MEETING DATE:	10 April 2014	NHS North Lincolnshire Clinical Commissioning Group **REPORT TO THE** **CLINICAL COMMISSIONING GROUP** **GOVERNING BODY**
AGENDA ITEM NUMBER:	Item 6.1	
AUTHOR: **JOB TITLE:** **DEPARTMENT:**	Caroline Briggs Director of Commissioning NL CCG	

COMMISSIONING PLAN

PURPOSE/ACTION REQUIRED:	For Approval
CONSULTATION AND/OR INVOLVEMENT PROCESS:	To date, engagement has taken place with Council of Members and stakeholders via an engagement event held on 31st January. Health and Wellbeing Board received an update on the overall plan on the 25 March. Better Care Fund Plans have been worked up with North Lincolnshire Council, Northern Lincolnshire and Goole Foundation Trust and GP's
FREEDOM OF INFORMATION:	*Is this document releasable under FOI at this time? If not why not? (decision making guide being developed)* **Public**

1. PURPOSE OF THE REPORT:

To receive and approve the final planning submissions made the NHS England on the 4 April, initial planning submission for ambitions and quality premiums.

NL CCG is required to lead the production of a 5 year strategic plan for North Lincolnshire to bring together the plans for CCG, Northern Lincolnshire and Goole Foundation Trust, Rotherham, Doncaster and South Humber and North Lincolnshire Council. In addition, it must (2014/15 and 15/16) set out a detailed two year Operational plan including finance and activity plans.

NL CCG is also required to develop, with North Lincolnshire Council, a plan for the Better Care Fund, supported by the Health and Wellbeing Board.

The initial upload of finance, activity and plans for ambitions was required by 14th February. The final submission of the finance, activity and a narrative plan was required to be submitted to NHS England by 4th April. Dialogue between the CCG and the area team has taken place to refine these plans and provide assurance to NHS England that the plan is robust, fits with the NHS England direct commissioning plans (for primary care, public health, specialised services, military health and offender health) and triangulates with provider plans.

The appendices to this report cover

Appendix 1
Sets out the ambitions for improving outcomes across the 6 ambitions

Appendix 2
Sets out the financial plan and supporting commentary

Appendix 3
Is the final Better Care Fund Plan

The CCG has also submitted a first version of the Strategic Plan and Plan on a Page. The final draft will be refined following further discussion with NHS England and local partners and considered at the Governing Body on the 12th june.

A final version of the plan will be published on the CCG website following submission in June.

2. STRATEGIC OBJECTIVES SUPPORTED BY THIS REPORT:

Continue to improve the quality of services	**X**
Reduce unwarranted variations in services	**X**
Deliver the best outcomes for every patient	**X**
Improve patient experience	**X**
Reduce the inequalities gap in North Lincolnshire	**X**

3. IMPACT ON RISK ASSURANCE FRAMEWORK:

Yes	**X**	**No**	

The risk framework for 2014/15 will include delivery of the commissioning plan, priorities, CCG outcome indicators and financial plan

4. IMPACT ON THE ENVIRONMENT – SUSTAINABILITY:

Yes	**X**	**No**	

The plan and delivery of the priorities and actions contained are aimed at reducing unnecessary travel

5. LEGAL IMPLICATIONS:

Yes		**No**	**X**

6. RESOURCE IMPLICATIONS:

Yes	**X**	**No**	

The overall plan contains the Financial plan for 2014/15 to 2018/19

7. EQUALITY IMPACT ASSESSMENT:

Yes		**No**	**X**

An equality impact assessment on the overall plan will be included in the final document. Individual elements of the plan remain subject to individual assessments

8. PROPOSED PUBLIC & PATIENT INVOLVEMENT AND COMMUNICATIONS:

Yes	**X**	**No**	

Engagement of a stakeholder group regarding proposals for 2014/15 and 2015/16 has been completed to feed into this plan. Further public and patient involvement will continue in the delivery of the plan. The five year strategic plan is informed by the on-going Healthy Lives, Healthy Futures engagement programme and the longer term plans will be regularly reviewed in light of the emerging Healthy Lives, Healthy Futures plan.

9. RECOMMENDATIONS:

The CCG is asked to: -
• Receive and approve the
  o Ambitions and Quality Premium
  o Financial Plan
  o Better Care Fund Plan
• Delegate to the CCG Engine Room to continue to refine the Strategic Plan with partners and receive the final draft on the 12 June

APPENDIX 1

Ambitions and Quality Premium

Outcome measures

The spreadsheet attached sets out the ambitions for improving outcomes across the 6 ambitions and should be read in conjunction with this section. This describes the final ambition levels set and highlights where changed from the draft submission in February

Outcome 1

(E.A.1) Potential Years Life Lost (PYLL) (as per draft plan submitted)

Current baseline data is taken from Levels of Ambition Atlas (CCG). 3.2% reduction applied to 14/15 position as set out in national Quality Premium guidance. Additional 1% year on year reduction applied to 2018/19.

Outcome 2

(E.A.2) Health-related quality of life for people with long-term conditions (LTC)

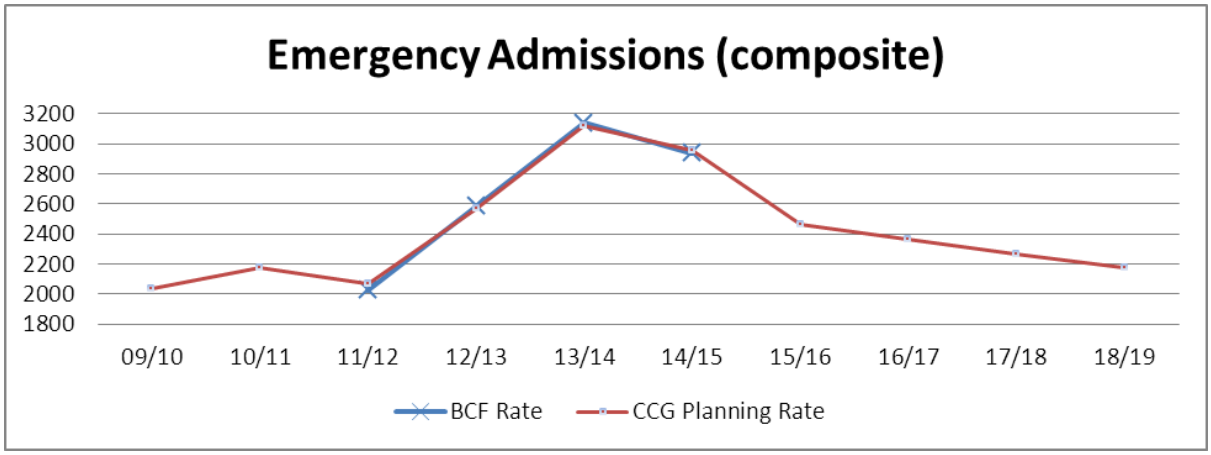
Current baseline data is taken from Levels of Ambition Atlas (CCG). North Lincolnshire currently at same level as NHS England therefore 1.5% increase applied year on year to achieve upper quartile position by March 2016. For 2016/17 onwards this has been revised from the draft submission to reflect a further 0.5% improvement followed by 0.25% in 2017/18, which is a change from then.

Outcome 3

(E.A.4) Avoidable emergency admissions (composite measure)

Baseline data uses the 12/13 published ISR (indirectly standardised rate) and uses this to forecast the 13/14 position based on local intelligence (21.8%). This represents a significant increase in activity for these indicators in 13/14.

As this indicator also forms part of the Better Care Fund (BCF) metrics, the same trend has been applied to this indicator as that in the BCF. The BCF indicator is based on a statistically significant decrease (5.39%) in 14/15. This can be seen in the graph below.



14/15 has been assumed at 5.39% and 15/16 at 16.61% in line with the BCF 22% reduction requirement to deliver the reduction in acute provider spend. All subsequent years are assumed at 4% reduction.

Outcome 5

(E.A.5) Increasing proportion of people having a positive experience of hospital care

Current baseline data is taken from Levels of Ambition Atlas (CCG). 1% decrease in proportion in people reporting a poor experience applied year on year to 2018/19. Already above England position (142.0). Aim to achieve next quartile by 2018/19. Range 108.6 - 208.8.

Outcome 6

(E.A.7) Increasing proportion of people having a positive experience of care outside hospital, in general practice and the community

Current baseline data is taken from Levels of Ambition Atlas (CCG). 0.5% decrease applied year on year to 2018/19. 0.5% decrease applied to take into next quintile (6.3 – 7.4). Range 2.6 - 13.0. Following further discussion we have clarified that this relates to primary care and primary care out of hours and therefore kept as per the draft.

Quality Premium Measures

E.A.1 PYLL

This is a pre-set cell that pulls the 14/15 position through from PYLL within the Ambitions for Improving Outcomes (detailed above).

E.A.4 Avoidable emergency admissions (composite measure)

14/15 position taken from Ambitions for Improving Outcomes (detailed above) and seasonally profiled based on seasonality of baseline data provided for BCF.

E.A.3 IAPT – proportion entering treatment against level of need

Baseline taken from April to December 2013 forecast outturn. Target requirement is 15% or, if already achieving then to show further improvement.

As North Lincolnshire is already one of the best performing services increase kept at a conservative level (1% of applicable population each year) and profiled as per outturn.

Quality Premium Local Priority

There is a requirement to agree a local quality premium. The quality premium is paid to CCG in 2015/16 for performance in 2014/15. The guidance sets out the process for calculation of the premium payment. The percentage payment aligned to the local measure is set by NHS England at 15% of the total quality premium payment.

Proposed measure; C3.12 Hip fracture: timely surgery

Patients with a fractured hip should receive surgery on the day of admission or the day after. This indicator forms part of Domain 3 and aims to improve outcomes associated with timely surgery. At the time of considering the draft plan we did not have available local performance data, which has now been identified. The local performance against this indicator is less than 60% for NLAG and HEY and therefore a target of 75% is proposed which is greater than current national average of 71%

Other Measures

E.A S1 Dementia diagnosis rate

Baseline taken from QOF 12/13. Prevalence predicted using dementia calculator tool. National guidance indicates that rate must be 67% by March 2015. 15/16 assumes performance sustained at this level offsetting increase in prevalence.

E.A.2 IAPT Recovery rate

Baseline taken from 13/14 forecast outturn and set at required 50% rate as per national guidance. Current recovery at 54.8% YTD but November and December 2013 dropped below 50%. RDaSH confirm performance will return to plan in 13/14.

E.A S 5 Number of C. difficile infections in 2014/15

Trajectory for this indicator has now been set by NHS England at 37 in 2014/15

#REF! Name: #REF!

Read the definitions in the Everyone Counts: Planning for Patients 2014/15 - 2018/19 Technical Definitions for CCGs and Area Teams before completing the template
Read 'Setting 5-year ambitions for improving outcomes A how-to guide for commissioners' before completing the template

2. Ambitions for Improving Outcomes

Outcome Ambition 1

E.A.1

i) What is your ambition for securing additional years of life from conditions considered amenable to healthcare?

E.A.1	PYLL (Rate per 100,000 population)	
Baseline	2151.9	Please insert baseline - these are provided in the Levels of Ambition Atlas
2014/15	2083	
2015/16	2062.2	
2016/17	2041.6	
2017/18	2021.2	
2018/19	2001	

Note: PYLL forms part of the 2014/15 Quality Premium.

Outcome Ambition 2

E.A.2

ii) What is your ambition for improving the health-related quality of life for people with long-term conditions?

E.A.2	Average EQ-5D score for people reporting having one or more long-term condition	
Baseline	73.1	Please insert baseline - these are provided in the Levels of Ambition Atlas
2014/15	75.31	
2015/16	76.44	
2016/17	76.82	
2017/18	77.21	
2018/19	77.4	

Outcome Ambition 3

E.A.4

iii) What is your ambition for reducing emergency admissions?

E.A.4	Emergency admissions composite indicator	
Baseline	2565.4	Please insert baseline - these are provided in the Levels of Ambition Atlas
2014/15	2951.1	
2015/16	2461	
2016/17	2362.5	
2017/18	2268	
2018/19	2177.3	

Note: the composite avoidable emergency admissions indicator forms part of the 2014/15 Quality Premium and is a measure in the Better Care Fund.

Outcome Ambition 5

E.A.5

iv) What is your ambition for increasing the proportion of people having a positive experience of hospital care?

E.A.5	The proportion of people reporting poor patient experience of inpatient care	
Baseline	144.7	Please insert baseline - these are provided in the Levels of Ambition Atlas
2014/15	141.8	
2015/16	140.4	
2016/17	139	
2017/18	137.6	
2018/19	136.2	

Outcome Ambition 6

E.A.7

v) What is your ambition for increasing the proportion of people having a positive experience of care outside hospital, in general practice and the community?

