Updated Jan 15

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 Friday 9th January 2015. 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 Lincolnshire**
Clinical Commissioning Groups	**North Lincolnshire CCG**
Boundary Differences	**There are small variations between the CCG and LA boundaries, which are managed within well-established arrangements. The small variations are not sufficient to warrant a neighbouring CCG to be part of this Better Care Fund plan.**
Date agreed at Health and Well-Being Board:	**09/12/2014**
Date submitted:	**09/01/2015**
Minimum required value of BCF pooled budget: 2014/15	**£634,000**
2015/16	**£12,370,000**

	£11,006,000 per CCG Allocation **£940.000 Disabled Facilities Capital Grant** **£424.000 Social Care Capital Grant**
Total agreed value of pooled budget: 2014/15	**£4,545,000**
2015/16	**£12,370,000**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Original signed North Lincolnshire CCG
By	Dr Margaret Sanderson
Position	Chair
Date	

Signed on behalf of the Clinical Commissioning Group	Original signed North Lincolnshire CCG
By	Allison Cooke
Position	Chief Officer
Date	

Signed on behalf of the Council	Original signed North Lincolnshire Council
By	Simon Driver
Position	Chief Executive
Date	

Signed on behalf of the Health and Wellbeing Board	Original signed North Lincolnshire Health and Wellbeing Board

By Chair of Health and Wellbeing Board	Councillor Rob Waltham
Date	

c) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	**Synopsis and links**
Health and Wellbeing Board , Memorandum of Understanding (MoU) Adobe Acrobat Document	Provides the framework for partnership working between the LA and CCG and provides the overarching governance for the Board.
ICP Terms of Reference (TOR) Adobe Acrobat Document	Sets out the Terms of Reference for the Integrated Commissioning Partnership. The ICP seeks to develop existing joint commissioning arrangements and identifies opportunities for joint commissioning to improve the health and wellbeing of communities.
IWP Terms of Reference, Adobe Acrobat Document	Sets out the Terms of Reference for the Integrated Working Partnership, which is responsible for the development of a partnership framework to develop and deliver integrated services and monitor the integration plan.
Joint Strategic Needs Assessment (JSNA) http://nldo.northlincs.gov.uk/IAS/sa/	The JHWS sets out the priorities and actions which the HWB Board are committed to achieving across the life stages, starting well, growing well, living well, retiring and ageing well and dying well.
Joint Health and Wellbeing Strategy Technical document Adobe Acrobat Document	Sets out the partnership agenda and evidences the process by which the strategic priorities were agreed.
North Lincolnshire Clinical Commissioning Group Unit of Planning Plan for the Commissioning of High Quality Services for North Lincolnshire; 2014/15- 2018/19 Adobe Acrobat Document	This document sets out the five year strategic plan for the North Lincolnshire Unit of Planning and the vision for health services across North Lincolnshire.

BCF Governance Structure and TOR for Joint Board  Adobe Acrobat Document  Adobe Acrobat Document  Microsoft Word 97 - 2003 Document  Microsoft Word 97 - 2003 Document	Sets out the joint governance structure for the management of the Frail and Elderly work programmes including BCF
HLHF's documentation – • Engagement summer 2013/outcome and feedback • Feb engagement booklet 'Moving the conversation on' 2014 • Consultation on Hyper Acute Stroke and Ear, Nose and Throat Inpatient Surgery – closed 26th September HLHF Consultation Feedback Report  Adobe Acrobat Document	
Safeguarding Adults Business Plan  Adobe Acrobat Document	Sets out theLocal Safeguarding Adults Board priorities
Adults Services Local Account 2014  Adobe Acrobat Document	The Local Account sets out what we have achieved and how adults social care has performed against its priorities
CCG IMT Strategy  Adobe Acrobat Document	Sets out the CCG's vision for IMT including supporting the integration of services
Health and Wellbeing Board - Integration Statement	Describes North Lincolnshire's agreed approach and commitment to integration including the principles and conditions for

 Adobe Acrobat Document	integrated working

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
By 2019 people living in North Lincolnshire will be empowered and supported to be in control and to maintain their independence for as long as possible.

If they start to struggle or a crisis occurs the health and social care system will provide a person centred service that is co-ordinated and integrated to provide high quality care and achieve the best possible outcome.

Hospital admission will only take place where there is a clear clinical reason and re-ablement and discharge arrangements will enable people to return to their own home or a care home as soon as possible.

The vision for North Lincolnshire is set out in the Health and Wellbeing Strategy, it states "North Lincolnshire is a healthy place to live where everyone enjoys improved wellbeing and where inequalities are significantly reduced".

The Health and Wellbeing Board is committed to integrated working. Our ambition will be achieved by transforming our approach to better care, service delivery and commissioning to ensure a good social return on investment, and ensure that people are provided with support in their homes and in their communities.

Consultation and engagement with patients, local residents and the local communities tells us that people want :

- To be supported to maintain their independence as long as possible and are confident to remain living at home for longer
- To feel in control of long term conditions and helped to manage these appropriately
- To feel safe
- To have their health and care needs met closer to home in community settings
- To feel a part of their community and are less isolated
- That Carers feel able to continue in their caring role
- To be supported back into community services following a period of intervention.

We have listened to what our communities are saying to us and what they want from service provision. Full details of how we have engaged them are set out in a later section of the document but we aim to design the new system to take into account what they have asked for and building on the work that we have already put in place.

We are committed to person centred care that is based on the following core principles;

- Individuals will be supported to be resilient and safeguarded
- Families and Carers will be supported
- Communities will be safer and stronger

The case for change section later in the document sets out the health needs of the North Lincolnshire population, drawing on the JSNA and JHWS, which clearly set out the changing demographics of our population particularly in relation to the proportion of over 75's which is growing at a faster rate than our comparitors. Against this backdrop the Better Care Fund plan sets a vision to support our elderly population whilst shifting how we use our resources across the community away from hospital and residential care and into community and home based care, whilst increasing self-care and independent living. This is part of the Northern Lincolnshire vision for Healthy Lives Healthy Futures. The diagram below illustrates how we want to change health and care in the future with more care provided in or near to patients' homes and less care delivered in a hospital setting.

Healthy Lives, Healthy Futures is the review of health and care services in North and North East Lincolnshire. It is led by two Clinical Commissioning Groups (CCGs), North Lincolnshire CCG and North East Lincolnshire CCG, working with all our local health and care partners. The review is linked to similar programmes within the East Riding of Yorkshire and Lincolnshire. It is driven by national best practice recommendations around the services we offer, and is aimed at ensuring that we develop a health and social care system that delivers safe, high quality and affordable services for many years to come.

We want to ensure that whenever it is safe and deliverable, the majority of interventions are provided as close to people's homes and communities as possible. We also know that we need to make the best use of the money we have to spend on healthcare, in the face of a very challenging financial environment.

Therefore over the next five years more services will be delivered in the community at the lowest possible point of support and intervention. The Single Organisational Model (Appendix1) enables us to redesign services to ensure that support and interventions are delivered according to need and people are safeguarded and

protected with timely and effective support to reduce crises and support a return home/community in an integrated way.

Our collective ambition as articulated in our joint Integration Statement is to transform services to provide sustainable integrated care and support that:

- Empowers our local population by building on their strengths and supports them to be more resilient through making sure they have the knowledge and skills they need to be independent and more self-caring
- Unlocks citizen resource that supports existing social networks and builds collective community capacity
- Underpins our key commitments of supporting choice, maintaining independence, intervening at the earliest point, providing access to early advice and interventions to create a more resilient population
- Informs innovative and transformational approaches to commissioning, contracting and financing to enable a social and financial return on investment

This will be delivered by whole systems integration that is owned by all with a shared accountability for achieving positive outcomes and delivering efficiencies across health and social care.

There is a commitment across the patch to honestly share and work together to overcome some of the organisational and system challenges, which currently inhibit the development of further integration.

The frail and elderly strategy work is focussed on setting out clear and tangible actions to achieve this including our ambition to work towards more strategic integration and joint commissioning arrangements

It has been further underpinned from a governance perspective by the establishment of a Joint Board to oversee the wider health and social care system and ensure that the frail and frail elderly programme delivers the aims and objectives agreed across the health and social care economy.

We are clear on the level of ambition and the schemes and plans to deliver this will be jointly programmed managed and we have appointed a Joint Programme Director to enable this to happen with a shared accountability that measures impact and outcomes.

We will compare ourselves to comparitors and continue to use evidence to drive service integration and delivery and want to be in the top quartile of performance nationally as a demonstrable commitment to implement our vision.
b) What difference will this make to patient and service user outcomes?

The outcomes that we expect to see for people who are frail and elderly or have long term conditions are;

- People are confident to remain living at home for longer
- People feel in control of long term conditions
- People feel safer
- People have their physical and mental health and care needs met closer to home in community settings
- People feel a part of their community
- People are less isolated
- People and practitioners / clinicians are supported to manage risk and long-term conditions appropriately
- Carers feel able to continue in their caring role
- People are supported back into community services following a period of intervention

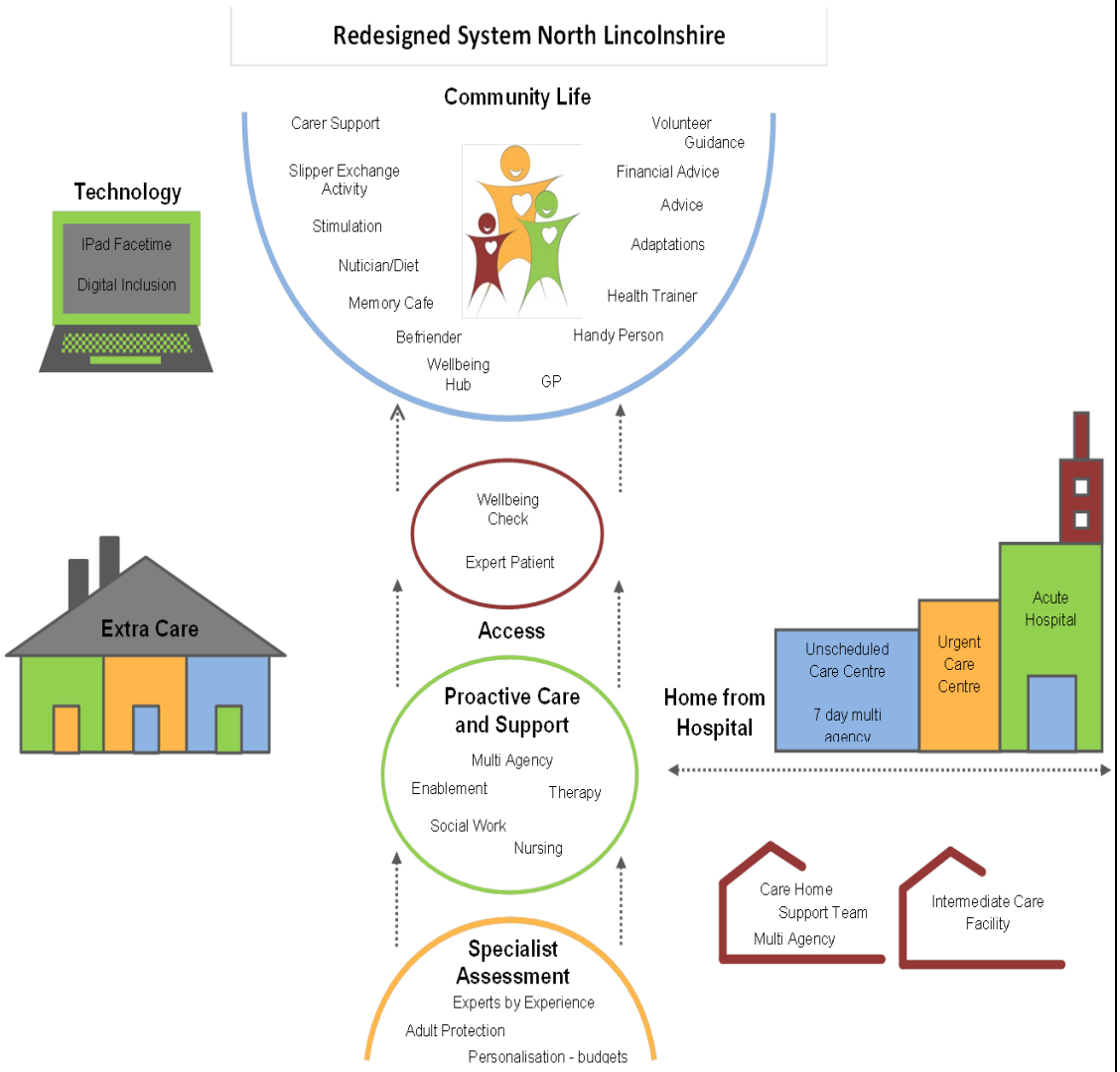
Ultimately

- People will tell their story once
- People will keep well
- People will be safe and stay safe
- People will live independently
- People will be supported to prevent deterioration and detect problems early
- People will receive better more integrated care across health and social care settings
- People will have their confidence restored to live independently
- People will feel able to continue caring for relatives

This will mean that people routinely report that they feel in control of their care, are leaders in decision making and determining their own care and treatment and are supported by integrated ways of working thus empowering them to live well.

The schemes and services outlined in this submission will result in a whole system redesign (See diagram below). The health and social care system will be built upon the premise of right care, right service, right time, and right place, with the right management to enable more people being supported at home and in their community of choice.

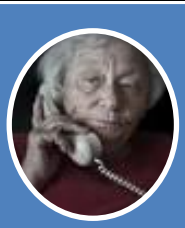
Early identification and prevention will be embedded at every point of the journey and will focus on both the physical health and mental health needs of the individual, to ensure that care and support is delivered at the lowest possible point of intervention. The system will ensure that those whose care cannot be safely managed in the community will be placed in residential and nursing home provision and where possible for those admissions to be for the shortest possible duration being supported by re-ablement services to integrate back into the community. Through the development of step up and step down protocols between practitioners and agencies, individuals will be offered “staged” (through more targeted services) seamless transition, back to universal services.



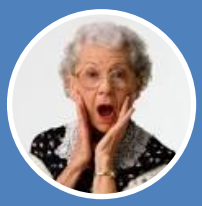
We will transform all parts of the system during this process resulting in delivery through a combination of clearly set out specifications and contracts. This may mean a variation to local contracts to achieve new outcomes, collaborative approaches to commissioning and in some cases testing the market to bring in new and innovative providers. The difference this will make is described in Albert and Violet's story.

Violet and Albert's experience demonstrates how the system will change to focus on prevention at every level. Our ambition for Violet and Albert is integrated care across the system.

Violet lives independently but is been increasingly lonely since her husband died. Her husband was a keen handyman and also drove her where she needed to go. Violet has become more unsteady on her feet and falls more often than she used to.

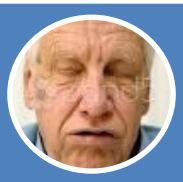


Violet calls 999 on a regular basis as she keeps falling and is concerned about who will find her. She also makes regular trips to her GP, not because she is unwell but because she is worried. Violet's GP thought she may need a little more support so contacted the Well-being Hub in her locality who put arranged for a befriender to come and see her, she then contacted the handyman to make minor adaptations, grab rails.



One night Violet had a fall she called 999, an ambulance came out to her. Instead of being taken to hospital the responder called SPA who send RATL to go to Violets home. Violet received the clinical treatment she needed and is supported to stay home (Proactive care and support services and 24/7 working supports this). Violet felt confident to stay at home as she is linked into her local community (via Hubs) her befriender is aware of her fall. Further assessment is undertaken (Integrated locality team) and Disable Facilities Grant agreed to undertake more adaptations. Violet takes part in the expert patient's programme, that designed around her needs and this helps Violet to determine what her priorities are and to stay well in the community

Ultimately our commissioning and service delivery approach is to deliver better value for money and invest in what works by co-designing the system with partners and people.



Albert is a proud man with a military background. He suffers from chronic bronchitis and emphysema and says he can manage so avoids the GP and other health staff. When it gets really bad Albert knows that he will go to hospital and has been admitted numerous times. Despite attempts to support Albert on discharge from hospital, Albert has refused as he is not going to keep talking about his health issues to numerous people and he feels that his health condition is not going to get better so there is little point.

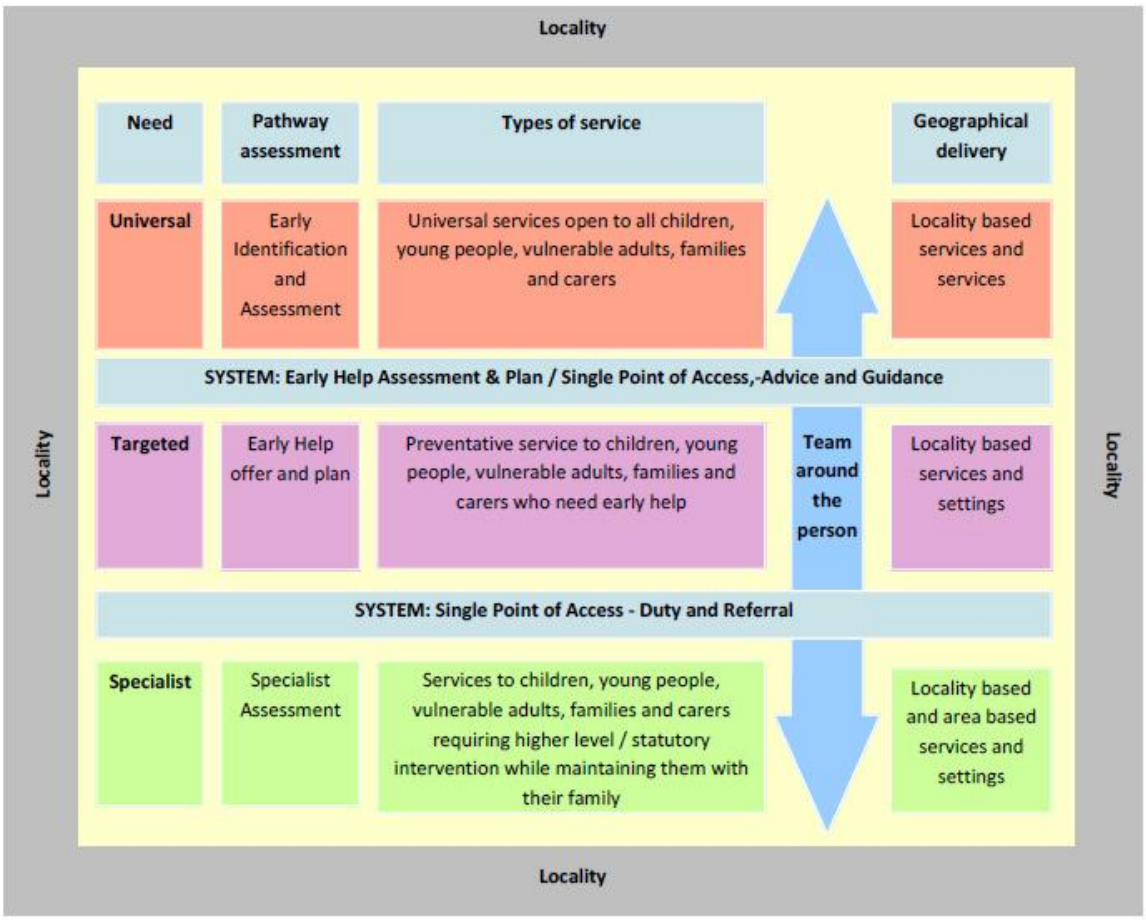
Albert is entitled to safe and well checks (wellbeing service). The wellbeing service talks to Albert about the Integrated Locality teams and becoming an expert for his own care. He recalls that the hospital staff and his GP were also saying similar things. Albert starts to build up trust and agrees to the Integrated Locality Team undertaking an assessment. Albert is accepting of the idea and agrees that the Integrated Locality Team can undertake an assessment and allocate an accountable professional whom will co-ordinate his care plan.

Albert determines what his care plan is and starts to want more information about how he can manage his condition better. He i identified by the Integrated Locality team as being at risk of numerous hospital admissions, therefore regular reviews his car plan take place. Albert starts to recognise that if he goes to the G earlier he will not have to be admitted to hospital and whilst h condition will remain he can improve his quality of life. For th first time in years Albert does no go into hospital during winter

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?

The Single Organisational Model, adopted by North Lincolnshire Health and Wellbeing Board, shows how services can be designed on need underpinned by developing community resilience;

- **universal**, early identification, promoting **wellbeing** delivered in **localities**
- **targeted,** early help and assessment, and
- **specialist**, acute services and specialist social work services



The systems model, discussed with the public and stakeholders under Healthy Lives, Healthy Futures describes how currently a large proportion of the money we spend on healthcare is focussed on hospital services at the specialist level and there is a commitment to shift that focus, to invest in and provide more opportunities for people to look after their own health at home and develop community resilience in their local communities increasing the availability and use of targeted and universal services.

We acknowledge that this shift in the landscape of services is a challenging task but patients and service users are telling us that their preference is to have the majority of their care delivered in their home and communities. We therefore need to respond collectively to this expressed preference. Reliance on acute services in both physical and mental health settings will be reduced by meeting needs and supporting people

with long-term conditions better in the community, should people require a stay in hospital then this will be for the right reasons at the right time. We will continue to invest in services which have an evidence base e.g. reablement and rehabilitation, building upon our performance in reducing delayed discharges and transfers of care. This will ensure that people are helped to regain their independence after episodes of ill health as quickly as possible with clear multi-disciplinary plans and arrangements for discharge, and as necessary with appropriate community based health and social care services.

Use of residential and nursing care will only be for those whose needs cannot be safely met in the community. Our front line workers both health and social care will feel more confident and competent in assessing all needs and supporting people to stay well and keep well, and deliver non-acute emergency care in the community.

In order to reduce the current pressures on emergency care in hospitals there will need to be a shift to meeting needs earlier and investment in lower cost preventative services and with proactive anticipatory care to avoid people falling into crises. To deliver this, clearly set out specifications detailing outcomes and key performance indicators are being developed. Services are being asked to risk profile their populations in order that those patients and service users at risk of multiple attendances or longer term admission and or reliance on care home provision, can be identified early and placed on proactive care plans and enabled to live in their own homes within their own communities. The role of the named clinician or care worker will be key to this happening.

In addition, professionals will be trained in the early recognition of issues, which effect esteem and wellbeing which may be early indicators to deterioration, and will prioritise interventions to prevent this from occurring. We recognise that the health and wellbeing of each individual is broader than their physical health needs and therefore we are aiming to ensure that all community teams have the competence to screen for and recognise key mental health conditions and refer onto specialised mental health services where appropriate. This will ensure that early identification of symptoms of isolation and loneliness can be identified alongside evidence based assessment of mental health conditions with key links to work underway in primary care currently on dementia diagnosis and management. All of which impact severely on an individual's health and wellbeing and ability to remain active and independent..

We will use the BCF to restructure our care according to need within the tiers detailed in the single organisational model described:

Wellbeing Offer delivered in localities (Universal Services)

We are developing and strengthening our wellbeing offer to enable people to stay well, provide peer support and locally developed expert patient training programmes to encourage self-care.

Four Wellbeing Hubs have opened during the last six months across the localities to enhanced and strengthen our local wellbeing offer and a fifth will open early in 2015. These hubs will include all preventative services commissioned and provided by the local authority and will be developed in consultation with the community and those

that require preventative support.

It is the aim of the wellbeing offer

- To provide access to services in local communities through wellbeing hubs which are accessible, flexible and responsive to need
- To ensure that those who are in most need in the community are identified and enabled to access the lowest appropriate level of service in a timely manner
- Where service users have more complex needs and receive more specialist services and support, they can access this locally and the staff involved with these individual service users have the skills to meet their needs and the number of staff offering care and support is kept consistent and to a minimum, whilst promoting and maximising independence
- To ensure that individuals can remain active, retain their independence if necessary with some community or volunteer support and live independently for as long as it is safe for them to do so
- That the wellbeing offer is consistent across the localities whilst flexibly reflecting the needs of individual communities
- To reduce loneliness and isolation through the development of a wider range of activities both in the buildings and in the local community
- To ensure that vulnerable people and their families have access to the information they need, when they need it

Examples of existing services that are now accessible through the community Wellbeing Hubs are:

- handyperson service – to help with small maintenance jobs that enable people to live safely in their own homes
- community meals service and information about social lunch clubs etc
- access to nail care service – which enables people to stay mobile
- nutrition advice
- carers advice and information
- adult community learning and employment opportunities
- wellbeing conversations for the > 75 yrs – to enable early identification and signposting to additional support
- access to befriending support
- community safety advice such as fire safety and falls prevention
- access to health services such as health trainers and smoking cessation services.

These services are evidenced based and contribute to the wider strategy of keeping people well and connected to the local communities. The wellbeing offer is being delivered through the four hubs alongside other community facilities providing a comprehensive network of social, psychological, practical and physical support.

There will be **better information and guidance provided** at Wellbeing Hubs as part of an integrated approach to wellbeing and prevention, including the voluntary and community sector. This will ensure that those not yet experiencing higher levels of need but whom may do so in the future are supported to remain healthy, independent and well. Locally we recognise that isolation and feelings of isolation

have a long term detrimental impact on physical and emotional wellbeing, therefore we will empower local people through befriending, mentoring and self-management. In addition we are making clear links as required into the risk profiling and named professional arrangements to enable those who appeared more vulnerable or at risk of any deterioration could be identified early and linked into the appropriate level of service.

