North East Lincolnshire Better Care Fund

Vision for Local health and social care services

We have adopted a system wide approach to delivering integrated and sustainable services that produce better quality outcomes for our local population within the available health and social care budgets. Our plans build from the joint strategic needs assessment (JSNA) which highlights a growing elderly and increasingly frail population. The proportion of older adults in North East Lincolnshire is set to increase in the next five years, placing additional demands on services. North East Lincolnshire also contains specific pockets of deprivation which continue to present challenges for service design and provision. In particular we are facing challenges related to health inequalities and variations in life expectancy for men and women and between different wards in our locality.

By ensuring that all citizens eligible for social care can access the advice, information and help they need, we aim to support people to keep well, directing clients to preventative services wherever possible. We are working to strengthen the public health offer, by ensuring that this is focused on preventative wellbeing, rather treatment services. To support our transformative journey we have aligned the adult social care approach to the wider vision for health and wellbeing locally, focusing on prevention, putting the community at the centre of service re-design, and supporting people to take greater responsibility for their own health and wellbeing.

We are using an assessment approach which is asset based focusing on wellbeing and prevention. It is intended that the assessment approach will produce better outcomes and value for money.

The Better Care Fund is reflective of our own aim to invest in further integration which will help us to shift the emphasis and activity away from hospital settings. Further integration will create efficiencies, and improve cooperation and coordination across the system, which in turn will improve patient/ service user experience. Together with our system partners in North Lincolnshire we have evolved a whole system model to deliver the right care, in the right place, by the right people, as close to home as possible, releasing the capacity and innovation which exists within our community to promote healthy living, self-care and prevention and reducing the risk of problems escalating and leading to unplanned hospital admissions.

Our comprehensive whole system model

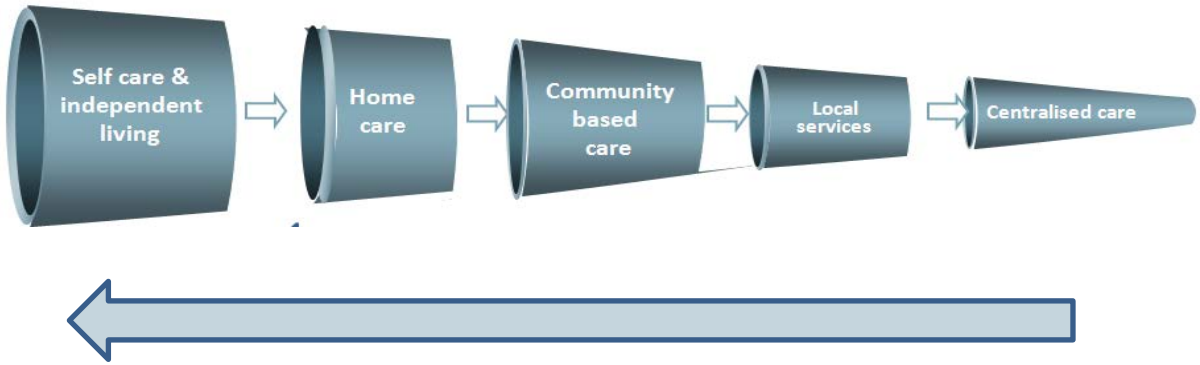


Figure 1. HLHF funnel of transformation

The HLHF programme enables the realisation of the five year forward view locally we will move our system closer to the fully integrated health and social care by 2020. We want people to live independent, healthy lives, supporting one another and taking control of their own health. When they do need care however, they should have access to it by;

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

Intrinsic to our vision therefore is that people should be enabled to get back to managing their own health as quickly as possible. Under the umbrella of the Better Care Fund, we will boost re-enablement opportunities, continue to invest in intermediate tier services and develop our outcome evaluation capability. This means that services which support people with long term conditions are just as important as those which manage urgent health issues. This is critically important to the realisation of our vision as it embeds a whole system approach where every component, service, pathway and support element is of equal value.

Critical to this vision, and part of our BCF plan will be the ability of individuals to access professional support and advice through our integrated single point of access (SPA). The SPA will continue to be expanded this year. To enable people to access the support they need when they need it, BCF supports delivery of extended services throughout the week through our 7 day working initiative. This has already begun to support the shift from traditional patterns of care within the hospital setting towards a community based model (via for example, expanded GP opening hours).

The success of SPA in managing demand can be seen from the information published within North East Lincolnshire's Local Account. A comparison between the figures in the Local Account for 2013/14 and 2014/15 and the latest 2015/16 figures, demonstrates that the calls to SPA have increased in this period. This provides us with an increased opportunity to appropriately direct callers, and to proactively respond to identified need. SPA enables us to provide a consistent and coordinated response. It is arguable that had SPA not been available to respond to these increased calls, the callers may have presented elsewhere in the system at increased cost. ASCOF figures regarding service users' ease of access to information demonstrates that North East Lincolnshire's score (79.7) is higher than the England average (74.5). The SPA Manager was shortlisted for the Management and Leadership Award in this year's North East Lincolnshire Health and Social Care Awards. The SLI mystery shopping exercise rated SPA's phone service as excellent.

http://www.northeastlincolnshireccg.nhs.uk/data/uploads/publications/north-east-lincolnshire-local-account-2014-15-digital-version-2.pdf
http://www.northeastlincolnshireccg.nhs.uk/data/uploads/publications/local-account-a4_youtube-v2.pdf

Our view is that SPA's successes more than justify its continuance.

Our work on developing the community based equipment service (Assisted Living Centre) has enabled more people to access equipment and technology, which supports them to live safely at home and to seek re-assurance and help when and where needed. Some highlights from the first year of the Assisted Living Centre include:

- Building on good attendance figures in quarter 1, there was a further 105% increase in the number of people using the service in quarter 2, evidencing the popularity of the service. Over 2,000 people have so far visited the service
- The number of low level assessments completed is increasing month on month; low level assessments were launched as an innovative new concept by the Assisted Living Centre, to meet prevention and wellbeing needs, and are clearly in demand
- Self-purchase items are being purchased to meet prevention and wellbeing needs; in Q1 a total of £34 worth of kit was purchased, in Q2 this rose to £1,300 demonstrating the need and desire for people to self-purchase aids to daily living. Purchases are supported by specialist therapy advice and guidance, and no profit is made
- 100% of low level assessments are undertaken at the time of presentation at the service

- In October and November 2015, all users of wheelchair services via the Assisted Living Centre were 'extremely likely' or 'likely' to recommend the service, excepting 1 user.

Figures in respect of the final two quarters of 2015/16 are being finalised, but it seems clear that the success of the Assisted Living Centre to date supports its further continuance. The Assisted Living Centre was a finalist for 'Newcomer of the Year' award at this year's North East Lincolnshire Health and Social Care Awards.

Our current vision is a continuation of the vision submitted within our previous BCF plan, and is also reflected in the joint (CCG and local Council) adult social care strategy at - https://portal.nyhcsu.org.uk/documents/5665646/5860313/Adult+Social+Care+Strategy/461f6203-8bee-40fd-a0fc-5cd7e04028e7

A description of the aspects of the change the local area is intending to deliver using the BCF

North East Lincolnshire Council and CCG have been jointly working to deliver adult health and social care since 2007 via a section 75 agreement. In this way, BCF runs parallel to the development of North East Lincolnshire's existing integration journey, rather than representing a change of direction. Realising our vision will enable patients and services users to take a more active role in their own health and care management. Evidence shows that when people are given autonomy over their own condition, outcomes improve.

We set out within our previous BCF plan (section 2c) at page 7) how the HLHF programme will contribute to change across Northern Lincolnshire. Within a provider and commissioner partnership, we are developing a new model of care. This work draws together the modelling for Commissioner Requested Services, BCF and individual projects describe in detail how services will look. Outcomes from the BCF schemes are described in the project initiation documents (PIDs) . The PIDs also set out the intended impact of each scheme.

All BCF schemes (excepting 7 day working) are referenced in our Adult Social Care Strategy. We believe that the schemes work collectively over the lifetime of the Strategy (2015-18) to deliver the objectives expounded within it.

All schemes designated within our previous plan have been scored and evaluated utilising the BCF planning and evaluation self-assessment tool. All schemes have been subject to quarterly monitoring throughout the year and/ or are monitored by a board or steering group, which includes professionals and community members. This means that evaluation is on-going as part of 'business as usual', rather than a one-off activity for the benefit of our BCF plan. Some schemes have been subject to independent evaluation.

A review of the Just Checking scheme indicates its contribution to cost savings and increased responsiveness for service users. For example, Just Checking enables domiciliary care providers to respond to telecare alerts when no friends or family are available. In such circumstances, such alerts would otherwise

be picked up by Rapid Response nurses. The Just Checking response offers an instant cost saving at £12 per hour, compared with the average cost of a Rapid Response nurse of £18 per hour. There is also a further saving because domiciliary workers responding via Just Checking are generally known to the service user and are familiar with their needs; this means they can address the need promptly and in the most time efficient way. Calls from known domiciliary workers are generally shorter than those delivered via Rapid Response nurses who are attending an unknown service user; we have estimated that a Rapid Response call could potentially last for an hour. The Just Checking service also provides reassurance to service users and their families, that someone who is familiar with their needs can step in to offer appropriate support when needed, thus adding to quality of life for service users and carers.