E.A.7	The proportion of people reporting poor experience of General Practice and Out-of-Ours Services	
Baseline	7.6	Please insert baseline - these are provided in the Levels of Ambition Atlas
2014/15	7.56	
2015/16	7.52	

2016/17	**7.48**
2017/18	**7.44**
2018/19	**7.4**

3. Quality Premium Measures

E.A.1

i) Potential years life lost (PYLL) from ammenable causes in 2014/15

E.A.1	PYLL (Rate per 100,000 population)
2014/15	2083

E.A.4

ii) What trajectory are you aiming for in the composite avoidable emergency admissions indicator in 2014/15?

E.A.4	Emergency admissions composite indicator
Q1 2014/15	651.8
Q2 2014/15	646.7
Q3 2014/15	814.8
Q4 2014/15	837.9

E.A.3

iii) For IAPT, what proportion of people that enter treatment against the level of need in the general population are planned in 2014/15 and 2015/16?

E.A.3	The number of people who receive psychological therapies	The number of people who have depression and/or anxiety disorders (local estimate based on National Adult Psychiatric Morbidity Survey 2000)	Proportion
Q1 2014/15	600	13460	4.46%
Q2 2014/15	650	13460	4.83%
Q3 2014/15	625	13460	4.64%
Q4 2014/15	625	13460	4.64%
2015/16	2635	13460	19.58%

	Indicator Definition (please specify the local measures chosen) max 4000 characters	2014/15		
		Numerator	Denominator	Measure
Local Priority 1	C3.12 Hip fracture: timely surgery	182	242	0.7521

#REF! Name: #REF!

Read the definitions in the Everyone Counts: Planning for Patients 2014/15 - 2018/19 Technical Definitions for CCGs and Area Teams before completing the template

5. Other Measures

E.A.S.5

i) Number of C.Difficile infections in 2014/15

E.A.S.5	2014									2015			2014/15 Total
	April	May	June	July	August	September	October	November	December	January	February	March	Total
Number of C. Difficile infections	4	1	3	3	2	4	3	4	3	3	3	4	37

E.A.S.1

ii) What dementia diagnosis rate are you aiming for in 2014/15 and 2015/16:

E.A.S.1	Number of people diagnosed	Prevalence of dementia	% diagnosis rate
2014/15	1592	2376	67.00%
2015/16	1623	2422	67.01%

E.A.S.2

iii) What level of IAPT recovery are you aiming for in 2014/15 and 2015/16?

E.A.S.2	The number of people who have completed treatment having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved "caseness" and at final session did not)	(The number of people who have completed treatment within the reporting quarter, having attended at least two treatment contacts) minus (The number of people who have completed treatment not at clinical caseness at initial assessment)	% recovery rate
2014/15	808	1615	50.03%
2015/16	851	1702	50.00%

APPENDIX 2
Financial Plan

NHS NL CCG FINANCIAL PLAN COMMENTARY - 2014/15 TO 2018/19

1) INTRODUCTION

This commentary supports the 5 year Financial Plan submission to NHS England by 4th April. A short summary of the figures in board report format are shown at Appendix 1.

The commentary below for the first two years is broadly in line with previous papers/submissions, with the outer years added as new sections under each heading.

First Two Years: 2014/15 to 2015/16

For 2014/15 the CCG has a commissioning / programme budget allocation of £205,754m (£212,741m 2015/16) and a Running Cost Allowance (RCA) of £4.212m (£3.785m 2015/16) as per the Planning framework and NHS England announcements and letter of 31 January 2014.

The plan originally assumed a carry forward of the CCG 2013/14 surplus of £4m which is still expected to be achieved. However, we have been advised locally that only £2-3m of the B/fwd surplus is likely to be returned to the CCG in 2014/15, with a further £1-2m in 2015/16. For the purposes of this plan submission the figure of £3m for CCG use, on the basis that up to £1m is at risk and any shortfall would be covered by other contract flexibilities (following recent finalisation of contracts) and a possible reduction in reserves. As a last resort, marginal rates funding will need to be used to cover any remaining shortfall with implications on the level of change and momentum that can be achieved in advance of the introduction of BCF, further impacting on the 2015/16 financial plan.

Subject to approval, any B/fwd surplus funds drawn down will be used to support transformation/ integration for example on: transition to Healthy Lives Healthy Futures (HLHF), new models of care and the development of ambitious joint operational plans under the Better Care Fund (BCF).

For reference, the forecast outturn for 2013/14 (as at month 9) has also been included on the financial plan submission. The 2014/15 figures are based on estimated contract values and best indicative values of activity including values for service growth in community and continuing care services in particular, proposed adjustment to Specialist Commissioning for HEYT, and latest QIPP proposals. This has been extrapolated forward for 2015/16.

Last Three Years: 2016/17 to 2018/19

For the last three years of the 5 year finance plan, the programme expenditure budget allocations are based on NHS England's CCG Allocation Growth projections 2016/17 to 2018/19, with the assumption that no growth or change in Better Care Fund (BCF) additional allocations/investments from 2015/16 can be presumed at this stage. However the CCG intends to look to pool more than the mandated figure with NLC from 2016/17 onwards if possible. This will be a decision made by the Joint Board for Health and Social Care Services (Frail and Frail Elderly) in 2014/15 (hereafter referred to as Joint Board).

For RCA allocations, reference was made to the NHS England publication entitled "Calculation of CCG Running Costs Allowances 2014-15 to 2018-19", and the indicative RCA allocations per head of population over the 5 year period. Though this document indicates an expected reduction in the RCA allocation per head of population from £22.07 in 2015/16 to £21.53 in 2018/19, the CCG's financial plan has been based on its RCA remaining at the 2015/16 figure for the last 3 years of the planning period, because the growth in the CCG's resident population is forecast to grow at a similar rate to offset the cash reduction in the per capita RCA.

2) OVERALL FINANCIAL DUTIES

First Two Years: 2014/15 to 2015/16

The CCG has planned to achieve the required 1% surplus overall in both years, on a recurrent basis, subject to delivery of the QIPP programme and management of other risks for 2015/16 as well.

The plan template however, indicates a surplus of 1.47% in 2014/15 at £3,144k (which is 47% higher than in the first draft plan) because NHS England have indicated that they wish the CCG to defer their usage of £1m of the 2013/14 b/fwd surplus until 2015/16, and have used the mechanism of the CCG generating a higher in year surplus (rather than making an in year deposit of funds) to achieve this aim. However, operationally, there should be no impact on planned service delivery which results from this presentational change in reporting the CCG's year-end performance.

The underlying recurrent position reflects the month 6 return to the Area Team. The financial plan template probably overstates the underlying recurrent position, as it starts from 2013/14 forecast outturn (and necessitates an intermediate validation check against the exit run rate in the underlying CCG's position c/fwd from 2013/14) rather than simply starting from the CCG's baseline budget position. In addition, the CCG's recurrent position is also affected by the additional non-recurrent spend required to support the level of ambition for 2015/16.

As required, the CCG has a plan to invest 1.5% (£3.086m) of its recurrent allocation, non-recurrently in 2014/15, as well as setting aside 1% of its recurrent allocation (£2.058m) to establish the "Call to Action Fund". This means that the CCG has 2.5% non-recurrent "headroom" in total for 2014/15, which then falls back down to 1% for 2015/16 (£2.127m). These are held in reserve as earmarked funds.

In overall terms the non-recurrent resources must cover expected financial risks and support investment in a more integrated health care system that is able to work 7 days a week.

This will include "joining the dots" between HLHF, BCF, named GP (Elderly Care Fund) and PM Challenge Fund, to ensure the capacity is in place to reduce admissions/length of stay to/in Hospital in 2015/16. A joint Frail and Elderly Implementation Group including providers and stakeholders has been established to ensure the new 'system' is in place as soon as possible in 2014/15. This will include a joint implementation plan with NLAG to live within the resource available developed by end of April and incorporated within the SDIP (Service Delivery and Improvement Plan) of the contract and business cases to area team for use of non-recurrent monies. The system will require the best possible return/impact from this non-recurrent investment and detailed, jointly owned, project managed action plan to ensure a safe transition.

The general headroom will be used first to support the delivery of "safe services" as well as non-recurrent spend relating to transformational change in readiness for 2015/16.

The CCG is establishing processes for agreement on appropriate use of the Re-admissions penalty, Marginal Rates and Call to Action funds (held non recurrently in reserves) to deliver the required change in the system. This means funding support for developing new models of care across a number of providers. This will support measures to reduce non elective and avoidable hospital admissions/ better discharge planning and enhancing the effectiveness of the new urgent care model to deal with all year round, not just winter pressures.

Business cases are required to utilise all of these earmarked funds and are being developed in agreement with our Providers to take to the HLHF Management Board/equivalent oversight group and the UCWGs for approval for onward submission to the Area Team of NHS England, as soon as possible after the end of April. The speed with which these are approved by the Area Team may affect the ability to deliver the full year effect of savings planned and the cost of financing them externally, though a 2 week turn-around of business case approvals is expected.

The £1.8m BCF for 2014/15 held in reserves has been created from old s.256 re-ablement and carers support funding. It is now assumed that 0.3% (£634k) for BCF in 2014/15 will go direct to LAs and not through CCGs. This fund increases to £11m in 2015/16 (£12.3m including capital grants for social care and disabled facilities to be received directly by NLC).

£0.845m has also been recurrently set aside for the Named GP 'Elderly Care Fund' based on £5 per head of registered GP population as per the guidance in 2014/15. This attributes funds to individual Practices on the basis of the number of 75+ aged patients they had at Sept 2013 (the most recent list size information). The funds are contained within a specific earmarked CCG reserve.

It was decided at Council of Members on 27th March that the approach will be to develop one 'outcomes based' service specification that will offer practices a degree of flexibility to meet the needs of their practice population. The development of this is being taken forward with GP input to agree what those outcomes should be and some general principles to underpin the specification.

An estimated £4.40 per head is held in reserves for a proposed levy for former PCT provisions nationally equating to £0.68m as requested by the Area Team.

The contingency budget for both 2014/15 and 2015/16 is currently planned to be maintained at £2m (0.94% in 2014/15 falling to 0.92% in 2015/16). The £2m figure has been recurrently created but will be shown as applied non-recurrently each year in the external plan returns in line with the guidance received. Pressures exceeded the contingency in 2013/14 mainly due to budgets in the wrong place/rebasing and growth in acute and continuing care spend etc. Therefore a further risk reserve (of £1.4m in 2014/15 and £5.3m in 2015/16) which is held for these pressures as well as for the potential removal of previous contract ceilings, in year cost pressures, NHS Property Services (NHSPS) "void recharges" to CCG's, investment in HLHF and QIPP slippage, for example.

Governance arrangements for the release of contingency and risk reserve will be agreed at the CCG Engine Room.

Last Three Years: 2016/17 to 2018/19

Again the CCG is expecting to maintain a 1% underlying surplus throughout the remaining three years of the financial plan.

In addition, as the CCG's plans for HLHF/BCF, integration and sustainability of the whole local health economy start to 'go live', the CCG is anticipating that it will maintain a similar level and use of non-recurrent funds (e.g. headroom, marginal rates, BCF, named GP fund, etc.) as established in 2015/16 to ensure delivery in the medium term.

3) RUNNING COST ALLOWANCE (RCA) EXPENDITURE

First Two Years: 2014/15 to 2015/16

The CCG's Running Cost budget is within the RCA supplied. The allowance is £4.212m for a population of 169,395 and is effectively a reduction to only £24.86 per head. Per the letter of 31st January 2014 the revised RCAs for 2015/16 is 10% lower at £3.785m, only £22.13 per head per the finance plan template. This means that the impact of incremental drift and any other 2014/15 inflationary increases will have to be absorbed by CCG, CSU as well as NHSPS and each organisation will have to contribute to meet the 10% RCA efficiency target reduction in 2015/16.

By relative size, the existing base RCA from 2013/14 is split three ways: £1.814m (53%) for the CSU, £2.254m (43%) for the CCG and £162k (4%) for NHS Property Services (NHSPS). However, it is assumed that external income for spare accommodation in Health Place should be obtained by NHSPS to marginally reduce the share of the CCG's RCA which is used by them. At this stage, an element of the CCG's RCA is being used non-recurrently to ensure that the organisation has some flexibility to respond to this RCA challenge, e.g. via funding set up costs as well as skill mix changes made in year. However, there is significant risk in the ability of the CCG to deliver these savings in the context of the management capacity required to deliver more ambitious plans around HLHF and BCF and this is reflected in the risk section of the template. The reductions in RCA to 2018/19 down to £3.771m (£21.55 per head for the CCG) need to therefore be worked through over the next few months with these organisations.