The model of delivery for the wellbeing offer is based on an 'Early Help' approach, offering universal services to the majority, whilst targeting specific resources to those who are the most vulnerable in our communities. It is anticipated that this 'offer' will overlap with our proactive care and support model of integrated teams based in five localities. There will be a seamless overlap with the following:

Proactive Care and Support (Targeted)

Proactive care and support is aimed at maintaining the independence and wellbeing of individuals by working with them to create and implement sustainable health and care plans. It will move care of the person away from costly reactive 'critical care' services to more universal and targeted services that can be planned and orchestrated in a coordinated manner. This will support reductions in non-elective admissions to acute hospital beds and admissions to care home and respite facilities reduce the need for permanently funded placements and delayed transfers of care. It will lead to the increased use of prevention and assessment services, independent living services, extra care sheltered housing and appropriate preventative health services. Overall, it will shift the balance of care from crisis intervention to happy, healthy, independent living which empowers people thus reducing the requirement for costly care.

The new multi-disciplinary Proactive Care and Support service has built on the integrated teams established in each of the five localities, the teams now provide targeted and co-ordinated care and support services to those patients who through risk profiling are deemed to have some risk of deterioration which may result in non-elective admission. This service is to mobilise rapidly, providing a range of services, dependent on individual need, promoting positive outcomes and prevention of deterioration.

These services work to the following :

- Person-centred practice
- Holistic assessment
- Timely response with earlier intervention
- Active case management
- Risk stratification
- Proactive and preventative care
- Promotion of independence
- Partnership working
- Co-ordination of care planning and delivery to avoid duplication
- Robust multi-disciplinary team (MDT) working
- Self-management

- Making ‘every contact count’

These teams are continuing to be developed to ensure that they connect with Primary care in the development and management of all patients >75yrs registered with an accountable GP and those who within the top 2% high risk patients being managed in primary care.

Accountable Professionals for integrated assessment and packages of care. A care co-ordinator within each team who will act as one point of contact for people who require support. The aim is to enable people to tell their story only once and support is co-ordinated with a very strong link to the primary care teams.

Through the appropriate use of risk stratification those with long term conditions are identified as requiring support from a Multi-Disciplinary Team. The fundamental element of success for this is the use of the **shared summary care** record.

Care Co-ordination and Personalised Care Plans will be consistently provided for those at high risk of hospital and or care home admission, those requiring complex care and those discharged from hospital. This will be performance managed through the patient experience metric over the next two years.

The Care Co-ordinators will be the link between primary and community care. They will be employed via Integrated Locality Teams therefore having a clear understanding of all aspects of the persons care. This will be the central point for personalised care plans.

An Extra Care scheme and extended supported living schemes for the frail and elderly and those with complex disability are planned to replace institutional care. This will enable people to have their own tenancies within the community, with wrap around provision that is needs led.

Specialist Services

A model of **integrated unplanned care** was implemented in Scunthorpe General Hospital in October 2013 with significant further development to the model during 2014. This includes an Integrated Urgent Care Centre, Ambulatory Emergency Care, including GP Out of Hours services, a Single Point of Access providing the ‘warm transfer’ of patient calls from NHS 111, and providing the gateway to support through rapid response services(RATL) which includes social care, advice and a Clinical Decision Unit both internal and external to the hospital The specification clearly defines the delivery expectations around this service and clearly defined outcome metrics which are being tracked via the system wide Urgent Care Assurance and Monitoring Group.

7 day working across the system. Implementation of accessible health and social care practitioners and services working seven days a week have now commenced roll out. 8-8 seven day social work services have been strengthened already and will work within the RATL concept to ensure coverage across all localities for a rapid access to an appropriate care and response. The extension of the hospital social work team operates in the urgent care centre, the frail elderly assessment and

support teams on the wards and as part of the integrated discharge service. A clearly defined Operating Framework detailing how this service will enhance social care assessment within the hospital setting has been produced and early benefits on improvements in access are being reported.

Intermediate Care services have already been extended by 50% and will be further integrated to provide a seamless social, nursing and therapy service to support people to regain independence quickly. An early version has been in place from January 2014 and a fully operational integrated service is expected to open in a new facility in Winter 2015. Greater coordination will take place between locality based services and the specialist teams to ensure a flexible and seamless transfer in and out of each service with the aim of returning people to independence and the lowest tier of care wherever possible following proactive support and intervention.

Care Home Support Service and Safeguarding in placement teams will manage the access to all the care home placements, (with a strong link to adult protection investigations and preventative work). This service will again be integrated to ensure that a holistic plan of care is available to all patients being admitted either in a temporary or permanent placement. In turn will we also be able to monitor the improvement of quality and evaluate their effectiveness.

There has been additional resource into this team via Continuing Health Care and Funded Nursing Care providing proactive case management of those at risk of increased care costs and admission to hospital. The Safeguarding in Placement Team will conduct the statutory reviews of the residents and proactively manage end of life care.

A pilot of the service in care homes has begun to carry out targeted interventions with residential and nursing homes who are outliers on emergency admissions and will provide training and professional support to the care and nursing staff to anticipate care and health needs and reduce avoidable hospital admissions. There is now further development of full integration to include Mental Health Services within the team.

The service will identify those at highest risk using a combination of hospital admission data, trigger conditions and primary care data.

The aim of the Care Home Support Service will be to:

- Educate and increase awareness within homes with regards physical, mental and social care
- Reduce hospital admissions and nursing home transfers
- Enhancing health-orientated education and training of care home staff
- Improving early detection of illness and, therefore, promote early intervention
- Generating savings within the health and social care economy

We began piloting this service during 2014/15 and this has already demonstrated positive feedback from the homes experiencing increased input. Active care plans are in place, particularly with those residents not currently on district nursing caseloads and the service has been able to manage a number of presenting clinical

issues which would otherwise have resulted in a 999 call or GP call out. Safer care checks are being carried out and a number of residents have been supported to remain in their preferred place of death. The impact is currently being reviewed and it will expand through use of the better care fund in order to be fully functioning in 2015/16.

The provision of the Better Care Fund will act a key enabler to bring together, extend and better focus a whole range of services across the district. It will allow us to address the gaps in provision that we have currently identified and ensure that patients have a seamless experience and where boundaries between care provision become non-existent.

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.

A full review and refresh of all data sets has been carried out recently to determine the focus of the better care fund initiatives and the potential impact they may have. Consideration has been given to data and intelligence contained within the JSNA covering the health needs, public health measures and demographic profiles across the localities. We have refreshed all our practice profile data matching it with hospital activity covering a range of public health metrics, admission risk factors and disease prevalence to understand where demand and need is highest within North Lincolnshire. The following sections detail our current knowledge of the area and its issues:

North Lincolnshire is located on the southern side of the Humber estuary and covers an area of approximately 85,000 hectares. It has a GP registered patient population of just over 170,000, and a resident population of 169,000, with more than half of this number living in North Lincolnshire's growing market towns and village settlements. The main population centres are Scunthorpe Town, Barton and Brigg.

Age profile and growth - The population is slightly older than the national average, with a median age of 43 years compared with 40 years of age nationally. Currently there are *32,510 people aged 65+* resident in North Lincolnshire including, *14,440 aged 75 years and older and 4,030 aged 85+.* Between 2002 and 2013 the 85+ population grew by 37% in North Lincolnshire, compared with a 24% growth nationally. This trend looks set to continue for the next 20 years. By 2020, the local population is expected to *grow by 4%,* whilst the number of *over 65s will grow by a further 19%.* The older population has grown fastest in our market towns and villages, where more than half of our older population currently live.

Diversity - The resident BME population is relatively small compared with regional neighbours, representing an estimated 7% of residents, compared with 19% nationally. The largest growth in this population in the last decade has been amongst White Europeans, who make up more than half of the local BME community. The next largest community are people of Bangladeshi origin. These communities have a much younger age profile than the White British population, consequently the number of older people in these communities' remains relatively small.

Deprivation – In terms of deprivation, North Lincolnshire ranks around the national average, ranking 132nd out of 354 districts in the country for the IMD score, (where 1 = most deprived and 354 = least deprived LAD). Less than 1 in 5 of older people in North Lincolnshire are dependent on low incomes, a rate similar to the national average.
These averages mask considerable internal inequalities in North Lincolnshire, by locality, by GP practice and by neighbourhood, with the highest concentrations in Scunthorpe, although there are smaller pockets of deprivation is some of our rural communities including Barton, Winterton and parts of Axholme.

Living and support arrangements
An estimated *4%* of resident older people (aged >65yr) live in care homes in North Lincolnshire. This rises to 16% of >85yrs. This is similar to the national average with the vast majority of this age group continuing to live in their own home, with the support of informal and formal carers. A

third of >65yrs live alone in North Lincolnshire and this figure is projected to rise further, as life expectancy increases and as more people in their middle years live alone.

Older (>65yrs) residents make up 19% of the resident population, but more than a third of all non-elective admissions each year. Two thirds of these older patients are aged >75yrs and 12% are admitted from care homes. In 2013/14 there were 7458 emergency admissions to hospital of local patients aged 65+, including *550 admissions to* hospitals outside the Northern Lincolnshire area, representing a directly standardised rate of 3898 per 100,000.

In 2013/14, 8% of the >65yr population were in receipt of local authority funded support services in North Lincolnshire, including 31% of people aged >85yrs. As this older population increases in number, the pressure on local health and social care services is likely to grow.

Health needs - Life expectancy at birth is improving each year but remains below the national average for males in North Lincolnshire. Healthy life expectancy has also improved over the last two decades, although at a much slower rate, and lags 17 years behind overall life expectancy. However, these averages mask significant internal inequalities health and wellbeing in North Lincolnshire, with a 10 year gap in life expectancy between North Lincolnshire's 10% most and least affluent residents.
Currently just over half of males in North Lincolnshire can expect to enjoy a relatively healthy working life up to 68 years of age. In some of our most deprived neighbourhoods, healthy life expectancy falls below 65 years.

Public health issues - On the face of it, North Lincolnshire should be a relatively easy place to lead a healthy lifestyle, with larger than average areas of green space per head of population, relatively easy access to open countryside, above average income, lower than average house prices, higher than average rates of employment, and improving educational attainment, although levels of adult qualifications remain low. Yet the number of people at risk of lifestyle related diseases remain above the national average in North Lincolnshire, with

- higher rates of adult smoking, including in pregnancy
- higher incidence of smoking related diseases, such as lung cancer and COPD
- higher incidence, and rising levels of adult obesity and lower levels of physical inactivity

Further details are contained at www.apho.org.uk/

Some of these factors are linked with North Lincolnshire's industrial legacy, and its strong working class roots and cultural traditions. For example, whilst smoking rates are falling locally, they have not declined as fast here as they have elsewhere. Car ownership is high in North Lincolnshire and use of cars for shorter journey's is above average, especially in our rural areas. These lifestyle factors, combined with an older population profile, all contribute to North Lincolnshire's:

- higher rates of hypertension in the adult population,
- higher rates of Type 2 diabetes,
- higher rates of chronic kidney disease
- higher rates of cancer
- higher premature death rates from causes considered preventable
- increasing numbers of 'younger' old people living with multiple chronic conditions

Health and wellbeing segmentation -
Wellbeing Acorn

These demographic and lifestyle differences are reflected in a number of national social, health and wellbeing profiles of North Lincolnshire's population. According to one leading health segmentation tool, (Wellbeing Acorn) North Lincolnshire has a higher than average proportion of the population within the ***'health challenges'*** segment. This group contains some of the highest levels of smoking, the lowest levels of physical activity and healthy diet, and the highest levels of 'elderly ailments'. This latter group includes older people with 2 or more age related conditions, including MSK, heart disease, failing eyesight and diabetes.

The ***Health Challenges*** segment represents more than 1 in 4, 26%, of the North Lincolnshire population compared with 16% nationally.

Other health risk segments which are over represented in the local population include:

- ***Respiratory risks*** – people with a higher risk and incidence of respiratory conditions such as COPD and asthma.
- ***Countryside concerns*** – ageing 'empty nesters' living in rural areas, with a growing number of age related conditions

At the same time North Lincolnshire has a higher representation of relatively healthy older people living in the population, including a higher proportion of:

- ***'Perky pensioners'*** – who are relatively healthy, but suffer from higher rates of raised blood pressure and high cholesterol, as well as arthritis and hearing impairments
- ***'Sensible seniors'*** –well educated retirees with a good diet, low rates of smoking and alcohol consumption, but with a higher than average prevalence of conditions associated with ageing

Wellbeing Acorn - Segments

Segment	% resident population	Estimated numbers in North Lincolnshire	% Yorkshire & Humber	% England
Health challenges	**25.7%**	**43,690**	**25.1%**	**15.8%**
Limited living	*1.2%*	*2,040*	*1.5%*	*1.1%*
Poorly pensioners	*3.8%*	*6,460*	*4.6%*	*2.7%*
Hardship heartlands	*4.7%*	*7,990*	*6.9%*	*4.4%*
Elderly ailments	*8.8%*	*14,960*	*6.0%*	*5.2%*
Countryside complacency	*7.2%*	*12,240*	*2.5%*	*2.4%*
At Risk	18.6%	31,620	25.1%	22.1%
Dangerous dependencies	*2.2%*	*3,740*	*3.0%*	*1.4%*
Struggling smokers	*4.1%*	*6,970*	*3.8%*	*2.4%*
Despondent diversity	*0%*	*0*	*0.3%*	*2.1%*
Everyday excesses	*2.1%*	*3,570*	*7%*	*5.8%*
Respiratory risks	*7%*	*11,900*	*4.6%*	*2.4%*
Anxious adversity	*1.3%*	*2,210*	*2.2%*	*3.5%*
Perilous futures	*1.8%*	*3,060*	*2.1%*	*2.3%*
Regular revellers	*0.1%*	*170*	*2.1%*	*2.2%*
Caution	***26.0%***	***44,200***	***24.3%***	***26.6%***
Rooted routines	*3.5%*	*5,950*	*4.3%*	*4.9%*
Borderline behaviours	*1.3%*	*2,210*	*5.5%*	*7.7%*
Countryside concerns	*9.9%*	*16,830*	*5.0%*	*5.2%*

Everything in moderation	*11.3%*	*19,210*	*9.5%*	*7.8%*
Cultural concerns	*0%*	*0*	*0%*	*1%*
Healthy	***29.6%***	***50,320***	***28.9%***	***35.6%***
Relishing retirement	*10%*	*17,000*	*7.1%*	*7.5%*
Perky pensioners	*9.8%*	*16,660*	*5%*	*3.7%*
Sensible seniors	*2.2%*	*3,740*	*1.2%*	*1.6%*
Gym & Juices	*0%*	*0*	*2.8%*	*5.3%*
Happy families	*2.9%*	*4,930*	*4.6%*	*7.1%*
5 a-day greys	*0.6%*	*1,020*	*3.0%*	*4.6%*
Healthy, wealthy & wine	*4.1%*	*6,970*	*5.2%*	*5.8%*
Total registered patient population	*100%*	*170,000*	*100%*	*100%*

McKinsey Integrated Care Model – Patient segmentation 70+

Estimated numbers and % in North Lincolnshire	**Mostly healthy**	**Elderly with 1 LTC**	**Elderly with 2+ LTCs**	**Elderly with Severe enduring mental illness**	**Elderly with Dementia**	**Elderly with Cancer**	**Elderly with Learning disability**	**Elderly with severe physical disability**
No (%) 70+s	4,900 (22%)	4500 (21%)	8000 (36%)	300 (1%)	800 (4%)	2500 (11%)	<1%	700 (3%)
Health and social care cost per head	£17,25	£1,906	£3,733	£12,777	£12,280	£4132	£28,660	£16,869
Total cost per annum	£8.4m	£8.5m	£29.8m	£3.6m	£9.8m	£10.2m	£0.8m	£12.3

The largest spend area amongst >70yrs are older people with 2 or more long term conditions. This is also the group with the highest risk of emergency admissions and, as they get older, multiple emergency admissions. This group is projected to grow in number. However, the highest costs per head are associated with population groups where we can also expect significant growth in the next 10 years.
Healthy Lives, Healthy Futures has the focus of working across Northern Lincolnshire to address these issues on a wider scale. However, BCF is allowing North Lincolnshire area to look at a more focussed, individualised, approach to care provision linking through to the Five Year Forward Vision (5YFV).
All of the schemes we have chosen to focus on via BCF will have an impact of this growth area. The link of each of the schemes to one another and the ability for services to be interconnected allows further scope for improved health and care outcomes.

Emergency admission rates and locality and GP practice variation
There is significant variation in emergency admission rates between localities and between GP practices, see tables below. This is accounted for largely by their patient profiles, including age, deprivation, age related long term conditions and care and nursing home patients.

Table 1: Locality* profile: Population profile of localities -

	Axholme	**Barton and Winterton**	**Brigg and Wolds**	**Scunthorpe North**	**Scunthorpe South**	North Lincolnshire
Resident population (% of North Lincs) (2012)	22,808 (14%)	33,684 (20%)	31,130 (19%)	26,125 (16%)	54,624 (32%)	168,400 (100%)
65+* % resident population	4550 (20%)	6590 (20%)	6820 (22%)	4040 (15%)	9550 (17%)	31,550 (19%)
75+* % resident population	1860 (8%)	2770 (8%)	2920 (9%)	1890 (7%)	4760 (9%)	14200 (8%)
85+* % resident population	580 (3%)	711 (2%)	824 (3%)	585 (2%)	1331 (2%)	4030 (2%)
% Pensioner Poverty (IDAOP) (2010)	16%	14%	15%	24%	19%	19%
Male life expectancy yrs	80.6	78.1	80	75.4	77.8	78.3
Female life expectancy yrs	82.9	84.1	83.5	81.4	82.2	82.8
% 65+s living alone (2011)	27%	28%	27%	32%	33%	31%
No. of care homes (no of care home beds) (March, 2014)	5 (150)	14 (340)	19 (500)	9 (400)	18 (600)	65 (1990)
Care home beds per 1,000 75+	80.6	122.7	171.2	211.6	126.1	140.1

PCMD, ONS, Public Health, 2014
on 2013 ONS midyear resident population estimates (rather than location of GP practice)

Table 2 Locality profile: Lifestyle risks and health needs

	Axholme	Barton and Winterton	Brigg and Wolds	Scunthorpe North	Scunthorpe South	North Lincolnshire
% GP registered adult patients who smoke (2013)	18%	20%	17%	29%	26%	23%
No of patients registered with heart disease (2013)	1307	1247	1266	935	2966	7721
No of patients registered with COPD (2013)	464	565	447	433	1394	3300
No of patients registered with dementia (2013)	165	132	190	104	412	1000
No of patients registered with heart failure (2013) (per 100 75+)	185	248	190	153	497	1270
No of patients registered with cancer (2013)	596	669	673	360	1140	3440
No of new cases of cancer diagnosed per annum (2013)	152	163	172	85	322	890
Patients registered with palliative care needs (2013)	18	31	48	17	98	210
Number of deaths at home/nursing/residential care home 2013	84	138	140	112	200	670

Source: QoF, PCMD, Public Health, 2014

In addition to the above data, a formal risk stratification tool Health Intelligence has recently been commissioned and the roll out process has commenced through primary care to support the unplanned care DES. Early data reports have focussed on profiling the high risk over 18s who are at very high risk of emergency admission and then working through the levels of risk to provide headline numbers. An extract of the first stage report is attached here and clearly defines the numbers that are contained in the very high and high risk cohorts and those who would be suitable for rapid response and community intervention.

Adobe Acrobat Document

- RISK LEVELS FOR OVER 18s – FIRST STAGE REPORT

The planning process for the better care fund initiatives has taken account of intelligence coming from both clinical services within the acute trust and community and social care services providing care outside hospital. There are clear pressures within the system that have continued since winter and a sense that acuity levels remain high particularly at pressure points within the week. The data and feedback shows peaks in attendances at A&E and also subsequent admissions particularly in relation to > 65 yrs and greater numbers related to certain care homes and certain general practices. Work is underway to identify the cohorts of patients who would be impacted the most from the better care fund initiative and the first phase of interventions will be targeted to those areas.

Benchmarked Information: The CCG has reviewed the benchmarked data supplied within the Better Care Fund Fact Pack. The analysis of non-elective admission rates against peers indicates that there are significant opportunities of around 10 – 19% reduction levels if evidence based integrated care was fully implemented and the HWBB delivered a comparable performance to the top quartile performers. The aim by delivering a 11.5% reduction in non-elective admissions across the North Lincolnshire locality, is to set a level of ambition which brings the HWBB into top quartile performance. This is ambitious plan requires significant re-alignment of current service provision and further investment and commitment to address the gaps to realise this. The cash releasing element of this reduction is key to achieving the better care fund levels of spend.

Please note that the benchmark/baseline information used in this submission has been updated to current information. Previous data used was 17,158; the updated baseline is now 19,995. Having put in a query to the Taskforce it was confirmed that using up to date information is acceptable. This is reflected in Annexe 2 of the analysis model and the metrics model used to understand the wider impacts.

As previously described the Better Care Fund work programme across Northern Lincolnshire is a catalyst to the changes we aim to achieve through the Healthy Lives, Healthy Futures work. BCF and any risks or successes related to it are seen within the wider auspice of HLHF therefore any gaps will be monitored and address through the wider programme.

The modelling work which has been undertaken with PA Consulting will provide a basis of the further work with PwC which looks at wider redesign and change plan.

In addition, there is a further indication within the benchmarked data sets that the health and social care economy could also deliver a reduction of between 3% and 13% on A&E

attendances overall. Following analysis, the focus of this work needs to be patients with long term conditions; particularly those with more than one and the risk stratification work will clearly identify these within the very high risk i.e. top 2% of the practice populations with a view to developing clear, shared care plans. These care plans need to set out how services will manage these patients differently to way in which they currently do and it is our view that co-production of these plans across a range of service providers but more importantly with the patient themselves is key to the success of this programme. It is for that reason that we have chosen the patient experience metric to directly track the numbers of patients who have been involved in the design and review of their plans. In addition and alongside this, we will also directly measure the number of social care service users who have control over their own life – a measure, we see, as key to maintaining independence.

Admission and Attendance Costs

The document attached provides an overview of base costs (excluding contractual agreements) associated with A&E attendances, ambulance journeys and admission costs. The latest phase of the modelling work has been carried out with support from PA Consulting as part of the NCAR process. This process utilised the activity data in relation to each scheme and modelled the actual cash releasing savings that will be associated with the service changes. This will form the basis of the value for money test against invest to save schemes. It is acknowledged within the risk log that whilst the modelling work has been carried out using tariff payments there is a NHS Provider risk to this method. Further work will be completed during Q4 of this financial year, in conjunction with Joint Board, HLHF and PwC to have accurate cost and payment detail for a local financial and operational plan which will be system wide.

We have a good understanding of our population demographics and the drivers for our expenditure but that we have further work to ensure that we use this effectively to ensure that our investments are targeted at the right areas to achieve maximum return on investment both financially and in achieving improved outcomes for our population. Using support available from the central team we have worked with PA Consulting to run a modelling and financial analysis of the schemes purely for the Better Care Fund schemes.

In addition to this, as part of the Healthy Lives Healthy Futures programme we have engaged PwC to support us across Northern Lincolnshire in supporting the development of our delivery plan, including financial analysis and modelling. We expect that the wider additional impacts of the Better Care Fund schemes will bring further cohesion to the wider system and service development.

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

The key to ensuring the schemes we have chosen to include in the Better Care Fund was ensuring we had tested the assumptions we were making. In order to do this we introduced the concept and ran a 'Perfect Week', week of 10th November 2014, where all expected schemes would behave according to this plan.

It is widely acknowledged that to ensure a sustainable reduction in admissions you must

allow for a system wide approach to the delivery of care. This should include a number of schemes which are multi-faceted across a range of providers.

During the 'Perfect Week' four schemes were implemented to assess the sustainability of the schemes and potential impact they may have. Those schemes were:

- Rapid Assessment, Time Limited
- Frail Elderly Assessment Support Team
- 7 Day social workers
- Mental Health Liaison

The initial activity data of these schemes are showing:

Total people seen during the 'Perfect Week'	FEAST	RATL	OPMH	Social Services
48	28	5	13	33
%	58.3%	10.42%	27.08%	68.75%

These schemes were implemented with only a lead in time of three weeks. None of them were completely fully staffed nor had they had the opportunity to develop clear pathways and protocols for 'hand-off' of patients through services. The Joint board agreed it would take a risk and trial what was possible.

This evidence is encouraging that with the appropriate amount of planning and phased approach to improvement, each of these services will impact on the metrics as outlined in this document.

FEAST aims to undertake a comprehensive assessment at the earliest possible point of care to ensure that people are able to avoid an admission where appropriate. This also means that all tests are considered on merit of benefit and reduction of harm to this group of people. 58.3% of those seen in the 'Perfect Week' through FEAST had an improved outcome in relation to LoS and reduction in inappropriate testing. There was also an increase in multi-agency working which allowed for a decrease in times 'telling the story'.

RATL aims to prevent people attending hospital as all. Within 'Perfect Week', 10.42% of people within our scheme cohort were avoided from attending hospital. They stayed in their usual place of residence, had just as high standard of care but did not have to make unnecessary journeys to health and care providers.