Estimated costs for Telecare or averted Rapid Response calls for the first 9 periods, based on averages taken from 986 calls totalling 519 hours:

- Cost for domiciliary workers to attend via Just Checking £ 6336
- Alternative cost for Rapid Response to attend for the same length of time £ 9504
- Alternative cost for Rapid Response to attend if each visit took an hour £17748.

The independent report of the first phase extra care housing scheme highlights that complex care packages have decreased by £78 per week, and non-complex by £73 per week, per resident. The report also includes excerpts from interviews with satisfied residents, such as –

> "[so your health has improved since moving in here?] Yeah, a lot. A great lot. I'm, I don't like to use the word depressed but I think when I reflect on it I think I was quite depressed whilst I was in there. But here I feel, well I feel really happy in here, you know, and I'm just, I was excited to come and I'm even more excited now I'm here, you know, and there's, I mean there's lots of things that I think the staff want to do but it's things take time to evolve don't they?"
>
> "Oh I'm much friendlier here, because here we are an individual, you see, here you've got your own front door, I know, and I had my own front door where I was, but there was no community feeling, there was no meeting room or anything, anything like that".
>
> "Oh, and my family, and it's taken a lot of pressure off my family [being here], because they were very worried about me".

The latest Preventative Services Market Development Board report can be found at http://www.certfoundation.co.uk/ (please go to the resources tab, and select the report for 2015).

In addition, the BCF process (including the individual schemes) has been subject to an internal audit and found to offer "significant assurance". As a result, all previous schemes will continue to be supported. Evaluation demonstrates that each of the schemes which are already operational have made, and continue to make a contribution to effecting the changes set out within our previous plan (section 2c) at page 8); such as –

- Improved quality and outcomes

- Improved signposting
- Increased development of community wellbeing and prevention services
- Improved choice and control.

Support to care homes and strands of 7 day working which are not yet fully operational will be fully rolled out to deliver the changes listed above. Additional time has been spent on refining and revising these schemes prior to full roll out, to secure genuine confidence and 'buy in' from all relevant professionals to ensure successful delivery.

In addition to the above – largely a continuation of our previous BCF plan – we are developing further structures and strategies to secure and support the change set out herein including our revised policy on micro- commissioning to encourage a wellbeing focus in all front line assessment and care planning.

Our previous plan set out the alignment of BCF plans with others such as -

- Healthy Lives, Healthy futures programme
- The health and wellbeing strategy
- The CCG five year strategic plan
- The council plan
- The NEL joint adult social care strategy
- Local strategies for implementation of change related to the Care Act

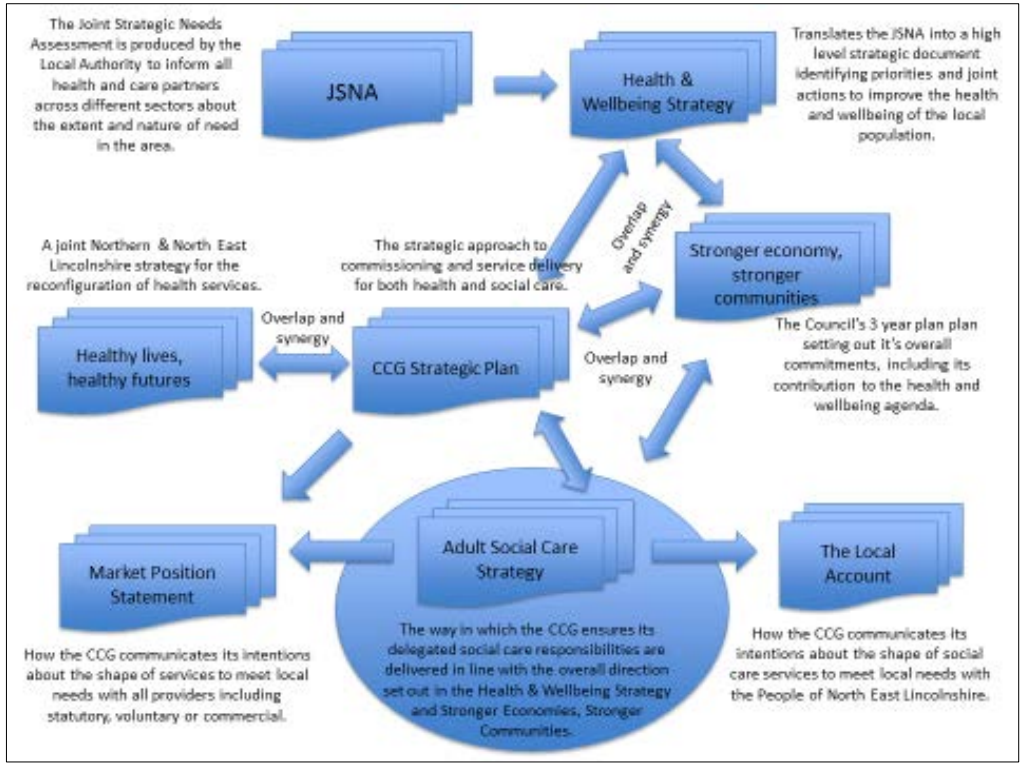
NB the above plans were attached to our previous BCF bid and are therefore not reattached, with the exception of the NEL joint Adult Social Care Strategy which has been refreshed, and a link for which appears above. The council has continued its strategic focus on delivering a stronger economy and stronger communities and has recently adopted an outcomes framework, to which the CCG has also subscribed. The outcomes framework includes the following outcome- 'all people in NEL enjoy good health and wellbeing'. The outcomes framework will form the basis of all partnership working in the borough and a developing "place shaping" approach. We want the people in our borough to manage their own health, take responsibility to live independently from services, and become self-supporting communities. The Council is in the process of creating a set of indicators and performance measures which will be utilised to assess our future success.

The NEL Health and Wellbeing Strategy provides the overarching framework to improve the health and wellbeing of the people of North East Lincolnshire, with its vision to take action to foster healthy people living in healthy places. Its delivery requires collective effort, not just by health and social care but by

other council services, the police and fire service, businesses, the voluntary, community and faith sectors and many others. The supporting implementation plan relating to the improvement of local service quality identifies the Healthy Lives Healthy Futures programme (within which BCF sits) as key to achieving this aim. We have developed our commissioning strategy so that it supports the delivery of the Health and Wellbeing Strategy, and which is complementary to and aligned with other key local strategies and programmes, including health strategies, that contribute to this agenda.

ASCOF data reveals that North East Lincolnshire's score for the quality of life of adults and carers receiving social care is slightly above the England average. PSS evidences that over 60% of North East Lincolnshire's population is extremely satisfied or very satisfied, with just over a further 30% being quite satisfied, with the care and support services they receive. From these figures we deduce that our current mix of schemes, both within and outside of BCF, is achieving success in supporting the needs of the local population.

The diagram below sets out the intersection between some of North East Lincolnshire's policies/ strategies.



Further plans are being developed and refreshed such as:

- The revision of the housing strategy (referred to above), to include an increased focus on prevention and wellbeing. A first draft has been completed
- The development of a North East Lincolnshire prevention strategy, which will serve as a 'call to action' across all parts of the health and social care system, and beyond, in support of the aims of BCF and more
- The development of a North East Lincolnshire integrated information and advice strategy, which aims to facilitate coherent, coordinated and effective information and advice. Whilst SPA is a key contributor to the aims of the strategy, its wider aims will include making preventative signposting everyone's business (i.e. will be reflective of the making every contact count philosophy). The development of this year's annual public health report, which will focus on experiences of growing older in North East Lincolnshire, and in particular on those who are lonely and socially isolated. North East Lincolnshire's aging demographic has already been evidenced, but by definition, it is difficult to establish how many older people

in the area are lonely and/ or isolated. However, the impact of loneliness and isolation on health and wellbeing is well established. Via the stakeholder engagement activities which will underpin development of the public health report, we will seek to develop and implement innovative approaches to tackling this problem, and create a baseline against which to measure success. The support to care homes initiative (which also supports those in the community) will contribute to this.

Respond to changes to the local public health needs and the broader demographic and socio-economic changes in the local area

The number of older people in North East Lincolnshire has been increasing and has already been a factor in strategic commissioning plans. It is anticipated that in the period 2015-2018 there will be a 5.9 per cent increase in the number of people expected to be frail over the age of 65 and there will be a growth in the population for whom we need to prevent or delay the need for support (Appendix 2 of the adult social care strategy provides full details on local demographics and levels of need). This increase is likely to place increased demand on adult social care and other services. Enhanced approaches to managing demand are required and will be adopted. BCF schemes such as just checking, extra care housing and support to care homes (for example) will support the over 65 demographic in particular (although not exclusively). The support to care homes scheme will help those with complex long term conditions residing in the community, nursing or residential care through a multi-agency co-ordinated and proactive response to individual needs. This will include regular care reviews, an urgent (same day) response for deteriorating individuals, and support following a hospital stay/ period of re-enablement in intermediate care, to facilitate an earlier discharge than would otherwise be possible. Support will include use of new technologies and telemedicine to ensure fast, effective clinical input.