Last Three Years: 2016/17 to 2018/19

It is assumed that the CCG will be able to stabilise its RCA expenditure over the last 3 years of the financial plan, because as the nominal rate of RCA per head of population is forecast to fall, this will be broadly offset by an equivalent increase in the CCG's population base. At this stage, it is also expected that the organisational split of the RCA between CCG, CSU and NHS PS will remain broadly the same as in 2014/15 and 2015/16.

4) DEMOGRAPHIC ASSUMPTIONS

First Two Years: 2014/15 to 2015/16

Based on ONS population projections, 0.72% population growth has been used for 2014/15 and 0.71% for 2015/16 for the NLAG contract only specifically earmarked for use in Community Services. As the Finance plan template does not allow selective distribution of growth to individual providers within the same category of healthcare (e.g. Community Services), this funding was initially shown as demographic growth but presented finally in the submission as transferred to non-demographic growth on Community Services in line with the CCGs commissioning intentions. In addition the activity modelling to support planned contract expenditure reflects the current activity case-mix down to specialty level, and latest Payment By Results (PBR) guidance.

Last Three Years: 2016/17 to 2018/19

In the same way as the first two years, demographic growth has been calculated on the acute contact and transferred to Community Services for each of the last three years. The total growth funding attributed to Community services of £500k each year explicitly exceeds pure demographic growth, and is provided to assist with the increased service configuration which will be required in order to ensure that the health economy remains sustainable in the medium term.

A total of £500k per annum growth (in excess of pure demographic growth) is also included to deal with the anticipated demand for Continuing Care, which is over and above the 5% inflationary uplift which is in excess of “raw” demographic growth over the period.

5) FINANCIAL UPLIFT ASSUMPTIONS

All Years: 2014/15 to 2018/19

In accordance with the Planning framework the CCG has based its financial uplifts on the following table:

	2014/15	2015/16	2016/17	2017/18	2018/19
CCG Allocation Growth	2.14%	1.70%	1.80%	1.70%	1.70%
Inflation					
• Secondary Care & General	2.8 - 2.2%	2.7%-2.2%	4.4%	3.40%	3.30%
• Prescribing	7.00%	7.00%	7.00%	7.00%	7 .00%
• Continuing Healthcare	4.0%	4.0%	5.0%	5.0%	5.0%
Provider Sector Efficiency	-4.0%	-4.0%	-4.0%	-4.0%	-4.0%
Tariff Deflators					
• Acute Services (Non CSNT Provider)	-1.50%	-1.50%	-0.4%	-0.6%	-0.7%
• Acute Services (CSNT provider)	-1.20%	-1.30%	-0.4%	-0.6%	-0.7%
• Non Acute Services	-1.80%	-1.80%	-0.4%	-0.6%	-0.7%
CQUINs change	0%	0%	0%	0%	0%

It is important to note that:

- A simpler version of this table has been used in the finance plan submission, with adjustments to overcome the “blanket allocation” of the same uplifts to all providers forced by the template.

- The CCG has used 7% for Prescribing and 4% (rising to 5% from 2016/17 onwards) for Continuing Healthcare, taking into account all relevant factors and in agreement with the budget holders, before QIPP.

- In 2014/15 and 2015/16 the nominal increase in the net efficiency factor for non-acute services is slightly larger than for acute services. This is because an allowance has been made to allow acute providers to comply with the recent recommendations of the Francis & Keogh reports.

The impact locally of new PbR rules on the CCGs contracts (in conjunction with the Specialist Commissioning defund) is still being worked through. However, this risk to the CCGs will need to be addressed via the contingency and risk reserve which has been set based on 2013/14 experience and expected pressures. Any contract flexibility in 2014/15 will go towards any shortfall in the B/Fwd surplus form 2013/14. Budgets will be updated in year to reflect finalised contracts, individual final uplifts and confirmed B/fwd surplus etc.

6) CAPITAL ASSUMPTIONS

First Two Years: 2014/15 to 2015/16

The CCG would like to support a bid by co-commissioners at the Area Team for a Primary Care capital grant to obtain premises and IT systems in particular in a number of localities, to support the outcomes of HLHF and new models of care. The CCG will therefore work with the Area Team to develop a business case. NHS England have retained GP IT funding, but for the purposes of this plan it is assumed that a non-recurrent allocation for GP IT will be made to the CCG during the financial year, at a similar value as in 2013/14 – and so GP IT is expected to have a neutral impact on this plan. However, new guidance needs to be reflected upon and Governing Body advised accordingly. The CCG has also made a bid for its own IT needs to NHS England for 2014/15, but this will not be required as it was funded and actioned from 2013/14 national capital slippage.

Last Three Years: 2016/17 to 2018/19

Once the HLHF project has progressed beyond the public consultation phase, it is expected that the capital requirements of the local health economy will become clearer, and a firmer bid for capital resources and Area Team support will be made from next year, as part of the annual financial plan refresh exercise.

A small IT replacement programme for CCG staff of £25k has been included for 2018/19.

7) COMMISSIONING INTENTIONS

First Two Years: 2014/15 to 2015/16

The JSNA, which itself reflects on population changes, has been used to identify needs and priorities for the population of NHS NL CCG which GP members were consulted on. In addition, benchmarking information, using ONS, Atlas of Variation, Commissioning for Value and monitor guidance re transformation of services etc., was used to ensure both investments and QIPP opportunities were maximised within the CCGs financial framework. It has also aided the development of proposals for future models of care to support HLHF.

Expenditure Assumptions

Assumption	Approach in plan
30% marginal tariff for non-elective activity & use of the 70% top slice	The top-slice has been incorporated into the finance plan in line with guidance, using 2013/14 month 9 contract monitoring information. There will be opportunities to access this resource for investments for jointly agreed schemes via business case to the Area Team per narrative section 2.
Financial impact of non-payment for readmissions	Non-payment for 30 day re-admissions is not modelled back into the contract baseline non-recurrently in line with the issued guidance, although overall contract cash envelopes are to be finally agreed and use of penalties will be agreed with partners. This is shown in reserves. Funding for post discharge support and re-ablement services has been separately earmarked from recurrent resources.
Contract sums	The contract envelopes are based on: the case mix from the last 12 months (i.e. activity which spans two financial years, so this is not technically out-turn). • The latest PBR Tariffs • The last PBR rule changes. • Demographic growth based on ONS information • 2.5% CQUINs
CQUINS payments	Tariff guidance has been adopted at 2.5%
Better Care Fund	The Section 256 Agreements for Social Care and Re-ablement funding will be incorporated into the s.75 pooled budget called BCF, along with carers support funding. This agreement will be subject to review and assurance process with the CCG and the LA and a governance process has been developed for decision making around the fund via a Joint Board. H&WB will monitor to ensure benefits and outcomes are achieved. The final BCF template will be submitted separately following sign off by NLC and NLCCG in March, which includes broad plans stretching the level of ambition, timescales, metrics, governance and risk management arrangements.

Last Three Years: 2016/17 to 2018/19

At the moment the last three years of the financial plan assume a continuation of the CCG's direction of travel, as established by 2015/16. The annual JNSA refreshes will be used when available to amend the implementation of these plans in due course, as appropriate.

8) QIPP AND INVESTMENT PLAN

First Two Years: 2014/15 to 2015/16

The Table below provides a summary of the CCG's QIPP and Investment plan for 2014/15 (and 2015/16).

QIPP CATEGORY	2014/15 GROSS VALUE £000s	2014/15 INVESTMENT £000s	2014/15 NET VALUE £000s	2015/16 GROSS VALUE £000s	2015/16 INVESTMENT £000s	2015/16 NET VALUE £000s
Focused on Acute Care	3,790	220	**3,570**	630	0	**630**
Focused on Non Acute Care	3,071	196	**2,875**	2,316	196	**2,120**
BCF de commissioning	-	-	0	6,346	6,346	**0**
Total QIPP Schemes	**6,861**	**416**	**6,445**	**9,292**	**6,542**	**2,750**

The QIPP schemes planned for 2014/15 and 2015/16 reflect the net savings that the CCG feels is realistic but stretching, within the context of HLHF and BCF. Internally the CCG is reporting the QIPP savings both gross and net, and will feed out investment funds to service areas as appropriate. However in the template they are automatically shown net within the service line where the QIPP impact is expected, from the start of the financial year.

CCG investments are mainly centred on delivering the identified QIPP schemes for 2014/15 and 2015/16 and those required in the guidance to establish in 2014/15 a "Call to Action Fund" of 1% (£2.058m), and (£6,346k) for BCF schemes to deliver the £11.0 m of acute de-commissioning savings in 2015/16 . The CCG is also working towards going beyond the mandated levels for 2016/17 onwards to maximise economies of scale for BCF to have the biggest impact possible, and has mapped for example, resources spent collectively on frail and elderly persons, which will be monitored as a shadow budget in 2014/15 by the Joint Board.

The full year effect of additional staffing to facilitate faster and improved pathways in Continuing Healthcare, will not only improve the quality and responsiveness of services for patients, but also produce efficiency savings on the cost of inappropriate care packages for the CCG.

The remaining investment is targeted on implementing an 'advice only' process across NLAG for Respiratory / COPD services, risk profiling as an enabler, and to facilitate community diabetes services for people with long term conditions.

An updated process for review and identification of QIPP schemes has been agreed with the CSU re horizon scanning and governance processes using all available information and linking into the Relationship Managers with Practices in the CCG.

A non-recurrent QIPP investment reserve of £0.25m has been planned for, of which the majority will support new models of care, held in general reserves.

Last Three Years: 2016/17 to 2018/19

Detailed QIPP schemes for 2016/17 onwards are being developed, but the level of QIPP is broadly set at £2m in 2016/17 increasing to £2.25m in 2017/18 onwards to allow for in year cost pressures and generating further investment for change to deliver HLHF, support further reconfiguration/integration etc.

9) FINANCIAL RISKS AND MITIGATION STRATEGIES

First Two Years: 2014/15 to 2015/16

The key risk is in delivering the changes required in the system in the timescales i.e. BCF, HLHF etc. In particular the assumption of an immediate return on investment and sufficient capacity in primary care.

Specific outstanding risks to be finalised / confirmed include:

- Confirmation of brought forward surplus from 2013/14
- Resolution of outstanding issues with NHS England e.g. HVs/HEYT specialist/walk in services costs re. Market Hill.
- Local impact of PbR/contract modelling
- Local impact of new Specialist Commissioning rules on providers (and confirmation of no revisiting of baselines)
- Potential national risk pool contribution for Trusts in difficulty in 2015/16
- Allocations - Distance from Target/Pace of change in future years

In addition, general risks remain as in previous years around QIPP delivery/ implementation of HLHF/ New models of care/ BCF, plus:

- Engagement of the wider GPs in clinical commissioning, changing primary and secondary clinical behaviour
- Underlying cost/activity growth above those modelled in the plan
- Investments not delivering the required improvements/savings
- Transition costs e.g. HLHF/ decommissioning to release BCF resources
- Increasing Continuing Care claims/ package costs for vulnerable people.
- Resource reduction, reduced financial freedoms, non-recurrent flexibility and management resource/capacity etc.

These risks will be mitigated through a track record of internal review, tight financial control, risk and contingency reserves, increased partnership working and transformation, use of contract levers and incentives and OD work with CCG and GPs. It will be this ownership that ensures the changes to healthcare are delivered within the Commissioning Plan.

Specific risk mitigation strategies include:

- The retention of a contingency fund of circa 0.9% in each year, which is in excess of the 0.5% minimum contingency level in the guidance.
- The creation of a risk reserve for general risks of £1.44m in 2014/15 (£5.4m in 2015/16), in addition to the earmarked reserves for re-admissions, general headroom, the Call to Action Fund, Marginal Rates, and the Elderly Care Named GP Fund.
- However, £3.086m of non- recurrent resources (i.e. the normal headroom) has had to be used to create this reserve & balance the plan.
- Wherever possible QIPP will be incorporated within contracts.
- Risk sharing with other CCGs in 2014/15 (e.g. main acute contracts with Humber, as well as NHS111 across Yorkshire & Humber- tbc).
- Risk sharing (or gain sharing) within contracts – e.g. a contract ceiling on the main acute contract (tbc) and other informal arrangements with providers. If this is not achieved the risk reserve will be used to cover the potential additional activity.
- 2 Relationship Managers working with Practices to support budget and performance management, identify opportunities including around pathways and reducing unwarranted variation.

This Financial plan will be developed further in line with the development of the Strategic 5 year plan due 20th June (final draft). It is also expected that for our unit of planning (North Lincolnshire) plans will be aligned as much as possible with the plans of Co commissioners, Providers and NLC as contracts and section 75 (BCF) are agreed/signed. Leadership of the organisations are committed to this and project plans reflect the milestones for this work.