OPMH Liaison Service has a focus on working with patients, families and other health and care professionals to ensure the best possible outcome for that person. During 'Perfect Week' 27.08% were seen and received a full review and were either taken on to Mental Health Service case load or had their care requirements reviewed with a more appropriate outcome.

7 day Social Services have demonstrated a great impact on patient care. Having seen 68.75% of those who went through the schemes related to BCF, there has been increased social assessment and a much reduced length of stay as a result of being able to speed up processes which are often difficult to navigate when moving through different

organisational boundaries.

We recognise that delivering a reduction in non-elective admissions is wider than the Frail and Elderly population and therefore our system wide Implementation Plan details a number of other initiatives agreed across the organisations that will contribute to a delivery of reduced emergency admissions and better support the management of patients more upstream in their pathways. The initiatives are also designed to have a positive effect overall on length of stay, right care at the right level and rapid assessment for issues such as stroke where there is a clear evidence base that without it, the burden on long term care requirements is significant.

Our target reduction of 11.5% equates to a reduction of 2,775 non-elective admissions per annum.

The Implementation Plan will be monitored through the Frail and Frail Elderly Implementation Group and via the contracting processes in place on a fortnightly basis. Each of the schemes has a lead manager responsible to ensure the deadlines are met.

Key milestones include the delivery of a wide range of initiatives which will contribute to deliver of the reduction plans. These include all the better care funded schemes detailed in Annex 1. In addition a number of other initiatives and service developments have been agreed across the North Lincolnshire area, as part of the Healthy Lives, Healthy Futures programme and via the NHS contracting process. These will have an impact on all emergency admissions and the delivery of improved and more joined up care. These include the delivery of a dedicated stroke assessment and admissions unit, delivery of paediatric assessment facilities and full implementation of the Unplanned Care Model and service specification.

The key milestones are summarised below

Scheme	Jan	Feb	Mar	Apr	Ma	Mar	15/16	16/17
Community Well Being Hubs	In place and developing							
Care Home Support	Recruitment, integration and specification			Delivery				
Carers Support Services	Development of intent of service and planning			Delivery				
EMAS pathway redesign task and finish	Analysis, Planning and redesign			Delivery				
Rapid Assessment and Time Limited service (RATL)	Recruitment to 7 day and reengineering current services to new model				Delivery			
7 day social work	Delivery (begins in full December 15th)							

teams		
Frail Elderly assessment unit	reconfiguration	
Assessment and Discharge Services	Recruitment, integration and planning	Delivery
Older People Mental Health Liaison	Recruitment	Delivery
Discharge to Assess	Planning, development, commission and recruitment	Delivery
Integrated Locality Teams	In place and delivering, further development and recruitment ongoing	

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

In developing this plan the oversight and governance has been via the Health and Wellbeing Board. Partnership working is at the heart of the HWB and the associated arrangements. A Memorandum of Understanding (MoU) provides the framework for the governance of the HWB

The HWB is supported by the Integrated Commissioning Partnership (ICP) and the Integrated Working Partnership (IWP). The purpose of the ICP is to develop existing joint commissioning arrangements and identify further opportunities for joint commissioning, where they will deliver added value.

The ICP took the lead on the development of the plan for submission in April 2014.

The IWP is responsible for the development of a partnership framework to develop and deliver integrated services, championing integration, developing, implementing and monitoring the IWP integration statement and plan.

The-Joint Board for Health and Social Care (Frail and Frail Elderly) has been operational since March with equal membership drawn from both the CCG and Local Authority to oversee the wider system of health and social care and provide governance oversight to this plan and associated spend. The governance framework

includes financial management, performance and impact monitoring and service change assurance processes. The Joint Board is now clearly accountable for the mobilisation of the plan and receives monthly updates on the implementation actions. In addition it maintains oversight of all agreed outcomes, performance metrics and finances, taking responsibility for instigating actions and service change should the activity and performance metrics be off track and makes any decisions regarding deployment of contingencies. From October the Joint Board membership has been extended to include Northern Lincolnshire and Goole Foundation Trust and Rotherham, Doncaster and South Humber Foundation Trust. Terms of reference have been revised to reflect this but will remain under review to ensure they remain fit for purpose.

All partners have signed up to the development of the Section 75 agreement which will be in place from April 2015. This will be developed using the model agreements provided for BCF. This will provide the future governance between the CCG and NLC and Provider Organisations to ensure that the ambitions of the Better Care Fund are achieved and will include consideration as to whether additional resources are pooled in the future beyond the minimum mandated requirements. This will also include consideration of hosting and lead arrangements.

We are committed to pooling budgets for health and social care funding where it is prudent to do so, and where it will demonstrably improve outcomes and value for money. There will continue to be a focus on joint commissioning, a shared data set and outcome framework in order to drive quality, safety, a service user focus and value for money.

North Lincolnshire has a strong history of performance and outcome monitoring utilising the Outcome Based Accountability and Turning the Curve Methodologies. These would be the vehicles for ensuring that outcomes are achieved in relation to the payment by performance element and metrics.

Financial Risk Sharing arrangements are agreed as part of the BCF plan. In order to manage the risk across the whole of the community, the BCF risk share arrangement has been agreed in the context of the wider system and Healthy Lives Healthy Futures programme across Northern Lincolnshire. The BCF risk share has been agreed between the CCG, the Local Authority, NLaG and RDaSH, and is reflective of the performance fund.

All programme arrangements have been reviewed following a National Gateway Team Review of the Healthy Lives, Healthy Futures programme in June 2014. The North Lincolnshire change programme, including Better Care Fund and the Frail and Frail Elderly Programme are effectively linked.

The North Lincolnshire Frail and Elderly Strategy and Implementation plan to support BCF are being led through a jointly appointed Programme Director reporting to the Joint Board and supported by the Frail and Elderly Implementation Group with membership from all partners.

Oversight and communication

Regular reports on progress and outcomes are being provided to the CCG Governing Body meetings in Public and the Health and Well Being Board.

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

The Joint Board was established in March 2014 with delegated commissioning responsibility. The Joint Board oversees all key work programmes, financial management, reporting and budgetary control, risk management, performance and evaluation processes related to the Frail and Elderly strategy. This includes oversight and management of the Better Care Fund (Section 75 agreement once in place). The Joint Board is chaired by the Chief Officer of North Lincolnshire CCG and consists of the following membership from each organisation from October:

North Lincolnshire CCG	North Lincolnshire Council
• Chief Officer (Chair) • Chief Financial Officer • 2 Governing Body GPs • Director of Commissioning	• Chief Executive • Director of Policy and Resources • Director of People • Assistant Director of Adult Services • Assistant Director of Prevention and Commissioning
North Lincolnshire and Goole Hospitals NHS Foundation Trust	**Rotherham, Doncaster and South Humber Foundation Trust**
• Chief Executive	• Chief Executive

The Joint Board meets monthly. The minutes are received by the CCG Governing Body, the Council and the Foundation Trusts.

In broad terms:

The Joint Board is accountable for delivering the BCF Plan including management of the pooled budget and delivery of outcomes and performance measures to be incorporated into the Section 75 agreement. This includes finance, contract and performance management responsibilities. In addition the Joint Board has responsibility for determining the most appropriate contracting model for delivery, taking into consideration the length of tenure of existing contracts with providers and the flexibilities available.

Reporting to the Joint Board, a Frail and Frail Elderly Implementation Group with membership across CCG, Council, Northern Lincolnshire and Goole Foundation Trust, Rotherham, Doncaster and South Humber Foundations Trust, East Midlands Ambulance Service and North Lincolnshire Homes, has been established and meets fortnightly to deliver the vision and work streams as set out in the Better Care Fund submission. It operationally leads the activities and milestones related

to delivering the Frail and Frail Elderly work programme and oversee the delivery of the implementation plan. In addition it also reports into the Integrated Working Partnership (IWP) to ensure all work streams are clearly aligned with the overall integration strategy and the agreements made around progressing integration across the area.

The Frail & Frail Elderly Implementation Group is responsible for the:

- design and development of all work programmes relating to the vision for Frail and Frail Elderly services ensuring strategic fit with the wider strategy and integration agendas
- ensuring delivery of all key work streams and service areas relating to the investment from the Better Care Fund
- tracking agreed development plans to ensure that the programme is delivering its objectives
- holding each stakeholder to account for delivery and committing to alleviating any system blockages which are hindering progress
- working with the finance working group to establish financial management and reporting arrangements for the management of the associated budget and spend in relation to the Better Care Fund agreement
- operating within the governance arrangements as agreed at the Joint Board
- developing proposals for future commissioning of services for sign off by the Joint Board
- ensuring the delivery of all performance metrics associated with the Better Care Fund and escalating to Joint Board if the metrics are off track
- ensuring the risk log is accurately populated and kept up to date for reporting to the Joint Board
- developing robust evaluation processes to track impact and benefit of investment decisions
- monitoring and reporting any impacts as a result of service change

A Programme Director to support delivery has been appointed from the 1 October 2014

In addition there are Performance and Finance Groups supporting the Implementation Group and Joint Board providing oversight and technical advice on all performance, finance and activity metrics.

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. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

Ref no.	Scheme
1	Community Wellbeing Hubs
2	Care Home Support Service
3	Carers Support Services
4	EMAS Pathway Redesign (Task & Finish)
5	Rapid Assessment Time Limited Service (RATL)
6	Social Work Assessment and 7 Day Access
7	Frail Elderly Assessment & Support Team (FEAST)
8	Assessment & Discharge Service
9	Older People's Mental Health Liaison (OPMH)
10	Discharge to Assess
11	Integrated Locality Teams

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?** *Please rate on a scale of 1-5 with 1 being very unlikely and 5 being very likely*	**Potential impact** *Please rate on a scale of 1-5 with 1 being a relatively small impact and 5 being a major impact* *And if there is some financial impact please specify in £000s, also specify who the impact of the risk falls on)*	**Overall risk factor** *(likelihood *potential impact)*	**Mitigating Actions**	**Named Lead**	**Deadline**
The timescale of the requirements to deliver the BCF are tight with regards achievement within 15/16	3	4	12	Project Teams are expected to provide detailed business cases to FEIG during Jan/Feb 15 to ensure sign off prior to 15/16	Scheme project leads	Feb 15
The potential for the planned activity reduction not to be delivered leading to an overspending on BCF budget	3	4 (financial risk – max £3.4m P4P)	12	The Risk Share requires the CCG to contribute non recurrently to any remaining overspend in 2015/16 Performance Monitoring and assurance for each scheme/organisation will allow for	TP/MW/PW/MH	Ongoing monthly monitoring And by end March 16, application of risk share

				P4P to be delivered through accountability of each provider		
The impact of the BCF allocation on CCG finances requires the CCG to deliver savings from other expenditure programmes	4	4 (financial risk £1.24m)	16	The CCG is part of the wider HLHF programme which will be monitored monthly and where a scheme is not delivering the required savings, remedial action is taken. In addition to this there is a process in place for QIPP schemes outside of the BCF which underpin the achievement of the CCG's financial plan 2015/16 is already in train. The contingency reserve (£1.24m) in the BCF has been earmarked to meet this risk	TP/MW/MH/PW	Review monthly Action no later than March 16
The schemes identified as part of the BCF do not deliver expected reduction in activity	2	5	10	A clear performance framework with KPIs is in development and will be monitored regularly to identify any concerns and take the necessary corrective action. This will be undertaken through providers and commissioners working together to ensure the performance monitoring of each scheme is done consistently	Chair Performance Group	Mar 2015
The providers are unable to recruit fully the workforce to deliver against the expected timelines	3	4	12	Will be monitored via the Frail and Frail Elderly Implementation Group and through the programme	Chair FE Implementation Group	As per project timescales

				management. Requirements to be fed into provider and system workforce strategies and NHS workforce planning requirements. Phased impact assessment takes account of the phased implementation and embedding of changes.		
Social Care services are not adequately protected	4	4 £1.43m (including risk share)	16	The plans clearly articulate the commitment to protect social care in line with original plan by 2016-17 The joint board consider and review the whole system of health and social care	NLC - BM	Apr 2015
Performance Monitoring mechanism does not provide adequate accountability	2	3	6	The performance monitoring mechanism will be developed from the provider perspective to ensure quality outcomes are the main focus. Each KPI will be interlinked with each organisation to ensure ownership of KPIs through a system wide approach	Chair Performance Group	
The analysis and modelling work is based on current tariff allocation. NHS Providers will not have accurate impact acknowledge ment of either achievement or not	4	4	16	Resource allocation and modelling work is being developed further throughout Q4 in line with HLHF to ensure a system wide approach and local financial agreements of payment mechanisms	NHS Providers	Mar 2015
Fixed asset and stranded costs are not considered or	2	3	6	Provider organisations will work together across all sectors	NHS Providers	Mar 2015

apportioned in the savings				to ensure a follow through of impact regarding fixed and stranded costs. This will be achieved through HLHF allowing for full system integration of both success and risk management		

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

Northern Lincolnshire Health and Social Care system is working together under the auspice of Healthy Lives, Healthy Futures (HLHF). The Better Care Fund is a catalyst towards a more integrated system in particular HLHF. In this context further integration of services and risk share arrangements will be necessary to achieve the required area wide improvement. At this point in time attention is focused on the first step of Better Care Fund success.

Initial agreement on principles to govern resource planning across the health community (in this instance this relates to NLCCG and NLaG) from 2015/16 has been reached, based around control of activity and cost growth, and integration led by health & social care professionals. This agreement will underpin the wider transformation process, of which the BCF plans are one part. There is clear agreement from all parties that the BCF initiatives must deliver their part of the demand control agenda.

The risk management arrangements adopted to support the wider health community plan will therefore support delivery of the BCF initiatives.

The initial BCF pooled budget for 2015/16 is £12.37 million (Table 1) built up as follows:

BCF Pool Income	£m
LA Capital (DFG and Social Care)	1.364
Previous S256 (Reablement and Social Care)	4.449
Carers Grant	0.425
P4P	3.39
CCG	2.742
	12.37

Table 1: Better Care Fund 2015/16

1. Managing the Financial Risk

It is recognised by all partners in the North Lincolnshire health & social care system that we need to have a realistic and robust risk share agreement in place to mitigate the financial risk of delay or failure to achieve the required outcomes. The partners acknowledge the financial risk to the whole system and the risk sharing agreement underpins a robust performance delivery framework.

There is a system-wide risk that even with a strong contract and performance management framework agreed with all provider organisations, the benefits may not be achieved. Failure to deliver the planned reduction in emergency activity supported by increased investment in out of hospital care will create significant cost pressures for the whole system which will be resourced by all partners in line with the agreed risk share.

2. The Business Case Process

Any investment from the Better Care Fund will require the production of a Business Case which will be critically appraised by a task and finish business appraisal group before they are submitted to the Joint Board for approval. The Business Case will need to be supported by a detailed service specification and a contract with clear financial values, activity targets and KPIs where appropriate. It is recognised and acknowledged that a number of schemes may contribute to the overall change in activity and this will need to be taken into account when agreeing /approving the business case.

The planning process for the Better Care Fund will be divided into three distinct but linked phases:

- **Phase 1: Development of an outline case**.
An outline case for new investment must be prepared and as a minimum it should clearly demonstrate links to the key objectives of the BCF. The outline case will be presented to the Joint Board where a decision will be made as to whether the scheme should progress to the next stage;

- **Phase 2**: **The Business Case**.
A Business Case must be completed and will contain as a minimum, the case for change, the service specification, financial values, activity targets and KPI's and a timescale for mobilisation. The case will initially be agreed for recommendation at the Frail and Elderly Implementation Group to ensure consistency of service developmer and key inter-dependencies have been considered. The case will then be discussed

by the Joint Board where a decision will be made on the next steps (approve, defer with recommendation or decline as not feasible at this point or not in line with Health Lives, Healthy Futures);

- **Phase 3**: **Post Implementation Review**.
The Joint Board will require a report at six months and twelve months post implementation of the new service model. This report will outline the service and financial benefits achieved from the new model compared with those outlined in the initial plan. The outcome of this report to the Joint Board will be a decision on the future of the new service and a decision on the level of the performance element of the project to be released.

In addition to the specific post implementation review report, the scheme will have summary level KPIs reported to Joint Board on a monthly basis, thus ensuring a clear understanding of benefits realisation by the board members

To ensure that all parties have a shared responsibility to deliver the changes require from the BCF, payments for new projects will be made in two tranches. The first tran 70% will be made following the implementation of the new service and the balance, 30% will be paid for delivery of the agreed outputs.

Where it can be clearly demonstrated that a business case does not achieve the required return on investment, further work will be undertaken to ensure that the targ Return on Investment is achieved or bettered. If corrective action does not deliver the required improvement, the Business Case will be subject to an in depth review and t Joint Board may decide to disinvest.

As part of the implementation programme there will be a schedule developed to ensu Business Cases are taken to Joint Board appropriately and in line with the mobilisati plan of the Better Care Fund i.e. those which are fundamental will be expected to be implemented early in Q4 etc.

3. Implementing the Risk Share agreement

By its nature a pooled budget provides an appropriate vehicle for sharing risk between the associated parties. The agreed principles of the risk share are:

- the financial impact of unpredictable incidences on system wide deliverables should be shared proportionately, dependent on the scheme and service, amongst the parties to the agreement. This supports a general principle that all parties equally contribute effort to the effective delivery of the schemes;

- Where the impact is so financially significant that individual bodies could be

at financial risk, the parties will work together to mitigate the impact.

The agreed ground rules, as part of this risk-share arrangement and the areas we have covered include;

- Finalising the details of the risk-share regarding the risk and cost of the BCF underperforming;
- How the delivery element (30%) will be used if the agreed outputs are not achieved;
- How we share the benefits where the BCF targets are exceeded;
- Where services within the BCF are existing services that have already been contracted by either CCG or LA, there are a number of other considerations that will impact on risk sharing. These include:
    - Who is the current host commissioner;
    - Who provides the existing services and what arrangements are in place to monitor delivery and performance measures (inc KPI's);
    - Whether changes to existing provider arrangements will have direct and indirect impact on non-BCF services currently provided;
    - Whether current contract management arrangements are fit-for-purpose.

Only the financial elements of services covered by the Better Care Fund (BCF) are eligible for risk sharing (although there may be flexibility to add to the arrangement subject to agreement by all parties and by approval of the Health and Well Being Board). e.g. where budgets are held locally for services outside the BCF but cover similar services as the Better Care Fund.

Responsibility for the management of the Better Care Fund (Pooled Budget) is split between NLCCG and NLC by mutual agreement.

All parties recognise that risks associated with the Better Care Fund need to be funded by it and not be a pressure on individual organisational budgets outside the Better Care Fund. As such, it is recognised as a part of this agreement that any net provider or commissioner cost pressure created as a result of this risk management arrangement is an issue which must be resolved through the wider risk management arrangements established for the health community resource allocations, and should not generate any further net cost pressure within the system. This is essential to the effective operation of the wider shared risk concepts

being developed as a key basis for local resource planning.

4. Details of the Risk Share agreement

As previously explained, the Risk Share will need to cover four key elements and these are considered below:

- **The risk and cost of the BCF underperforming**

  The BCF plan requires the CCG to provide additional funding in 2015/16 of £6.132 million (£3.39 million of which relates to the P4P element outlined in the metrics) and it had initially been assumed that this resource will be released from savings in the volume and cost of emergency activity at our main provider (NLaG).

  The current BCF plan assumes new investments in 2015/16 of £4.89 million, leaving a contingency reserve of £1.24 million (see Table 2):

Investment Schemes	£m
NLAG - Frail Elderly Assessment Service	1.13
NLAG - Care Homes Liaison	0.4
NLAG - RATL	1.43
RDaSH - RAID/MH Liaison	0.5
NLC - Wellbeing	0.5
NLC - 7 Day Social Work	0.634
NLC element - Locality Teams	0.3
	4.89

	2015/16	
Provider	**£'m**	**%**
NLaG	2.96	60.5%
RDaSH	0.50	10.2%
North Linc Council	1.43	29.3%
New Investments	**4.89**	**100.0%**

Table 2: Investment Plans 2015/16

Investments will be supported by a business case that clearly identifies the activity, expected quality outcomes and financial savings that they will deliver. The business cases will be critically appraised by a task and finish business appraisal group.

A modelling tool has been used in order to assess the financial impact of the investments. The estimated savings achieved from these investments are £4.114 million and are summarised below (Table 3):

	£'m
Residential Admissions	0.09
Re-ablement	0.15
Delayed Transfers of Care	0.02
Avoidable Emergency Admissions	3.39
Length of Stay	0.47
TOTAL SAVINGS	**4.114**

Table 3: Estimated Savings in 2015/16

The Risk Share will be managed as follows:

I. Delivery Risk

The contract (S75 agreement) will be worded to allow the payment to providers to be made in two distinct trances:

- **Implementation of service** – 70% of total contract value

- **Delivery of agreed outcomes** – 30% of contract value

	2015/16		
Provider	**£'m**	**70%**	**30%**
NLaG	2.96	2.07	0.89
RDaSH	0.50	0.35	0.15
North Linc Council	1.43	1.00	0.43
New Investments	**4.89**	**3.43**	**1.47**

The risk share assumes that the delivery payment will be linked to the achievement of the P4P metric – i.e. reduction in non-elective emergency admissions activity and assumes that this will be the product of all of the planned investments and cannot be attributed to any individual scheme.

The performance framework will provide a mechanism by which to identify matters which may impact on achieving the target reduction through agreed scheme related activity and KPIs. The scheme specific measures can be linked to the delivery payment and will be agreed and signed off by the Joint Board as part of the business case approval process.

It has been accepted that any under-performance against the planned activity reductions will result in a reduction in the delivery element of provider payments.

The sliding scale of delivery and payment is further illustrated in the CCG Commissioning Risk

Any residual cost through failure to achieve the financial targets within BCF will be allocated through HLHF programme delivery and financial modelling to ensure a certainty of delivery and ownership across the wider health and social care system.

II. CCG Commissioning Risk

The current plans do not deliver the level of savings for the CCG required to fund the additional investment in 2015/16. Set out below is the impact on the CCG in 2015/16:

	£'m
CCG transfer - from current healthcare spend	6.13
Funded by:	
Planned Savings from new BCF investments	4.114
Gross Shortfall	2.01
Less;	
Use of contingency fund	1.24
Current Funding Gap	**0.77**

Set out below are a few worked examples of the impact for the providers and the commissioner (CCG):

		Percentage Delivery of Planned Reduction			
	Plan	75%	80%	90%	115%
	£'m	£'m	£'m	£'m	£'m
Gross Savings	4.12	3.16	3.30	3.73	4.70
Planned Investments	4.89	4.89	4.89	4.89	4.89
Surplus / Deficit(-)	- 0.77	- 1.74	- 1.60	- 1.16	- 0.19
Funded by:					
Withheld Delivery Payment					
-NLaG		0.44	0.33	0.22	
-RDaSH		0.08	0.06	0.04	
-NLC		0.21	0.16	0.11	
Commissioner Impact - CCG	**0.77**	**1.00**	**1.05**	**0.79**	**0.19**

The calculation of the delivery payment to providers is based on the following assumptions:

	Delivery
Delivery	Payment
Less than 75%	0.0%
75% delivery	50.0%
80% delivery	62.5%
90% delivery	75.0%

It has been assumed that any shortfall after the implementation of the performance (delivery or commissioning) will be met non-recurrently by the CCG and this is included in the 2015/16 financial plan. It is anticipated through the modelling work already undertaken with PA Consulting and further commissioned support through PwC as part of HLHF there will not be a longer term financial shortfall.

6) ALIGNMENT

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

The Plan is consistent with the North Lincolnshire 5 year Strategic Plan agreed in June 2014. This draws on the Joint Health and Wellbeing Strategy which focuses on what partners can do better together to add value and identify opportunities for working together differently, whilst delivering value for money. It also fits with the 5 Year Forward Vision from NHS England.

The plan is a catalyst to the overarching strategy for Northern Lincolnshire; Healthy Lives, Healthy Futures which sets out the vision for the configuration of health services across the area.

Healthy Lives, Healthy Futures is the review of health and care services in North and North East Lincolnshire. It is led by two Clinical Commissioning Groups (CCGs), North Lincolnshire CCG and North East Lincolnshire CCG, working with all our local health and care partners. The review is linked to similar programmes within the East Riding of Yorkshire and Lincolnshire. The review is driven by national best practice recommendations around the services we offer, and is aimed at ensuring that we develop a health and social care system that delivers safe, high quality and affordable services for many years to come.

We will ensure that whenever it is safe and deliverable, the majority of healthcare services are provided as close to people's homes and communities as possible. We also know that we need to make the best use of the money we have to spend on healthcare, in the face of a very challenging financial environment.