Evidence of the input of service users and public engagement

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

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

The NEL joint adult social care strategy was developed through engagement and extended interviews with key professionals and through discussion and debate at the NEL community forum. The Council's scrutiny committee had an opportunity to shape and comment on the strategy.

Community engagement took place in developing the health and wellbeing strategy. We aim to include stakeholders in all aspects of needs assessment work and commissioning. We can point to numerous examples of where co-commissioning has been an integral part of the development of service models e.g. extra care housing development, the assisted living centre, carer's support services, social prescribing and Healthwatch. Our innovative work in releasing community capacity is based on a partnership led by the communities we serve, and supported by commissioners and service managers

As part of the Care Act implementation programme, an expansive engagement and consultation schedule was developed. The aim of the schedule was to inform the community of the coming changes, and seek dialogue on implementation possibilities. As the legislative underpinning for BCF, the Care Act engagement and consultation scheme is of direct relevance to the implementation and development of BCF.

The CCG has compiled a list of engagement activities undertaken in the last year. A similar engagement plan is in development for the 2016-17 period, which will include some of the engagement events already mentioned above and others (e.g. the CCG's refreshed commissioning intentions, and update to its Market Position Strategy). Most BCF initiatives include their own communications and engagement plan within their PID to ensure service user and public input. The CCG operates through use of designated work areas known as 'triangles' e.g. the 'Older People, Carers and Dementia Triangle'. These triangles comprise a commissioner, a clinician and a community member. In this way all key areas of CCG work feature public involvement. The CCG is supported in its work via its community membership body ACCORD, which contributes to all areas of activity.

Changes to service delivery that will help to bring about this vision for the future

The single point of access (SPA) offers an 'intelligent dispatch' mechanism, ensuring that callers reach the right person at the right time. The operation of SPA offers more than just an advice officer function; it includes an enhanced triage element both within and out of hours. It offers a streamlined multi-agency approach to enable smooth transfer from call handling to appropriate health and social care responses. Further planned developments of the SPA include –

- Community nurse call Integration: those requiring both routine appointments and more urgent response from community based nurses and end of life care services will only need to call one number (or use the web interfaces) to arrange visits or get advice - day or night
- Supported discharge: those being discharged from hospital inpatients will benefit from a coordinated multi-agency support package facilitated by SPA, in coordination with the hospital in-reach team (HIT) and others
- NHS 111: improving connections between the SPA and the NHS 111 framework.

The recent appointment of the SPA manager will provide renewed focus on genuine integration and cooperation, i.e. staff will not just be co-located, but will feel themselves to be part of, and contributing to, a shared vision. We believe this will –

- Promote wellbeing
- Contribute to preventing and delaying needs
- Improve the quality of care and support access
- Improve patient and service user outcomes
- Reflect the HLHF 'shift to the left' philosophy (see figure 1 above).

Relationship between the BCF plan for 2016-17 and longer term sustainability and transformation plans (STPs)

Proposed priorities in the STP year one include the continuance of established transformation programmes which have been developed through the HLHF programme in North East Lincolnshire. The current transformation programme includes the BCF schemes which form an important part of reducing hospital admissions, enabling people to remain as independent as possible in their own homes through access to equipment and re-ablement services, and deployment of more appropriate and effective services via the SPA. Within years 2-5 of the STP the aim will be to deliver aggregate and sustainable financial balance by working collaboratively with other commissioners and providers to determine the appropriate location and mix of service provision to meet the needs of the wider STP footprint. The STP is being developed as the wider context of devolution emerges.

How BCF plans will contribute to the on-going delivery of the aims and changes set out in the Care Act 2014

Prevention is key to promoting wellbeing and avoiding or delaying a progression of needs. We are continuing to develop a comprehensive approach to wellbeing and prevention, made up of a number of primary, secondary and tertiary prevention threads. For example, NEL promotes wellbeing and prevention via –

- The Just Checking initiative supports a fully responsive service to those who wish to remain independent at home, by enabling flexible working for domiciliary providers. Just Checking allows domiciliary providers to react to presenting situations without having to go through a bureaucratic process of seeking agreement to re-commission a package of care. Providers have the ability to stay, resolve and stabilise the situation drawing on the Just Checking budget. This extra input is non-chargeable to the service user and is delivering results in terms of reduced care home placement and respite episodes. The initiative also gives domiciliary providers the security of knowing that they will be paid for the impromptu support delivered, thus contributing to their economic viability, and to our duty to promote a sustainable market. This responsive service both promotes service user wellbeing, and prevents escalation of need
- The SPA has successfully reduced the demand for services. Acting as a 'front door' to assessment functions which have been re-designed for compliance with the Care Act, the revised approach is an asset based approach, and views the individual holistically in the context of their whole

family; it is intended to free social workers to return to core social work values, drawing on their professional judgement, and supporting them to avoid assessments which simply 'tick boxes'. Data collated via SPA also enables identification of areas of unmet need (both geographically and in terms of service provision) which could be responded to via applications to the preventative services market development board

- The preventative services market development board provides funding for community based initiatives which will promote wellbeing and prevent needs for care and support. The project has been successful in attracting additional funding into the area, and in achieving a credible social return on investment. It has supported the creation of cost effective services with a universal offering which in turn contribute to a diverse market place, offering users increased choice and control.

In addition to the above specific examples, the CCG and council are working together to further develop the Care Act's vision of integration and cooperation, via for example, specific initiatives which will –

- Improve coordination of information and advice
- Improve liaison between children and adult services
- Improve liaison between public health and wider services.

Evidence base supporting the case for change

The issues that the BCF will be used to address in the local area

In NEL there is increased demand for local health and care services due to an ageing population, higher than average deprivation levels and increasing numbers of people with long term conditions. In addition, a projected financial deficit of £104m by 2020 in health and care organisations operating in North and North East Lincolnshire, and key skills shortages within the health and social care economy underpins the HLHF case for change

The programme is committed to improving the quality of care and outcomes for local people, balanced with the need to ensure service sustainability and affordability for the future. The delivery of an enhanced out of hospital model which enabled health and care professionals to provide more joined up services closer to people's homes and communities forms the basis of the system wide model of care.

BCF will support the delivery of the HLHF vision in:

- Enabling providers to deliver a comprehensive service from supporting prevention and self-care through community based care to specialist and tertiary care

- Providers taking an integrated approach so that people have access to a seamless services
- Producing higher quality care and affordable services.

Identification of the opportunity to improve quality and reduce costs, based on segmented risk stratification

The North East Lincolnshire population presents with a significant gap in life expectancy between North East Lincolnshire and those born elsewhere in England, and there is a gap in life expectancy within the borough between the most and least deprived communities. There is a higher risk of death from preventable causes when compared to other parts of the country, specifically deaths from heart disease are 16 percent more likely in North East Lincolnshire when compared to the England average; Mortality from cancers are 11 per cent higher than the England average. The area is set to have a higher than average proportion of its population aged over 65 as a result of greater life expectancy; however the population will also have a greater population of frail elderly people, as a result of the reduced level of disability free life expectancy. This is fully documented within the JSNA and within the HLHF case for change documents.

Older and frail elderly patients typically require more health and social care for conditions such as dementia and often present with multiple co-morbidities.

BCF will help us to:

- Improve our preventative service offer
- Enhance re-ablement and ensure resettlement following hospital admission or individual crisis episodes
- Reducing unplanned hospital admissions through a range of initiatives designed to offer care and support closer to home.

How integration will be used to improve the issues identified

North East Lincolnshire Council and North East Lincolnshire CCG have historically worked together to deliver an integrated system for health and social care since 2007 and so as authorities we are starting at a very different point from other areas.

As described earlier the aims of the Better Care Fund are reflective of our own aim to invest in further integration. Further integration will help us to shift the emphasis and activity away from hospital settings by investing further in a tier of intermediate and community care pathways. It is also anticipated that further integration will create efficiencies, and improve cooperation and coordination across the system, which in turn will improve patient/ service user experience.

Our vision is to deliver the right care, in the right place, by the right people, as close to home as possible, releasing the capacity and innovation which exists within our community to promote healthy living, self-care and prevention. The HLHF programme has helped us to work across the Northern Lincolnshire health and care system to develop new approaches and learn from new practice that is emerging.