Impact analysis also needs to be undertaken around the CCG's distance from target (as well as the new social care/primary care formulas).

Last Three Years: 2016/17 to 2018/19

Whilst the CCG obviously lacks detailed knowledge of new risks which may arise during the last three years of the financial plan, a prudent approach has been followed (based on past experience and to offset the significant risk associated with BCF & NLAG decommissioning). Therefore, the CCG has still retained a similar, but increased level of risk reserves above contingency, as follows:

- 2016/17 - £5,144k,
- 2017/18 - £8,772k and
- 2018/19 - £10,245k

10) CONCLUSION

Overall the CCG's 5 year Financial Plan is as challenging as previous years. However, the key message is that the CCG with partners need to work at pace to design and deliver the scale of change required in the local health and social care community. The challenge is to make contract arrangements for transformation and integration in 2014/15 and beyond, count. If in 2015/16 activity reductions are delivered to pay for BCF (and sufficient capacity can be mobilised in primary, community and social care, a significant risk) the remaining years should be easier than in the preceding ones.

However, with the case nationally for BCF being unproven in delivering an immediate rate of return and the need to deliver change over the long term for HLHF, there is a significant risk the impact will knock into 2016/17 and beyond requiring careful management. Hence a level of QIPP and risk reserves have been assumed that would reflect this in part, or if not needed, provide further potential investment funds for change.

Therese Paskell, CFO & Business Support, 3rd April 2014

APPENDIX 1

NORTH LINCOLNSHIRE CCG DRAFT FINANCE PLAN 2014/15 TO 2018/19

		FOT	DRAFT PLAN		LAST 3 YEARS OF 5 YEAR PLAN		
		YEAR 0 2013/14 £000s	YEAR 1 2014/15 £000s	YEAR 2 2015/16 £000s	YEAR 3 2016/17 £000s	YEAR 4 2017/18 £000s	YEAR 5 2018/19 £000s
	INCOME						
1	Recurrent Programme Allocation - After Headroom Transfers	196,565	200,610	208,486	216,508	220,129	223,812
2	Recurrent Running Cost Allocation (RCA)	4,230	4,212	3,785	3,780	3,775	3,771
3	Other Programme Allocation Changes	7,924	9,143	7,399	2,280	2,384	2,340
	TOTAL	**208,719**	**213,965**	**219,670**	**222,568**	**226,288**	**229,923**
	GROSS EXPENDITURE						
1	**Acute Services**	113,015	112,049	104,640	104,058	102,426	100,696
2	**Mental Health Services**	13,788	12,928	12,715	12,788	12,740	12,682
3	**Community Health services**	13,887	12,934	13,372	14,500	15,478	16,438
4	**Continuing Care Services**	21,869	20,857	20,661	21,720	22,603	23,572
5	**Primary Care Services**	31,682	30,177	30,894	32,512	34,267	36,178
6	**Other Programme Services** - Pay:	54	54	54	54	54	54
7	**Other Programme Services** - Non Pay:	6,194	17,610	31,269	30,774	32,511	34,092
	Total Programme Expenditure	**200,489**	**206,609**	**213,605**	**216,406**	**220,079**	**223,712**
8	**Running Costs**	**4,230**	**4,212**	**3,785**	**3,780**	**3,775**	**3,771**
	TOTAL DIRECT EXPENDITURE	**204,719**	**210,821**	**217,390**	**220,186**	**223,854**	**227,483**
	SURPLUS	**4,000**	**3,144**	**2,280**	**2,382**	**2,434**	**2,440**

NORTH LINCOLNSHIRE CCG DRAFT FINANCE PLAN 2014/15 TO 2018/19

		FOT	INITIAL PLAN		LAST 3 YEARS OF 5 YEAR PLAN		
		YEAR 0 2013/14 £000s	YEAR 1 2014/15 £000s	YEAR 2 2015/16 £000s	YEAR 3 2016/17 £000s	YEAR 4 2017/18 £000s	YEAR 5 2018/19 £000s
1	**ACUTE SERVICES**						
1	Northern Lincolnshire & Goole Hospitals NHS FT	85,746	84,786	76,773	76,080	74,617	73,081
2	Hull & East Yorkshire NHS Trust	11,854	11,409	12,248	12,297	12,223	12,138
3	Doncaster & Bassetlaw NHS FT	3,077	2,949	2,911	2,922	2,905	2,885
4	Sheffield Teaching Hospitals NHS FT	1,035	965	953	957	951	944
5	Sheffield Children's Hospital NHS FT	372	290	287	288	286	284
6	United Lincolnshire Hospitals NHS Trust	951	904	892	896	890	884
7	Leeds Teaching Hospitals NHS Trust	830	840	829	832	827	821
8	East Midlands Ambulance Trust	4,986	5,116	5,024	5,044	5,014	4,979
9	Other Secondary & Tertiary Care Services	1,339	1,323	1,306	1,311	1,303	1,294
10	Exclusions / Non-Contract Activity	2,413	2,692	2,656	2,667	2,651	2,632
11	Clinical Assessment and Treatment Centres	0	0	0	0	0	0
12	Collaborative Commissioning	412	775	761	764	759	754
		113,015	**112,049**	**104,640**	**104,058**	**102,426**	**100,696**
2	**MENTAL HEALTH**						
13	Rotherham, Doncaster & South Humberside FT	13,321	12,451	12,227	12,276	12,202	12,117
14	Mental Health Pooled Budget	467	477	488	512	538	565
		13,788	**12,928**	**12,715**	**12,788**	**12,740**	**12,682**
3	**COMMUNITY HEALTH SERVICES**						
15	NLAG Community Services	11,558	11,214	11,642	12,693	13,610	14,508
16	Other Community Based Services	459	469	479	501	518	535
17	Hospices	1,251	1,251	1,251	1,306	1,350	1,395
18	Integrated Fund Expenditure - Carers Support	619	0	0	0	0	0
		13,887	**12,934**	**13,372**	**14,500**	**15,478**	**16,438**
4	**SERVICES FOR VULNERABLE PEOPLE**						
19	CHC Adult Fully Funded	11,805	10,390	9,776	10,290	10,604	10,972
20	CHC Adult Joint Funded	2,138	2,224	2,312	2,428	2,549	2,677
21	CHC Assessment & Support	4,476	4,655	4,841	5,083	5,337	5,604
22	CHC Children	742	772	803	843	885	929
23	Funded Nursing Care & Other Care Packages	948	986	1,025	1,077	1,130	1,187
24	Mental Health - Non RDASH	1,176	1,223	1,272	1,336	1,402	1,472
25	Learning Disabilities	584	607	632	663	696	731
		21,869	**20,857**	**20,661**	**21,720**	**22,603**	**23,572**
5	**PRIMARY CARE SERVICES**						
26	Prescribing Costs	27,609	28,037	28,714	30,224	31,874	33,675
27	Central Drugs	691	753	806	862	923	987
28	Out Of Hours Service	2,034	453	445	447	444	441
29	Home Oxygen Costs	361	357	352	377	403	432
30	Local Enhanced Services	577	577	577	602	623	643
31	Primary Care IT	410	0	0	0	0	0
		31,682	**30,177**	**30,894**	**32,512**	**34,267**	**36,178**
	OTHER PROGRAMME SERVICES						
6	Pay	54	54	54	54	54	54
7	Non Pay - General	2,017	2,652	2,667	2,785	2,879	2,974
7	Non Pay - Earmarked Reserves - See Appendix 3	4,177	14,958	28,602	27,989	29,632	31,118
		6,248	**17,664**	**31,323**	**30,828**	**32,565**	**34,146**
8+9	**RUNNING COSTS**	**4,230**	**4,212**	**3,785**	**3,780**	**3,775**	**3,771**
	TOTAL DIRECT EXPENDITURE	**204,719**	**210,821**	**217,390**	**220,186**	**223,854**	**227,483**
	SURPLUS	**4,000**	**3,144**	**2,280**	**2,382**	**2,434**	**2,440**

APPENDIX 3
Better Care Fund Plan

Better Care Fund planning template – Part 1

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

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

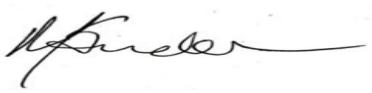
To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

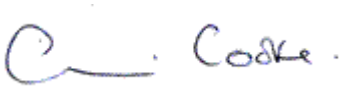
1) PLAN DETAILS

a) Summary of Plan

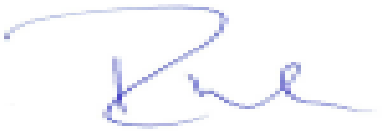
Local Authority	**North Lincolnshire**
Clinical Commissioning Groups	**North Lincolnshire CCG**
Boundary Differences	There are small variations between the CCG and LA boundaries, which are managed within well established arrangements. The small variations are not sufficient to warrant a neighbouring CCG to be part of this Better Care Fund Plan
Date agreed at Health and Well-Being Board:	Draft agreed **14/02/2014** and progress and updates agreed **25/03/2014**
Date submitted:	**04/04/2014**
Minimum required value of ITF 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	 North Lincolnshire CCG
By	Dr Margaret Sanderson
Position	Chair
Date	04/04/2014

Signed on behalf of the Clinical Commissioning Group	 North Lincolnshire CCG
By	Allison Cooke
Position	Chief Officer
Date	04/042014

Signed on behalf of the Council	 North Lincolnshire Council
By	Simon Driver
Position	Chief Executive
Date	04/04/2014

Signed on behalf of the Health and Wellbeing Board	 North Lincolnshire Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Rob Waltham
Date	04/042014

c) Service provider engagement

Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

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 and this provides 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.

The development of the BCF plan and the supporting frail and elderly implementation plan are therefore key to the vision for North Lincolnshire which has been developed through the Integrated Commissioning Partnership (ICP) and the Integrated Working Partnership (IWP) as working groups of the Health and Wellbeing Board. The IWP membership includes representatives of health, social care and wider partners and providers within North Lincolnshire.

The 'Healthy Lives, Healthy Futures' Programme is established across Northern Lincolnshire (North Lincolnshire and North East Lincolnshire) led by the two CCG's, working closely with the Northern Lincolnshire and Goole Foundation Trust and other partners, including North Lincolnshire Council and NHS England North Yorkshire and Humber Area Team. The goal is to produce strategic proposals for sustainable services going forward.

The BCF plan reflects and builds upon the vision set focusing on the existing priority programme for the frail and elderly, which includes a wide range of health providers as active participants, together with Local Authority Services and other Social Care Providers including Residential Care and the voluntary and community sector.

A system wide workshop to further 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 proposals in relation to the Elderly Care Fund resource allocated by the CCG (the £5 per head of population). Partners have agreed to use 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. Partners taking part in the programme include social care, adaptation services, NLAG (acute and community representative), RDASH (older peoples mental health team),, GP's, prevention services, 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. This will be further developed and refined through a series of workshops on a monthly basis. The second workshop takes place on the 11

April and will focus on testing the proposals against the desired outcomes.

Detailed proposals are being worked up in partnership between the CCG, NLAG, RDASH and adult social care.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

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. The feedback from the engagement is currently being collated and will continue to be used to shape plans. Mechanisms for both include 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 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 has engaged with the public and stakeholders during January and February 2014 in relation to its operational plan for 2014/15 and 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 Well-being Board. In addition they have been invited to and have attended the ICP and IWP when the BCF has been discussed.

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

e) 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.
Frail and Elderly Implementation Plan http://webarchive.northlincs.gov.uk/EasysiteWeb/getresource.axd?AssetID=57407&type=full&servicetype=Attachment	Sets out the actions to achieve the transformation of services to provide sustainable person centred co-ordinated care and support that is delivered closer to home and in communities.
Joint Strategic Needs Assessment (JSNA) http://webarchive.northlincs.gov.uk/EasysiteWeb/getresource.axd?AssetID=57406&type=full&servicetype=Attachment	Joint LA and CCG needs assessments of the health and social care needs of the local population in order to improve the health and wellbeing of the population
Joint Health and Wellbeing Strategy (JHWS)  Adobe Acrobat Document	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 CCG Plan for the Commissioning of High Quality Services for North Lincolnshire; 2013/2014 "Right Care , Right Place"  Adobe Acrobat Document	The plan sets out the commissioning intentions of NL CCG for 2013/14 and the vision for the future.
BCF Governance Structure and TOR for Joint Board  Adobe Acrobat Document  Adobe Acrobat 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 http://www.healthylivehealthyfutures.nhs.uk/wp-content/uploads/2014/02/HLHF-brochure.pdf http://www.healthylivehealthyfutures.nhs.uk/wp-	

content/uploads/2014/02/Healthy-Lives-healthy-Futures-Easy-Read-booklet.pdf http://www.healthyliveshealthyfutures.nhs.uk/wp-content/uploads/2014/01/NHS-CSU-6pg-summary.pdf http://www.healthyliveshealthyfutures.nhs.uk/wp-content/uploads/2013/12/HLHF-promoting-the-case-for-change-feedback-report-FINAL-29.11.13.pdf	Links to HLHF website
Safeguarding Adults Business Plan  Adobe Acrobat Document	Sets out the local safeguarding adults board priorities
Adults Services Local Account 2012/2013  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  Adobe Acrobat Document	Describes North Lincolnshire's agreed approach and commitment to integration including the principles and conditions for integrated working

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

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

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

The Health and Well Being 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.