As part of the Healthy Lives, Healthy Futures programme review work undertaken to date, two services have been consulted on. The consultation ended on 26th September 2014 with decisions taken in November 2014 on:

- Hyper-Acute Stroke Services
- ENT Inpatient Surgery

In addition to the service changes we have consulted on, we have a wide range of on-going work supporting the delivery of our vision to move services closer to people's homes and communities. This work includes:

- Moving services out of hospital settings and into communities where this is more beneficial
- Enhancing out of hours provision to offer services that fully support people at evenings and weekends
- Working more effectively with our partners (local authorities and healthcare providers) to improve integration of care and therefore improve outcomes for people
- Making the best use of the technology available to support people to care for themselves at home
- Providing better, more accessible information that will help people to care for themselves and make healthy choices

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

The North Lincolnshire 5 year Strategic Plan (2014/15 – 2018/19) sets out a vision where people are supported to live independently where possible. People can access support close to home when they need it and are supported to return to independence following periods of illness through proactive re-ablement. This vision reflects the views of the local population as gathered through an engagement process using Experience Led Commissioning™ 'Keeping Well and Maintaining Independence' undertaken during 2013. The local population highlighted that they want support to maintain their health and independence with access to universal support that helps them manage their own health. The plans set out in this BCF plan directly correlate with the views expressed by the local population and the vision set out in the Strategic Plan.

The metrics and impact described through the BCF submission aligns with the longer term journey around service transformation across North Lincolnshire. The milestones and service changes delivered by utilising the enablers of the BCF form steps along the way towards realising the 5 year Strategic Plan. The BCF plan represents a joining together of the strategic intentions of the CCG, GP commissioners and providers, the LA, Acute and Mental Health Trusts.

These plans are also aligned with the strategic and business plans of Northern Lincolnshire and Goole Foundation Trust and Rotherham Doncaster and South Humber Foundation Trust as submitted to Monitor in terms of strategic direction and approach.

Leadership arrangements are in place supported by PwC to develop a sustainable plan for Northern Lincolnshire through Healthy Lives Healthy Futures, which will draw together transformation plans across the all commissioners and providers. This BCF plans forms a key component of that plan. Leadership is aligned across all organisations.

All providers and commissioners have spent time over the last three months developing a plan of integration and inclusive working across Northern Lincolnshire. This includes primary, secondary, community and mental health as well as both Local Authorities in the region.

The Accountable Officers in this area have agreed that the Lead Accountable Officer for Healthy Lives, Healthy Futures will be the Chief Executive of North Lincolnshire and Goole Hospitals NHS Foundation Trust. This role will be supported by the programme management office which also has clear lines of accountability for the Better Care Fund.

In demonstration of this, the Accountable Officers agreed and requested the involvement of central support in modelling the schemes and potential benefits that can be achieved. Each of the Accountable Officers have signed up to the model developed by PA Consulting and have agreed the principles of the work undertaken.

In making these connections and clarity of alignment of vision the intention of further and explicit integration of health and social care will be planned over the next three months ensuring full implementation planning from Q1 of 2015/16.

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.

The CCG has expressed an interest in co-commissioning primary care with NHS England at Level 2. Whilst the required governance changes are prescribed by NHS England, locally we will align delivery and strategy with the BCF and Healthy Lives, Healthy Futures. We are currently working with NHS England to establish governance arrangements. NHS England are represented in the Healthy Lives Healthy Futures Programme Board as commissioners to support the alignment of plans, and are also engaged with the frail and frail elderly programme through the work with NHS IQ.

To support the development of Joint Commissioning the CCG is reviewing the Primary Care Strategy to set out a clear vision for primary care going forward that will support the development of sustainable services and the vision set within this plan.

The Better Care Fund plan links closely to practice plans for the Elderly Care Fund- the local implementation of the Accountable GP for > 75 yrs. Aims of the plans are to reduce hospital admissions and maximise health and independence through care

planning and improved self-management. Whilst each practice has developed its own plan, there are similarities across all and the agreed monitoring process will ensure benefits are clearly identified and measured to inform decision making regarding use of funds in subsequent years. Common themes within plans include use of 'birthday cards' to inform patients and invite them for a health check, appointments of increased duration to support robust assessment, care planning and management of older people with complex needs, participation in MDT discussions about patients, and proactive management to reduce non-elective admissions

All local practices are delivering the Proactive Care DES, NLCCG have had some long –standing information governance issues which have prevented the use of the risk stratification tool, however these issues are now resolved and the practices will utilise this data going forward to identify high risk patients and those at increasing risk of hospital admission.

North Lincolnshire now has a GP Federation (Safecare) with a representative engaged with the Frail and Elderly Programme. Much of this engagement has happened during the series of NHS IQ events focussing on the Frail and Elderly during March to October 2014. This has allowed a number of GPs with a keen interest in developing strategy and initiatives in this area to come forward. There is GP representation on the Joint Board and a representative from this Federation is a member of the Frail and Frail Elderly Implementation Group.

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.

a) Protecting Social Care Services

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

Protecting Social Care Services in essence means that those who require support will receive support in line with their assessed need and at the right time and in the right place. The eligibility criteria will remain the same – locally our Fair Access to Care provision is for moderate need and above, however, we recognise that more can be done at the preventative level in order to ensure that people remain well, feel part of their communities, are leaders in the management of their own physical and mental health to prevent and offset crises later on. As part of the council transformation plans we are committed to investing in wellbeing and preventative services in order to effectively support people at the right level with the right care and support whilst managing the demand on the reducing resources. Whilst maintaining the current eligibility criteria, we have developed and implemented as detailed, the community based wellbeing offer, whereby individuals will have access to activities, information and support to enable independent living for as long as possible.

In addition, we are committed to maintaining and improving our intermediate care services and continue to provide high quality targeted support services that support and enable to get back to independence as quickly as possible, keeping them healthy and at home for longer. Protecting social care services extends to the benefits of offering a wide range of intermediate services which is an effective way of managing peoples' needs at the lowest level.

We will continue to invest in supporting carers to keep them well and engaged in caring for a family or friend. Our focus will be on tackling the risk factors associated with ill health and a poor quality of life, rather than reacting to crises and also greater alignment of our current services with those within health to reduce duplication and ensure better productivity, impact and use of resources.

We recognise by utilising shared assessment process and up skilling frontline staff to recognise both health and social care needs, we will more effectively mobilise services across the health and care spectrum. We are committed to providing similar levels of workforce development to the health and social care workforce to support the delivery of the Better Care Fund plans and integrated working.

ii) Please explain how local schemes and spending plans will support the commitment to protect social care

Funding has currently been utilised to provide timely assessment, care management, review and commissioned services to those with substantial or critical need. We have also invested funding in preventative services, such as the Health and Wellbeing Hubs, the implementation of Safe and Well checks across all localities starting with the over 80s and rolling out to 75's, coffee mornings, social activities, personal care needs, befriending and the voluntary driver service, finance, volunteering, enhancement of community meal service to included fresh cooked options, health advice/ healthy eating and home safety. The spending plans will ensure that a range of universal services are available across North Lincolnshire which are important for early identification of need, promoting wellbeing, self-care and support.

Services to be protected are those that have a direct interface with the NHS with a focus on the frail and elderly, such services would be described as Targeted and Specialist services and consist:

- our proactive care and support teams who are part of the Integrated Locality Teams providing case management for older people
- integrated unscheduled care scheme at the hospital
- Intermediate care and rehabilitation services both bed and community based

Investment and funding has increased in relation to 7 day access to social work assessment, 8am – 8pm and in order to meet the potential requirements of the new Care Act requiring additional assessments to be undertaken for people whom have historically not accessed social care services, people whose capital falls below the new higher threshold and the equality duty to offer and provide equal service to carers.

In order to reduce admissions to hospital and residential and nursing care homes we will invest an additional 15% to grow our proactive care and support services.

We recognise that initiatives and different ways of working will require pump priming in order to maintain and increase our performance against the metrics, e.g. increase in rehabilitation and re-ablement services. The proposed RATL scheme will provide a much needed clinical oversight to the community reablement team by providing a better co-ordinated link with intermediate care services and with universal services – this will enable more effective service delivery that will be better equipped to meet the increase in people being supported at lower levels in the community.

The Council's Joint Strategic Assessment articulates that:

- More support services will be provided in the community and at the lowest point of support and intervention. This will include an enhanced wellbeing offer delivered through four local wellbeing hubs
- Fewer older people with long term conditions will be admitted to hospital in crisis, as more people receive proactive 24/7 care and support

- Reliance on urgent or acute care will reduce as more people with long term conditions are helped to manage their own conditions in the community
- The use of residential and nursing home care will be limited to those whose needs cannot be met safely in the community
- Intermediate care services will be extended further to support people to regain independence post hospital discharge
- A new, extra care sheltered housing scheme will be developed for older frail people and people with complex needs
- The action plans developed from the Experience Led Commissioning work on services for people with multiple long term conditions and dementia will be implemented
- More people will be taking control of their own care and support.

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.)

The BCF plan outlines a commitment to ensure that those services that are currently provided using the additional 256 NHS funding – Reablement S256 and Social Care S256 and Carers Grant are maintained as they are crucial to the success of the whole system, this equates to £4.2m (including NHS Carers Funding). In addition the level of services that require protecting through BCF is £2m to ensure that the right level of service can continue, specifically in the targeted and universal levels (intermediate care, occupational therapy, community equipment and community wellbeing). This enables those services to be maximised to meet a growing number of people's needs in order to reduce the number of people requiring long term packages of care or requiring admission to hospital.

The plan shows a commitment to protect additional social care services to a total of £2m, however, in 2015-16 this has been reduced by £1m in order to ensure overall affordability of the CCG budget plans. There is a contingency included within the plan, which may be used to cover any emerging pressures in either the LA or the acute provider.

The level of protection will be £2m in 2016-17.

There has been an increase in the population of people aged over 85 in North Lincolnshire of 37% which is 15% more than England average. It is anticipated that this will increase by a further 46% by 2021, therefore it is important that we can protect the level of services providing care and support in order to minimise the impact on specialist and acute levels of care.

To do this, there has been an investment in Adult Social Care services by the council in 2014/15 budget (0.8% increase – overall the total net spend on LA services has reduced by 0.6% from 2013-14 to 2014-15) to transform services over a period of time; moving towards people self-managing in the community, investing in prevention and targeted services. This includes a 43% increase in spend on preventative services (£1,993k in 2013-14 to £2,842k in 2014-15). The outcomes to date of the transformation has been a reduction in the number of long term packages of care, whilst increasing the numbers of people we are working with in the community (increase in the number of contacts of around 16% and an increase in assessments of 9%, reduced number of long term packages of care 3.5% although costs have not reduced due to the level of frailty and complexity of our older population). In support of this direction of travel, the level of performance in respect of ASCOF has been maintained, 16 out of 19 measures are above the English average. The LA budget plans reflect the changing demand for services and demonstrates a level of service investment achieved through transformation savings. This equates to total council savings of £10m and re-investment of £9.2m of which £3.6m are savings (efficiencies and transformation (£3.45m and remainder income from charges) in adult social care

with £3.8m re-investment. In summary, the council transformation plans align to the vision of BCF outcomes. In light of the planned reductions in government funding for local authorities (a reduction of 29% in 2015/16) the council has a medium term financial plan that continues to maintain Adult Social Care Services at the required level, incorporating demographic changes, to deliver our transformation outcomes and BCF outcomes – this is based on the expectation that the funding outlined in the BCF Plans for protection of social care services will be available.

The Council's financial plan for 2015-16 will need to be reviewed to take account of the £1m reduction in protection of social care services.

The indicative allocation of the £135m within BCF for North Lincolnshire, to implement the Care Act duties is £432k. This amount has been identified as part of the financial plan to ensure we can meet the new duties.

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

The key functions identified that require additional resources as part of the BCF allocation to meet the requirements are:

- Local Adult Safeguarding Board
- IT systems development
- Information advice and guidance
- Legal support
- Advocacy
- Support to carers

The Council has an implementation plan, governed by a strategic group and are engaged with the national stock take that the LGA is co-ordinating. The Care Costs modelling tool has been undertaken to provide an analysis of further resources that will be required to meet the new duties.

The North Lincolnshire Adults Partnership will have oversight on ensuring that local services are shaped and developed to meet the new requirements of the Care Act. The Partnership is a stakeholder/reference group which brings together representative partners from all adult workforce sectors as well as adult representatives and focuses on the collaborative work of agencies and services, help to secure the added value of integrated working and in partnership with adult representatives to help ensure improved outcomes and reduced inequalities for vulnerable adults, and their families and carers in North Lincolnshire.
There are a range of citizen representatives on the partnerships, including the Carers Advisory Partnership – to ensure the needs of service users are clearly voiced, heard and used to shape and develop service delivery and quality.

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

As part of the Better Care Fund plan a total of £425k has been set aside specifically for carer support services, however, in addition to the specific resources carers will benefit from the community wellbeing hubs and services. The investment sits alongside the current level of investment by the council to support carers and will be targeted to meet the new requirements of the Care Act.

There is a well-established Carers Support Service within North Lincolnshire with established collaborative approaches to commissioning the right services for carers. Ongoing work with the Carers Advisory Group will enable need and carer involvement in the design of future commissioned services. The Council reorganisation of adult services has created a new Adult and Family Carer Support Service to develop alternatives to residential care for people living at home, these will be moulded on the national programme 'shared lives' The jointly agreed carers strategy identified the need to improve advice and information which will be integral to the wellbeing offer.

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

The Council's medium term financial plan included the assumption to protect social care services equating to £2m in 2015-16. Although this will be achieved in 2016-17 with the BCF, this causes a £1m gap in the overall budget 2015/16.

There is potential for reductions across the whole Adult Social Care system to compensate including some delays in the development of the wellbeing hubs or opening of new intermediate care unit.

All partners have committed to work collaboratively to identify resources to cover this gap in 2015/16 and mitigate the risk of this reduction in order to avoid unintended consequences in the whole system, such as effectiveness of reablement and delays in discharges.

There is a strengthened focus on the Care Act investment required, which will support more effective implementation.

a) 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

Over the past five years North Lincolnshire has seen a reduction in permanent admissions of older people to residential and nursing care homes per 100,000 population and an increase in the reablement services. This demonstrates that we have robust relationships and systems in place to ensure the safe transfer of people whom are eligible for social care into the community.

Building upon our success in having reablement services at the hospital overnight we have invested in 24/7 working at the hospital and are moving towards greater integration with the clinical teams. This has enabled more rapid availability of social care assessments both within the Urgent Care Centre and Clinical Decision Unit with a particular input to the dedicated Frail and Elderly Assessment and Support Team developed through this plan targeting those patients who would be most likely to result in short stay admissions due to waits for assessment. It is also targeting patients who have already been admitted to wards to enable reductions in lengths of stay and further impact on any delayed discharges. The service although only just recently implemented, is already providing a more integrated team approach between hospital staff and social care in the management of frail elderly and a positive outcome of this will be knowledge transfer across professions ensuring better and more sustainable understanding of appropriate service options for patients. In addition it will enable rapid and supportive discussions on those options to take place with patient's families to ensure that account is taken of carers needs in the process which has a significant impact on care decisions.

Proactive care and support, integrated care within the five localities. In order to reduce admissions to hospital and residential and nursing care homes resources have shifted to proactive and support services.

There will be increased rehabilitation and reablement promoting self-help. The integrated teams will have an extended remit to provide rapid responsive home from hospital care linked to the RATL and hospital social care teams. The council is investing £3.8m in building a new purpose built intermediate care facility, which will create a 50% increase in the bed base and are developing an enhanced home from hospital services linked to 7 day integrated urgent care centre at the hospital.

b) 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

Use of the NHS Number as the primary identifier:

The NHS Number is recorded in the social care record at initial contact, where NHS Services are involved in supporting the client.

An Information Sharing Charter has been agreed across Humber which sets down the principles for sharing records, and is based on a consent model. The Charter will be reviewed as part of the NHS Number Capture Project, which is considering the capture, validation and use of the NHS Number as a key identifier for integrated

services/systems.

It is a key project in the Council's I.T. Strategy 2014-15.

The First Contact form is currently being revisited to review the addition of the NHS Number, to enable the NHS number to be captured for all clients at the first point of contact.

Meetings have been held with the network providers for the NHS and the Council. Connections are already in place for key council buildings to have secure access to the NHS Spine (N3 network). There are also integrated wireless connections available for NLAG devices and an ongoing project to provide the same access to the CSU device.

We are engaged with our Social Care Case system supplier to provide a validation of the NHS Number service via the NHS National Spine. Initially this will be a batch process but their roadmap for 2015 has software developments which will enable a validated NHS number to be allocated at first contact.

The plan to move to the NHS Number as primary identifier consists of four phases:

Phase 1 – Review the NHS Number capture points
A review of the Single Access Point (SAP) process will ensure capture of the NHS Number at the beginning of the Social Care pathway, which will form the unique identifier for the client during their pathway journey. The new process will be in place by 1st April 2015.

Phase 2 – Review of information sharing protocols
To ensure all parties are clear on the sharing of information a review of the current data sharing protocols between the Council, NHS and other providers will be undertaken. This will also include implementing the secure methods of communication to be used across the partner organisations. The Council has already obtained agreement to meet the standards for Information Governance Toolkit and continues to work closely with partners to review and improve our Information Governance policies and processes. The Council has an Information Governance Officer and supporting team to support and drive forward change in this area including regular employee training via e-learning and specialist training events.

Phase 3 - To ensure the NHS Number meets Validation Requirements
A project has been initiated to identify a solution to validate the NHS Number in Council Case Management Systems using the Personal Demographics Service (PDS) provided by the Spine.

OLM Group Ltd, the Council's social care system provider are engaged with their customers on developing their product to provide NHS number validation files for upload to PDS and to receive the validated numbers and update the client records. In discussions it is expected that OLM Group Ltd will use the NHS Number as a key client identifier in a future release of the software in place of the optional field in the current release.

To support validation, the council recognise the need to put a focus on data quality, as NHS number matching could potentially generate a high volume of duplicates and other data quality issues.

Project Milestones for Phases 1 -3 are:

- Form Project Board – September 2014
- Undertake feasibilities – October – December 2014
- Select solutions – January 2015
- Award contracts (if required) – January 2015
- Implement solutions – February – March 2015
- Review outcomes – April 2015

A full risk register will be included in the project. Initial risks considered are:

1) Irresolvable data sharing issues which will be considered against new guidance from the NHS on the outcomes of the Protecting Health and Care Information consultations in September 2014

2) Editing validated NHS Numbers making them inaccurate, which is being explored with the software suppliers to create a non editable field once the NHS Number has been validated

3) Difficulties in obtaining the NHS Number from the client during initial Social Care assessments. A method of looking up NHS Numbers is being explored to reduce these potential gaps

4) Failure of the integration with the PDS tool for validating NHS Numbers entered onto the Social Care Case Management System. Alternative methods of validation are being considered as a back up to the failure of this integration which do not require a connection via the Spine (N3 network)

Phase 4 the development of an Integrated Digitised Care Record

The Local Authority, CCG and Trust are engaged with a wider Humber based IT Strategy Group which is taking forward system integration and record sharing across the wider Humber locality. This group has not been successful in its bid to the Integrated Digital Care Record Fund for £5.5m to support an £11m project to implement a 'Unified Health and Wellbeing Hub' across 17 organisations in the Humber, which encompasses 4 LA's, 2 Acute Trusts, Community Care Organisations, 4 CCG's and Primary Care.

However the local CCG and North Lincolnshire Council has submitted a joint Capital bid to enable the development of a local hub to patient and service user summary records.

The Hub will consist of a clinical portal to share health and care records across professionals, a patient portal to enable patients and service users to access and contribute to their health and care record and an Information Hub, which provides information and sign posting to the most appropriate service.

This whole solution will make available key information from the core systems used for Health and Social Care to form a holistic record of the care and health needs and services received by a patient/client. This will enhance the availability of client information and provide sign posting for practitioners to seek additional information where required.
It will offer a more streamlined approach to ensuring people only tell their story once and have co-ordinated support packages in place.

The use of the NHS Number as a key identifier is an essential component to any integrated care record.

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))

We are committed to adopting systems based upon APIs and Open Standards.

The CCG Information Management Technologies group is fully engaged with the needs of providing integrated technology solutions. Initial discussions have been completed and a formal project is being setup for October 2014. This includes an application to Integrated Digitised Care Record" unified health and wellbeing hub" funding to develop a Humber wide care record solution.

All projects have to consider the availability of Open Standards and APIs during the feasibility stage. A better understanding of the options will be completed during the feasibilities undertaken October-December 2014 which will evaluate available API"s/Open Systems and their ability to offer integration between existing systems.

API's and Open Systems will have a requirement to openly publish their interfaces within the contract to ensure they are available to other providers to support further integration as required.

Risks that will be considered during the feasibility stage will include:

1) Key suppliers failure to agree to implement or engage with Open Standards. Initial discussions with our key providers demonstrate a willingness to adopt Open Standards to support integration and data sharing.
2) Additional costs of implementing and maintaining API's across key systems. The total cost of ownership for an API's will be included in the feasibility process.
3) Suppliers ceasing to trade. All suppliers will have an ESCROW agreement as part of the contract to ensure the code is available to alternative suppliers. Supplier's financial sustainability will be included in the tendering process and renewed when contracts are under review.
4) Failure of API's to transform data into the correct format to feed into an different system. The Hub approach will only extract and merge data at the hub for presentation and will not feed data back into core systems. This minimises the data source from being corrupted. A comprehensive testing and standards approach will be taken when implementing the hub solution to ensure it delivers the outcomes expected. This will be repeat prior to any upgrades or additional data sourcing being added in a controlled testing

environment,

We currently use;

SystmOne, a clinical computer system that allows clinicians to view information and add data to their records based on shared clients and task functions.

EMIS Web, a tool that allows primary, secondary and community health care practitioners to view and contribute to a Service User's records.

Care First 6, a software solution for the creation of the Electronic Social Care Record and performance functionality.

Capita One (One, eStart, IYSS) – This product has API capabilities.

MARACIS is an NHS application used by the mental health services to manage their case loads and services. It has the ability to record the NHS Number

The supplier is actively engaged in projects to connect into the NHS spine and integrating into the main health systems.

Discussions with current suppliers have started on their response to implementing the requirements of the Better Care Fund.

Agreement has been made for a short term solution to use the Foundation Trust interface of WebV to ensure accessibility for both GPs and community service users who have access to SystmOne.

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, professional clinical practice and in particular requirements set out in Caldicott 2.

We are committed to ensuring the appropriate controls are in place.

The Council, CCG and Trusts take their Information Governance responsibilities very seriously and as such have good controls in place. There is an Information Governance Policy Framework that sets out the Council's responsibilities and activities in relation to Information Governance.

Compliance has also been received for the Data Protection and Freedom of Information elements of the Framework. Other parts of the framework will be audited in due course.

Information Governance roles have been assigned to a selection of key council officers, including the Caldicott Guardian to advise on procedures to ensure compliance with the Caldicott principles.

All employees are trained in Information Governance to a suitable introductory standard, with key roles receiving advanced level training. This is set out in a three

year training plan.

A contractual Information Governance statement has been agreed to ensure the Council's contractors understand the Information Governance standards demanded by the Council.

The Integration of Public Health into the Council in April 2012 required that assurance be provided to the NHS to demonstrate that suitable Information Governance controls are in place within the Council. The NHS was satisfied with the Council's policies/procedures. An action plan is in place to monitor and improve our controls in-line with Public Health as the transformational plans are further developed and implemented.

We are committed to the seven Caldicott principles of appropriate information sharing;

- **Justify the purpose,** every proposed use or transfer of personal confidential data within or from an organisation should be clearly defined, scrutinised and documented, with continuing usage regularly reviewed, by an appropriate guardian
- **Use of personal confidential information when necessary,** personal confidential data should not be included unless necessary. The need for Service Users to be identified should be considered at each stage of satisfying the purpose
- **Use the minimum necessary personal confidential data,** where personal confidential data is essential this should be to promote safe and effective care of an individual
- **Access to personal confidential data should be on a strict need to know basis,** confidential information about Service Users or patients should be treated respectfully
- **Everyone with access to personal confidential data should be aware of their responsibilities,** policies and procedures are in place to uphold information sharing governance issues that is known, understood and adhered to by the workforce
- **Compliance with the law,** all use of personal and confidential information must be lawful
- **The duty to share information can be as important as the duty to protect patient confidentiality,** health and social care professionals should have the confidence to share information that is in the best interests of their Service Users

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

i) 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

Each Locality team implemented integrated ways of working just over a year ago and have worked on local risk stratification of those with the most complex needs, utilising an assessment and review tool within the context of a multidisciplinary team that agrees the need and support requirements for each patient. Those with the highest need will have an identified lead professional allocated at that time and it is this professional who will link very closely with the named GP and care coordinator within primary care.

Locally we have determined those angina, heart failure, diabetes, COPD and carer breakdowns are among the common causes of unplanned admissions for chronic long-term conditions and diseases in the > 75yrs.

According to national estimates, 2,220 people >75yrs in North Lincolnshire will be living with three or more conditions which are likely to include some of the above. Not all of these cases will be severe and not all people who suffer from these conditions will be at a high risk of unscheduled admission, however, the risk and complexity increases with age. Our initial estimates are 15.6% at high risk of admission.

Based on our risk stratification and a further review of all data sets identified plus national and international best practice achievements, we will be working closely to monitor those classified at high risk of hospital admission. Due to a number of challenges which have now been overcome, GP practices have only just started implementing a Risk Profiling Tool which utilises Primary and Secondary Care data to identify people at high and increasing risk of deterioration. Early findings are emerging from this process and practices are working with the wider Locality Teams to manage these patients.