Data that supports the case for change, including quantifying levels of unmet need, issues of service quality, and inefficiencies in service delivery

The CCG's business intelligence underpins the case for change and commissioning intentions identifying areas where the area is an outlier in terms of quality and service delivery as well as cost and inefficiencies. This includes the JSNA as a tool for identifying unmet need. The NEL joint adult social care strategy referred to earlier identifies levels of need and eligibility for services; we have also develop a market position statement and commissioning priorities that will enable us to shape the care market locally. We described in the NEL joint adult social care strategy our transformational approach which is built upon on going service development and review, a focus on prevention, a willingness to explore alternative service delivery models which deliver better value for money and raising income through reviewing fees and charges.

A coordinated and integrated plan of action for delivering that change

Specifics of the overarching governance and accountability structures in place locally to support integrated care

All schemes are monitored via either:

a) usual contractual processes (e.g. Just Checking which is monitored via the domiciliary care contract; invoice claims against the Just Checking budget must be supported by an additional report with case studies for monitoring purposes. Current domiciliary contracts, of which Just Checking is a part, were re-tendered with community involvement in tender process)

b) its own management mechanism (e.g. the Extra Care Housing steering group, which monitors and reports on progress, and has commissioned an independent report into its activities to date).

In addition, each scheme is managed by an individual lead. Each lead creates a high level report for the BCF lead each month; this presents an opportunity for clarification and challenge. In the preceding year, the BCF lead provided monthly reports to the Partnership Operational Group (comprising senior members of the CCG and Council) to provide oversight and assurance. This group has been key to developing NEL's wider integration strategy (i.e. within and outside of the confines of BCF). The remit and approach of the group is being reviewed to reflect new joint management arrangements between the council and the CCG. Periodic reports to the Health and Wellbeing Board are planned. The terms of reference for the Partnership Operational Group were

attached to our previous BCF plan, which sets out the former governance and accountability structures. New arrangements are to be put in place to govern the BCF programme in the light of recent changes.

Our previous BCF plan has been subject to an internal audit, and found to offer 'significant assurance'. The involvement of audit will continue until completion of BCF requirements.

In addition to the above, NEL has an integrated management structure:

- The DASS role is now delivered by a senior member of the CCG who leads across health and social care on behalf of the CCG and Council
- The Council's assistant director of adult services and health Improvement is a joint appointee of the CCG and Council, and line manages a number of staff responsible for delivering BCF schemes, including the BCF lead
- The director of children's services (DCS) is supported by the CCG's assistant director for children's commissioning, working together via the joint children's partnership board
- The director of public health continues to have a role in supporting both the council and CCG in developing joined up commissioning plans
- The council and CCG are developing joint commissioning approaches across the full spectrum of health and social care activity as part of the ongoing journey towards full integration
- The council has three elected members on the CCG's partnership board.

Arrangements in place to support joint working

NEL has a long history of integrated working supports a culture of joint working, supported by a section 75 for health and social care. This has been further enhanced recently by the creation of a number of joint roles across the council and CCG, including roles at a senior executive level. The CCG and Council have agreed joint strategic outcomes for the area, and are developing plans to ensure delivery of these outcomes across the system.

At an operational level the providers are working together to develop and deliver integrated services for individuals. A multi-agency board has been developed to support the delivery of the areas single point of access (SPA). The organisations involved have worked together to enable co-location of staff to a single point to enable shared learning and development, and has recently appointed an overarching manager who will assume the management of the total team, regardless of their employer. Work is also progressing to further develop the intermediate tier, urgent and crisis care services and integrated discharge processes. All of these arrangements provide governance and accountability structures to support joint accountability.

On-going discussions are taking place in the locality as part of the work of the Healthy Lives Healthy Futures programme as to the most appropriate model for delivering integrated health and social care both within North East Lincolnshire, the wider Northern Lincolnshire footprint and the STP footprint. Partners are working together to articulate a new accountable care system which will ensure better utilisation of resources to deliver shared health outcomes, improved quality and sustainable services.

Key milestones associated with delivery of the plan of action

An action plan has been created via a programme management tool called Covalent. The use of Covalent as a management and monitoring tool was referenced in our previous BCF plan.

Risk log with evidence that it has been developed in partnership with all stakeholders and a description of how risks will be managed operationally

Each scheme has its own risk log. Risk logs are monitored via:

a) Usual contractual processes (e.g. the Assisted Living Centre (ALC), the risk log for which was developed with the involvement of the ALC Steering Group and Board. Since its launch in 2015, the ALC – including risks - has been monitored via its service specification)

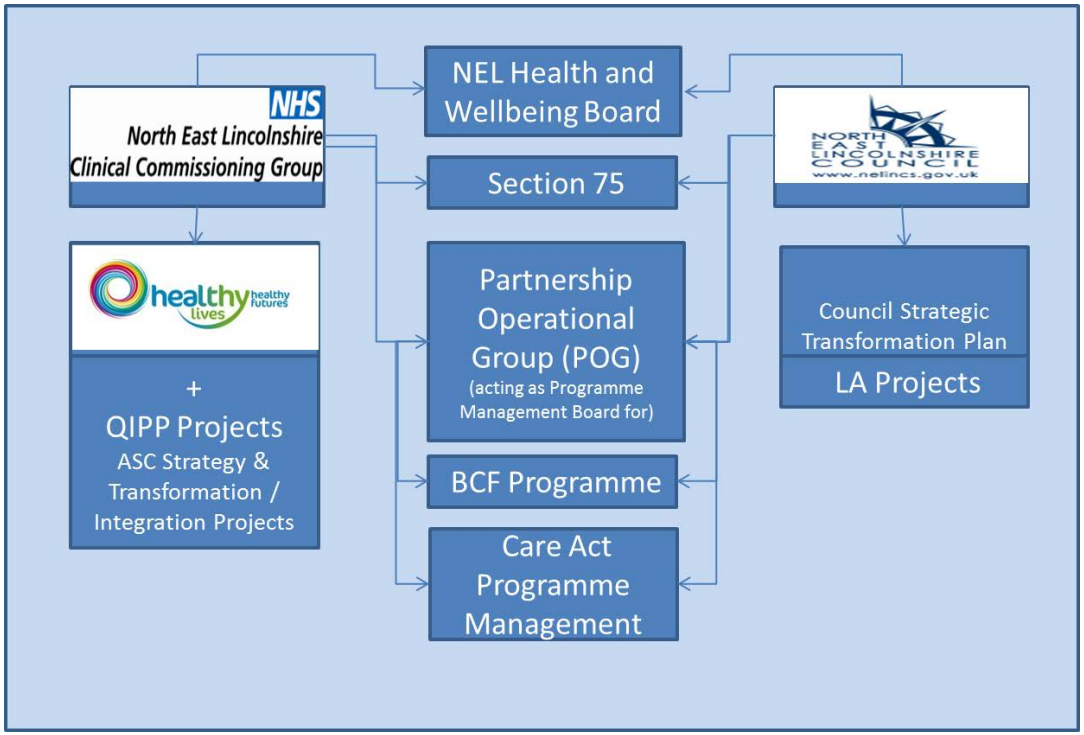
b) Its own management mechanism (e.g. the SPA Board, which is responsible for the on-going development and expansion of the SPA vision).

Where risks appear to be escalating these are challenged via contract monitoring and/ or via the scheme lead. Where appropriate, risks are highlighted by the BCF lead via line management and/ or drawn to the attention of senior management, and the Health and Wellbeing Board. The CCG's corporate risk register also contains an overarching BCF risk. The risk register within the previous BCF plan has been refreshed.

The level at which strategic issues will be dealt with within structures

Strategic issues have historically been managed via the Partnership Operational Group but this will now be embedded as part of the routine management via the joint management team arrangements.

Diagrams to explain structures for decision making and governance



Approach to financial risk sharing and contingency

No specific contingency funding has been set aside within the "BCF", as the financial risk sharing arrangements for the BCF schemes, both in terms of the costs of the investments and the activity impact of the schemes across the wider system, form part of the overall partnership arrangements that are in place between health and social care in North East Lincolnshire.

A approach to risk sharing on NEAs and DToCs in line with national conditions 7 and 8 –

NEL's approach to risk sharing across health & social care as set out within the s75 agreement is submitted with our original BCF plan. Risks are monitored/ managed as part of the CCG's governance arrangements.

Risk sharing arrangements have also been established as part of the Memorandum of Understanding that is in place between the CCG and local providers (NLAG, NAViGO, Care Plus Group and Core Care Links Ltd). This involves a cross organisational approach to the management of risks as and when they arise.

Risks associated with not meeting BCF targets in 2016/17

The BCF schemes are an integral part of the wider partnership arrangements that the CCG has with NELC. The schemes are part of the savings plans the CCG has in place for adult social care and as such non delivery of targets would impact on the delivery of savings. The level of potential financial risk across health and social care has been assessed as £6.9m, with £0.2m of this linked to "BCF" schemes.

Risk sharing arrangements in place in the health and social care system

The existing risk sharing arrangements already in place as part of the section 75 agreement between NELC and the CCG will be used for the BCF. The risk sharing arrangements established between the CCG and the local providers as part of the Northern Lincolnshire memorandum of understanding will be used to support the risk associated with the non- delivery of the target.

