand why the individual is accessing A&E & then working with them to:

- Ensure they have a better understanding of their condition,
- Agree with the individual a care plan
- Provide them coping mechanisms so that they no longer need to attend A&E
- Ensure any additional services required for the individuals care are put in place.

NEL is also in the process of implementing the “extensivist” model of care, which will work specifically with those consuming the most Health and social care resource to:

- Ensure that individuals have a better outcome for a longer period of time
- Individual and family are satisfied with the care that the individual has received.
- Reduced cost of the individual to the system
- Reduced A and E attendances
- Reduced Urgent admissions
- Reduced Length of Stay and reduced re-admissions
- Reduced bed days per 1000 patients over 65
- Increased return to work for working age population for those with long term conditions
- Reduction of system pressures across all providers, including primary care

The approach we have adopted as part of our multi agency risk and quality panel will be

applied to the schemes above, essentially meaning that a lead professional, e.g. social worker, Nurse or mental health practitioner will be identified as the main contact for the patient/service user and will be responsible for that individual's case management.

ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population

The extensivist team will consist of a clinician supported by a team comprising of a nurse, social worker and a patient navigator, who will together ensure that the individual has a detailed assessment and that they are then supported to ensure that can navigate the system and access the services that they need. This model is being fully supported by the acute trust, the mental health provider, and community services to ensure that any services identified as required by the extensivist team are available to them promptly.

Where an individual is identified as End of Life by the extensivist team they will be passported through to the specialist end of life team to ensure that they and their family receive the care and support planning required.

Both of the above MDTs will be supported by the GP practices who through the national & local enhanced services are accountable for their top 2% of their registered list & specifically the over 75s.

In addition to the above there is a well-established Risk and Quality Panel to ensure the appropriate management of those individuals who are either complex social care or eligible for continuing health care.

iii) Please state what proportions of individuals at high risk already have a joint care plan in place

From preliminary work undertaken in relation to a range of initiatives associated with BCF, we are confident that all of the individuals classed as high risk are receiving appropriate services and that these services may be delivered from different organisations/parts of the system. We are currently undertaking a cross referencing exercise to determine where these individuals (4700 based on population data) are being looked after under a joint care plan. We aim to complete this exercise by the end of this financial year.

Given the context and history of close working between the former CTP, now CCG and the local authority in North East Lincolnshire, we have well established systems for agreeing jointly funded packages of care between adult social care and continuing health care. While these individuals have triggered the eligibility threshold and have been allocated a jointly funded package, they will not necessarily fall within the category "high risk" as described above.

However the approach to agreeing jointly funded packages is embedded and will be applied to different cohorts of service users and patients going forward.

8) ENGAGEMENT

iii) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

Northern Lincolnshire commissioners, including North East Lincolnshire council and North East Lincolnshire CCG have embarked on a significant transformational programme, Healthy Lives, Healthy Futures, which has been operational for the past eighteen months.

Engagement on the Healthy Lives, Healthy Futures programme and the development of the Adult Social Care Strategy has supported the development of the local approach and development on the Better Care Fund. There have been two phases of public engagement firstly from July 2013 to November 2013 and then from January to April 2014 as part of the development of the Healthy Lives, Healthy Futures development of service proposals and preamble to formal consultation. The Better Care Programme will contribute to and share a number of key work streams related to Healthy Lives, Healthy Futures.

A comprehensive exercise on engagement with the public has been undertaken over the last eighteen months in relation to Healthy Lives, Healthy Futures, full details of which (including details of specific forums, groups and stakeholders) can be accessed at

<http://www.healthyliveshealthyfutures.nhs.uk/>

The process undertaken and the documentation developed charts a narrative which demonstrates that patient and service user voices have been heard and modifications made as a result, for example as a result of our first engagement exercise, a transport group was established to focus on issues of service user access to care.