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

The GP contract from April 2014 required the identification of a lead GP for all registered patients >75yrs. This is supported by the Elderly Care Fund in 2014/15, which sits outside the BCF but whose use is aligned to the BCF. Practice plans are beginning to deliver the Care Coordination role across primary care which is acting as the accountable professional with the ability to ensure the right assessments take place and the right care level is mobilised. They create a robust link between the general practice team and the wider community and social care team and ensure that MDTs for individual patients are delivered to coordinate and reduce duplication. The risk profiling work within primary care has formed a key part in the identification of those individuals who either are actively at risk currently of an unplanned admission or those who may go on to be at risk if intervention does not take place. This has then formed the cohort of patients that the Care Coordinators are currently working with in conjunction with the Locality Teams. The framework for delivering this has come through the management of the Elderly Care fund with a set of clear outcomes that are agreed with primary care and monitored for impact. The current review of the Locality Teams which has concluded its first stage will take account of this new development and will ensure that future structures include the role and

function. The performance monitoring of this will be in line with the monitor plan for the additional schemes through the BCF plan and wider HLHF system.

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

The current providers of care across the system utilise different forms of care plans to assess need and plan and deliver services from. It is our aim that there is alignment across the system of the style, content and quality of the care plan and implementing the DES within primary care is the first phase of delivering this. We do not currently routinely collect the number of high risk patients who have a joint care plan but our choice of patient experience measure indicates that this is an area we are focussed on and are doing further work on.

The Elderly Care Fund contract with Primary Care requires the collection and reporting of data on a quarterly basis including the number of >75yrs patients with a multi-disciplinary care plan in place. The first collection of data was completed in October 2014. It is our expectation that within the service specifications for the care home support service, RATL and locality and primary care team development, it will detail the standard of care planning. Further work is taking place to understand the impact of this and how it will link with schemes moving forward.

8) ENGAGEMENT

a) 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

The development of the Frail and Elderly Implementation Plan and proposals for the utilisation of the Better Care Fund plan reflect insights gained through a number of engagement activities undertaken in 2013/14 in particular ;

- *Keeping well and maintaining independence part of the Experience Led Commissioning programme of activities*,
- *Healthy Lives Healthy Futures.*
- *The Care Homes Review*
- *Carers engagement*

North Lincolnshire's vision for the Better Care Fund and the Frail and Elderly is based on what people have told us is most important to them.

What people have told us;

The Experience Led Commissioning facilitated engagement "Keeping Well and Maintaining Independence" gathered insight from over 200 service users, carers and the public to understand what needs to be in place in order to ensure that the population including frail and elderly and their carers feel confident, are able to be well, stay well and able to live an independent life to the full.
In essence people told us that to keep well they need to be;

- In control
- Able to pursue my life purpose (caring for others)
- Supported by a close social network of family, friends who share and understand the experience
- Confident with one main trusted point of contact who is linked to the health and social care system (not necessarily a clinician)
- Confident that the trusted contact is able to join up conversations within and between services
- Able to concentrate on coping and keeping well and doing as much as possible to care for others with support
- Supported to preserve mobility
- Confident that services will recognise emotional as well as physical conditions

Key messages from the Healthy Lives Healthy Futures first phase of engagement include;

The **focus on relationship based care and not clinical integration,** i.e**.** conversations matter, with people feeling that a trusted point of contact providing seamless care is more important than understanding the integrated model of care.

Independence keeps people well, people want to remain independent for as long as possible and they want to use health services as little as is necessary.

Strong Support Networks, people want to be independent and choose how to live their life, but when they need support the clear message is that this needs to be delivered closer to home, in the community and by trusted family, friends or carers.

Tapping into community and life expertise will yield rewards in relation to increased ownership of those who may be more vulnerable. The engagement demonstrated that there is an appetite amongst the communities and localities to support each other.

A second engagement phase for Healthy Lives Healthy Futures setting out the overall service model has taken place through February and March 2014 and we are embarking on a further phase. The feedback from all elements is shaping plans for service configuration going forward. Data has been drawn from discussions with GP practices, Patient and Public Engagement Groups; stakeholder events, open space events and public roadshows.

What people have told us: Residential Care Review

The Residential Care Review included consultation with older people as well as carers. Views were sought in relation to the following; Living in a Care Home, the information that people require, the Carers perspective, the role of communities and partnership working.

Living in a care home

- I choose what I want to do
- People recognise my individuality and understand my likes and dislikes
- I am involved in my community
- I maintain my mobility and skills
- I maintain my independence
- I do as much as I can for myself
- I am involved in the day to day running of my care home and join in with tasks

Information

- I have information that is easy to understand
- I can compare cost and quality to know which the best service for me is
- I have someone to help me when I need help at the beginning
- I know where to find information
- I have information that is consistent
- I have help to make informed choices especially if I am experiencing a crisis
- I understand the cost
- I understand specialist care
- I have information that is accurate in an appropriate format
- I have access to information that is up to date

Carers

- I know that the person I care for is enjoying themselves on a break
- I have a choice of activities available such as themed weekends.
- I have support for my family member that I can access quickly if I have an emergency
- I enjoy activities with the person I care for
- I do activities with my family member / friend, with support as part of the activity so that we can both enjoy ourselves

Communities

- I am part of my community
- People join in activities at my care home
- I go out regularly to do activities that I enjoy
- I have transport that enables me to go out
- I have one to one support that enables me to do activities in my community

- I choose the activities that I enjoy
- I have a network of people who support me – carers, family, friends, community and if needed, paid support staff

Partnerships

- I am involved in the care of my family member
- Professionals work together to provide an efficient and effective service
- I can contact a named person
- I have a say in the way that care is provided

What people have told us (Carers)

The North Lincolnshire Commissioning Strategy for Carers 2009-2014 provided a framework for the planning and development of services for carers aged 18+ in North Lincolnshire. Through discussions with our key partner Carers, and other stakeholders significant progress has been made against the aims and priorities that were set for the period 2009-2014.

- **Independent** – Carers will access what they need when and where they need it
- **Respect** – Carers will decide what their own needs are
- **In control** – Carers will know how much money they are entitled to
- **Involved** – Carers will design their own support plan
- **Healthy** – Carers will stay healthy and recover quickly from illness
- **Safe** – Carers will feel secure in the home of their choice
- **Confident in the future** – Carers will feel able to pursue a fulfilling life and have a life of their own
-

This means that, in the future, we expect that carers will say:

- *"*I am supported to maintain my independence for as long as possible"
- "I understand how support works, and what my entitlements and responsibilities are"
- "I am happy with the quality of my support"
- "I know that the person giving me support will treat me with dignity and respect"
- "I am in control of my support"

Better Care Fund Development

The Health and Wellbeing Board is a public meeting, and the CCG Governing Body also meets in public. There is therefore opportunity at both for the public to participate and ask questions about all agenda items.

In addition the CCG drew on engagement events with the public and stakeholders in developing the full Operational Plan for 2015/16 which includes the Better Care Fund. The Frail and Elderly Implementation Plan has also been shared with the Senior Forum.

Healthwatch are represented on the Health and Wellbeing Board. In addition they have been part of the NHS IQ programme running in 2014 to support the frail and Frail Elderly Programme

The Council consulted the public on plans to extend intermediate care facilities during the Summer of 2013. The consultation paper was supported by an on line questionnaire and a series of public meetings. Partners were also consulted. As a consequence the Council is proceeding with a £4,000,000 purpose built intermediate care facility on an existing Council site which will become operational during 2015.

The development of this plan has therefore been based on the rich insights gained and will continue to be tested with the public, service users and stakeholders as the plan is finalised and implemented

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

i) NHS Foundation Trusts and NHS Trusts

This plan has been developed during 2014 with connections and inputs across a range of partnership arrangements set out below in which our providers as key members.

In finalising the plans and undertaking the detailed modelling to support the Trusts have been integral and their sign off through the Joint Board on behalf of the health and wellbeing board.

The Health and Wellbeing Board membership includes representatives from Northern Lincolnshire and Goole NHS Foundation Trust, and Rotherham and Doncaster and South Humber NHS Foundation Trust. A focus on the frail and elderly was agreed as one work stream within the integrated working programme during 2013 and this provided the vehicle for the development of the Better Care Fund plan.

Integration is a core component of the Better Care Fund Plan and all partners within North Lincolnshire have signed up to the principles of whole systems integration in order to provide the right service at the right time, in the right place and with the right management, supported through the Integrated Working Partnership.

The development of the BCF plan and the supporting frail and elderly implementation plan are therefore key to the vision for North Lincolnshire and is being taken forward via the Frail and Frail Elderly Implementation Group which NLaG, RDaSH and EMAS are part of, to ensure that the full acute, community, emergency and mental health pathway elements are taken into account when schemes are being implemented.

We have used the 'large scale change programme' facilitated by the NHS Improving Quality Team to support the mobilisation of the plan. The first workshop took place on 12th March 2014 and there have been five events during the year with the final one being held on the 17th October 2014. Partners taking part in the programme include representation from the peoples and places directorates of the Council, NLAG (acute and community representative), RDASH (older peoples mental health team), GP's, Public Health EMAS, NHS England Area Team and Healthwatch. The overarching joint service model was further ratified with shared clarity on the vision for service provision to support the frail and elderly population. Events have focussed on re-affirming the vision, understanding the gaps, testing the proposals against the desired outcomes and agreeing implementation timelines.

In finalising this plan the process to develop and finalise our submission has helped to reaffirm our shared vision and to demonstrate our successful record of joint working. It has also highlighted a number of risks and the understanding that there is significant further development work required across the whole system. This needs to take account of current and projected demographic changes, activity requirements and a challenging financial position for both health and local authority partners.

Through the Frail and Elderly Implementation Group the key stakeholders agreed the need to 'test' our designed approach to system wide change. This meant that week commencing 10th November 2014; the system did a 'Perfect Week' pilot to test key schemes within the submission. Whilst the final report is still being written, this pilot showed positive signs of achievement against the proposed KPIs for system resilience and change management.

The evidence base used for the development of the schemes has further demonstrated the ability to achieve our stretched ambition for whole scale redesign. Engagement from service managers has meant that the schemes have been altered to reflect the reality of achievement and ambition to improve the quality of care provided across North Lincolnshire. Those staff have also been fundamental in agreeing the performance monitoring mechanism and integration of service delivery.

ii) Primary Care providers

A system wide workshop to develop the frail and elderly implementation plan was held on 5th February 2014. It brought partners together, including clinicians, residential and nursing care providers, the acute and community sector, social care, therapy services, GPs and CCG to discuss the strategy and changes required Several scenarios were explored to test the impact of potential BCF investment proposals.

These scenarios have also been tested with representatives from the GP practices alongside the development of the Elderly Care Fund resource allocated by the CCG (the £5 per head of population) and the nationally required enhanced service. We have worked to ensure alignment with the BCF initiatives such as the development

of community rapid response services and the enhancement of the role of the integrated locality teams to ensure that primary care is a central player utilising their care coordination role.

It was agreed that this role will be linked further with the risk stratification process and we will ensure that the approach to care planning across both primary and community care is aligned. This is now currently being implemented.

The GP federation are represented by a GP on the Frail and Frail Elderly Implementation Group and GP input into the NHS IQ workshops. Regular updates and discussions have taken place through the CCG's Council of Members meetings.

In addition to this primary care providers were involved in the development and delivery of the 'Perfect Week' as described above.

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

Discussions are currently ongoing through commissioning activity and monitoring with regard to new service developments. A dialogue day with commissioners and prospective commissioners of services was facilitated by council staff in relation to the development of Wellbeing Hubs. Information with regard to the model and delivery of service was received favourably by those in attendance and follow up meetings continue to be held to discuss ways of working and community need. Service reviews have been held within North Lincolnshire Council and have transformed both prevention and specialist service teams to deliver day and prevention services, differently in line with the model outlined.

Ongoing consultation and development with regard to the running of the Community Wellbeing Hubs will be through a steering group, with proactive representation from local residents, existing hub users and voluntary, community and 'other' services from the locality in which the hub is situated. Initial terms of reference have been drafted with the aim that the groups will offer support and challenge to hub management in shaping the services on offer, evaluating activity and contributing to future planning.

The Adults Partnership, a stakeholder group for service to vulnerable adults have an awareness of the frail and elderly strategy and will be engaged further in specific areas of development, there current focus is on the well being and 7 day social work services.

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?

There are significant impacts within the BCF for the acute provider and therefore consideration of these impacts has been a central element to both the contracting process for this year and beyond and the development of the BCF schemes and associated assumptions. The value of the BCF requires the identification of around £6m, some of which currently sits within the acute elements of the Trust contract. The areas being targeted for reduction in demand are Acute and Emergency Admissions, Accident and Emergency Attendances, Length of Hospital Stay. This equates to 11.5% of admissions that need to be avoided.

Against this backdrop and as part of Healthy Lives, Healthy Futures, there remains the need to ensure the residual acute services are robust and of high quality in order to ensure that the acute medical and surgical needs the whole population as well a frail and elderly can continue to be available and people receive the care they need in the right place at the right time. The main provider of these hospital based services is North Lincolnshire and Goole Foundation Trust and they are a provider of integrated hospital and community services for North Lincolnshire. We see this as a major benefit for the patients of North Lincolnshire as we are able to have discussions about the strategic development of the whole pathway with one provider and the Trust is able to utilise its internal structures to facilitate the shift in care from acute to community provision.

There is clear sign up to this across the patch and the aim of the Healthy Lives Healthy Futures programme is to shift the emphasis away from hospital based care by ensuring that people (all ages) are only admitted when they need acute and acute emergency care. The Better Care Fund expedites this by targeting the frail and elderly population

The reduction in hospital activity has been signalled as part of commissioning and contracting intentions for 2014 to 2016. This continues to be discussed and the impact of all investments under the Better Care Fund vision and initiatives will need to evidence the delivery of our shared direction of travel to enable the decommissioning of hospital based care.

Northern Lincolnshire health and social care community have commissioned a piece of work through PwC to model both localities impact from BCF as well as looking at a wider system approach to redesign. This piece of work is expected to be completed by the end of Q4 with an intention to commence implementation during 15/16. BCF is seen as a catalyst to this approach allowing the system to begin to make changes in readiness of additional redesign taking place.

The SGH site has during the last twelve months seen a slight increase in volume of admissions but a more significant shift 'acuity' (level of unwellness) of those requiring admission. This has resulted in periods of pressure for admission and breaches in the 4 hour target. This has been mitigated in part by mobilisation of the new unplanned care service and is being further strengthened by the investment in 7 day working across the health economy.
To underpin the assurance across the system a full Implementation Plan is in place

between all providers with clarity on timelines, investments and benefits of:

- the BCF proposals
- the unplanned care implementation plan to fully embed the unplanned care model
- the implementation plan for changes in paediatric short stay assessment and children's community nursing team
- decommissioning plans for SGH capacity

This is being managed through both the contracting structures and also the frail and elderly work programme arrangements.

The finance template reflects the risk of non-delivery and is considered within the overall financial plan of the CCG, NLC and NLAG.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

ANNEX 1 – Detailed Scheme Description

For more detail on how to complete this template, please refer to the Technical Guidance

Scheme ref	Performance Area
1	Integrated Community Services

Scheme name

Community Wellbeing hubs

What is the strategic objective of this scheme?

To enable vulnerable people to remain well and be able to live independently for as long as possible, whilst if requiring additional services they receive the right services (at the right level) at the right time in the right place i.e. local to them, thus reducing emergency admissions to care and higher level medical interventions and services.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

The model of delivery is an 'Early Help' approach based on progressive universalism i.e. Offering universal services to the majority whilst targeting the more skilled staff and resources to those who are the most vulnerable in communities. Through community profiling (including soft intelligence) groups and individuals would be targeted through a multi-agency approach including, voluntary and private sector, community groups, intergenerational links etc. The services offered to the 'targeted' cohort will be evidence based and outcome focused. The universal offer will be open to all through the open access hubs, where information, advice, support and signposting will be readily available. A priority group, particularly for the wellbeing conversations are those aged over 80.

The aim is to provide services in local communities though wellbeing hubs which are accessible, flexible and responsive to need. Hub services will be commissioned and delivered through a range of innovative and flexible methods in an attempt for the 'menu' of services to be responsive to need through individual or group support.

Partnerships with the adult case management teams will ensure that the most appropriate level of service is offered to the service users within a locality and ongoing monitoring and evaluation will establish where there are gaps in the universal and

community services and where the commissioning of additional services may need to be considered. The development of a small grants process will offer 'start up' funding for those wishing to become partners, giving the opportunity for local providers to bring 'taster' activities which may be of interest to service users.

Service users with more complex needs will access activities facilitated and delivered in the hubs. These activities will be developed and delivered by various providers and meet a range of needs. Service users will be supported to access specific activities with their personal care needs, met by personal assistants or specific service staff.

The inclusive activities available in the hubs will also be accessible to carers, ensuring that whilst service users may access specific services, carers can attend universally provided services simultaneously. Further joint work between the wellbeing hubs and Carers Support is planned, ensuring, local accessible services to carers across North Lincolnshire. Activities may include training for carers, dementia support and opportunities for ex carers to support existing carers.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

Longer term, high value projects will be commissioned through the Yortender process and may be part of a framework contract offering more frequent or blocks of activities for those accessing the hubs. Current Providers include Age UK, RVS, Mencap, Alzheimer's Society and locally, Carers support and various local council service e.g. libraries, sport and leisure etc.

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes
-

Health and Social Care Act 2012

Marmot M (2010) Fair Society, Healthy Lives: Strategic review of health inequalities in England post-2010, London: The Marmot Review highlights the importance of social determinants for addressing disparities in health outcomes for people 'having varying social positions' across the life span.
Kendig H & Phillipson C Building age-friendly communities: New Approaches to challenging health and social inequalities. Cited in If You could do one thing...Nine local actions to reduce health inequalities (2014). The research explores the impact of the environment on older people concluding by advocating for an 'age friendly' environment' approach which would facilitate improvements in the 'independence, participation, health and wellbeing of older people' .The proposed model goes some way to implementing this vision.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

No additional investment is required for this scheme. This is an enabler to maintaining people's independence and reduces isolation.

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The investment in universal and preventative services – the wellbeing offer will support the shift in meeting peoples need at the lowest level.

We have already seen a reduction in the number of people requiring long term packages of care by 3.5% from 2013-14. This is in the context of a rising population of over 65 year olds.
The Wellbeing offer will contribute indirectly to reduced non-elective admissions by supporting people with self-care.
It will also contribute to delaying entry to residential care as individuals remain living in their homes for longer.

Additionally, because services are available in the community for everyone there will be the availability of targeted support services to be offered for short periods of support, as part of step down arrangements from intermediate care or recovery from illness or bereavement. Thus having a positive impact on the effectiveness of reablement. The wellbeing offer is an integral part of the system of discharge from hospital, through volunteer support, more people will be able to access a wellbeing conversation and buddying support may be appropriate to support a return home from hospital. The wellbeing offer will minimise the impact of loneliness which has been reported to have a significant negative impact on a person's physical and mental health.
Targets are in development and although intended to be universally available for all older people, people with LD and MH and people with long term conditions each locality may have different target groups and age ranges.
There are approximately 14000 people over the age of 75, which are the generic baseline of people to become registered. Once registered we would expect to have more regular contact with the groups of people with an additional level of need.

Initial activity measures will include:
Number registered at Wellbeing Hubs
Number of referrals to Wellbeing Hubs
Number of people accessing activities
Number of activities/sessions available

The overarching impact of this scheme will be a reduction in ***non-elective admissions***. The integration of these services will have a net impact in NEL admissions of ***2275*** per annum. This equates to 11% of overall admissions to Scunthorpe General Hospital.

The overarching ambition for improvement in care for those in an acute setting is to reduce the Length of Stay by 2 days. To enable this to happen the Assessment and

Discharge Service will have the greatest impact.

Metric	Target
Reduction in Non Elective Admissions	114
Length of Stay	92 bed days

There will be an additional impact of other key performance indicators which will be monitored locally on a monthly basis, however, have not been included as metrics for this submission.

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The Frail and Elderly Implementation Group have overall responsibility to track all impact metrics and spend associated with the better care fund initiatives. All metrics will be compiled into a granular data set with clear trajectories to show progress month on month and the Joint Board will provide final oversight.

Further work will be carried out to understand patient's experience of the redesigned service and staff experience of working in a more integrated arrangement. Alignment of access criteria and operating policies will be a key outcome for this service change and all providers will be expected to deliver to a clear set of operational and quality standards.

Detailed reports are in the process of being developed which will demonstrate:

- Allocation of resource v spend on allocation per month
- Target impact per month v actual
- Improvement in patient and staff survey
- Impact reported (+/-) on any other scheme

These will be at patient level (none identifiable)

NLaG already produce a report which captures the changes in attendance and admission for those 65years and over. This will be used as a detailed report for aspects of service improvement for both acute and community support.

What are the key success factors for implementation of this scheme?

The key success factors for implementation of this scheme comprise:

- OD strategy working with the teams involved to assist in breakdown of boundaries
- Workforce planning which is across all professions to decrease duplication of assessments
- Clear guidance on expectation of teams from senior management within each agency
- Engagement of staff in the development and improvement of services
- Sound data trails for monitoring

- Transparent decision making for each organisation
- Integration of IT systems for patient related data for each health and social care professional
- Recruitment of appropriate staff to support collaborative working and passion for change
- Engagement of Care Homes across the patch in developing care pathways for patients and carers
- Engagement of GPs as part of Dementia money allocation in ensuring effective return on investment and care plans for patients

Scheme ref	Performance Area
2	Integrated Community Services

Scheme name

Care Home Support Service

What is the strategic objective of this scheme?

The strategic objective of this service is to ensure those who are in 24/7 care are in appropriately, that they are cared for in the be possible way through having staff who are educated and have increased skills in line with other community services moreover, this service will reduce the need for people to be admitted to hospital with a condition which could have been treated in the persons usual place of residence.

The rationale for a pilot is to support the Health and Social Care system to assess the early impact and to allow time to adjust the specification as needed. Consideration will then be given by the Joint Board on future commissioning arrangements for the service in 2015/16.

Overview of the scheme

Current Position

A pilot which was run with minimal community staffing focussed on the top 5 admitting residential homes across North Lincolnshire. This team focussed on educating staff regarding falls prevention, mental health and admission avoidance. The pilot demonstrated a great success in the early intervention stage with a reduction of 60% admissions across the scheme.

Future Vision

The Care Homes Support Service will be a multi-disciplinary approach or virtual team who are available for all nursing and residential homes within North Lincolnshire to draw upon to ensure education, training and skills are developed to the benefit of their residents.

The service will focus on supporting and improving the levels of care provided to older people in home settings with the explicit aims of:

- Reducing referrals to the Emergency Department, ambulance journeys and overall hospital admissions for preventable conditions.
- Increasing the number of residents who have had comprehensive and holistic integrated assessments of their needs and have a written personalised care

plan with an identified named professional responsible for their care.
- Increasing the number of residents who have experienced an evidenced based dementia and memory assessment and who have received ongoing referral and support if they are identified to be at risk of memory deterioration.
- Provide additional safeguards to residents without capacity

Provide focussed and targeted training and development to individual homes who have repeated patterns of the cause for referral.

The service will operate at two levels offering skills and expertise in the following areas:

- Holistic integrated assessment including evidence based dementia screening
- Intensive clinical care and management of urgent health needs including minor illness and injury
- Falls prevention and management and occupational therapy
- Medicines Management
- Mobility, physiotherapy and rehabilitation
- Speech and language support and feeding management
- Catheter health
- Tissue viability
- End of Life care, DNACPR
- Adult protection plans and mental capacity assessment
- Deprivation of Liberty protocols
- Mental Health Act

It will provide a strong link back to the relevant primary care providers that are currently in place to support the home and draw on medical advice as needed.

This service will also work in collaboration with Rapid Assessment Time Limited Service and the Integrated Locality Service to support pro-active medical assessment at an intermediate tier level and this will also be in a position to provide medical input to the Care Home Support Service.

The service will take a two tier approach:

Tier 1

Tier 1 is to provide a rapid and enhanced support service to named residents within the care setting who are at risk of deteriorating and requiring unplanned admission. There will be a need to review the data and carry out a risk profiling exercise to identify those who have had multiple admissions with homes being able to access the service for residents where there is a concern around deterioration and mental capacity. The service will provide interventions within the care home with the added ability of being able to mobilise the relevant elements of both the patch wide Rapid

Assessment, Time Limited (RATL) service and the Locality team. This will ensure that care is proactive, rapidly provided and can be flexed according to need with the aim that the resident remains in their current setting. In addition they will make a significant link back into primary care and agreements will be sought with supporting practices to work in partnership particularly in situations where medical input is required to support the resident to remain in the setting and avoid unnecessary admission to hospital.

Inputs:

All residents within the care home settings will be expected to have a coordinated, written care plan. This will meet the standards set out by North Lincolnshire and will be evidenced based.

The CHSS will identify those residents in need of ongoing case management and ensure they are referred into the relevant community based service as appropriate.

In conjunction with the homes, they will identify those residents through a risk profiling exercise, who are most at risk of admission and agree access to the relevant professionals to proactively forward plan and manage their care to prevent un-necessary admissions.

They will act as the conduit between the care home and the supporting GP practice and ensure that the named GP is fully aware of the residents needs and participates actively in their medical and care management.