How CCG plans have been set and how these relate to BCF risk sharing arrangements

The finance plans are based on the schemes that were in place in 2015/16 and have been agreed as part of the partnership arrangements in place between NELC and NELCCG

How any funds that are released will be spent

The schemes are already in place as they are a continuation of what was in place in 2015/16, as such all of the funding is fully committed.

Plans to be Jointly Agreed

The Health and Wellbeing Board will review the draft BCF plan on 18th April 2016. It is aware that the intention for this year's plan was likely to be the continuation of schemes under the previous plan.

Engagement with Providers

As North East Lincolnshire has been working in an integrated way since 2007, the changes for providers represented by this year's BCF plan are perhaps less significant than for other areas which are newer to integration. All relevant providers are aware of the continuation of schemes this year. The greatest areas of change are within the support to care homes and SPA, and these are the areas in which providers have been most heavily involved (i.e. in developing future plans and approach). The support to care homes implementation group is a multi-disciplinary team including GPs, nurses, social workers, mental health professionals, practice managers and commissioners and has developed the project plan and specification. Care home providers have been kept updated and involved throughout the scheme's development. Similarly the SPA Board comprises clinical staff, commissioners, representatives from the community and all key providers (e.g. focus, Care Plus Group, Navigo, NLaG, Core Care Links, Yarborough and Clee Care, primary care). The Board will continue to develop the SPA vision and plan with the newly appointed manager. This level of involvement seeks to provide a 'doing with' rather than a 'doing to' commissioning approach, which is more likely to secure the 'buy in' of those on which the schemes depend to deliver high quality services and positive outcomes.

Implications for local providers have been set out clearly for HWBs

The HLHF programme brings together all local providers and commissioners, representing a forum in which collaboration is key to delivering system change. Over the past year the partnership has been working to develop a system wide plan to reduce the financial gap and to achieve both quality improvements and improved outcomes for service users. Health and wellbeing board chairs for both North and North East Lincolnshire are present on the programme board and there are regular updates to each board area. BCF schemes contribute to the delivery of the HLHF programme outcomes at each locality level; the HLHF operational group is the forum in which all providers and service leads come together to plan, manage delivery and risks associated with their respective programmes.

Disabled Facilities Grant (DFG) allocation

The council and CCG have recently entered into a joint management arrangement which will offer both organisations greater oversight of adult services and related, preventative services, traditionally delivered by the council. Through these revitalised management arrangements it will be possible to ensure greater co-ordination of services and functions, of which strategic housing is a part, and is integral to supporting people to live at home and within their communities. Currently there is a significant backlog of disabled facilties grants within the system. This is in part attributable to the low level of funding traditionally allocated to this area of activity and due to inadequate support from the occupational therapy service, leading to significant delays in processing times. This has the potential to create greater dependencies on home care support and there is also the potential for individuals to be accommodated in residential care settings for longer than planned, although more work is needed to understand the interdependencies within the health and care system in relation to DFG administration. Due to recent changes in management structure our joint adult services lead now provides oversight of

housing funding, disabled adaptations and the assisted living centre, enabling the better coordination of housing adaptations. Immediate action has been taken to ensure the recruitment of an occupational therapy lead to progress the backlog of applications, supported by the enhanced level of funding now allocated via the BCF. The council will also be reviewing its housing assistance policy to enable the prioritisation of applications and resources to ensure better outcomes for users, minimise delays and reduce costs within the health and care system locally.

Joint agreement across commissioners and providers as to how the BCF will contribute to a longer term strategic plan

The BCF plan has been shared with partners and as described earlier is very much a part of the wider infrastructure to deliver sustainable services across Northern Lincolnshire via the HLHF programme

An assessment of future capacity and workforce requirements across the system has been undertaken

As part of the HLHF programme a comprehensive assessment of wider workforce issues has been carried out and a strategic approach is in development which will try to address not only issues in relation to skills shortage, but a forward agenda which maximises the skill mix, ensures that cultural issues around integration can be addressed and the workforce is orientated around supporting clients and patents to live well and independently wherever possible. NELCCG has been affected by difficulties in recruiting GP vacancies and practice nurse posts. A number of initiatives have been invested in to support recruitment and also to develop alternative roles to support GP capacity.

Maintain Provision of Social Care Services

Local adult social care services will continue to be supported within BCF plans in a manner consistent with 2015-16

We have reviewed the answer we gave at 7b), page 27-29 of our previous BCF bid and would re-endorse the statements therein. There have been some high level amendments (e.g. the Priorities Framework must now be viewed in conjunction with the Care Act's eligibility criteria) but the intentions we set out previously remain equally relevant. All schemes which formed part of our previous BCF plan are continuing. Any changes in approach in the intervening period have been informed by analysis of what is or is not working (in terms of delivering value for money, quality services and positive outcomes). Irrespective of operational changes in approach, services continue to be supported in a manner consistent with 2015/16.

The council has implemented the local increase in council tax to facilitate the delivery of sustainable adult services, specifically with a view to addressing the new minimum wage requirements. The council has also reviewed its charging policies to ensure that resources can be used deployed to those who most need support.

Definition of support has been agreed locally and, as a minimum, maintains in real terms the level of protection as provided through the mandated minimum element of local BCF agreements of 2015-16

The working definition remains that which was set out in our previous BCF plan:

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

Our adult social care strategy sets out the key challenges facing adult social care in the face of on-going financial restraint within local government and details the ways in which we aim to mitigate the effects of financial reductions. We believe that our model of integration enables us to explore opportunities to do things differently, deliver person centred care whilst at the same time delivering efficiencies. We recognise that we now need to accelerate the pace of change and be more ambitious if we are to continue to meet the needs of the most vulnerable and remain in a financially sustainable position. In part this approach is based on involving communities and service users and defining new and imaginative responses to the needs presenting. Where practicable we are helping communities to play a greater role in supporting people, to alleviate the pressure on traditional, statutory services.

The approach and figures set out in 2015-16 plans will be the same for the current year and is consistent with the 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14. The schemes are part of the NEL adult social care strategy. Further details are contained within each scheme

How local demographic change will impact upon social care

An analysis of the 2011 census data has underpinned our adult social care strategy and transformation principles which will enable us to manage demand. This indicates:

- A marginal increase in the number of people over the age of 65 compared to 2001 census (31,500 compared to 31,100)
- The increase in 2015 is accounted for entirely within the 65-74 age group with no increase in the over 75s
- It is anticipated that there will be a slight reduction in the number of people over the age of 75 when compared with 2001 census forecasts.
- The growth from 2015-2018 in the older population is still in line with previous estimates and is represented below:
    - A 3.6 per cent increase in the total population over the age of 65
    - A 7.1 per cent increased in the total population over the age of 85
    - A 5.9 per cent increase in the total population expected to be frail over the age of 65
    - A 7.0 per cent increase in the number of people with dementia

- A 9.2 per cent increased in the number of people with severe dementia

£440k has been set aside within the BCF for the implementation of the Care Act, which is the same as the previous year.

What the requirements of the Care Act mean in terms of changes to the delivery of local services

Key changes within the Care Act which are relevant to all BCF projects include –

- Primary focus on wellbeing and prevention; numerous providers have been supported to consider how promotion of wellbeing might apply in their context/ setting, and specifications have been updated to reflect new requirements. Refreshed strategies (e.g. the Housing Strategy) have been reviewed to ensure that consideration of wellbeing and prevention is core to future planning
- A reinvigorated approach to coordination of information and advice (in development); will involve all providers and straddle delivery of all BCF projects (as well as non-BCF projects, such as our developing Social Prescribing Initiative). The importance of information, advice and signposting has been reflected in revised specifications. On-going work with providers will dictate further changes to ensure a genuinely coherent system
- Assessment and support planning paperwork has been revised and trialled across providers with the involvement of the council's transitions team.
- The advocacy service has been re-tendered (with community involvement) and re-launched to offer a coherent and comprehensive advocacy service.
- Partnerships; the CCG and council are reviewing their existing relationship with a view to even greater cooperation and integration. The integrated management structure referred to earlier is part of this, along with the joint initiatives mentioned (e.g. increased working between children and adult services/ transitions' team). The way in which these core partners interact with wider partners is also being considered, with a view to securing greater coordination and efficiencies in delivery. This will include a refresh of the current health and social care Market Position Statement, setting out our local vision for services.

A single officer led the Care Act implementation and the BCF programme ensuring links between the two.

As a result of longstanding partnership working, North East Lincolnshire has an early advantage in delivering on the integrated vision set out within the Care Act having. Each BCF scheme includes elements of integrated care, which are reflective of the area's wider integration agenda. Processes, policies and procedures were reviewed in the lead up to implementation of the Care Act, and have continued to be in the period since implementation, as more lessons are learned. It is the on-going review of our processes, policies and procedures which underpins our work on integration. The issues highlighted by the impending report 'The Care Act: one year on' in development by the Care Act Implementation Manager/ BCF lead, will highlight opportunities for greater partnership working and inform our further integration planning.