In addition to this, we have actively reached out to traditionally marginalised groups and the Equality Impact assessment for the service changes proposed as part of the first phase of the programme was conducted in conjunction with local groups with protected characteristics.

This ethos and approach will continue as service developments emerge.

The local Healthwatch have been actively engaged in the support and development of these initiatives and the strategic direction of travel for health and social care services locally.

Service design and redesign processes are informed and shaped by the CCG “Triangles” (an innovative partnership of manager, lay representative and clinician for each service area) and our Community Forum, made up from local lay representatives. These mechanisms are embedded into CCG work and support the work of the Health and Wellbeing Board.

All key local providers have been engaged as part of the Healthy Lives, Healthy Futures programme and continue to participate actively in its development, ensuring that the direction of travel and particular schemes are embedded in their operational plans.

In addition to this there is a weekly local providers' forum which commissioners attend fortnightly and where there is local engagement regards strategic and operational delivery.

In line with the mandate requirements on achieving parity of esteem for mental health, plans do not have a negative impact on the level and quality of mental health services.

The North and North East Lincolnshire CCGs have also spent the last few months discussing the review with key members of our community such as MPs, councillors, including local health scrutiny, and other NHS organisations to make sure they have had the opportunity to contribute to the work so far. Local elected members have been involved in discussions at the CCG board, the Health and Wellbeing board, health and wellbeing scrutiny and at engagement events for the wider council membership. This engagement has helped shape potential options for future service delivery and has contributed to the development of this plan.

b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

iii) NHS Foundation Trusts and NHS Trusts

The "Healthy Lives, Healthy Futures" (HLHF) programme has been developed and communicated through a number of formal and informal consultation and engagement events in which providers have been actively involved.

Our local NHS Foundation Trust – Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) is a key stakeholder on the Healthy Lives, Healthy Futures Programme Board and has been involved in all key service development proposals

All service development proposals have been worked up with full engagement from contracting departments from both commissioners and providers and therefore operational plans are fully aligned.

All organisations are supportive of the developing plans and the CCG and LA have committed to continued engagement.

ii) primary care providers

The joint work on the Healthy Lives, Healthy Futures programme between North East Lincolnshire CCG and North East Lincolnshire Council from which the BCF plan has been developed, has been overseen by the NELCCG Council of Members which comprises all 30 practices in North East Lincolnshire who provide primary care.

The Council of Members has been full engaged in the design, development and delivery

of the transformation programme and has overseen and ratified all key decisions associated with the work.

It has also engaged with the Local Pharmacy Network and the local primary care eye care providers to ensure that where service transformation needs to be supported by grass roots delivery, local providers are geared up for different ways of working.

iii) social care and providers from the voluntary and community sector

The Releasing Community Capacity (RCC) project is driven by and focuses on the community and could not succeed without meaningful participation from all sections of it. From the community members who chose to come on the Change Champions training to those now running a successful social enterprise as a result, community involvement is at the heart. The project has engaged with everyone from teenagers to older people, and from many ethnic groups. In addition, a project board guides all of the RCC work and two community representatives sit as board members. They helped scope and shape the project and now oversee its delivery.

From the releasing community capacity work, community members support the ideas behind a £6m *Ageing Better* Big Lottery bid. This work was led and driven by the voluntary and community sector, with support from public organisations and a not-for-profit partner. Unfortunately the bid was unsuccessful, but partners have agreed to continue to run the programme and to explore alternative funding sources.

Through the Preventative Services Market Development Board development, colleagues have engaged with a VCS capacity organisation (CERT) and explained the key deliverables; namely the stimulation of a new tier of prevention and substitute services run from and for the community. The delivery partner has in turn engaged with many existing community groups to explain where the current gaps and opportunities are and enable grass roots interventions to be delivered.

c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

A 1.9% reduction in non-elective admissions (general and acute) against the 2014 (Actual / Forecast), this equates to a reduction in cost for the CCG of £560,716. Local providers are fully aware of the planned savings and these reductions have been built into the providers plans