The initial focus will be around those:

- Residents with a long term condition who have experienced multiple exacerbations.
- Residents without a current care plan.
- Residents who are awaiting discharge back to the home following a recent admission.
- Residents with a form of cognitive impairment
- Residents who have had a stroke and remain under review.
- Residents who have had a recent fracture or three or more recent falls.
- Residents who are on an end of life pathway.
- Residents without capacity who maybe being deprived of their liberty
- Residents subject to an adult protection plan

Outputs:

A monthly metrics and outcomes data set will be agreed in order to monitor impact and assess ongoing contribution to the delivery of the above aims.

In addition a set of resident focussed quality measures will be developed to enable

reporting on experience for those in receipt of care from the service.

TIER 2

Tier 2 will focus on up-skilling nursing and residential home staff to better manage residents who may be at risk of unnecessary admission. This will commence with targeted work by the Care Home Support Service with those with the highest numbers of admissions and where there are patterns in the reason for admission. Interventions will be based on the development and use of a quality matrix to identify the most appropriate areas to instigate the support process. The team will be multi-professional and will focus on developing care pathways, training and working with homes to implement best practice standards such as the Gold Standard Framework for palliative care. There will be access to specialist skills through this team such as medicines management, Dementia Champions, improving the nutritional status of patients and reducing falls. In addition the team will have a key role in ensuring potential safeguarding issues are proactively managed.

Inputs:

This element of the service will be provided by a range of the most relevant professionals in the team, depending on the needs of the home and the issues identified.
Interventions will take the form of:

- A signed agreement with the Managers/decision makers of the home that they agree to the assessment process and the provision of a shared development plan.
- Review of case records and relevant data sets for residents with multiple admissions
- Provision of a diagnostic exercise to understand the drivers for admission and areas for prevention and reduction.
- Implementation of the required actions contained in the development plan.
- Engagement with the Council and NHS QA framework
- Assessment of polypharmacy for residents across each home

Outputs:
Based on the quality matrix and associated metrics set out in the aims, an agreement will be made with each home to provide them with a tailored data set that will be jointly monitored. Reduction ambitions and quality improvement measures will be agreed with the home and this will be monitored in quarterly review meetings with them.

In addition they will proactively seek out residents through the risk profiling process and link back into the primary care, elderly care coordination function.

The team will be in operation 7 days a week and will provide a single referral contact

point.

The delivery chain

The Joint Board consisting of NLCCG, NLC, NLaG and RDaSH will act as the commissioner for the roll out of the pilot scheme and all inputs, output and metrics will be reported on a monthly basis through to the Board.

A review of the impact of scheme will take place on monthly basis with a formal review at the end of the financial year to consider extending the current pilot arrangements whilst developing a formal specification to move into more formalised commissioning arrangements.

The pilot will build on the current Locality Team model which currently provided by NLaG in collaboration with NLC. To further build on this, the intention is to work in collaboration with RDaSH and locality GPs to ensure that the team is able to provide an integrated health and social care response as appropriate.

The Joint Board will consider a range of options for future commissioning which may include a Lead Provider, Single provider or Independent sector options.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

A pilot which was run with minimal community staffing focussed on the top 5 admitting residential homes across North Lincolnshire. This team focussed on educating staff regarding falls prevention, mental health and admission avoidance. The pilot demonstrated a great success in the early intervention stage with a reduction of 60% admissions across the scheme.

The older people mental health team which will be part of the Care Home Support Service has demonstrated a reduction in antipsychotic prescribing, attendance in A&E due to challenging behaviour and delirium. It is anticipated that through bringing these teams together to a virtual service further and wider benefits will be achieved.

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

The level of investment required to support the Care Home Support Service included in the BCF investment plan is £400,000

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan

Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The overarching impact of this scheme will be a reduction in ***non-elective admissions***. The integration of these services will have a net impact in NEL admissions of ***2275*** per annum. This equates to 11% of overall admissions to Scunthorpe General Hospital.

The overarching ambition for improvement in care for those in an acute setting is to **reduce** the Length of Stay by **2 days**. To enable this to happen the Assessment and Discharge Service will have the greatest impact.

Metric	**Target**
Reduction in Non Elective Admissions	228
Length of Stay	92 bed days

There will be an additional impact of other key performance indicators which will be monitored locally on a monthly basis, however, have not been included as metrics for this submission.

- Improved Patient satisfaction survey
- Improved staff satisfaction survey
- Reduction in duplication of assessment
- Increased use of rehabilitation and reablement
- Increased appropriate care planning
- Telling story once
- Reduction in bed moves for patients
- Reduction in cancelled elective surgery
- Reduction in outpatient appointments

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The Frail and Elderly Implementation Group have overall responsibility to track all impact metrics and spend associated with the better care fund initiatives. All metrics will be compiled into a granular data set with clear trajectories to show progress month on month and the Joint Board will provide final oversight.

Further work will be carried out to understand patient's experience of the redesigned service and staff experience of working in a more integrated arrangement. Alignment of access criteria and operating policies will be a key outcome for this service change and all providers will be expected to deliver to a clear set of operational and quality standards.

Detailed reports are in the process of being developed which will demonstrate:

- Allocation of resource v spend on allocation per month
- Target impact per month v actual
- Improvement in patient and staff survey

- Impact reported (+/-) on any other scheme

These will be at patient level (none identifiable)

NLaG already produce a report which captures the changes in attendance and admission for those 65years and over. This will be used as a detailed report for aspects of service improvement for both acute and community support.

What are the key success factors for implementation of this scheme?

The key success factors for implementation of this scheme comprise:

- OD strategy working with the teams involved to assist in breakdown of boundaries
- Workforce planning which is across all professions to decrease duplication of assessments
- Clear guidance on expectation of teams from senior management within each agency
- Engagement of staff in the development and improvement of services
- Sound data trails for monitoring
- Transparent decision making for each organisation
- Integration of IT systems for patient related data for each health and social care professional
- Recruitment of appropriate staff to support collaborative working and passion for change
- Engagement of Care Homes across the patch in developing care pathways for patients and carers
- Engagement of GPs as part of Dementia money allocation in ensuring effective return on investment and care plans for patients

Scheme No	Performance Area
3	Integrated Community Services

Scheme name

Carers Support Services

What is the strategic objective of this scheme?

To respond to the Care Act 2014 in order to ensure that all organisations support carers appropriately and in accordance with its legal responsibilities/duties

To ensure that the National priorities set out in specific Carers legislation and the National Carers Strategy are aligned with locally identified needs

Overview of the scheme

Current Position

North Lincolnshire Council in conjunction with the health community is currently coming to an end of the recent Carers Strategy and is in the process of developing one for the coming years.

Carers are key stakeholders in our care and support system. For this system to be sustainable into the future, we need to increase our capacity to encourage and enable families to make positive informed choices about how they contribute to care. In addition carers are individuals with their own aspirations. Alongside their role as a carer they may need support so that they can live healthy and independent lives and pursue a career, an education or social activities.

The vision of the National Carers' Strategy is that "the needs of carers must, over the next 10 years, be elevated to the centre of family policy and receive the recognition and status they deserve". Putting People First sets out a commitment to transform the way in which care and support is delivered. Neither of these aspirations are deliverable without the other. Commissioning for care and support requires reform in order to place carers where they deserve to be.

Data from 2011 Census shows that the number of carers in North Lincolnshire has continued to grow, mirroring the national trends. In 2001, there were 15,952 carers in the sub-region, the comparable figures for 2011 being over two thousand higher at 18,161 (nearly 11% of the population). In 2011 over 11,000 people in North Lincolnshire were providing between one and nineteen hours per week care, 6.6% of people who live in North Lincolnshire. A further 2,381 people were providing between 20 and 49 hours care. 4,684 people were providing 50 hours or more of care every week. There is widespread recognition that there is a need to support carers in the valuable activities that they undertake.

Future Vision

There are seven underpinning key themes to which the Carers Strategy and future plan will be linked in to**:**

1. **Independent** – Carers will access what they need when and where they need it
2. **Respect** – Carers will decide what their own needs are.
3. **In control** – Carers will know how much money they are entitled to.
4. **Involved** – Carers will design their own support plan.
5. **Healthy** – Carers will stay healthy and recover quickly from illness.
6. **Safe** – Carers will feel secure in the home of their choice.
7. **Confident in the future** – Carers will feel able to pursue a fulfilling life and have a life of their own.

The inclusive activities available in the wellbeing hubs will also be accessible to carers, ensuring that whilst service users may access specific services, carers can attend universally provided services simultaneously. Further joint work between the wellbeing hubs and Carers Support is planned, ensuring, local accessible services to carers across North Lincolnshire. This would include e.g. training for carers, dementia support and ongoing opportunities for ex carers to meet in the hubs and potentially support existing carers.

The delivery chain

The Joint Board consisting of NLCCG , NLC, NLaG and RDaSH will act as the commissioner for the roll out of the pilot scheme and all inputs, output and metrics will be reported on a monthly basis through to the Board.

A review of the impact of scheme will take place on monthly basis with a formal review at the end of the financial year to consider extending the current pilot arrangements whilst developing a formal specification to move into more formalised commissioning arrangements.

The pilot will build on the current Locality Team model which currently provided by NLaG in collaboration with NLC. To further build on this, the intention is to work in collaboration with RDaSH and locality GPs to ensure that the team is able to provide an integrated health and social care response as appropriate.

The Joint Board will consider a range of options for future commissioning which may include a Lead Provider, Single provider or Independent sector options.

The evidence base

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Annual cost: £425,000 This is not deemed as additional investment, this allocation will come from monies already agreed.

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The overarching impact of this scheme will be a reduction in ***non-elective admissions***. The integration of these services will have a net impact in NEL admissions of ***2275*** per annum. This equates to 11% of overall admissions to Scunthorpe General Hospital.

The overarching ambition for improvement in care for those in an acute setting is to reduce the Length of Stay by 2 days. To enable this to happen the Assessment and Discharge Service will have the greatest impact.

Metric	**Target**
Reduction in Non Elective Admissions	114
Length of Stay	92 bed days

There will be an additional impact of other key performance indicators which will be monitored locally on a monthly basis, however, have not been included as metrics for this submission.

- Improved Patient satisfaction survey
- Improved staff satisfaction survey
- Reduction in duplication of assessment
- Increased use of rehabilitation and reablement
- Increased appropriate care planning
- Telling story once
- Reduction in bed moves for patients
- Reduction in cancelled elective surgery
- Reduction in outpatient appointments

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The Frail and Elderly Implementation Group have overall responsibility to track all impact metrics and spend associated with the better care fund initiatives. All metrics

will be compiled into a granular data set with clear trajectories to show progress month on month and the Joint Board will provide final oversight.

Further work will be carried out to understand patient's experience of the redesigned service and staff experience of working in a more integrated arrangement. Alignment of access criteria and operating policies will be a key outcome for this service change and all providers will be expected to deliver to a clear set of operational and quality standards.

Detailed reports are in the process of being developed which will demonstrate:

- Allocation of resource v spend on allocation per month
- Target impact per month v actual
- Improvement in patient and staff survey
- Impact reported (+/-) on any other scheme

These will be at patient level (none identifiable)

NLaG already produce a report which captures the changes in attendance and admission for those 65years and over. This will be used as a detailed report for aspects of service improvement for both acute and community support.

What are the key success factors for implementation of this scheme?

The key success factors for implementation of this scheme comprise:

- OD strategy working with the teams involved to assist in breakdown of boundaries
- Workforce planning which is across all professions to decrease duplication of assessments
- Clear guidance on expectation of teams from senior management within each agency
- Engagement of staff in the development and improvement of services
- Sound data trails for monitoring
- Transparent decision making for each organisation
- Integration of IT systems for patient related data for each health and social care professional
- Recruitment of appropriate staff to support collaborative working and passion for change
- Engagement of Care Homes across the patch in developing care pathways for patients and carers
- Engagement of GPs as part of Dementia money allocation in ensuring effective return on investment and care plans for patients

Scheme No	Performance Area
4	Integrated Community Services

Scheme name

EMAS Pathway Redesign (Task and Finish)

What is the strategic objective of this scheme?

To develop pathways for specific clinical conditions which will allow for alternative routes to care opposed from attendance at A&E.

To work closely with the Integrated Locality Team, RATL and GPs to build relationships

Overview of the scheme

Current Position

There has been little collaboration between organisations to develop pathways for specific conditions to allow for attendance avoidance for patients who may be appropriately alternatively managed.

Forward Vision

A short term task and finish group will be developed to look at the viability of service change, pathway development and monitoring of the expected outcomes.

At the point of writing this document the detail is not yet available for full understanding; however, there is also no financial investment in this scheme.

The development of this pathway will see the link developed with other community based services outlined within the BCF document. These include:

- Rapid Assessment, Time Limited Services
- Integrated Locality Services
- GPs
- Care Home Support Services

The delivery chain

The Joint Board will oversee the roll out of the pilot scheme and all inputs, output and metrics will be reported on a monthly basis through to the Board.

A review of the impact of scheme will take place on monthly basis with a formal review at the end of the financial year to consider extending the current pilot arrangements whilst developing a formal specification to move into more formalised commissioning arrangements.

The pilot will build on the current Locality Team model which currently provided by NLaG in collaboration with NLC. To further build on this, the intention is to work in collaboration with RDaSH and locality GPs to ensure that the team is able to provide an integrated health and social care response as appropriate.

The Joint Board will consider a range of options for future commissioning which may include a Lead Provider, Single provider or Independent sector options.

The evidence base

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

There are no investment requirements for this service. It is expected that this is a short-term task and finish group.

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The overarching impact of this scheme will be a reduction in ***non-elective admissions***. The integration of these services will have a net impact in NEL admissions of ***2275*** per annum. This equates to 11% of overall admissions to Scunthorpe General Hospital.

The overarching ambition for improvement in care for those in an acute setting is to reduce the Length of Stay by 2 days. To enable this to happen the Assessment and Discharge Service will have the greatest impact.

Metric	**Target**
Reduction in Non Elective Admissions	114
Length of Stay	Not applicable

There will be an additional impact of other key performance indicators which will be monitored locally on a monthly basis, however, have not been included as metrics for this submission.

- Improved Patient satisfaction survey
- Reduction in duplication of assessment
- Increased use of rehabilitation and reablement
- Increased appropriate care planning
- Telling story once
- Reduction in cancelled elective surgery

- Reduction in outpatient appointments

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The Frail and Elderly Implementation Group have overall responsibility to track all impact metrics and spend associated with the better care fund initiatives. All metrics will be compiled into a granular data set with clear trajectories to show progress month on month and the Joint Board will provide final oversight.

Further work will be carried out to understand patient's experience of the redesigned service and staff experience of working in a more integrated arrangement. Alignment of access criteria and operating policies will be a key outcome for this service change and all providers will be expected to deliver to a clear set of operational and quality standards.

Detailed reports are in the process of being developed which will demonstrate:

- Allocation of resource v spend on allocation per month
- Target impact per month v actual
- Improvement in patient and staff survey
- Impact reported (+/-) on any other scheme

These will be at patient level (none identifiable)

NLaG already produce a report which captures the changes in attendance and admission for those 65years and over. This will be used as a detailed report for aspects of service improvement for both acute and community support.

What are the key success factors for implementation of this scheme?

The key success factors for implementation of this scheme comprise:

- OD strategy working with the teams involved to assist in breakdown of boundaries
- Workforce planning which is across all professions to decrease duplication of assessments
- Clear guidance on expectation of teams from senior management within each agency
- Engagement of staff in the development and improvement of services
- Sound data trails for monitoring
- Transparent decision making for each organisation
- Integration of IT systems for patient related data for each health and social care professional
- Recruitment of appropriate staff to support collaborative working and passion for change
- Engagement of Care Homes across the patch in developing care pathways for patients and carers
- Engagement of GPs as part of Dementia money allocation in ensuring effective return on investment and care plans for patients

Scheme No	Performance Area
5	Proactive Care Integrated Community Services

Scheme name

Rapid Assessment Time Limited Service (RATL)

What is the strategic objective of this scheme?

The strategic objective for the Rapid Assessment Time Limited Service is to offer an alternative provision of care to people who may have otherwise had either an attendance or admission to hospital.

Overview of the scheme

Current Position

Aspects of the RATL service currently exist across the health and social care community, however, they are not provided through a seamless approach which has the ability to respond and work with both East Midlands Ambulance Service and the Single Point of Access as part of the Urgent Care model previously commissioned. Whilst there have been small improvements in care provision demonstrated over the previous months there has been little in the way of major impact to reduction in attendance and Non-Elective Admissions to the Scunthorpe site.

Future Vision

RATL is an integrated set of “functions” which provide rapid response and short term intervention (typically from one hour up to six weeks) for adults >18yrs demonstrating frailty markers.

RATL will operate 365 days per year – core services within RATL will operate from 8am – 8pm seven days per week; some elements of RATL will operate overnight. Rapid response would be defined as “within one hour” of a call being received. The first contact will be through an Emergency Care Practitioner who will have the skill base to assess a patients care needs initially, this will then move on to an MDT approach through the Integrated Locality Services, the first link there will be the Locality Co-ordinator. This will be seamless in the eyes of the person requiring the care intervention.

RATL will operate on the basis of need from a referral by a local health or social care practitioner. In this way, it will provide an inclusive service.

Based on the current pattern of need, the main area of demand for the RATL service

will be older people demonstrating frailty markers. The RATL service will:

- provide rapid/time limited support to people at a time of a significant change in their health and/or social circumstances so that they are able to stay in and/or return to their previous "living arrangements" or
- support people for a period of time so that they are then able to make decisions about the changes which are right for them and their family.

The further changes in practice that will arise as a result of developing the RATL service will be working collaboratively with the Assessment and Discharge Service:

- Assessment prior to discharge from hospital will no longer take place: instead, people will be discharged into the care of the RATL service in order for the assessment of their needs to take place in their 'normal' setting. The benefit of this approach will be that assessment can take place in a more appropriate environment thus discharge is not delayed by non-medical matters.
- The Team will adopt the framework set out in the "Silver Book" which advocates a routine screen covering the 12 main conditions with a full assessment of anyone who has any of the frailty syndromes – this common assessment could be used by the health & social care community as a whole.

  The team will be made up of an integrated team of practitioners who have a common understanding and confidence in managing the common frailty markers such as confusion, falls and polypharmacy
- A clinical decision unit is not just within a secondary care setting, with the services and practitioners that work within both primary and community care and clinical decision unit is where the patient is assessed – be it in GP practice, home, care home or secondary care. The RATL service will enhance and broaden this concept
- The RATL practitioners would have the authority to make a "decision without precedent" if the outcome would be an admission avoidance.

RATL will not be a separate service it has been designed to been integrated with both primary/community services and secondary care to foster trust between practitioners which is essential if the flow of care is to be achieved.

In essence, in reflecting the recommendations from *The Silverbook* the RATL will be an integrated team of health and social care professionals. Key roles will include prescribing, nursing, occupational therapy, physiotherapy and social care. This team will coordinate the care in the first 24 hours of whilst developing a care plan for recovery and independence maintenance.

The RATL service will be commissioned to:

- Offer an alternative to attendance and/or admission to secondary care where appropriate;
- Reduce the need for complex care packages;
- Avert or manage crises by providing a rapid response and the right amount of integrated care to the person at home during a period of change;
- Coordinate the response and communication during a time when the person's normal "living" arrangements are in a state of flux.

The RATL service will work as part of the Integrated Locality Teams, however, for the purpose of BCF submission they are being presented separately as they will have different impacts of the metrics for performance management and effectiveness:

The key element will be expansion of the Emergency Care Practitioner (ECP) team already in place. They will be the initial professional to respond within the one hour framework and will undertake comprehensive assessments which will transfer patients into the most appropriate teams/ service if necessary. They will also identify patients who could be managed in primary / community settings as an alternative to admission. The ECP and EMAS would take also take responsibility to transfer patients out of A&E / CDU home through support of the RATL service.

The delivery chain

The Joint Board will oversee the roll out of the pilot scheme and all inputs, output and metrics will be reported on a monthly basis through to the Board.

A review of the impact of scheme will take place on monthly basis with a formal review at the end of the financial year to consider extending the current pilot arrangements whilst developing a formal specification to move into more formalised commissioning arrangements.

The pilot will build on the current Locality Team model which is currently provided by NLaG in collaboration with NLC. To further build on this, the intention is to work in collaboration with RDaSH and locality GPs to ensure that the team is able to provide an integrated health and social care response as appropriate.

The Joint Board will consider a range of options for future commissioning which may include a Lead Provider, Single provider or Independent sector options.

The evidence base

During the 'Perfect Week' four schemes were implemented to assess the sustainability of the schemes and potential impact they may have. Those schemes were:

- Rapid Assessment, Time Limited

- Frail Elderly Assessment Support Team
- 7 Day social workers
- Mental Health Liaison

The initial outcome of these schemes are showing:

Total seen during Perfect Week	**FEAST**	**RATL**	**OPMH**	**Social Services**
48	28	5	13	33
%	58.3%	10.42%	27.08%	68.75%

These schemes were implemented with a lead in time of three weeks. None of them were fully staffed nor had they had the opportunity to develop clear pathways and protocols for hand-off of patients through services.

This evidence is encouraging that with the appropriate amount of planning and phased approach to improvement in services each of these services will have an impact of the metrics as outlined in this document.

With regards to RATL local evidence demonstrated the ability to avoid 10% of attendances to hospital during that period. This was achieved through direct calls from SPA or GP referral, which meant that the patient did not have to attend the hospital in the first place. It is therefore considered a safe assumption that with the appropriate staffing, advertising etc. this will be a rate of return achievable in the long run when considering the potential impact of service improvement.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

The level of investment required to support the RATL service and included in the BCF investment plan is £1.427 million

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The overarching impact of this scheme will be a reduction in ***non-elective admissions***. The integration of these services will have a net impact in NEL admissions of ***2,275*** per annum. This equates to 11% of overall admissions to Scunthorpe General Hospital.

The overarching ambition for improvement in care for those in an acute setting is to reduce the Length of Stay by 2 days. To enable this to happen the Assessment and Discharge Service will have the greatest impact.

Metric	Target
Reduction in Non Elective Admissions	455
Length of Stay	183 bed days

There will be an additional impact of other key performance indicators which will be monitored locally on a monthly basis, however, have not been included as metrics for this submission.

- Improved Patient satisfaction survey
- Improved staff satisfaction survey
- Reduction in duplication of assessment
- Increased use of rehabilitation and reablement
- Increased appropriate care planning
- Telling story once
- Reduction in bed moves for patients
- Reduction in cancelled elective surgery
- Reduction in outpatient appointments

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The Frail and Elderly Implementation Group have overall responsibility to track all impact metrics and spend associated with the better care fund initiatives. All metrics will be compiled into a granular data set with clear trajectories to show progress month on month and the Joint Board will provide final oversight.

Further work will be carried out to understand patient's experience of the redesigned service and staff experience of working in a more integrated arrangement. Alignment of access criteria and operating policies will be a key outcome for this service change and all providers will be expected to deliver to a clear set of operational and quality standards.

Detailed reports are in the process of being developed which will demonstrate:

- Allocation of resource v spend on allocation per month
- Target impact per month v actual
- Improvement in patient and staff survey
- Impact reported (+/-) on any other scheme

These will be at patient level (none identifiable)

NLaG already produce a report which captures the changes in attendance and admission for those 65years and over. This will be used as a detailed report for aspects of service improvement for both acute and community support.

Further information and performance will be captured at a local level and reported via CCG through normal contracting routes. This will include patient experience matrix i.e. Friends and Family Tests.

What are the key success factors for implementation of this scheme?
The key success factors for implementation of this scheme comprise: • OD strategy working with the teams involved to assist in breakdown of boundaries • Workforce planning which is across all professions to decrease duplication of assessments • Clear guidance on expectation of teams from senior management within each agency • Engagement of staff in the development and improvement of services • Sound data trails for monitoring • Transparent decision making for each organisation • Integration of IT systems for patient related data for each health and social care professional • Recruitment of appropriate staff to support collaborative working and passion for change • Engagement of Care Homes across the patch in developing care pathways for patients and carers

Scheme ref	**Performance Area**
6	Proactive Care Patient Flow
Scheme name.	
Social Work Assessment and 7 Day Access.	
What is the strategic objective of this scheme?	
The objective of this service is to provide Social Work Services within the North Lincolnshire and Goole Hospitals NHS Foundation Trust, namely Scunthorpe General Hospital, to vulnerable adults and their carer with the emphasis on facilitating timely, appropriate and safe discharges from either hospital wards or the Urgent Care Centre. This will be through 7-day access to social work statutory assessment, (8am – 8pm) Hospital Social Work within the wards, Emergency Care Centre and A&E (includes overnight social care presence in A & E) The team will also support and facilitate the discharge arrangements from outlying hospitals; Grimsby, Hull and Doncaster.	
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?	

The team will form part of the Assessment and Discharge Service in the early identification of people and be pro-active in providing early advice, information, sign posting and support to facilitate timely discharges from the Urgent Care Centre or in-patient wards. This is support for adults >18yrs who are or may be in need of Community Care Support and Locality Services.

The purpose of the Hospital Social Work Team (HSWT) is to provide advice, assessment and discharge services that may be needed to support people to leave hospital in a way that best meets both their and their carer's needs. Leading to the management of a seamless transition to care planning and future needs development.

Two of the requirements of the BCF are:

- 7-day working in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
- Joint approach to assessment and care planning

Assessment and Discharge notifications time frames will be achieved for all in-patients.