Specific support to improve outcomes for Carers

No specific monies have been earmarked for additional carers' support services. We have a joint health and social care budget which is used innovatively to provide dedicated carers' support.

All Carers' services were reviewed to ensure Care Act compliance and are appropriate to meet local need. Carers' services in NEL for some time have been led by carers, who were included in recruitment, tendering, reviewing and monitoring of all services commissioned. Carers' services are delivered against the required specifications. We continue to review services to identify improvements and additional ideas for innovative best practice.

Services being commissioned for carers included the:

- NEL carers' support service (advice, information, specialist benefits advice, advocacy, support groups, befriending, counselling, holistic therapies, social activities, training, lifelong learning fund, carer case workers and a specialist substance misuse carers support worker).
- Carers support worker services
- Alzheimer's Society – Carers' support
- Carers' Breaks –sitting and respite services, summer scheme for carers of those with learning disability during college holidays, social activities across the year.
- Carers' emergency alert card scheme including carer discounts on production of the card at local businesses and services

All of the above services offer a robust range of services to meet local carer needs; many of these services are open to all carers as universal prevention and wellbeing services to ensure wherever possible the impact of caring is reduced or delayed and carers are supported to maintain their caring role while having a life of their own. Carers are offered the opportunity to evaluate services to establish whether outcomes have been met, satisfaction levels, improvements/ gaps and also how the services have supported Carers to maintain their caring role. Carers continue to report that their outcomes are being met by these services with high levels of satisfaction.

7-day services across H&SC to prevent unnecessary non-elective (physical and mental health) admissions

There are a number of service areas where 7 day services are already in operation, including:

- Community nursing (adults and paediatric)
- Crisis response services
- Single point of access (SPA)

However, there is more work to do in refining the scope of the services available and ensuring that the available capacity meets 24/7 need. In particular, the responsiveness of adult social care, domiciliary care and residential care to support weekend discharges needs to be considered.

There is already a GP out of hours' service which ensures that urgent care is available 24/7. Extended hours general practice access up to 8 pm on weekdays is available for 93% of the population and there is a local pilot covering half of the population which is testing out a model for 7 day access to general practice. GP input into the SPA is also partially in place, but not yet 24/7. There is further work to do during 2016/17 to develop the strategy and refine the implementation plan for full general practice 7 day access by 2020. Within 16/17 we will:

- Agree the strategy with stakeholders, including the public
- Work with the local stakeholders and review the evidence available to understand more about requirements for planned general practice at weekends
- Learn from the local pilot of 7 day working and develop a specification for 7 day general practice, to begin implementation from 1st September 2016
- Refine the requirements for GP input into the wider urgent care model, including out of hours home visits and GP support to clinical advice hub
- Establish a minor ailments scheme within Pharmacies, to support access across 7 days.

The home from home service operates 24 hours a day 7 days a week to manage the acute episodes for patients with confusion and dementia, including appropriate discharge planning. There is further work to do in-year to establish how the existing mental health services align with the community crisis response model, and how the response can be improved for acute discharges over the weekend (non-confusion/dementia). An overarching 7 day plan, which captures all of the elements of the service (existing and planned), will be developed during 2016/17.

Preventing unnecessary non-elective admissions (physical and mental health) 7 days a week

The CCG has a plan for the development of an out of hospital urgent care infrastructure, which will support the prevention of unnecessary non-elective admissions. The existing elements of the single point of access (SPA) and community crisis response already operate over 7 days; further detailed planning will take place in-year to ensure:

- greater integration with mental health
- Capacity, demand and workforce planning of the crisis response service to ensure it can meet the response targets of 1 hour, 24/7.
- A clinical advice hub, specifically for health and care professionals, will provide real-time advice to support alternatives to hospital admission. Integration with NHS 111 is already in place, and further work is planned to support 999 'green' dispositions and to increase the GP support forcrisis

response for 999 on the scene responses. This is a workstream of the SPA development and is primarily designed to prevent the need to convey to hospital.

We are is developing a more integrated, urgent care response at the 'front door' of the hospital, to deal more effectively with those patients that self-present or are conveyed to the hospital. This will include the paediatric assessment unit, medical assessment unit, end of life team, minor injuries element of A&E, GP advice, community crisis response (including adult social care); the focus being on seeing and treating (including the ambulatory care model) and ensuring appropriate arrangements are put in place to support individuals at home in a timely manner. Some elements still require more detailed plans and timescales to be developed. The CCG is holding a series of events starting w/c 21st March 2016 to firm up these plans.

Supporting the timely discharge of patients, from acute physical and mental health settings, on every day of the week

Driven by the System Resilience Group's (SRG) 8 high impact initiative targets, there are clear targets for weekend discharge rates, compared to weekly average rates (7 day discharges with weekend discharges at 80% of weekday rate). The 7 day working plan to achieve this is included within the five priorities for transforming discharge planning:

- A SPA accessible discharge hub is required that is a single point of access for Diana Princess of Wales (DPoW) operations and is accountable for the organisation and timely establishment of the onward care needs of complex discharges – this will transform the current default operational ownership and the associated processes
- All provider approach to "Assess from Admission"
    - review & estimated date of discharge (EDD)
    - morning focused process to secure bed base for new admissions
    - weekend process to secure higher weekend discharge rates
    - relevant multi-disciplinary team working towards EDD
    - due reference to the DToC definitions and charging legislations to ensure agreed processes meet the requirements
- Information & advice on discharge
- Contract/service alignment such that assessment/service start is planned at EDD

- Services to support discharge
    - Intermediate Tier service development – integrated all service step down/rehab, Discharge to assess (bed & home supported by enhanced home care)
    - housing, equipment, out of area, end of life

Delivery plan for the move to 7-day services including key milestones and priority actions for 2016-17

The detailed plan for DToC is currently under development. Where services are already in the process of being implemented, there are delivery plans in place which include key milestones and priority actions for 2016/17. As stated above, there is also a need to develop an overarching 7 day plan which encompasses all of the various work streams that are have been established to develop and deliver 7 day working. This is a priority for 2016/17.

Local partners will work together to ensure that NHS providers meet the milestones for inclusion of the Clinical Standards for 7DS in 2014/15, 2015/16 and 2016/17

As outlined earlier we are working collaboratively with our partners through the HLHF programme to ensure the delivery of safe, quality and sustainable services.

Better data sharing between H&SC based on NHS number

The health community recognises that it is important that all staff are fully empowered to support data sharing between care settings. To support this:

- All staff are required to attend mandatory information governance training, explaining to them the fundamental principles of data sharing and their associated responsibilities.
- Through staff briefings all care or service user facing staff have a clear understanding for their responsibility in regards to the data sharing consent model.
- Electronic care systems have been configured to support and guide staff in appropriate data sharing.

To help with partner provider engagement, a number of cross organisational structured workshops are planned to ensure that stake holders have ownership in the data sharing process and governance models. Key care pathways will be examined holistically to gain a shared understanding of the minimum data sets required by care givers at each stage in a pathway. This will allow the planning of data sharing processes and gap analysis on where process/ system development is required to fulfil the needs of the services.

Key outcomes for the North East Lincolnshire locality are:

- An agreed cross partner plan outlining the digital roadmap developments by June 2016.
- An agreed consent sharing model by all partner organisations.
- Improved utilisation of public facing online systems.
- Electronic referral services being well utilised within Primary Care.
- Enhanced mobile technology enabling truly agile care services.
- Up-to-date key citizen information being available on demand across care settings.
    - A starting point for this will be the sharing of the Primary Care record and improved utilisation of the enhanced summary care record.
- Short term improved utilisation of existing data views to bridge any data sharing gaps until integrated systems online.

The NHS Number is being used as the consistent identifier for health and care services

The wider Health Community within North East Lincolnshire recognises the importance of the use of a standard identifier across care settings. To ensure a standard identifier is used, all local Social and Health Care systems within the locality use the NHS number as a mandatory field, providing a consistent field utilised across all care providers.

Interoperable Application Programming Interfaces (APIs) are being perused

The wider care community is working towards implementing its agreed digital road map which outlines a joint approach to delivering a joined up care service which aimed to be paper free at the point of care by 2020. This will require electronic systems to be appropriately implemented, where consent allows, to facilitate real time sharing of all care records. In addition, in order to support extended hours and community based services, the health community is committed to providing shared access to records within wide ranging care settings, in order to facilitate this, a number of initiatives have been completed or are underway:

- The local adult social care providers, the majority of local primary care providers and the community care providers all use the SystmOne Clinical System, allowing for an electronic shared health record.

The implementation of a summary care record -(SCR) with additional information, allowing a service user the choice of sharing a view of a significantly wider scope of information to all systems with SCR functionality. At a wider national level Interoperability between the two main primary care systems is being developed to allow implement 'click through' data sharing functionality. It is expected that this functionality will become available from November. Other providers are working directly with clinical system providers to ensure that data sharing is provided at API level. The local acute trust has a sharable view of

their electronic record available using a standard web interface. Roll out is expected to be completed by October 2016. The local acute trust is also expecting to have interoperability with their EPR and Primary Care Systems by April 2017, although this time scale has yet to be confirmed by the suppliers.