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 inhibit the delivery of integration and the frail and elderly strategy work is focussed on setting out clear and tangible actions to achieve this. It will be further underpinned from a governance perspective by the recent establishment of a joint board to oversee the wider health and social care system and ensure that the frail and elderly programme delivers the aims and objectives agreed across the health and social care economy.

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

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 approach (Appendix1) is being utilised to ensure that support and services 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.

The Single Organisational Model has three core components 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 and there is a commitment to shift that focus, to provide more opportunities for people to look after their own health at home and in their local communities.

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 or communities. We therefore need to respond collectively to this expressed preference. Reliance on acute services will be reduced through long-term conditions being better managed in the community, should people require a stay in hospital then this will be for the right reasons. We will continue to invest in services which have an evidence base e.g. re-ablement 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 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 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 from high-cost reactive services to lower cost preventative services and anticipatory care to avoid people falling into crises. To deliver this, clearly set out specifications detailing outcomes and key performance indicators will be developed. Services will be required to risk profile their populations in order that those patients and service users at risk of multiple attendances or longer term reliance on care home provision, can be identified early and placed on proactive care plans. The role of the named clinician or care worker will be key to this delivery.

In addition, we recognise that the health and wellbeing of each individual is broader than their physical health needs and therefore the community mental health workers will be a key component to all integrated teams. This will ensure that early identification of symptoms of isolation and loneliness can be identified alongside evidence based assessment of dementia, 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 structure our care according to need within the tiers

detailed in the model:

Well Being 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.

Our local well being offer 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. Examples of existing services that will be accessible through the community well being 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 over 75's – 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 well being offer will be accessed in localities and will be delivered through four community well being 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 well being hubs as part of an integrated approach to wellbeing and prevention. This will include 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 there will be clear links made when 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 wellbeing offer will develop a 'level 2' concept of more intensive support which is still within the universal offer but overlaps 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)

The aim of proactive care and support is to maintain the independence and well-being of individuals by working with them to create and implement sustainable 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. The purpose is to reduce unscheduled admissions (to acute hospital beds, 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 and reduces the financial burden of costly care.

The new multi-disciplinary Proactive Care and Support service will build on the integrated teams established in each of the 5 localities, the teams will 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 unplanned admission. The aim of this level of service is to mobilise rapidly to provide a range of services depending on need which result in the promotion positive outcomes and the prevention of further deterioration. These services will work to the following key principles and the outcomes will be tracked:

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

Specialist

Accountable Professionals for integrated assessment and packages of care,

There will be a co-ordinator and one point of contact for people who require this ensuring that people tell their story only once and support is co-ordinated in and around the community. Those with long term conditions will be known and supported by a Multi-Disciplinary Team (MDT) whom will encourage improved self-management of long-term conditions and ensure that the **shared summary care** record is up to date and completed to inform the clinical care in and out of hours.

Care Co-ordination and Personalised Care Plans will be provided for those at high risk of hospital admission, for those requiring complex care and for those discharged from hospital. Care Co-ordinators will develop personalised care plans in conjunction with the proactive care and support services for people who are at high risk of hospital admissions.

An Extra Care scheme and extended supported living schemes for the frail and elderly and complex disability are being planned for 2016. This will enable people to have their own tenancies within the community, with wrap around provision that is needs led.

A new model of **integrated unplanned care** has been implemented from October 2013. This includes an integrated Urgent Care Centre, 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 including social care, advice and a clinical decision unit.

7 day working across the system, there will be accessible health and social care practitioners and services working 7 days a week. This will be in place from April 2014.

The Intermediate Care services will extend by 50% and be integrated to provide a seamless social, nursing and therapy service to support people to regain independence quickly. An early version will be in place 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.

Joint care home support team (Safeguarding in placement)

The purpose of this service is to manage the access to all the care home placements, adult protection investigations and preventative work to improve quality to monitor and evaluate their effectiveness and to provide 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.

The service will also 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.

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 joint care home support team will be to,

- 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

Our plans are to develop this approach during 2014/15 in order to be fully functioning in 2015/16.

What Difference Will be Made from the Changes?

The schemes and services outlined above will result in a **redesigned system. (Appendix 3)** The health and social care system will be built upon the premise of right care, right service, right time, 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, 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.

People who are placed in residential and nursing care will be managed by the Joint Care Home Support Team and will be regularly reviewed to ensure that people do not become overly dependent and to promote wellbeing and prevent drift. This will enable those people that require longer term residential and nursing provision to receive better quality and more intensive support. We expect all parts of the system to have to transform during this process and will deliver this through a combination of clearly set out specifications and contracts for current services, 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

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 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.

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 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.

Violet and Albert's experience (**Appendix 4**) 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.

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

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

The implementation of the frail and elderly implementation plan is key to the delivery of the Better Care plan. The integrated system will:

- **Put the person at the centre**
- **Identify need early**
- **Deliver services that target assessed need, closer to home**
- **Collaborate with the person at all stages of decision making**
- **Support people to lead their plan**
- **Improve outcomes**
- **Maximise independence and lead to better self-care and management**

We recognise that the journey will involve further changes to the way in which people experience assessment and service delivery, but the journey is underway.

Through the Health and Wellbeing Board, partners have committed to ' whole system integration' across, all life stages starting with growing well, living well, retiring well and ageing well and across all levels of needs and across the workforce sectors paid and unpaid.

Risk will be managed at the lowest level, with a common purpose, common direction, shared goals and outcomes.

We are all responsible for holding each other to account for achieving positive outcomes, with professional accountability being embedded in everything that we do.

New models of service delivery will stem from the work being undertaken by the Integrated Working Partnership. We will build on the success of co-location and locality working between health and social care to collaborate on models of care and service delivery that are centred around the person and not buildings or services. Every plan will be outcome based to enable people to stay in control and be as independent as possible.

The ICP provides the platform currently to ensure that the LA and CCG commission and procure services jointly. Examples of work completed to date include the Community Support Team being placed at the hospital overnight to reduce hospital admissions. We are also planning to develop an additional Extra Care Scheme in collaboration with a provider. The Extra Care Scheme will provide a home for life, and will enable people to live in their community of choice with their own tenancy with bespoke and wrap around provision where this is needed and required.

Our key objectives are to detect problems early and prevent deterioration so that people will keep well and stay safe; more people will live independently and we will be able to reduce long term residential care and reduce avoidable hospital admissions.

We want to support reablement and support carers to stay well so that they can continue to be effective carers.

The move to 7 day working will positively impact on maintaining and building on progress in relation to reducing delayed discharges of care.

Information will be shared in an appropriate and timely way to maximise wellbeing, proactive care and support, safeguarding and experience; and aggregated to allow

effective identification and management of need and outcomes across our health and care economy.

How will we measure the aims and objectives?

The number of joint assessments and plans will increase, through investing in co-ordinating assessment and care

The volume of emergency and planned care in hospital, together with the number of residential and nursing home admissions and placements will be reduced through a focus on early support and community provision.

Feedback will tell us that the experience and quality of care is improved and that people feel in control of their own support and lead their plans.

We will see;

- Reduction in A&E attendances
- Reduction in avoidable emergency admissions
- Reduced length of stay in hospital
- Reduction in care and nursing home admissions
- Reduced length of stay for residential and nursing home provision
- People feel confident to manage Long-Term Conditions in the community (People and Professionals)
- More people feel safe
- Reduced isolation
- An increase in the proportion of older people who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

There are a range of schemes and changes covered by our joint work programme as part of the BCF plans. An initial evaluation has taken place in order to understand the impact in terms of health benefit, their contribution to the delivery of the frail and elderly implementation plan and the return on investment in terms of cost versus reduction in

hospital activity. This evaluation and analysis will be further developed in preparation for the BCF pooled arrangements in 2015/16 to ensure sustainability of the Better Care Fund going forward. The schemes, changes and developments include:

- A wellbeing offer to support community response, prevention, early support and self-management of care needs.

- Continued and further investment in re-ablement (including intermediate care) at the targeted and specialist level to include a new hospital team under one integrated manager with all social care professionals represented including mental health within the hospital operating 7 days from April 2014.

- Integrate NHS and Social Care Systems around the NHS number to ensure that frontline professionals have access the information they need in real time. This will ensure joint care planning can take place and support patient's wishes not to have to repeat their story

- We will roll out the whole systems integrated model of care, building on existing care planning, use of risk stratification tools, care co-ordination and multi-disciplinary ways of working and locality teams.

- Undertake a review of the use of Telecare to support targeted provision to enable self-management, improve people's experience and access, support people to remain competent and confident and focus on individuals in greatest need.

- We will also review existing services to ensure that we commission outcomes based on intelligence of what works. We will reinvest where necessary to enable integrated working. This will drive efficiencies and will deliver better value for money. A focus for investment will be proactive and targeted support to maintain people in their own homes and in the community, as well as ensuring people are enabled to return home promptly following admission.

- The BCF will be used to build a triangulated support system with GP's, District Nurses and Social work around care homes through the development of a care home support team.

- Continued investment in support to carers to keep them well. The investment in carers will be reviewed to ensure we are in a position to implement the changes as a result of the Care Bill.

- The model of GP support to residential and nursing homes will be reviewed. There is evidence that outcomes for frail and elderly people can be improved where care homes have strong and robust relationships with a key practice or practices. This has to be balanced however with the individual's right to choice of which GP they register with and for many the choice maintaining continuity of care.

- We will work with Residential and Nursing Homes to implement the Gold Standard framework (GSF) in relation to improved end life care planning.

- In response to an Experience Led Commissioning programme on End of Life, investment has been made in 2013 into the Home Healthcare team provided by

Northern Lincolnshire and Goole by the CCG to support people at End of Life needing palliative care. Work is also being taken forward in implementing Advanced Care Planning which will support people to remain at home and not be admitted unnecessarily to hospital.

We will also review opportunities in how we manage Continuing care eligibility and assessments to identify opportunities to commission additional services to meet continuing care needs and the embedding of use of personal health budgets

We recognise that achieving our vision will mean significant change across the whole of our current health and care provider landscape. Whilst GP's play a significant and pivotal role in this, all providers of health and social care services will need to change the way they work. The CCG and Local Authority Commissioners continue to work together to stimulate the market place, and effect the required change to ensure that this happens at scale and pace.

The proposals include the need for investment in community based clinicians and increased services to support acute care in the community. This will involve an upskilling of the current workforce to enhance their rapid assessment and diagnostic skills; it will involve greater skill mix and the development of new roles and it will result in clinicians working across a range of settings outside organisational boundaries. Clearly this is an ambitious plan and work is currently underway with NLAG and the LA to define what can be clearly implemented in Phase1 to enhance the current models of service provision and address any significant gaps. The focus of this will be the extension of services to encompass 7 day working and realigning them to operate a joint and rapid assessment process to address current pressures created by non-elective admissions. Phase 2 will then focus on a comprehensive review programme of a number of community services some of which is currently underway such as the Locality Teams with a view to increasing their impact across the system. This will also need to connect clearly with the emerging plans for the Care Coordinator role within primary care to ensure that services are responsive and connect appropriately.

In addition to the implications for the acute sector, there is a need to review, enhance and integrate mental health services provision into the models of care. The focus of this will be to ensure robust and holistic mental health assessment is an integrated part of the rapid assessment process. This will include upskilling teams to deliver effective dementia assessment and diagnosis and being able to mobilise services to address the needs identified, quickly to prevent further deterioration as part of the dementia strategy for North Lincolnshire. This is being shaped by the outcomes from the ELC dementia programme undertaken in 2014/15. Work is underway with RDASH to understand how current services will need to be realigned to work within the future model.

An overview of the timeline is represented below review to reflect where are now

April to August 2014

7 day access to social care assessment will be in place in April 2014. This will not be a stand alone service but will be an integrated part of a Rapid Assessment, Time Limited Service tier which will effectively provide an agile, rapidly mobilised joint assessment and care service both in the community and in the hospital settings on the earliest part of the patient's journey. The aim will be to prevent admission, safely interrupt admission and

shorten length of stay. We will commence the review of all current services providing elements of this service currently and bring them together to provide coherent provision to an agreed, integrated specification.