- 100% of users will have an initial assessment or a review of their full assessment of their needs by the MDT prior to discharge
- The Assessment and Discharge Service will notify relevant Case Management Teams of individuals to be transferred for ongoing monitoring and review

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The Joint Board consisting of NLCCG , NLC, NLaG and RDaSH will act as the commissioner for the roll out of the pilot scheme and all inputs, output and metrics will be reported on a monthly basis through to the Board.

A review of the impact of scheme will take place on monthly basis with a formal review at the end of the financial year to consider extending the current pilot arrangements whilst developing a formal specification to move into more formalised commissioning arrangements.

The pilot will build on the current Locality Team model which currently provided by NLaG in collaboration with NLC. To further build on this, the intention is to work in collaboration with RDaSH and locality GPs to ensure that the team is able to provide an integrated health and social care response as appropriate.

The Joint Board will consider a range of options for future commissioning which may include a Lead Provider, Single provider or Independent sector options.

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme

- to drive assumptions about impact and outcomes

During the 'Perfect Week' four schemes were implemented to assess the sustainability of the schemes and potential impact they may have. Those schemes were:

- Rapid Assessment, Time Limited
- Frail Elderly Assessment Support Team
- 7 Day social workers
- Mental Health Liaison

The initial outcome of these schemes are showing:

Total seen during Perfect Week	**FEAST**	**RATL**	**OPMH**	**Social Services**
48	28	5	13	33
%	58.3%	10.42%	27.08%	68.75%

These schemes were implemented with a lead in time of three weeks. None of them were fully staffed nor had they had the opportunity to develop clear pathways and protocols for hand-off of patients through services.

This evidence is encouraging that with the appropriate amount of planning and phased approach to improvement in services each of these services will have an impact of the metrics as outlined in this document.

During 2013/14 we experienced significant increases in levels of need. The number of new individuals contacting us to enquire about services increased by 15.8%.

During the same period the number of people whose social care needs we assessed increased by 8.9%, many of whom came via the local hospital. A greater number of older people were admitted to residential and nursing care than in the previous year – up from 650 to 707 per 100,000 of population increasing the pressure on specialist services. The average age of people being admitted to care homes is increasing.

When people do enter a home they increasingly have complex needs. A significant number of the residential/ nursing admissions are for people with dementia.
A&E data identifies 33 people over the age of 65 attend A&E every day with 18 of these people being admitted

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan.

Annual cost: £634,000 This is not deemed as additional investment, this allocation will come from monies already agreed.

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The overarching impact of this scheme will be a reduction in ***non-elective admissions***. The integration of these services will have a net impact in NEL admissions of ***2,275*** per annum. This equates to 11% of overall admissions to Scunthorpe General Hospital.

The overarching ambition for improvement in care for those in an acute setting is to reduce the Length of Stay by 2 days. To enable this to happen the Assessment and Discharge Service will have the greatest impact.

Metric	**Target**
Reduction in Non Elective Admissions	114
Length of Stay	303 bed days

There will be an additional impact of other key performance indicators which will be monitored locally on a monthly basis, however, have not been included as metrics for this submission.

- Improved Patient satisfaction survey
- Improved staff satisfaction survey
- Reduction in duplication of assessment
- Increased use of rehabilitation and reablement
- Increased appropriate care planning
- Telling story once
- Reduction in bed moves for patients
- Reduction in cancelled elective surgery
- Reduction in outpatient appointments

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The Frail and Elderly Implementation Group have overall responsibility to track all impact metrics and spend associated with the better care fund initiatives. All metrics will be compiled into a granular data set with clear trajectories to show progress month on month and the Joint Board will provide final oversight.

Further work will be carried out to understand patient's experience of the redesigned service and staff experience of working in a more integrated arrangement. Alignment of access criteria and operating policies will be a key outcome for this service change and all providers will be expected to deliver to a clear set of operational and quality standards.

Detailed reports are in the process of being developed which will demonstrate:

- Allocation of resource v spend on allocation per month
- Target impact per month v actual

- Improvement in patient and staff survey
- Impact reported (+/-) on any other scheme

These will be at patient level (none identifiable)

NLaG already produce a report which captures the changes in attendance and admission for those 65years and over. This will be used as a detailed report for aspects of service improvement for both acute and community support.

What are the key success factors for implementation of this scheme?

The key success factors for implementation of this scheme comprise:

- OD strategy working with the teams involved to assist in breakdown of boundaries
- Workforce planning which is across all professions to decrease duplication of assessments
- Clear guidance on expectation of teams from senior management within each agency
- Engagement of staff in the development and improvement of services
- Sound data trails for monitoring
- Transparent decision making for each organisation
- Integration of IT systems for patient related data for each health and social care professional
- Recruitment of appropriate staff to support collaborative working and passion for change
- Engagement of Care Homes across the patch in developing care pathways for patients and carers
- Engagement of GPs as part of Dementia money allocation in ensuring effective return on investment and care plans for patients

Domain	**Measure**	**Indicator**
2. Delaying and reducing the need for care and support	When people develop care needs, the support they receive takes place in the most appropriate setting, and enables them to regain their independence.	2C. Delayed transfers of Care from hospital, and those attributable to adult social care
3. Ensuring that people have a positive experience of care and support	People who use social care and their carers are satisfied with their experience of care and support services.	3A: Overall satisfaction of people who use services with their care and support 3B: Overall satisfaction of carers with social services
	Carers feel that they are respected as equal partners	3C: The proportion of carers that report that

	throughout the care process Improving peoples experience of integrated care	they have been included or consulted in discussions about the person they care for

The key success factors for implementation of this scheme comprise:

- OD strategy working with the teams involved to assist in breakdown of boundaries
- Workforce planning which is across all professions to decrease duplication of assessments
- Clear guidance on expectation of teams from senior management within each agency
- Engagement of staff in the development and improvement of services
- Sound data trails for monitoring
- Transparent decision making for each organisation
- Integration of IT systems for patient related data for each health and social care professional
- Recruitment of appropriate staff to support collaborative working and passion for change
- Engagement of Care Homes across the patch in developing care pathways for patients and carers
- Engagement of GPs as part of Dementia money allocation in ensuring effective return on investment and care plans for patients

Scheme ref	**Performance Area**
7	Proactive Care Services
Scheme name	
Frail Elderly Assessment and Support Team	
What is the strategic objective of this scheme?	
The strategic objective of this scheme is to ensure the provision of safe, compassionate, holistic care for older people with frailty markers and their loved ones.	
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?	
Current Position October 2014 figures state that:	

- >65yrs equates to 22.1% of all A&E Attendances at NLaG. 50.5% of those attendances were admitted as an inpatient.
- >65yrs equates to 34.6% of all Non Elective Admissions, with their average LoS being 8.3 days

These figures are broadly in line with national average of expectation, however, there is still room for improvement of these figures to get to a point of upper quartile performance.

The Scunthorpe General Hospital currently has a small geriatric consultant base without dedicated staff to provide the care or interventions in the way in which older people may see further improved outcomes from.

Future Vision

The Frail Elderly Assessment Support Team will provide intervention, care, education, advice etc. to those >65yrs demonstrating frailty markers.

This will be aim of the service is to:

- Provide timely and appropriate diagnosis, treatment and advice
- Promote quality of life and independence
- Reduce the length of time that patients might otherwise spend in hospital
- Reduce the potential exposure to hospital (institutional) acquired harm
- Care for older people in an appropriate environment which promotes dignity, respect, kindness and compassion
- Treat everyone as an individual with consideration of their personal needs

It is recognised that frailty occurs through an individual's lack of resilience to physical, psychological or emotional challenge with a reduction in their ability to recover or their rate of recovery. Specialist skills are required to achieve an optimum outcome with this cohort of patients.

The recognised way to support patients who are frail is to provide early, comprehensive assessment by a team which includes doctor, nurse, therapists, pharmacist and social worker and for all team members to be attuned to the needs of this patient group.

By conducting a Comprehensive Geriatric Assessment (CGA), there is strong evidence to support improved outcomes for frail, older people. This CGA approach will support not only those who can return home (or back to community), but also those whose clinical condition does require hospital admission as it is known that a CGA will help to improve speed of recovery, reduce length of stay, reduce complications and reduce mortality.

The service will include:

- Medical staff (recommendation that this role is fulfilled by GPs/Consultants with a special interest in elderly medicine),
- Nursing staff, (RGN and HCA)
- Therapists (Physio, OT, SLT, Dietetics etc) – it is proposed that the OT staffing levels are sufficient to allow them, if necessary, to accompany the patient home to ensure the transfer occurs as planned the scheme is requesting additional

resource 7 days for OT, Physio and TI – there is no 7 day service for SLT and N&D built into this. The OT / Physio element will offer an outreach service to work alongside the locality teams
- Social workers
- Mental Health professionals
- Pharmacists (possibly a combination of hospital and community based practitioners)
- Administrative support.

Members of the FEAST service will have a dual role: firstly to contribute their expertise to the multi-disciplinary assessment and planning process and secondly to be the communication channel to their counterparts in Primary, Secondary and Community Care settings

The FEAST service will have access to a secondary care geriatrician and the range of diagnostic procedures as well as defined links to the RATL practitioners and Locality Teams. We also expect to develop the role of volunteers and links with the voluntary sector in order to support patients – for example on returning home, timely transportation and to provide reassurance/company for those without the support of family during their time in the Unit.

The aim of the service will be to complete the full multi-disciplinary assessment in order to confirm a management plan which allows the person to return home. Where the recommendation is for the person to be admitted to an inpatient bed, the comprehensive geriatric assessment (CGA) will ensure there is clarity about the required outcome from their inpatient episode and arrangements that will be needed for a safe & timely discharge.

The service will draw many of its patients from the Emergency Department but the option for direct admission will also be open to health & social care professionals working in the community. There is an expectation that the community practitioner who requests assessment via the service will remain involved throughout the process in order to support the transfer of the patient back to the home environment.

With a dedicate space the service will have capacity for 7 patients at any one time (the unit will comprise 5 chairs and 2 bed spaces) and will initially be open from 9am – 5pm as 51.6% of those over 65 years have been admitted Monday – Friday during core hours. The ambition of increasing these hours will depend on success rate of the service and the ability to ensure a return on investment for increasing the hours.

In addition to this there will also be an outreach element to the service to those who may already be an inpatient or require support in A&E and do not need to be move to another environment.

Again there will be a close collaboration with the Assessment and Discharge Service.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

The Joint Board consisting of NLCCG, NLC, NLaG and RDaSH will act as the commissioner for the roll out of the pilot scheme and all inputs, output and metrics will be reported on a monthly basis through to the Board.

A review of the impact of scheme will take place on monthly basis with a formal review at the end of the financial year to consider extending the current pilot arrangements whilst developing a formal specification to move into more formalised commissioning arrangements.

The pilot will build on the current Locality Team model which currently provided by NLaG in collaboration with NLC. To further build on this, the intention is to work in collaboration with RDaSH and locality GPs to ensure that the team is able to provide an integrated health and social care response as appropriate.

The Joint Board will consider a range of options for future commissioning which may include a Lead Provider, Single provider or Independent sector options.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

During the 'Perfect Week' four schemes were implemented to assess the sustainability of the schemes and potential impact they may have. Those schemes were:

- Rapid Assessment, Time Limited
- Frail Elderly Assessment Support Team
- 7 Day social workers
- Mental Health Liaison

The initial outcome of these schemes are showing:

Total seen during Perfect Week	**FEAST**	**RATL**	**OPMH**	**Social Services**
48	28	5	13	33
%	58.3%	10.42%	27.08%	68.75%

These schemes were implemented with a lead in time of three weeks. None of them were fully staffed nor had they had the opportunity to develop clear pathways and protocols for hand-off of patients through services.

This evidence is encouraging that with the appropriate amount of planning and phased approach to improvement in services each of these services will have an impact of the metrics as outlined in this document.

In addition to the local evidence, Sheffield Teaching Hospital NHS Foundation Trust demonstrated a positive impact of such a scheme with a 37% increase in patients who can be discharged on the day of their admission or the following day – with no increase in the re-admission rate. Thus implying that patient outcomes are not adversely affected by the faster throughput. Bed occupancy for emergency care for the elderly also reduced, allowing two wards to be closed. Sheffield also reported a decrease of in-hospital mortality for geriatric medicine of around 15%. At a notional bed day cost of around £300 per day there could be an estimated cost saving/avoidance of around £3.2m per annum. Sheffield note that this is a theoretical saving and is yet to be fully realised.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Revenue Costs

The proposed Unit would offer sufficient provision for 7 patients at any one time. The size of the unit has been based primarily on the required staff:patient ratio for nursing staff but has been tested, briefly, against a snap shot of data taken from the Symphony system which supports the management of patients in the Emergency Department.

The revenue consequences for the proposed scheme have been calculated on the basis that each role will need to be covered for 18 hours per day, 08.00 hours to 24.00 hours, in order to inreach and outreach 7 days per week, 52 weeks per year.

The level of investment required to support the FEAU service and included in the BCF investment plan is £1.134 million

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The overarching impact of this scheme will be a reduction in ***non-elective admissions***. The integration of these services will have a net impact in NEL admissions of ***2275*** per annum. This equates to 11% of overall admissions to Scunthorpe General Hospital.

The overarching ambition for improvement in care for those in an acute setting is to reduce the Length of Stay by 2 days. To enable this to happen the Assessment and Discharge Service will have the greatest impact.

Metric	**Target**
Reduction in Non Elective Admissions	114
Length of Stay	202 bed days

There will be an additional impact of other key performance indicators which will be monitored locally on a monthly basis, however, have not been included as metrics for this submission.

- Improved Patient satisfaction survey
- Improved staff satisfaction survey

- Reduction in duplication of assessment
- Increased use of rehabilitation and reablement
- Increased appropriate care planning
- Telling story once
- Reduction in bed moves for patients
- Reduction in cancelled elective surgery
- Reduction in outpatient appointments

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The Frail and Elderly Implementation Group have overall responsibility to track all impact metrics and spend associated with the better care fund initiatives. All metrics will be compiled into a granular data set with clear trajectories to show progress month on month and the Joint Board will provide final oversight.

Further work will be carried out to understand patient's experience of the redesigned service and staff experience of working in a more integrated arrangement. Alignment of access criteria and operating policies will be a key outcome for this service change and all providers will be expected to deliver to a clear set of operational and quality standards.

Detailed reports are in the process of being developed which will demonstrate:

- Allocation of resource v spend on allocation per month
- Target impact per month v actual
- Improvement in patient and staff survey
- Impact reported (+/-) on any other scheme

These will be at patient level (none identifiable)

NLaG already produce a report which captures the changes in attendance and admission for those 65years and over. This will be used as a detailed report for aspects of service improvement for both acute and community support.

What are the key success factors for implementation of this scheme?

The key success factors for implementation of this scheme comprise:

- OD strategy working with the teams involved to assist in breakdown of boundaries
- Workforce planning which is across all professions to decrease duplication of assessments
- Clear guidance on expectation of teams from senior management within each agency
- Engagement of staff in the development and improvement of services
- Sound data trails for monitoring
- Transparent decision making for each organisation
- Integration of IT systems for patient related data for each health and social care professional
- Recruitment of appropriate staff to support collaborative working and passion for

change
- Engagement of Care Homes across the patch in developing care pathways for patients and carers
- Engagement of GPs as part of Dementia money allocation in ensuring effective return on investment and care plans for patients

Scheme ref	Programme Area
8	Proactive Care

Scheme name

Assessment and Discharge Service

What is the strategic objective of this scheme?

To ensure patients have an assessment at the optimum point in their pathway to maximise their chance of rehabilitation/reablement for independent living.

Overview of the scheme
Please provide a brief description of what you are proposing to do including:
- What is the model of care and support?
- Which patient cohorts are being targeted?

Current Position

There is already an operational team within North Lincolnshire and Goole Hospitals NHS Foundation Trust. This focuses on the need to ensure patients are not subject to delayed discharges and have the opportunity to be discharged at the most optimum point of care in their pathway. This team already has health and social care professionals involved, however it has been recognised that there is now a need to increase capacity through using other teams who are now based within the hospital.

Future Vision

It is widely acknowledged that by have an integrated model, managed through one Line Manager will have the best rate of success. This will ensure that resources are focussed to one point and will be without organisational boundary.

The Assessment and Discharge Services will include social, physical and mental care professionals who have been trained as a Trusted assessor in order to ensure the appropriate assessments and plans for both admission and discharge take place.

This will be a 7 day service, complementing the plan of 7 day ward rounds, 7 day admission to bed based rehabilitation and intermediate care services. In addition to this there will be a 7 day provision for community equipment to support 7 day discharge home

with appropriate equipment and care in the community.

The additional services which will be impacted upon as part of this scheme are:

- Single point of access
- Rapid Assessment, Time Limited
- 7 day social services
- Frail Elderly Assessment and Support Team
- Older People's Mental Health Liaison
- Ambulatory Emergency Care

It is envisaged that this service will allow for more multi-disciplinary assessment of the person in need of care. Thus allowing for the correct professional to undertake assessment and manage the care requirements for that person. This may or may not entail a hospital admission.

With the inclusion of the Integrated Locality Services, it is envisaged that this service will ensure people are appropriately provided with care in the own home as a starting point of the persons pathway.

Further development of this service offer includes:

- Clear escalation plan which is to be communicated with all relevant parties
- Point of prevalence information about capacity and demand in both hospital and community settings, this is to include residential setting managed by NLC as well as that commissioned via NHS.
- Single management structure with personal from each profession included
- Trust assessor approach to identify appropriate place of care following patient being deemed to be medically fit.
- Clarity of personnel responsible and accountable at any one time
- Visibility of decision makers
- Senior review and support at all times

Whilst the lever for this improvement is based around the better care fund development, it is envisaged that this will provide an improvement in experience to all patients being seen within an acute setting.

The key components of the service will:

1. Assess the persons requirements to service need and consider where best the person can be treated
2. Have direct admission rights to all facilities within the health and social care community
3. Begin the discharge planning process at the point of admission to whichever service has been deemed most suitable
4. Provide staff with support, advice and training regarding discharge planning of both simple and complex patient discharges.
5. Work collaboratively with community services and teams such as Reablement, Integrated Locality Teams, RATL, Continuing Health Care, Older People's Mental

Health Liaison, Care Home Support Team, Social Services and GPs to ensure that persons' needs have been correctly assessed and are appropriately met on discharge.
6. Ensure the development of existing discharge services and transfer of care into community settings by developing key relationships where appropriate with other services such as Alcohol Liaison Nurses.
7. Provide all groups of staff with education and training with regard to their part of the service
8. Develop and produce information and literature for people regarding their pathway to assist them and prevent delays in their discharge.
9. Ensure an assessment of complex patients' needs takes place prior to admission and discharge.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

The Joint Board will oversee the roll out of the pilot scheme and all inputs, output and metrics will be reported on a monthly basis through to the Board.

A review of the impact of scheme will take place on monthly basis with a formal review at the end of the financial year to consider extending the current pilot arrangements whilst developing a formal specification to move into more formalised commissioning arrangements.

The pilot will build on a smaller scale service currently provided by NLaG and develop in collaboration with NLC, RDaSH and locality GPs to ensure that the team is able to provide an integrated health and social care response as appropriate.

Whilst the Joint Board will be monitoring the progress and development of this service, it is within the gift of the provider organisations to ensure this is a success. It is not envisaged that a commissioning decision can be taken to have this service provider from anywhere other than the current provider organisations

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

There are a number of organisations throughout the country who have already undertaken to integrate their staff and information to assist in developing these teams for the best outcome for patients and their carers.

NHSIQ have reported on a number of services showing these developments and in some cases between 60 – 70% admission avoidance from MAU/ED have been reported.

Through working with OPMH, HSWT and FEAU this will further strengthen the health and

care community's ability to care for patients in a system which suits their needs more.

During the 'Perfect Week' four schemes were implemented to assess the sustainability of the schemes and potential impact they may have. Those schemes were:

- Rapid Assessment, Time Limited
- Frail Elderly Assessment Support Team
- 7 Day social workers
- Mental Health Liaison

The initial outcome of these schemes are showing:

Total seen during Perfect Week	**FEAST**	**RATL**	**OPMH**	**Social Services**
48	28	5	13	33
%	58.3%	10.42%	27.08%	68.75%

These schemes were implemented with a lead in time of three weeks. None of them were fully staffed nor had they had the opportunity to develop clear pathways and protocols for hand-off of patients through services.

This evidence is encouraging that with the appropriate amount of planning and phased approach to improvement in services each of these services will have an impact of the metrics as outlined in this document.

Each of the professional teams named will have an impact of those entering the hospital as an admission. For those who are admitted this team will be able to further reduce admission yet will have the largest impact on the Length of Stay metric.

Other areas in the region have reported a reduction in length of stay by 2 days. It is envisaged that this will be achievable within Scunthorpe Hospital site using the similar methodology and operational processes.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

The investment for this scheme has already been accounted for within
7 day social work
OPMH
Hospital Therapy teams

Please see Part 2 for the investment in those services

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The overarching impact of this scheme will be a reduction in ***non-elective admissions***. The integration of these services will have a net impact in NEL admissions of ***2275*** per annum. This equates to 11% of overall admissions to Scunthorpe General Hospital.

The overarching ambition for improvement in care for those in an acute setting is to reduce the Length of Stay by 2 days. To enable this to happen the Assessment and Discharge Service will have the greatest impact.

Metric	**Target**
Reduction in Non Elective Admissions	114
Length of Stay	921 bed days

There will be an additional impact of other key performance indicators which will be monitored locally on a monthly basis, however, have not been included as metrics for this submission.

- Improved Patient satisfaction survey
- Improved staff satisfaction survey
- Reduction in duplication of assessment
- Increased use of rehabilitation and reablement
- Increased appropriate care planning
- Telling story once
- Reduction in bed moves for patients
- Reduction in cancelled elective surgery
- Reduction in outpatient appointments

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The Frail and Elderly Implementation Group have overall responsibility to track all impact metrics and spend associated with the better care fund initiatives. All metrics will be compiled into a granular data set with clear trajectories to show progress month on month and the Joint Board will provide final oversight.

Further work will be carried out to understand patient's experience of the redesigned service and staff experience of working in a more integrated arrangement. Alignment of access criteria and operating policies will be a key outcome for this service change and all providers will be expected to deliver to a clear set of operational and quality standards.

Detailed reports are in the process of being developed which will demonstrate:

- Allocation of resource v spend on allocation per month
- Target impact per month v actual
- Improvement in patient and staff satisfaction survey
- Impact reported (+/-) on any other scheme

These will be at patient level (none identifiable)

NLaG already produce a report which captures the changes in attendance and admission for those 65years and over. This will be used as a detailed report for aspects of service improvement for both acute and community support.

What are the key success factors for implementation of this scheme?

The key success factors for implementation of this scheme comprise:

- OD strategy working with the teams involved to assist in breakdown of boundaries
- Organisational buy in from clinical staff in NLaG, specifically Associate Medical Directors and Heads of Nursing/Therapy
- Workforce planning which is across all professions to decrease duplication of assessments
- Clear guidance on expectation of teams from senior management within each agency
- Engagement of staff in the development and improvement of services
- Sound data trails for monitoring
- Transparent decision making for each organisation
- Integration of IT systems for patient related data for each health and social care professional

Scheme ref no.	**Programme Area**
9	Proactive Care Patient Flow Integrated Community Services

Scheme name:

Older People's Mental Health Liaison

What is the strategic objective of this scheme?

Older People with mental health problems will have access to:

- Rapid assessment and treatment if suspected of or have cognitive impairment or other mental health problems including depression and delirium
- Ongoing support, education, advice, information and signposting for both older people with mental health problems and their carer

These will allow North Lincolnshire the opportunity to demonstrate that:

- We are working towards a Dementia Friendly Community
- The development of a community wide framework for peer support for those treating, caring for and living with a mental health problem

Overview of the scheme

Current Position

Mental Health services are currently commissioned within North Lincolnshire yet not in line with Parity of Esteem.

It is the intention of the Joint Board to commission improvements in acute liaison mental health services building on the experience/success of the RAID model in Birmingham which demonstrated that such investment will reduce length of stay and admissions in secondary care. Ensuring the service meets local requirements this has been tailored more in line with Doncaster's Older Peoples Mental Health Liaison Service. This is due to having a more comparable epidemiology and the same service provider. Therefore we will benefit from joint working, development of service already provided and cost efficiency of service provision.

Future Vision

The Older People's Mental Health service will provide assessment and interventions for acute hospital inpatients and those presenting both at the Urgent Care Centre over the age of 65 and those who are already known to community services, either health or social care, requiring some form of mental health support.

The benefits expected to be realised from this service development are:

- Reduced length of in-patient stay
- Reduced attendances at Accident and Emergency
- Reduced admissions, investigations and outpatient attendances by top 50 'frequent attenders'
- Reduced admissions from A&E into acute hospitals
- Increased proportion of patients returning to their usual place of residence
- Increased detection, diagnosis and treatment of depression, delirium and dementia
- Reduce incidents of fall during hospital admission and fracture neck of femurs

The service will be set up during 2014/15 on a pilot basis (funded from the System Resilience Fund) to test the design and impact on a range of quality and performance measures agreed as part of the specification. It will form a significant element of the service vision detailed in the Better Care Fund proposals and will support delivery of care in community based settings, supporting the reduction in un-necessary admissions.