Appropriate Information Governance controls are in place for information sharing in line with the revised Caldicott principles

To ensure that all partner organisations meet the correct governance standards, all providers have completed their IG Toolkit Level 2, which is the recognised national standard ensuring that appropriate governance controls are in place within any organisation.

The organisations involved in delivering care have a nominated and appropriately trained Caldecott Guardian, who are engaged in working practices within the organisations.

There are organisational HR mechanisms in place to proactively monitor and check that all sharing and security principles are being adhered to.

Local people have clarity about how data about them is used, who may have access and how they can exercise their legal rights

To ensure that the citizens are empowered to make an **informed choice** on whether they want to allow their record to be shared, a number of key processes have taken place including:

- Writing to affected service users
- Visual advertising campaigns, e.g. use of posters & leaflets in strategic locations.
- Articles in the local media
- Direct conversation with service users at point of care or entry into the care system. For some open public access points this is scripted to ensure a consistent and accurate message

Demonstrate how these changes will impact upon the integration of services

The majority of service users requiring care within the locality are appropriately informed to be able to make decisions about how their data is shared with care providers.

Progress made in adopting open APIs and open Standards

All Primary Care systems are obliged, through the national GPSoC framework, to use Open API's and Standards as interoperability mechanisms, this is in place now and agreements are being utilised to provided cross system communication. Non-GPSoC providers of local systems have also entered into wider discussions to provide connectivity. Please also see answer above on interfaces

The Digital Road Map outlines a joint approach to delivering a joined up care service which is **paper free at the point of care by 2020**. This will require electronic systems to be appropriately implemented, where consent allows, to facilitate real time sharing of all care records.

All Commissioners and major providers have signed up to the principles required to deliver the requirement outlined in the agreed Digital Roadmap.

All care providers are expected to continue renew their IG Toolkit Level 2 and are expected to have appropriate data sharing in place.

Joint approach to assessments and care planning and where funding is used for integrated packages of care, there is an accountable professional

All individuals across NEL who have significant health or social care needs, including those who have Continuing Health Care needs, have a named worker who acts as the case manager to coordinate the individual's health and social care needs (including assessment and care planning).

The population of NEL which is over eighteen years of age is 125,404. The following breakdown details those over eighteen in receipt of services, and the accountable professional in respect of them -

Caseload Holder		
Named Caseload Holder (these individuals are either a) long term, complex cases or b) those who have not yet moved from a more intensive period of case management following initial contact and care planning, to a process of annual review only, or c) CHC funded)	1297	59.17%
Caseload Team Named (these individuals have moved from intensive initial case management, to annual review only, via a designated team)	764	34.85%
No Caseload Holder/Team (these individuals have either a) just 'arrived' in the system and are awaiting allocation, or b) are in receipt of very low level services, such as telecare only, and thus do not require a designated professional or team on an on-going basis)	131	5.98%
Count of clients in receipt of a service as at 24th April 2016	**2192**	100%

Dementia services as an important priority for better integrated health and social care services.

Consultation on the local dementia vision, strategy and action plan has just been completed. The final documentation is currently being progressed for approval. The dementia steering group will lead on this vision throughout 2016/17 to ensure all national requirements/ targets are achieved as well as meeting local need. The action plan focuses on 7 key areas including;

- Raising awareness and understanding
- Advice, information and guidance
- Timely diagnosis and effective post diagnostic support
- End of life care
- Carers' support
- Skilled, knowledgeable and effective workforce
- Inclusion in service design, delivery and monitoring

The action plan attached to the strategy includes a review of the dementia pathway, which clearly maps health, social care and voluntary sector input throughout the dementia journey, the processes and referral routes. The pathway includes the need to ensure that early diagnosis is a priority as well as ensure a full and wide range of post diagnosis services are available to support those with dementia and their carers including the provision of admiral nurses, dementia advisors and specialist mental health support services.

Joint process to assesses and plan for care are in place

All individuals across NEL who have significant health or social care needs, including those who have Continuing Health Care needs, have a named worker who acts as the case manager to coordinate the individual's health and social care needs (including assessment and care planning).

At an operational level providers are working together to develop and deliver integrated services for individuals. A multiagency board has been developed to support the delivery of the area's single point of access (SPA). The organisations involved have worked together to enable co-location of staff to a single point to enable shared learning and development, and has recently appointed an overarching manager who will assume the management of the total team, regardless of their employer. The development of the new assessment tool and support plan described earlier has presented opportunities for joint assessment and support planning. The new tools are being used by staff at focus independent adult social work, Care Plus Group, Navigo and Foundations (drug and alcohol service).

A multi-agency discharge team has been successful in promoting better outcomes and shorter hospital stays for stroke patients expanding the work of the hospital in-reach team, this will provide greater opportunity for joint assessments and support plans. The use of the integrated care record assists in enabling joint assessment and support planning to be developed. A new initiative is also to commence in April 2016 to support clients in residential homes. This will use a multi-disciplinary core team approach (including a GP) to assess and meet the on-going needs of individuals.

Overcoming barriers to joint working

Due to the nature of the section 75 agreement (i.e. health and social care has been commissioned jointly since 2007) health and social care staff already work closely together on many aspects of decision making and as a consequence some barriers have been removed. This has recently been further enhanced by the creation of a number of joint roles across the council and CCG described earlier.

All individuals across NEL who have significant health or social care needs, including those who have Continuing Health Care needs, have a named worker who acts as the case manager to coordinate the individual's health and social care needs (including assessment and care planning).

At an operational level the single point of access (SPA) organisations involved have worked together to enable co-location of staff to a single point to enable shared learning and development and has recently appointed an overarching manager who will assume the management of the total team, regardless of their employer. The use of the integrated care record over the past three years has overcome barriers to joint working. With the consent of the individual both health and social care records can be viewed to assist professionals in identify appropriate provision. Work is also progressing to further develop the intermediate tier, urgent and crisis care services and integrated discharge processes. Social care staff are co-located in primary care centres in close proximity to the district nursing staff to assist in managing long term case management. A joint funding policy is in place to provide appropriate support to individuals who have both substantial health and social care needs and such cases are agreed at a multi -agency decision forum.

The role of accountable lead professional

The accountable lead professional will co-ordinate all aspects of the individual's health and care needs to ensure a seamless and timely response at time of need. This person will be a health professional where the individual has health needs outweighing social care needs and a social care professional where social needs are greater. They will be the first point of contact and be responsible for good clear communication across the individual's support network and to ensure the individual is central to the decision making process. A duty system is in operation for times when the key contact person is absent but with the use of the integrated care record, information is available (subject to consent by the individual) for both health and social care professionals to view. The SPA will be the first point of access/ out of hours access to integrated care record are available.

GPs will be supported in being accountable for co-ordinating patient centred care for older people and those with complex needs

GPs are key to delivery of the support to care homes and those with multiple long term conditions project, which focuses on all those residing within care homes and those with multiple long term conditions living in the community. This scheme relies on GP input into the multi-disciplinary team; each team will include (as a minimum) input from the patient's GP, nurses, social workers, mental health specialists, occupational and physiotherapists and the mobilisation of a wider network of health and social care professionals including speech and language therapists, Admiral Nurses, pharmacists and the third sector which will wrap around the individual in accordance with scheme requirements

The MDT will ensure that all individuals are appropriately supported to ensure their health and wellbeing needs are met. This includes assessments, on-going reviewing and effective care planning as required. It will engage in a programme of training and development to maintain the skills and competencies of the staff involved in the delivery of the service. This will include all mandatory and statutory training, continuing professional development and any other relevant training, including training which is condition specific e.g. dementia awareness, Carers' awareness. The programme of training, supplemented by contribution from the MDT and wider team's expertise, is designed to ensure that GPs feel supported in being accountable for co-ordinating their patients' care.

The impact of systems for people with Dementia and mental health problems

There is dedicated assessment provision for those with dementia and mental health problems. In focus Independent adult social work there are two specialist dementia practitioners who work closely with those with dementia and their Carers and with the specialist dementia services across NEL to ensure robust assessment, care planning and review is carried out for those with dementia and their carers. NAViGO mental health social enterprise deliver integrated mental health and adult social care needs assessments for those with functional mental health problems. In addition we have a dedicated carers mental health assessment worker who ensures Carers' needs and wishes form part of the service user assessment; where necessary this worker will also undertake a dedicated Carers assessment.

Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

All of this year's BCF schemes are a continuation of last year's work building on our long term strategy for integrated delivery will be:

- Additional staff resources to deliver 7 day working projects. These have been agreed in consultation with local professionals (see for example the first phase of extended GP working, which has been adopted by a collaborative of GPs working together)

- The support to care homes scheme represents a significant change to the way in which professionals have traditionally interacted with care homes and their residents. The scheme's vision, model and implementation plan was developed by an implementation group which includes a range of professionals. Presentations and regular updates on the scheme have been offered to care home providers, many of whom welcome the opportunity to work more effectively with other external professionals
- The SPA Board comprises clinical staff, commissioners, representatives from the community and all key providers (e.g. focus, Care Plus Group, Navigo, NLaG, Core Care Links, Yarborough and Clee Care, primary care). The board will continue to develop the SPA vision and forward plan with the newly appointed manager.