Well being offer delivered in localities supported by the creation of community wellbeing hubs including the handy person role which will enable minor adaptations to people's homes This will form a key part of the prevention strategy, reducing social isolation and increasing the communities ability to self care for longer.

The wellbeing offer will develop a 'level 2' concept of more intensive support but which is still within the universal offer but overlaps with our proactive care and support model of integrated teams based in five localities. (Beginning April 2014 and fully embedded March 2015)

Build on and strengthen integration across the community to provide proactive care and support beginning April 2014 and fully functional by April 2015. A full review of the current Locality Team structure will take place across the health economy, drawing on the emerging plans for the Care Coordination function within primary care and ensuring that community teams are aligned with the general practices they support. This may result in changes to the current specification going forward.

In light of the current admission numbers from care homes to the hospital, there is a commitment to jointly review the provision of care provided to nursing homes and within them. The proposal to develop a joint Care Home Support Team is currently being considered with a view to addressing the range of reasons for admission and both up skilling the clinical teams within the homes to manage those patients in sit and also providing a rapid response element for those patients at risk of deterioration. The proposals and findings will be considered in June 2014 with the aim to be fully functional by October 2014.

Working with NHS IQ in relation to systems re-designs across health, social care and wider partners to deliver the changes.

September 2014 to March 2015

Clear implementation of all actions associated with the Rapid assessment tier, Locality team tier and care home support service reviews to ensure plans are embedded to support winter 2014.

Access to equipment will be in place 7 days a week following a review of the current service arrangements, thus supporting people to remain in their own homes and to positively impact on reducing delayed discharges and transfers of care.

Accountable professionals in all localities by September 2014 with clear links via the Care Coordination roles through to the Locality Teams

Increase re-ablement services and intermediate care facilities with the new facility becoming fully operational in the winter of 2015

Use the NHS Number as the Unique Identifier for correspondence across the system and work further on joint assessment and record keeping.

Alignment with plans and related activity

The Joint Health and Wellbeing Strategy focuses on what partners can do better together to add value and identify opportunities for working together differently, whilst delivering value for money. Partners have pledged that they will;

- Work together for the benefit of people in North Lincolnshire
- Consult with local residents, including those who may be hard to reach or live in a community that is in need
- Ensure staff show commitment to work together
- Ensure that staff are aware of their roles and how they contribute to the wider health and wellbeing agenda (Making Every Contact Count)
- Be explicit about the actions they are committing to in order to reduce inequalities and increase wellbeing and provide evidence on performance and impact

The Integrated Commissioning Partnership (ICP), reporting to the HWB ,is responsible for overseeing joint commissioning intentions and is informed by the JSNA, and as such provides the linkages between the Health and Well Being Strategy and delivery of the BCF plan.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

The BCF will require the decommissioning of some existing NHS contracts to a value of approximately £7m. The areas being targeted for reduction in demand are Acute and Emergency Admissions, Accident and Emergency Attendances, Length of Hospital Stay. For indicative purposes, £7m equates to approximately 20% in all admissions.

There will however remain the need to ensure the residual acute services are robust in order to ensure that for acute medical and surgical needs the whole population as well a frail and elderly continue to be available and people receive the care they need in the right place at the right time with the right management.

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 targeting the frail and elderly population

The main provider of these hospital based services is North Lincolnshire and Goole Foundation Trust. They are a provider of Integrated hospital and community services for North Lincolnshire.

The reduction in hospital activity- has been signalled as part of commissioning and contracting intentions for 2014 to 2016. This continues to be discussed. The impact of the initial investment under the Better Care Fund vision and initiatives will need to be

evidenced during 2014/15 through reduced activity to enable the decommissioning of hospital based care.

The SGH site has during the last 12 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 will be 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 underdevelopment between the CCG and NLAG to bring together timelines, investments and benefits

- 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

A first version will be agreed by end of April

The Finance template reflects the risk of non-delivery and is considered within the CCG's financial plan

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Development of the plan

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 has therefore taken the lead on the development of this plan and has allocated part of its regular meeting to overseeing its development, inviting additional attendees, including Healthwatch to consult and support.

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.

2014/15

The governance arrangements for the oversight of the frail and elderly working

programme and management of all spend associated with the Better Care fund have now been agreed. This includes the establishment of the Joint Board with the inaugural meeting taking place on 27th March 2014. The Board consists of equal membership drawn from both the CCG and Local Authority to oversee the wider system of health and social care. A governance framework has been developed to include financial management, performance and impact monitoring and service change assurance processes. This along with a clear set of terms of reference was presented to the first meeting and agreed. This board will be accountable for the mobilisation of the agreed plan, and the delivery of the agreed outcomes, performance metrics and finances. It will also take responsibility for instigating actions and service change should the activity and performance metrics be off track and make any decisions regarding deployment of contingencies.

Future governance arrangements to form part of the section 75 agreement will be developed during 2014/15 to ensure that they can be in place by 2015/16. These will provide the future governance between the CCG and NLC to ensure that the ambitions of the Better Care Fund are achieved and will include consideration as to whether additional resources are pooled 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.

The ICP will remain to support joint commissioning activities. The on-going development of integrated working and the implementation of the delivery of the work streams to deliver against the strategy will be overseen via the IWP.

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

Financial Risk Sharing arrangements have been agreed in broad terms and will be developed further in order to mitigate any financial and service risk, ensuring that more services are delivered in the community to reduce avoidable admissions, increase re-ablement and people feeling confident to remain at home for longer thus reducing admissions and lengths of stays in residential and nursing care homes.

The Healthy Lives Healthy Futures programme will continue to be overseen by Healthy Lives Healthy Futures Programme Board reporting to the CCG Governing Body.

Oversight and communication

Regular reports on progress and outcomes will be provided to the CCG Governing Body meetings in Public, to Cabinet, and the Health and Well Being Board. The Cabinet process provides the constitutional forum for key decision making within the Local Authority and is supported by scrutiny and challenge across the Local Authority.

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

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 are developing a community based wellbeing offer, whereby individuals will have access to activities, information and support to enable independent living for as long as possible.

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, 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. 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.

Please explain how local social care services will be protected within your plans.

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 piloting 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, home delivery of frozen meals/shopping, health advice/ healthy eating and home safety.

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 of our proactive care and support teams, integrated unscheduled care scheme at the hospital, Integrated Locality teams, Intermediate care and rehabilitation services.

Investment and funding will increase in relation to 7 day working and in order to meet the potential requirements of the new Care Bill requiring additional assessments to be undertaken for people whom have historically not accessed social care services.

We will continue to develop and invest in care home support teams consisting of a clinician, social care, Therapist, Dietician and GP.

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.

b) 7 day services to support discharge
Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and 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 effectiveness of re-ablement 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 re-ablement services at the hospital overnight we are investing in 24/ 7 working at the hospital beginning April 2014. This will enable rapid availability of social care assessments both within the ED and Admissions Unit environments targeting those patients who would be most likely to result in short stay admissions due to waits for assessment. It will also target patients who have already been admitted to wards to enable reductions in lengths of stay and further impact on any delayed discharges due to social care assessments. The service will allow 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 patients families to ensure that account is taken of carers needs in the process which has a significant impact on care decisions.

A costed plan for 7 day services will be developed in 2014 well in advance of the 2014/15 winter period and associated pressures.

Proactive care and support 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.

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. The council is building a new purpose built intermediate care facility, which will create a 50% increase in the bed base.There will be enhanced home from hospital services linked to 7 day integrated unscheduled care centre at the hospital.

c) Data sharing
Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

Health Services use the NHS number as the primary identifier.

Where Specialist Adult Services engage with the NHS to support Adults the NHS number

is recorded in the case management systems, in many cases. For Social Care services using OLM Group Ltd CareFirst, the NHS Number is shown on the main client screen as a key identifier reference. If no NHS Number is recorded this is also flagged on the main client screen.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

The Local Authority is committed to using the NHS identifier. A gap analysis of usage is being undertaken to determine where it should be used but is not recorded as standard practice and to achieve consistent implementation as a primary identifier.

An action plan has been developed to achieve full implementation by March 15. .

Please confirm that you are committed to 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. We currently use;

Systm One, 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

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

Yes we are committed to ensuring the appropriate controls are in place.-

The council takes its Information Governance responsibilities very seriously and as such has 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 the actions.

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.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Each Locality team have been implementing integrated ways of working which involves 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. Those with the highest need will have an identified lead professional allocated at that time.

Locally we have determined that angina, heart failure, diabetes and COPD are among the common causes of unplanned admissions for chronic long-term conditions and diseases in the over 75's.

According to national estimates, 2220 people aged 75+ in North Lincolnshire will be living with 3 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, we will be working closely to monitor those classified at high risk of hospital admission. From April 2014 GP practices will implement a Risk Profiling Tool which utilises Primary and Secondary Care data to identify people at high and increasing risk of deterioration. Practices will work with the wider Locality Teams to manage these patients.

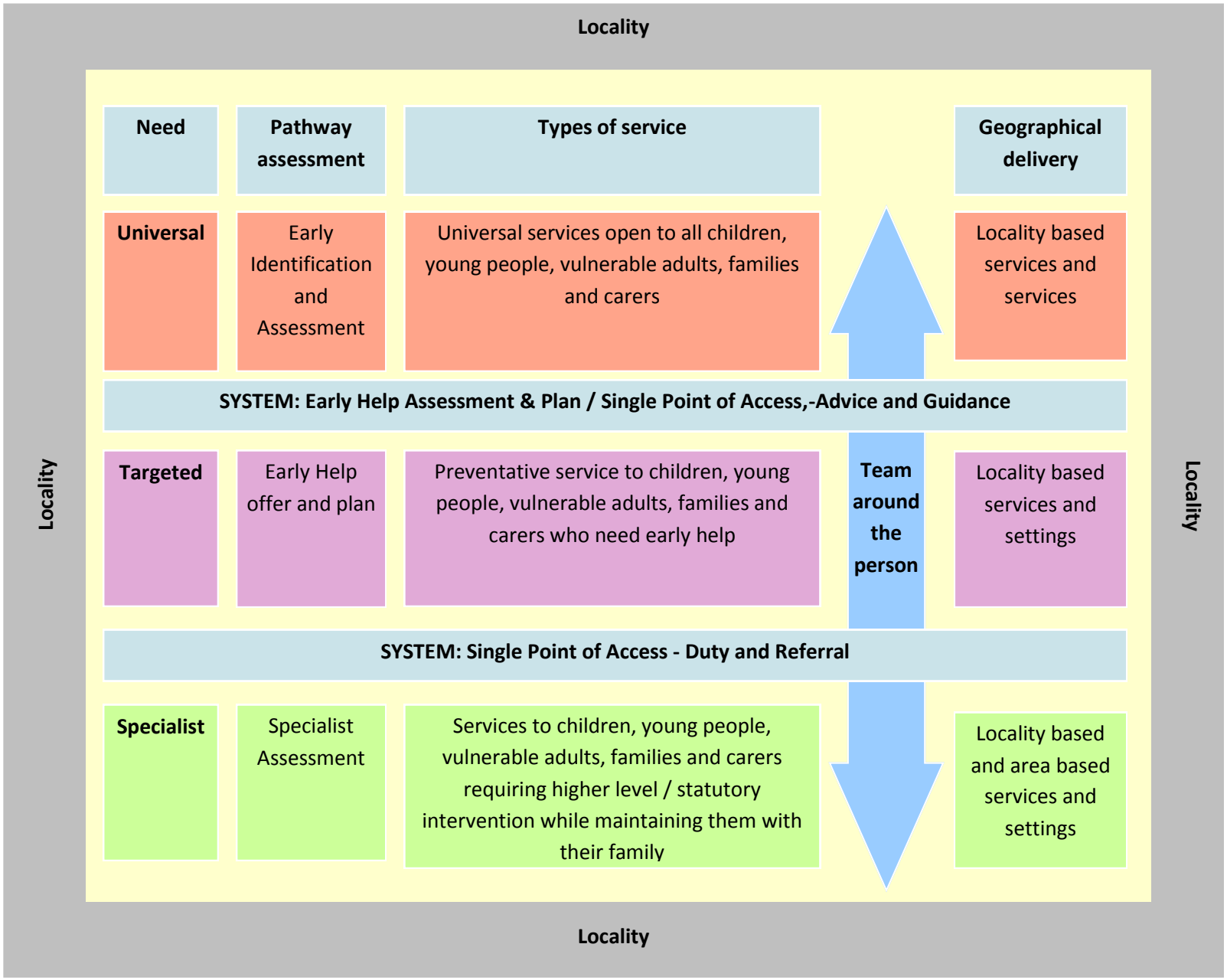
The GP contract from April 2014 requires the identification of a lead GP for all registered patients aged 75 plus. This is supported by the Elderly Care Fund in 2014/15, which sits outside the BCF but who's use is aligned to the BCF. Emerging plans are identifying the need to create a Care Coordination role across primary care to be able to act as the accountable professional with the ability to ensure the right assessments take place and the right care level is mobilised. They will 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 will form 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. They will then form the cohort of patients that the Care Coordinators will work with in conjunction with the Locality Teams. The framework for delivering this will come through the management of the Elderly Care fund and clear outcomes will be agreed with primary care and monitored for impact. The current review of the Locality Teams will take account of this new development and will ensure that future structures include the role and function if it evaluates effectively.