The rationale for a pilot is to support the Health and Social Care system to assess the early impact and to allow time to adjust the specification as needed. Consideration will then be given by the Joint Board on future commissioning arrangements for the service in 2015/16.

The delivery chain

The Joint Board will oversee the roll out of the pilot scheme and all inputs, output and metrics will be reported on a monthly basis through to the Board.

A review of the impact of scheme will take place on monthly basis with a formal review at the end of the financial year to consider extending the current pilot arrangements whilst developing a formal specification to move into more formalised commissioning arrangements.

The pilot will build on the current Locality Team model which currently provided by NLaG in collaboration with NLC. To further build on this, the intention is to work in collaboration with RDaSH and locality GPs to ensure that the team is able to provide an integrated health and social care response as appropriate.

The Joint Board will consider a range of options for future commissioning which may include a Lead Provider, Single provider or Independent sector options.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

During the 'Perfect Week' four schemes were implemented to assess the sustainability of the schemes and potential impact they may have. Those schemes were:

- Rapid Assessment, Time Limited
- Frail Elderly Assessment Support Team
- 7 Day social workers
- Mental Health Liaison

The initial outcome of these schemes are showing:

Total seen during Perfect Week	**FEAST**	**RATL**	**OPMH**	**Social Services**
48	28	5	13	33
%	58.3%	10.42%	27.08%	68.75%

These schemes were implemented with a lead in time of three weeks. None of them were fully staffed nor had they had the opportunity to develop clear pathways and protocols for hand-off of patients through services.

This evidence is encouraging that with the appropriate amount of planning and phased approach to improvement in services each of these services will have an impact of the metrics as outlined in this document.

The results Doncaster's Older People's Mental Health Liaison Service has demonstrated a positive outcome for service users and a significant financial saving to the whole health & social care economy.

Parsonage et al[i] highlighted that mental health co-morbidities substantially increase costs of physical health care. Estimates of the annual cost to the NHS for co-existing mental health problems in acute hospitals including medically unexplained symptoms are in the order £6 billion a year this is equivalent to around 15% of investment.

Living well with dementia; A National Dementia Strategy[ii]: identifies that older people occupy 70% of beds in acute hospitals half of these older people have cognitive impairment. Rates of 27% for depression (Ames and Tuckwell 1994[iii]), 27% for dementia (Bowler et al. 1994[iv]) and 29% for delirium (O'Keeffe and Lavan 1996[v]) are typical. Local demographics information predicts the incidence and prevalence of late onset dementia across the North East will increase significantly rising from 30,254 in 2009 to 50,896 by 2030 (68%)[vi]

No Health without Mental Health: a cross government mental health outcomes strategy for people of all ages[vii]: A high level objective of this strategy requires the a focus on the relationship between physical and mental health with the aim of improving the mental well-being of people with physical ill health and the physical health of those with mental health problems. The strategy suggests CCGs use innovative service models such as liaison psychiatry to improve the mental health of people with long-term physical conditions and medically unexplained symptoms.

Starting today: The future of mental health services final inquiry report[viii] (The Mental Health Foundation September 2013) acknowledges that there are significant benefits to establishing psychiatric liaison services in physical health care settings. It highlighted improvements to integrated patient care and cost savings that can be made through more effective care and rapid recovery.

Liaison Psychiatry in the Modern NHS: This report, published in 2012 by the Centre for Mental Health / NHS Confederation (Parsonage et al)[ix], is based on detailed case studies of five established Liaison Psychiatry services in England. The report supports the findings of the 2011 review of services in Birmingham (RAID). It also reinforces the prevalence of mental illness among people with physical health conditions is two to three times higher than in the rest of the population. Incidence is particularly high in the hospital setting, where around half of all inpatients suffer from a mental health condition such as depression, dementia or delirium.

Recommendations from the report are:

- Every General and Acute Hospital should have a dedicated Liaison Psychiatry service;
- Services should be established on a sustainable basis;
- A liaison service should focus mainly on complex and costly cases;

- Training and supervision of acute hospital staff should be a core function of all

Liaison psychiatry services;

- Outpatient treatment clinics should focus particularly on conditions that are not generally well managed in the community, for example medically unexplained symptoms and self-harm.

An assessment of the potential scope for cost savings was found in the conclusions of a meta-analysis of nearly 100 relevant research studies which found that psychological interventions for patients with physical conditions being treated in acute hospitals and similar settings reduce health care costs per patient by about 20% on average (Chiles et al., 1999[x]). This also appears to be broadly consistent with the findings of the RAID evaluation. Savings on this scale translate to potential cost reductions of around £1.2 billion a year at the national level, or £5 million a year for a typical 500-bed general hospital

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Based on the service development made within Doncaster Health and Social Care Community the expected investment is c£500,000

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The overarching impact of this scheme will be a reduction in ***non-elective admissions***. The integration of these services will have a net impact in NEL admissions of ***2275*** per annum. This equates to 11% of overall admissions to Scunthorpe General Hospital.

The overarching ambition for improvement in care for those in an acute setting is to reduce the Length of Stay by 2 days. To enable this to happen the Assessment and Discharge Service will have the greatest impact.

Metric	**Target**
Reduction in Non Elective Admissions	228
Length of Stay	323 bed days

There will be an additional impact of other key performance indicators which will be monitored locally on a monthly basis, however, have not been included as metrics for this submission.

- Improved Patient satisfaction survey
- Improved staff satisfaction survey
- Reduction in duplication of assessment
- Increased use of rehabilitation and reablement

- Increased appropriate care planning
- Telling story once
- Reduction in bed moves for patients
- Reduction in cancelled elective surgery
- Reduction in outpatient appointments

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The Frail and Elderly Implementation Group have overall responsibility to track all impact metrics and spend associated with the better care fund initiatives. All metrics will be compiled into a granular data set with clear trajectories to show progress month on month and the Joint Board will provide final oversight.

Further work will be carried out to understand patient's experience of the redesigned service and staff experience of working in a more integrated arrangement. Alignment of access criteria and operating policies will be a key outcome for this service change and all providers will be expected to deliver to a clear set of operational and quality standards.

Detailed reports are in the process of being developed which will demonstrate:

- Allocation of resource v spend on allocation per month
- Target impact per month v actual
- Improvement in patient and staff survey
- Impact reported (+/-) on any other scheme

These will be at patient level (none identifiable)

NLaG already produce a report which captures the changes in attendance and admission for those 65years and over. This will be used as a detailed report for aspects of service improvement for both acute and community support.

What are the key success factors for implementation of this scheme?

The key success factors for implementation of this scheme comprise:

- OD strategy working with the teams involved to assist in breakdown of boundaries
- Workforce planning which is across all professions to decrease duplication of assessments
- Clear guidance on expectation of teams from senior management within each agency
- Engagement of staff in the development and improvement of services
- Sound data trails for monitoring
- Transparent decision making for each organisation
- Integration of IT systems for patient related data for each health and social care professional
- Recruitment of appropriate staff to support collaborative working and passion for change

- Engagement of Care Homes across the patch in developing care pathways for patients and carers
- Engagement of GPs as part of Dementia money allocation in ensuring effective return on investment and care plans for patients

Scheme ref	**Programme Area**
10	Patient Flow Services

Scheme name

Discharge to Assess – Non Reablement Pathway

What is the strategic objective of this scheme?

This scheme is one of the schemes that forms part of the Patient Flow Service programme area.

The objective of this scheme is to ensure patients have an assessment of their on-going care needs in the most appropriate environment. The scheme is aimed at all adults with a frailty marker.

This will assist in all stakeholders strategic plans by having a clear drive to ensure care is offered in the right place at the appropriate time, increasing independence and decreasing the chances of institutionalisation.

This will also assist in attaining the aspiration of working more closely with Care Homes across the North Lincolnshire area.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Current Position

Currently people within the hospital are assessed in a linear model and by a range of professionals. Evidence has already been submitted from neighbouring organisations and within both Foundation Network and the Kings Fund to suggest that an MDT approach to care for Older and Frail patients will reduce their length of stay and improve outcomes for people in the longer term.

Future Vision

This model of care builds on those already piloted across the country and within North Lincolnshire. It is widely acknowledged that by having an integrated model, managed by one provider will have the best rate of success. This will ensure that resources are focussed to one point and will be without organisational boundary.

The aim of this pilot is to:

- Maximise patient independence prior to assessment
- Ensure the right environment for assessment by the right people
- Reduce the number of delayed discharges from Scunthorpe General Hospital
- CHC checklists and DSTs completed in a patient's post-acute phase
- Reduction in CHC spend
- Improved quality of DST completion
- Standardisation of criteria compliance
- Increase the integration of locality teams with both Care Homes and General Practice.

The initial assessment will take place by the Assessment and Discharge Service, using the Trusted Assessor approach. Once a person has been identified as meeting the criteria for Discharge to Assess they will be transferred to a 'Complex Assessment Bed'. At this point the service will be provided by the Locality Service with medical cover being provided by a GP.

The assessment will take place within the next 30 days, throughout this time conversations and care planning will take place with the person and their carer at the centre of discussions to ensure that the outcome and ongoing care is the most appropriate for them and has been designed as fully person centred.

Using this process we are expecting to see a reduction in permanent placements to residential care and an increase in reablement services, however, the latter should result in a less intensive package of care due to the person being brought out of the hospital sooner and provided with the appropriate care at the optimum point of their pathway.

The scheme will also contribute to the reduction in non-elective admissions by increasing independence, providing more timely assessment in the community to prevent emergency admissions.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

The Joint Board will oversee the roll out of the pilot scheme and all inputs, output and metrics will be reported on a monthly basis through to the Board.

A review of the impact of scheme will take place on monthly basis with a formal review at the end of the financial year to consider extending the current pilot arrangements whilst

developing a formal specification to move into more formalised commissioning arrangements.

The service could be commissioned by the CCG, by the Local Authority or by NLAG as a lead provider. The future commissioning model will be considered based on the pilot experience. For the pilot the CCG will commission care home beds and GP support.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Through the Perfect Week we were able to test the proof of concept and have local evidence, in practice that this scheme will have a positive impact

The key principles are evidenced through the Enhancing a Healing Environment schemes supported by DH, NHS England and the Kings Fund. Patients who are more accurately assessed and better cared for in an environment which best suits their needs has a positive impact on their outcome and levels of independence. Making an assessment of someone's on-going care needs outside an acute setting is a contributing factor to improved patient care and keeping people out of hospital .

At present this is most achievable within a Nursing/Residential home setting, we would like to move towards having this assessment take place in a patient's own home. This will take more time and resource to achieve.

The Health Foundation, now known as NHS Providers, undertook a review of how to improve the flow of older people within acute trusts. Much of this work began two years ago focussing on Frailty Assessment and Holistic reviews. The lead on from that work was developing a Discharge to Assess pathway. The recognition was there at the outset for the need to have inter-agency working with both the local authority and primary care.

During the 'Perfect Week' four schemes were implemented to assess the sustainability of the schemes and potential impact they may have. Those schemes were:
- Rapid Assessment, Time Limited
- Frail Elderly Assessment Support Team
- 7 Day social workers
- Mental Health Liaison

The initial outcome of these schemes are showing:

Total seen during Perfect Week	**FEAST**	**RATL**	**OPMH**	**Social Services**
48	28	5	13	33
%	58.3%	10.42%	27.08%	68.75%

In addition to these outcomes, 51.4% of the patients were assessed with a single process in place.

These schemes were implemented with a lead in time of three weeks. None of them were fully staffed nor had they had the opportunity to develop clear pathways and protocols for hand-off of patients through services.

This evidence is encouraging that with the appropriate amount of planning and phased approach to improvement in services each of these services will have an impact of the metrics as outlined in this document.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Nursing and Residential beds on a 52 week basis
GP Session allocation

Integrated Locality Services will not require any additional funding for this service as this is from within current resource allocation It is anticipated that having the assessment earlier in their journey will require less time than had the patient been an inpatient.

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The overarching impact of this scheme will be a reduction in ***non-elective admissions***. The integration of these services will have a net impact in NEL admissions of ***2275*** per annum. This equates to 11% of overall admissions to Scunthorpe General Hospital.

The overarching ambition for improvement in care for those in an acute setting is to reduce the Length of Stay by 2 days. To enable this to happen the Assessment and Discharge Service will have the greatest impact.

Metric	**Target**
Reduction in Non Elective Admissions	114
Length of Stay	303 bed days

Additional benefits will include:

- Improved Patient satisfaction survey
- Improved staff satisfaction survey
- Reduction in duplication of assessment
- Increased use of rehabilitation and reablement
- Increased appropriate care planning
- Decrease in hospital acquired harm whilst waiting discharge
- Reduction in HCAI
- Telling story once

- Reduction in bed moves for patients
- Reduction in cancelled elective surgery
- Reduction in outpatient appointments
- Increases support for families and patients on making a decision on their place of care

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The Frail and Elderly Implementation Group have overall responsibility to track all impact metrics and spend associated with the better care fund initiatives. All metrics will be compiled into a granular data set with clear trajectories to show progress month on month and the Joint Board will provide final oversight.

Further work will be carried out to understand patient's experience of the redesigned service and staff experience of working in a more integrated arrangement. Alignment of access criteria and operating policies will be a key outcome for this service change and all providers will be expected to deliver to a clear set of operational and quality standards.

Detailed reports are in the process of being developed which will demonstrate:

- Allocation of resource v spend on allocation per month
- Target impact per month v actual
- Improvement in patient and staff satisfaction survey
- Impact reported (+/-) on any other scheme

These will be at patient level (none identifiable)

NLaG already produce a report which captures the changes in attendance and admission for those 65years and over. This will be used as a detailed report for aspects of service improvement for both acute and community support.

What are the key success factors for implementation of this scheme?

The key success factors for implementation of this scheme comprise:

- Patient transport services are available
- GP engagement for undertaking medical responsibility for patient
- Appropriate homes interested in undertaking the role
- Availability of community services to respond to assessments
- Pace of assessments must be within timeframe for agreed service otherwise this only proves to move the bottleneck of delayed transfers

Scheme ref	Programme Area
11	Wellbeing Services

Scheme name

Integrated Locality Teams

What is the strategic objective of this scheme?

This scheme is part of the Wellbeing Services programme.

The objective of this scheme is to manage patients closer to home based on their ward/locality area. The principle behind this is that people will be cared for and supported within the area which they live by those who know the area best and are able to provide, care, treatment, advice and signposting.

The objective is to provide:

- Improved proactive care : through greater coordination and case management
- Rapid response: especially for equipment services.
- Supported discharge

The overarching vision of developing care closer to home is fundamental in considering the development of improved integration of health, social and voluntary care provision.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

This model of care builds on those already piloted across the country and with North Lincolnshire. It is widely acknowledged that by have an integrated model, managed by one provider will have the best rate of success. This will ensure that resources are focussed to one point and will be without organisational boundary.

This scheme has been in place prior to BCF, however, the further development of the scheme and change in community provision will include:

Community Equipment Service (CES)

The Equipment Service plays a central role in supporting both health and social care community services through the timely provision of equipment and wheelchairs to people within their own place of residence. The service also provides a repair and maintenance service for people who have equipment/wheelchairs issued by the service.

At present the service is achieving same day and next day where the service is responsible for the delivery of equipment and wheelchairs in 95% of cases. The proposal would be to expand the service to deliver the full range of services, 6 days a week with an

additional full on call service on a Sunday 8am – 8pm. Additional investment in equipment is also planned to be able to respond to increased support in peoples own homes

Expansion of Locality Coordinators (Responder post, new role based on pilot undertaken)

The main function of this role is to act as a clinical decision maker. This will involve:

- Providing the point of contact and communication link between the locality team and primary care in order for clinical decision making to take place.
- Providing the point of contact for patients (and their carers) where the condition is deteriorating/changing
- Coordinating activity across a range of organisations and practitioners for patients with complex needs

The role will support three groups of patients (and carers):

- Patients at high risk of unplanned hospital admission (including those in care homes)
- Patients requiring discharge from hospital (planned and unplanned)
- Patients with complex health & social care packages

The role will undertake the following types of activity:

- Review the daily list of patients admitted to hospital in the preceding 24 hours and work proactively to plan for discharge based on the Expected Date of Discharge (EDD) process.

  Working with the Assessment and Discharge service, the Locality Co-ordinator would identify those individuals who are already known to the locality, those who are likely to be new referrals to the locality team and those who are likely to be self-caring. S/he would agree where "in reach" is required from the locality team to proactively "pull" people through to discharge and arrange any additional training for the team (e.g. for new/infrequent procedures).

  The Locality Co-ordinator would be the point of contact and coordination for those patients with complex discharge requirements, ensuring all services are in place.

- Be available to take calls from GPs and make calls on behalf of the team in order to discuss the clinical condition of patients and agree plans for their care – the post holder will have access to SystmOne, WebV, EMIS and Care First systems in order to be able to understand the totality of information available.
- Liaise with the urgent care service and/or RATL to agree the response to patients

who have attended A&E but do not require admission to hospital.

- Take responsibility for responding when urgent needs are identified, acting, alerting and liaising as appropriate to ensure patient safety
- Take the lead role for overseeing the coordination of care for those on the "Top 10 list" – this group of patients will be identified by the locality team members on an on-going basis and will be those with the most intensive need for health & social care or those whose condition is fluctuating.
- Ensure contact is made within 48 hours with each patient who had an unplanned admission but was considered to be self-caring on discharge. The purpose of this contact will be to establish whether the reason for admission has been resolved, pick up those who are not able to self-care and inform the patient of the role of the locality team in the event of future need.
- Liaise with providers of community based schemes to direct people who would benefit from health promotion/prevention programmes e.g. Expert Patient Programme

7 day working OT and Physio to support in patients and A&E in order to be more responsive to get patients discharged to place of residence in a timely manner, reducing length of stay and to facilitate 7 day discharge to home / place of residence. These requirements will be assessed as the service is developed in line with hospital data of requirements for such professions.

Expansion of Community Macmillan team working 7 days in order to best support Community / Primary Care and Secondary care with End of Life, Expert advice and to prevent admission into hospital from care homes. It is recognised that more patients wish to die in their home / care home as preferred place of death.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved.

The Joint Board will oversee the roll out of the pilot scheme and all inputs, output and metrics will be reported on a monthly basis through to the Board.

A review of the impact of scheme will take place on monthly basis with a formal review at the end of the financial year to consider extending the current pilot arrangements whilst developing a formal specification to move into more formalised commissioning arrangements.

The pilot will build on the current Locality Team model which currently provided by NLaG

in collaboration with NLC. To further build on this, the intention is to work in collaboration with RDaSH and locality GPs to ensure that the team is able to provide an integrated health and social care response as appropriate.

The Joint Board will consider a range of options for future commissioning which may include a Lead Provider, Single provider or Independent sector options.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

http://www.england.nhs.uk/2013/11/01/interg-care-pioneers/

The Integration Pioneers website and Integrated Care Today publications, along with reports from Kings Fund have all helped develop the thinking about ensuring that North Lincolnshire moves faster to an integrated care model.

The North Lincolnshire Locality Team model was created based on the Torbay model

Foundation Trust Network March 2012 found that of the 16 acute trusts those who had integrated and collaborative working practices with non-acute services achieved a lower length of stay for older people. The effective use of this system through supporting the early discharge of older people from hospital significantly reduced the risk of these people becoming dependent on ongoing bed-based care.

During the 'Perfect Week' four schemes were implemented to assess the sustainability of the schemes and potential impact they may have. Those schemes were:
- Rapid Assessment, Time Limited
- Frail Elderly Assessment Support Team
- 7 Day social workers
- Mental Health Liaison

The initial outcome of these schemes are showing:

Total seen during Perfect Week	**FEAST**	**RATL**	**OPMH**	**Social Services**
48	28	5	13	33
%	58.3%	10.42%	27.08%	68.75%

These schemes were implemented with a lead in time of three weeks. None of them were fully staffed nor had they had the opportunity to develop clear pathways and protocols for hand-off of patients through services.

This evidence is encouraging that with the appropriate amount of planning and phased approach to improvement in services each of these services will have an impact of the metrics as outlined in this document.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

The current investment for the Integrated Locality Team is £1.8m
This covers the expansion of the services named above which then move into 7 day working across the patch.

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

The overarching impact of this scheme, as part of the overall programme will be a reduction in ***non-elective admissions***. The integration of these services will have a net impact in NEL admissions of ***2275*** per annum. This equates to 11% of overall admissions to Scunthorpe General Hospital.

The overarching ambition for improvement in care for those in an acute setting is to reduce the Length of Stay by 2 days. To enable this to happen the Assessment and Discharge Service will have the greatest impact.

Metric	**Target**
Reduction in Non Elective Admissions	341
Length of Stay	202 bed days

- Reduction in A&E attendance
- Reduction in NEL admissions
- Improved Patient satisfaction survey
- Improved staff satisfaction survey
- Reduction in duplication of service
- Increased appropriate care planning
- Telling story once
- Decrease in falls admissions

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The Frail and Elderly Implementation Group have overall responsibility to track all impact metrics and spend associated with the better care fund initiatives. All metrics will be compiled into a granular data set with clear trajectories to show progress month on month and the Joint Board will provide final oversight.

Further work will be carried out to understand patient's experience of the redesigned service and staff experience of working in a more integrated arrangement. Alignment of access criteria and operating policies will be a key outcome for this service change and all providers will be expected to deliver to a clear set of operational and quality standards.

Detailed reports are in the process of being developed which will demonstrate:

- Allocation of resource v spend on allocation per month
- Target impact per month v actual
- Improvement in patient and staff survey
- Impact reported (+/-) on any other scheme

These will be at patient level (none identifiable)

NLaG already produce a report which captures the changes in attendance and admission for those 65years and over. This will be used as a detailed report for aspects of service improvement for both acute and community support.

What are the key success factors for implementation of this scheme?

The key success factors for implementation of this scheme comprise:

- OD strategy working with the teams involved to assist in breakdown of boundaries
- Workforce planning which is across all professions to decrease duplication of assessments
- Clear guidance on expectation of teams from senior management within each agency
- Engagement of staff in the development and improvement of services
- Sound data trails for monitoring
- Transparent decision making for each organisation
- Integration of IT systems for patient related data for each health and social care professional

ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

Name of Health & Wellbeing Board	North Lincolnshire
Name of Provider organisation	Northern Lincolnshire and Goole Foundation Trust
Name of Provider CEO	Karen Jackson
Signature (electronic or typed)	Original signed

For HWB to populate:

Total number of non-elective FFCEs in general & acute	**2013/14 Outturn**	15831
	2014/15 Plan	14887
	2015/16 Plan	12149
	14/15 Change compared to 13/14 outturn	-944
	15/16 Change compared to planned 14/15 outturn	-2738
	How many non-elective admissions is the BCF planned to prevent in 14-15?	230
	How many non-elective admissions is the BCF planned to prevent in 15-16?	2275

For Provider to populate:

	Question	Response
1.	**Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?**	Yes, the Trust recognises the figures but the associated risks and actions are documented in the accompanying letter.
2.	**If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?**	N/A
3.	**Can you confirm that you have considered the resultant implications on services**	Yes the Trust has considered the resultant implications of the BCF and has escalated to Commissioners that it cannot be viewed in

	provided by your organisation?	isolation. The proposals within it are key enablers to the strategic vision for North Lincolnshire, a vision which all providers are working towards, however whilst the BCF is based up national tariff and not provider costs, significant financial risk exists. To enable progression, a risk share has been agreed between parties and the schemes within the BCF are incorporated within the wider Healthy Lives, Healthy Futures Programme

[i] Parsonage, M., Fossey, M. & Tutty, C. (2012) *Liaison Psychiatric Services in the Modern NHS,* London, Centre for Mental Health / Mental Health Network NHS Confederation.

[ii] Department of Health. (2009) *Living well with dementia: a national dementia Strategy*. London: Department of Health

[iii] Ames, D. and V. Tuckwell. 1994. Psychiatric disorders among elderly patients in a general hospital. *Medical Journal of Australia* 160(11): 671-675.

[iv] Bowler, C., A. Boyle, M. Branford, S. A. Cooper, R. Harper, and J. Lindesay. 1994. Detection of psychiatric disorders in elderly medical inpatients. *Age & Ageing* 23(4): 307-311.

[v] O'Keeffe, S. T. and J. N. Lavan. 1996. Predicting delirium in elderly patients: development and validation of a risk-stratification model. *Age & Ageing* 25(4): 317-321.

[vi] Social Care North East: Department of Health (2011), *Dementia North East England-2011 demographic update*. Newcastle. Dementia North East England

[vii] No Health Without Mental Health(2012): A Cross-Government Mental Health Outcomes Strategy for People of all ages. Centre for Mental Health, Department of Health, Mind, NHS Confederation Mental Health Network, Rethink Mental Illness,Turning Point.

[viii] *Starting today: The future of mental health services* final inquiry report[viii] (The Mental Health Foundation September 2013) Available at http://www.mentalhealth.org.uk/publications/starting-today-future-of-mental-health-services/

[ix] Parsonage, M., Fossey, M. & Tutty, C. (2012) *Liaison Psychiatric Services in the Modern NHS,* London, Centre for Mental Health / Mental Health Network NHS Confederation.

[x] Chiles, J., Lambert, M. & Hatch, A. (1999) The impact of psychological interventions on medical cost offset: a meta-analytic review. Clinical Psychology: Science and Practice, 3 (2), 204-220.