4) RISKS

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

Better Care Fund Risk Register attached at Appendix 2

Better Care Fund – Appendix 1 – Single Organisational Model



Print Risk Register

Update this page - columns G, H, I and J are automatically populated

North Lincolnshire Clinical Commissioning Group

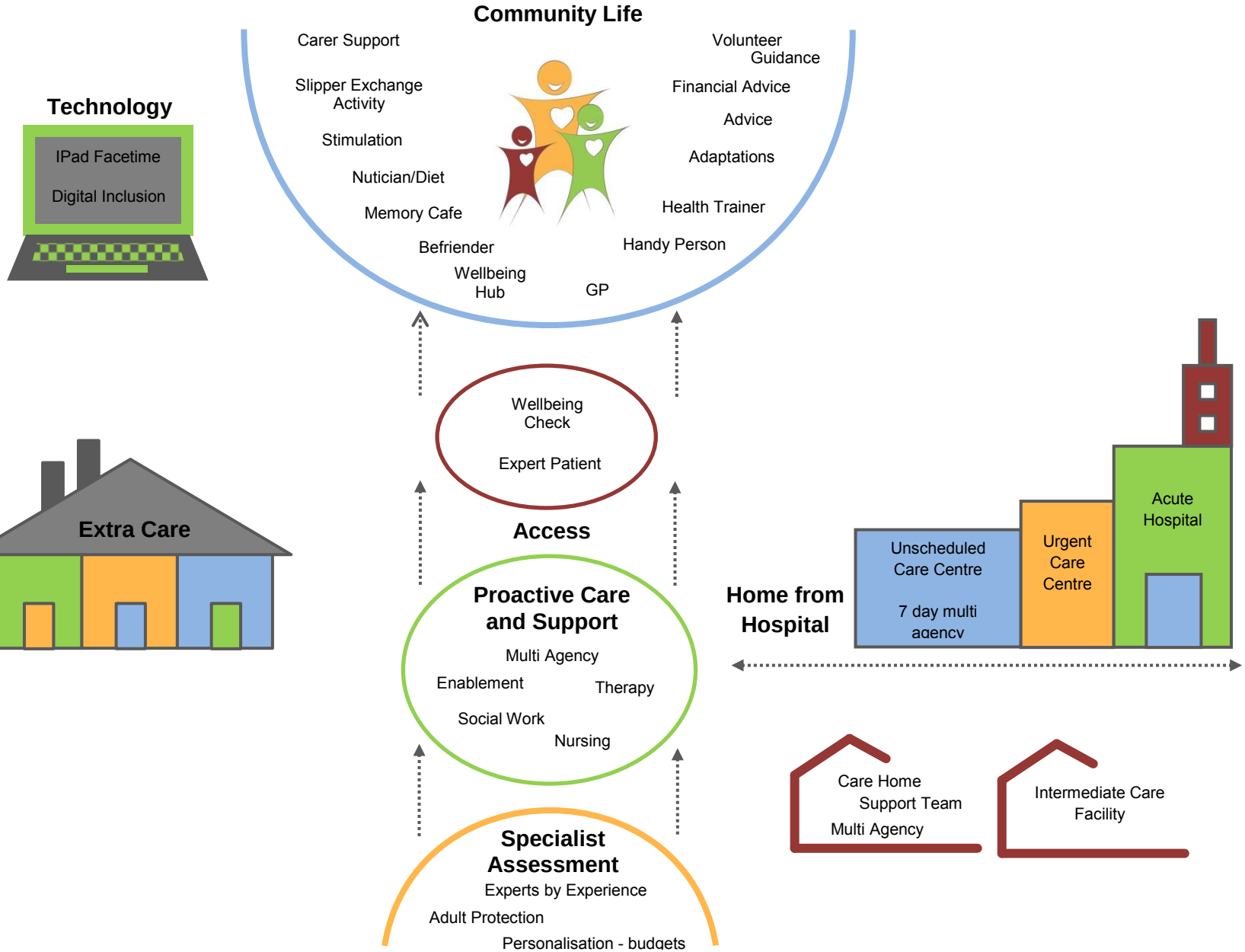
BETTER CARE FUND (BCF) RISK REGISTER

Risk ID	Link to Strategic Objective	Risk Description	Key Controls/Mitigating Risks	Current Risk Score: Impact	Likelihood	Risk Score	Status	Initial Risk Score	Movement	Assurance on Controls	Positive / External Assurance	Gaps in Control	Gaps in Assurance	Last Review Date	Lead
BCF01		The shift of funding from the Acute Sector necssary to establish the Better Care Fund without the equivalent reduction in demand for hospital services may impact on the remaining hospital sector. This might impact negatively on the improvements secured to date in terms of hospital mortality rates, achievement of NHS Consitition performance targets (A&E/waiting times) and the finanicial stability of the Foundation Trust and/or the CCG.	Healthy Lives/Health Futures Strategy. Frail & Elderly Strategy. Better Care Fund Plan. Providers collaborating on system integration and new ways of working. Integrated Commissioning Partnership, Integrated Working Partnership and Mortality Action Group in place. Analysis undertaken by CCG in relation to primary and secondary reasons for attending the Urgent Care Centre and reasons for hospital admission undertaken with NLaG to inform schemes to positively impact on reduction in avoidable emergency admissions.Joint Board established and first meeting held on 27 March 2014. Governance Framework &TORs developed	5	**3**	**15**	H			Existing Performance information and mortality information. Agreed plans developed with providers.	Initial feedback on draft plan received from Area Team and taken into account in 4 April 2014 version.	Frail & Elderly Implementation Group being established to support delivery		04/04/2014	
BCF02		Reliance on assumptions rather than 2013/ 2014 data may mean that the performance reward targets with are not achievable, resulting in a loss of funding to the BCF pool.	Investment in local customer saitisfaction work. Outcomes Based Accountability approach to performance monitoring of the outcomes. Evidence based approach to BCF in setting metrics and taking into account the latest performance data and current good performance levels. Joint Board established and first meeting held on 27 Matrch 2014. Governance Framework and TORs developed	4	3	12	M			Existing Performance information and mortality information. Agreed plans developed with providers.		Frail & Elderly Implementation Group being established to support delivery		04/04/2014	
BCF03		Operational pressures in both Health and Social Care restrict the ability of the existing workforce to mobilise the shift of services closer to home and into the community , meaning that the vision for Frail & Elderly people in North Lincs is not delivered	Better Care Fund. Healthy Lives Healthy Futures. Providers working together in Integration and new ways of working. Funds in 2014/15 for pump priming changes . NHSIQ Large scale change programme. Intergrated Working Partnership. Commitment to integrated working. Joint Board and Frail and Elderly Implementation Group.	4	**3**	**12**	M			Mapping of services/ implementation plan will provide some assurance. Metrics will be tracked on a monthly basis and capacity and demand will be managed and escalated accordingly.		Implementation plan in development. Agreement on key priority areas to be considered at the April meeting of the Joint Board		04/04/2014	

Risk ID	Link to Strategic Objective	Risk Description	Key Controls/Mitigating Risks	Impact	Likelihood	Risk Score	Status	Initial Risk Score	Movement	Assurance on Controls	Positive / External Assurance	Gaps in Control	Gaps in Assurance	Last Review Date	Lead
BCF04		Introduction of Care Bill, expected to achieve Royal Assent in 2014, may result in a significant increase in the cost of care provision from April 2016 onwards that currently cannot be fully calculated. This may impact on the sustainability of current social care funding and plans	Contingency Plans for 2016/17	4	3	12	M			Joint review on cost of care. Principles of Risk Sharing. Work is under way in relation to considering the impact on eligibility and how the schemes will enable us to support the right people at the right level of assessed need. The wellbeing offer and hubs will support lower level need.		Full impact assessment not completed		04/04/2014	
BCF05		Impact of severe weather	Winter preparedness plans. Better Care Fund plan. Elderly Care Fund to support accountable GP. CCG has non recurrent resources set aside for marginal rates/readmissions subject to approval by AT and UCWG that could assist if required	**3**	**2**	**6**	L			Additional resources may be made available nationally in year.	Assured Plan (by Area Team)	7 day working across the Health and Social Care system in advance of 2014/15 winter		04/04/2014	
BCF06		Reduction in national Health & Social Care budgets over and above current plans, including additional transfers between Health and Social Care, meaning that services cannot be maintained at current or planned levels, resulting in poor levels of care and reduction in outcomes	BCF Plan. Financial Risk Sharing. Joint Board TORs and governance arrangements cover all Frail & Elderllt, not just BCF	4	3	12	M			Regular Performance reports and BCF Project Plan. Scenario planning re budget risks in Health & Social Care. Shadow pool arrangements to be established. Governance Framework agreed				04/04/2014	
BCF07		Risk that providers (Health & Social Care) are not sufficiently engaged in the development & delivery of BCF Plan, meaning that Frail & Elderly strategy is not delivered, resulting in poorer outcomes of Frail & Elderly people	Provider Engagement in Frail & Elderly strategy. Integrated Working Partnership (IWP), NHSIQ change model. Adoption of the NHSIQ Change programme. Plan is based on whole system shift of resources away from acute to preventative model of health and wellbeing while supporting those with LTC	4	3	12	M					Establishment of the Frail & Elderly Implementation Group. Primary care links into Locality Integrated teams		04/04/2014	
A. Continue to improve the quality of services															
B. Reduce unwarranted variations in services															
C. Deliver the best outcomes for every patient															
D. Improve patient experience															
E. Reduce the inequalities gap in North Lincolnshire															

Likelihood / Impact	Negligible	Minor	Moderate	Serious	Catastrophic
Almost certain	5	10	15	20	25
Likely	4	8	12	16	20
Possible	3	6	9	12	15
Unlikely	2	4	6	8	10
Rare	1	2	3	4	5

Appendix 3 – Redesigned System North Lincolnshire



Our vision - the difference it will make to the lives of the people we support

Our aim is to provide care and support to the people of North Lincolnshire, in their homes and in their communities, with services that support the right people at the right time in the right place. As such we have committed to a Single Organisational Model of integrated working that is needs led.

Our ambition for integration

Our collective ambition is to transform lives and 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 that they have the knowledge and skills they need to be independent and more self caring

- Unlocks citizen resource that support 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

Locally we have agreed that the "Single Organisational Model" (SOM) will provide the basis on which services can be organised on levels of need and thus enable integration.

The model sets out 3 levels of need, universal (wellbeing), targeted (early help and support) and specialist (acute care and safeguarding) which are underpinned within localities. The changes and the difference to the lives of the people we support will be achieved by;

UNIVERSAL: Developing our Community Wellbeing hubs in localities to provide early support and intervention to prevent loneliness, provide information and guidance in relation to supporting people to keep healthy and manage their health needs and promoting independence.

TARGETED: Providing Proactive Care and Support, that will enable people to manage their long-term health needs, support reablement and prevent avoidable admissions to hospital and care homes, and enable people to get and stay well sooner and regain independence after episodes of ill health.

SPECIALIST: Provision of Specialist Services, that will enable people that require hospital or care home admissions to receive a high quality of service and to safeguard their needs, ensuring that for some, admissions will be for the shortest period possible to support a return back to home and communities.

Collectively we have a commitment to the following approaches:

Co-ordinating Integrated Care around people, this will be based on the premise that people are experts in themselves and support will be centred around them and delivered with them.

Learning from Experience, we will continue to implement the Expert Patient Programme and ensure that more people inform Experience Led Commissioning which further influences the market.

This will contribute to improved choice, self determination and control and will improve the experience of care by enabling people to feel confident in self-management leading their own support needs.

To achieve this we need to focus on the journey of the people themselves. The following case studies have been designed by understanding the experiences of people and their carers, together with the perspectives of front line professionals and service experience.

Violet and Albert's experiences, journey and outcomes are influenced by and are attributable to the changes that the Better Care Fund will deliver.

Violet

- Lives at home and has received support from the community wellbeing hubs to feel part of her community. Since her husband passed away Violet has been lonely and hence has been linked up with a befriender.
- Violet's befriender notices that she is struggling with getting around the home.
- Therefore the Handyperson undertakes minor adaptations, grab rails.
- Some time later Violet falls in the night and is taken to the Urgent Care Centre
- During the attendance at the Urgent Care Centre, the Clinicians treating Violet have full information regarding Violet's medical history and conditions (IT Systems talk to each other and single health and care plan in place)
- Violet receives the medical treatment she needs and is supported to go home (Proactive care and support services and 24/7 working supports this)
- Violet feels confident to go home as she is linked into her local community (via Hubs) and knows her befriender is aware of her fall
- Further assessment is undertaken (Integrated locality team) and Disabled Facilities Grant agreed to undertake more adaptations, e.g. stairlift
- Violet takes part in the expert patient's programme, that is designed around her needs and this helps Violet to determine what her priorities are and to stay well in the community

Albert

- Albert is a proud man with a military background
- Albert suffers from chronic bronchitis and emphysema
- Albert believes he can manage therefore 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 Albert being an expert for his own care
- Albert 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
- Albert is identified by the Integrated Locality team as being at risk of numerous hospital admissions, therefore regular meetings are held to review his care plan
- Albert starts to recognise that if he goes to the GP earlier he will not have to be admitted to hospital and whilst his condition will remain he can improve his quality of life
- For the first time in years Albert does not go into hospital during winter
- Albert likes talking about his time in the military and reminisces with his friend Tom who has dementia
- Albert's accountable professional spots that Albert can help others with dementia in Memory Cafes and thus Albert contributes to and feels part of community provision.

This template is to be used for part 2 of HWB BCF plans and replaces the original template available on the NHS England BCF webpage. The new version contains more information in the metrics section and is locked in order to assist in the NHS England assurance process .

This new template should be used for submitting final BCF plans for the 4th April

Association

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16. It is important that these figures match those in the plan details of planning template part 1 . Please insert extra rows if necessary

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15 /£	Minimum contribution (15/16) /£	Actual contribution (15/16) /£
North Lincolnshire Council	Y	634,000	*1,364,000*	*1,364,000*
North Lincolnshire CCG	Y		*11,006,000*	*11,006,000*
BCF Total			*12,370,000*	*12,370,000*
BCF Total		**£ -**	**£ -**	**£ -**

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Risk Sharing arrangements are being developed in order to mitigate any financial and service risk, ensuring that more services are delivered in the community to reduce avoidable admissions, increase reablement and people feeling confident to remain at home for longer thus reducing admissions and lengths of stays in residential and nursing care homes. If the shift of activity from acute to community based care is not achieved, the local acute Trust is likely to absorb that activity at additional cost to the CCG. Whilst the risk sharing agreement will set out how the resulting financial implications are managed, there will be a risk associated with the Trust not having the capacity to manage the additional activity. The governance arrangements being put in place will monitor delivery against the plan to ensure timely mitigation of risk. In addition, it is recognised that there may be limitations in the capacity of primary care to deliver the necessary proactive care required to ensure admissions are reduced and community based care

Contingency plan:		2015/16	Ongoing
Permanent admissions to residential and nursing homes	Planned savings (if targets fully	295,100	590,200
	Maximum support needed for other	295,100	590,200
and over) who were still at home 91 days after discharge from	Planned savings (if targets fully	13,200	26,400
	Maximum support needed for other	13,200	26,400
hospital per 100,000 population	Planned savings (if targets fully	2,400	2,400

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please add rows to the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£
7 day working; social workers	NLC	*634,000*		*250,000*		*634,000*		*0*	
Joint care home liaison	tbc	*0*		*650,000*		*600,000*		*960,000*	
Targeted, proactive community care and support	tbc	*0*		*0*		*2,747,000*		*5,050,000*	
Protection of social care	NLC	*0*		*0*		*2,300,000*		*2,000,000*	
Carers	NLC	*211,000*		*0*		*425,000*		*0*	
s256 reablement and social care	NLC	*3,700,000*		*0*		*3,700,000*		*150,000*	
Social Care Capital Grant	NLC						*424,000*		
Disabled Facilities Grant	NLC						*940,000*		
Contingency	Joint board	*0*		*0*		*600,000*		*0*	
Total		*4,545,000*		*900,000*		*11,006,000*	*1,364,000*	*8,160,000*	
Total		£ -	£ -	£ -	£ -	£ -	£ -	£ -	£ -

NOTE: Recu

Association

Outcomes and metrics

Please provide details of how your BCF plans will enable you to achieve the metric targets, and how you will monitor and measure achievement

Permanent admissions of older people to residential and nursing homes: The population of over 65's is expected to increase steadily over the next few years - increase expected of 5% per annum. This will have the affect of increasing the denominator for this measure. However it may also bring additional potentially frail people into the numerator. Activity regarding admissions has increased in 13/14, therefore whilst we have used the baseline of 12/13 the levels of ambition have taken account of 13/14 performance. Using the 13/14 performance levels represents a reduction in admissions for 14/15 from 225 to 203, which equates to 15% which is statistically significant, and against a growing elderly population is ambitious.
To achieve this metric we will further develop the well-being offer, increase proactive care and support services and the management of long term conditions by accountable professionals within the integrated locality teams. Given our current performance, that broadly matches the national and regional average performance and topped our comparator group average in 2012 2013 and 5th best in region, these measures should help us achieve a reduction in permanent admissions.
Proportion of people still at home 91 days after discharge from hospital into rehab and reablement services: Given North Lincolnshire's current performance, the ambition and target for this metric needs to be set accordingly, given that there will always be some people for whom reablement is unsuccessful or unsuitable, thus requiring them to leave their homes and be cared for elsewhere. Current performance is a result of careful implementation of a robust allocations process to target those most in need of, and able to benefit from the service. Maintaining performance above 90% will be supported and achieved by the increase in Intermediate Care facilities and 24/7 working. At the same time we are seeking to improve performance for proportion of people over 65 offered Rehabilitation and Reablement and this may bring a downward pressure on this measure. This will be achieved by developing the Intermediate Care service in an integrated way with health colleagues and developing proactive care and support services.
Delayed discharges: Analysis of the delays shows the 3 most frequent reasons are; Completion of assessment (29%), waiting for further NHS non acute care (27%) and patient and family choice (25%). We will therefore be targeting joint health and social care efforts to address these delays. As a result of robust partnership working, North Lincolnshire currently has a record of good performance compared to its peers. Continued vigilance and integrated working will contribute to continued performance, ensuring people receive care in the most appropriate place for their needs. This includes home based reablement services and Intermediate Care.
Reducing avoidable emergency admissions: This measure is a composite of the following and is not restricted to the frail/Elderly; Unplanned emergency admissions for chronic ambulatory care conditions (all ages), unplanned emergency admissions for asthma, diabetes and epilepsy in children, emergency admissions for acute reasons that should not require an admission (all ages) and emergency admissions for children with lower respiratory tract infections. Activity within the composite indicator has risen since 2012/13 and therefore the baseline used is 2013/14. The implementation of the new urgent care model in October 2013 and the actions within this plan will focus on reducing admissions and reducing lengths of stay through the proactive care of people within the community, including provision of specific support into care homes. The implementation of the joint care homes support team in April 14 will make a significant contribution to the reduction in avoidable admissions, with impact increasing in 15/16 as the service becomes embedded.
Proportion of older people offered rehabilitation and reablement: This local measure fits with the BCF criteria and compliments the measure 'Proportion of people still at home 91 days after discharge'. The proposed service expansion should act positively to the increase in Intermediate Care beds and reablement services. We will achieve this by working in an integrated way between health and social care services to expand the capacity of rehabilitation and reablement without adversely affecting the quality of outcomes for people. The increase in the bed base of the intermediate care service will support achievement of the metric, by increasing the availability of the service to the people whom would benefit most.
The performance measures will be monitored regularly by the Joint Strategic Board. A performance sub group reporting to this board will provide analytical detail in respect of the

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

We will adopt the national metric

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

The plans have been developed jointly across the CCG and Local Authority and NLAG.
Permanent Admissions of older people to a residential or nursing home: Using the Better Care Fund calculator (with a confidence interval of 75%) we have confirmed our analysis that we will target to achieve around 203 new placements in 14/15 giving a metric value of 606.8. This equates to approximately the same level of permanent admissions, however based on the growing population this should equate to a 6% decrease. Current Baseline data is from national information for 2012-13. Data is published annually. 75% confidence level used in the statistical significance tool. Using the Better Care Fund Calculator (with a confidence interval of 95%) we have confirmed our analysis that based on our current performance in 13/14 and the growing population this should equate to a 15% decrease, reducing permanent admissions from 225 to 203. Data is published annually. 95% confidence levels used in the statistical significance tool. Denominator is taken from Mid-year ONS estimates from 2011 - 2021, North Lincolnshire LA Population, 65 and over.
Caveats: None. Proportion of people still at home 91 days after discharge from hospital into rehab and reablement services; 2012/13 performance was 92.2%, which places North Lincolnshire joint 10th nationally and second in the region. 2013/14 projected performance is expected to be at 91.4%. Current Baseline data is from local information for 2013-14 as this is predicting fractionally higher than the baseline for 2012-13, which would result in an unachievable target. Data is published annually. Denominator is the number of older people aged over 65 offered rehabilitation services following discharge from acute or community hospital during the period 1st October to 31st December for the relevant year.
Justification: 75% confidence level due to small numbers. Denominator increased based on local intelligence and the numerator adjusted to retain a static metric value which is already well above average. Caveats: None
Delayed discharges; This measure is based on average days delayed and not number of people discharged from hospital. It is also a combined measure of delays attributed to NHS and/or social care. Current performance suggests that we should aim for a modest improvement in a rising trend on this indicator, therefore a metric value of 97.16 for April 2015 and 97.26 for October 2015. Therefore average days would be 131 and 132 respectively. Baseline is an average month based on published data from BCF for December 2012 – November 2013, however added December 2013 data instead of December 2012 (as indicating an increase). Denominator is taken from Mid-Year ONS Estimates from 2011-2021, North Lincolnshire LA Population, 18 and over. The statistical significance tool has been used in calculating Payment 1 and Payment 2. Justification: 75% confidence level used as 95% would give too large change in rate 12 months used so that seasonality can be taken into account. Caveats: For comparison purposes the numerator is shown as monthly average. For the Baseline, the numerator is divided by 12. For payment 1 & 2 the numerator is divided by 9 and 6 respectively, based on the number of months in the period.
Reducing avoidable emergency admissions: Baseline taken from published data for April 2013 - September 2013 then seasonally forecast to give an estimated position for 13/14. Denominator is taken from Mid-Year ONS Estimates from 2011-2021, North Lincolnshire LA Population, all ages.
Justification: 12/13 baseline provided felt to be inappropriate due to local knowledge of the 13/14 position being significantly higher therefore decision made to reset baseline to realistic level. This also is used as a baseline for the CCG planning submission. Each six month period was separately put through the statistical significance calculator with the respective population denominator for each payment to give full seasonality and now represents a reduction of 5.39% in 2014/15.
Proportion of older people offered rehabilitation and reablement; Baseline is taken from the published data for 2012-13 and is published annually. This denominator is all older people (over 65 years) discharged from hospital and the numerator is those who are offered reablement/rehabilitation services. The numerator for this measure acts as the denominator for the measure 'Proportion of people 65 and over still at home 91 days after discharge'. Justification; 75% confidence level due to the impact on the 91 day measure. A steady increase will be more sustainable than a sudden shift. Caveats; Must be seen in conjunction with the 91 day measure.

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

Not Applicable

Please complete all pink cells:

Metrics		Baseline*	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	649.9	N/A	606.8
	Numerator	205		203
	Denominator	31545		33456
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services *NB. The metric can be entered either as a % or as a figure e.g. 75% (0.75) or 75.0*	*Metric Value*	91.40	N/A	93.80
	Numerator	96		106
	Denominator	105		113
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	100.1	97.2	97.3
	Numerator	134	131	132
	Denominator	133885	134830	135725
		(jan 2013 - Dec 2013 as baseline) 12	Apr - Dec 2014 (9 months)	Jan - Jun 2015 (6 months)
Avoidable emergency admissions (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	3139.2	1297.7	1640.1
	Numerator	5330	2219	2824
	Denominator	169789	170991	172185
		(est Apr 13 - Mar 14) 12	Apr - Sep 2014 (6 months)	Oct 2014 - Mar 2015 (6 months)
Patient / service user experience *For local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used*		*(State time period and select no. of months)* 1	N/A	*(State time period and select no. of months)* 1
Proportion of older people (65 and over) offered reablement/rehabilitation services as a percentage of all older people *Please give full description*	*Metric Value*	2.1	2.2	2.3
	Numerator	103	108	113
	Denominator	4915	4915	4915
		(Oct 12 - Dec 12) 3	*(Apr 14- Jun 14)* 3	*(Oct 14 - Dec 14)* 3