Public and patient and service user engagement in this planning, as well as plans for political buy-in

Each of the BCF schemes has some level of community/ patient/ service user involvement either in the on-going management and monitoring, or in the inception and launch of a new scheme. The majority of the schemes include their own communications plans. The CCG's commissioning intentions for 2016 onwards (which includes health and social care) are being launched at a public engagement event in March 2016. An engagement plan, developed in cooperation between the CCG and the Council, will deliver activities across the coming year.

The health and wellbeing board received a report on progress for BCF in the year ending March 2016, and is poised to receive further updates at the next board meeting. The board is aware of the outline of the coming year's plans, and the portfolio holder has also been kept updated. In the lead up to implementation of the Care Act 2014, elected members were engaged in a series of information and discussion sessions. The principles within the Care Act, most notably in respect of integration and cooperation, underpin the BCF and provide its legislative foundation. Awareness of these principles formed part of members' briefings.

Demonstrate that the plan aligns to provider plans and the longer term vision for sustainable services

As described earlier, all local commissioners have signed up via a memorandum of understanding to working as whole system to deliver better quality sustainable services and a system plan was jointly developed in December 2015. Since then partners have been working towards an agreement to create an accountable care system in Northern Lincolnshire, which will have a place based focus and will be capable of creating collaboration across footprints. Our BCF plan is entirely consistent the HLHF programme in joint partnership to plan and deliver a sustainable system.

Demonstrate that mental and physical health are considered equal, and plans aim to ensure these are better integrated with one another, as well as with other services such as social care

Within the adult social care strategy we articulate our ambition for parity of esteem in relation to physical and mental health social care services. We have adopted the 6 principles of 'no health with mental health' within our health and wellbeing implementation plan. Our BCF plans show that our assess processes are well designed to take account of the full range of clients' needs. Through BCF we have also demonstrated that we are focussing on the specific needs of individuals' presentation with either mental health issues, confusion or dementia symptoms.

Clear alignment between the overarching BCF plan, CCG Operating Plans, and the provider plans

As described earlier we have worked with our commissioners and provider partners to establish a system wide plan via the HLHF programme; our STP, CCC plans and BCF plans are all congruent with the wider vision and the system. We have developed a memorandum of understanding which facilitates the starting date, including financial plans between commissioners and providers. In this way we can optimise resource, co-ordinate our activity and avoid cost shunting between organisations.

R**eassurance that any projected reductions in planned emergency activity are feasible**

The HLHF plan schemes form the basis for emergency activity reductions and have been modelled on the basis of identifying 'avoidable emergency admissions'. The HLHF governance structure includes groups that have focused on this modelling and the feasibility of its phasing over coming years with the addition that these assumptions have been further tested with the CCGs Council of Members

Confirmation that this provider is implementing their own risk management and action plans to respond to any planned change in activity

Planned changes to activity for any provider will be part of the central planning and oversight of the SRG. Variation from planned activity that occurs during improvement implementation will be managed as a risk and risk response to progress and this will require providers own risk management and action plans as well as the risks and risk responses that are shared, managed and overseen by the SRG.

Demonstrate a shared understanding of the critical path to successful delivery

SRG oversight of capacity and demand planning is on the basis of provider collaboration across the whole system. The critical path to successful delivery is that each part of the system is improved together with shared outcomes rather than small pieces of the system being improved in isolated areas.

Local risks and how these are being managed / shared

Local risks are demand and capacity based, particularly 7 day working and resilience and collaborative working based where joint working on effective improvement will require improvement of service that is sustainable. The risks of these types will be shared and managed through the oversight of the SRG.

Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care

The schemes in place were agreed in 15 16 and are in line with the national conditions guidance. We can confirm that this is clearly set out in the summary and the expenditure plan tabs of the BCF planning return template

Local risk sharing arrangements

A local risk sharing agreement ins in place as part of the section 75 agreement describe earlier. The £363k contingency funding has been reduced from 15/ 16 to reflect the risk sharing arrangement under the MOU that we have in place in Northern Lincolnshire.

NHS commissioned out-of-hospital services and services that were previously paid for from funding made available as a result of achieving their non-elective ambition, continue in a manner consistent with 15-16

Not applicable as we did not achieve our planned reduction in non-elective activity in 2015-16.

The value of NHS Commissioned Out of Hospital Services in 2015-16, compared to plans for 2016-17

This is analysed in the BCF template

Impact of any changes to the level of investment in NHS Commissioned out of hospital services

No material changes as schemes have rolled forward from 2015-16.

P4P performance in 2015-16 and how this has been used to drive the local decision on how to use this portion of the fund

The £0.5 million contingency in 2015/ 16 had to be used to fund non elective activity as we did not achieve our planned reduction in activity in 2015/16. The schemes have remained unchanged for 16 17 as they are felt to be key building blocks in the HLHF.

Local action plan to reduce delayed transfers of care (DTOC)

ASCOF figures demonstrate that NEL's DToC score (7.1) is significantly lower than the England average (11.1).

DToCs have been under scrutiny for two years in terms of:-

- How the CCG performs within the national DToC reporting framework
- What are the onward care pathways that contribute to the most DToCs
- What are the process issues contributing to DToCs
- How to build on the integrated working to secure further reductions in DToCs
- The guidance, best practice and requirements of The Care Act, BCF etc.
- Locally driven plans for service reconfiguration to reduce DToCs.
- Resilience planning

This has contributed to the development of a plan for further transforming discharge planning and onward care which forms part of the overall commissioning intentions for the out of hospital urgent care system and resilience. This broad plan will take and build on existing provider led work streams on DToC management over the transformation period of 2 years and focus on the five priorities for transforming discharge planning and onward care:-

- A discharge hub is required that is a single point of access for DPoW operations and is accountable for the organisation and timely establishment of the onward care needs of complex discharges – this will transform the associated processes
- All provider approach to "assess from admission"
    - Acute - review and estimated date of discharge
    - Acute – morning focused process to secure bed base for new admissions
    - All – weekend process to secure higher weekend discharge rates
    - All – relevant MDT working towards EDD
    - All – due reference to the DToC definitions and charging legislations to ensure agreed processes meet the requirements
- Information & advice on discharge implementation of SRG review ref Care Act requirements
- Contract/service alignment such that assessment/service start is planned at EDD not after

(domiciliary care, residential care, adult social care, therapy, home team)

- Services
    - Intermediate Tier service development – integrated all service step down/rehab, Discharge to Assess (bed & home supported by Enhanced Home Care)
    - Housing, equipment, out of area, EoL fastrack

The local area has an overall transformation plan that includes DToCs within it. The community has been working together to address the issues that have been identified as causing DTOCs, which include:

- Increasing the timeliness of domiciliary care provision to support discharge, and to enable packages to be initiated at the weekend.
- Establishment of an Hospital In-reach Team (HIT), who are proactively supporting discharges on the wards.
- Increased intermediate care / step down bed based care.

These principles have now been agreed by the NEL SRG.

The first principle on the development of a Discharge Hub has been prioritised with an outline action plan as follows:-

Plan Item	**Lead**	**Planned By**	**Status**
Secure SRG agreement on plan principles	CCG	June 2016	Complete
Establish suitable premises for co-located Discharge Hub Team	CPG/FOCUS	June 2016	Complete
Establish initial teams and set other team inclusion – minimum exiting Home and ASC in-reach teams	FOCUS	June 2016	Complete
Initial teams to move from their existing location	CPG/FOCUS	June 2016	Complete
Arrange access through NEL SPA first level selection menu via 256256	FOCUS	June 2016	Complete
Publicise team existence to Hospital Ops centre	FOCUS/DPoW	June 2016	Complete
Deploy Web V and agree protocols on how admission alert will be provided, reacted to and what other interaction will occur in reference to current notifications	DPoW	July 2016	In Progress
Add further teams (e.g Haven team)	FOCUS	July 2016	Incomplete

Secure arrangements for Dom Care provider liaison within the Discharge Team function	CCG/FOCUS	July	Incomplete
Review effectiveness of Discharge Hub to date	CCG/CPG/FOCUS	August	Incomplete
Align further enhancements to plans on Principles 2/3	CCG/CPG/FOCUS	August	Incomplete

Detailed action plans for the remaining principles are being agreed with a separation of what is "rapid deployment" and what is longer term.

Stretching local DTOC target -agreed between the CCG, Local Authority and relevant acute and community trusts

The locally agreed target that is being specified in CCG planning is to extend the annual DToC reduction trajectory by 3.5% (total bed days – all health and social care attributable). The plan to deliver the target will be finalised with all providers to NEL SRG. There is no other target than the 3.5% set by CCG. The area already performs well in relation to DToCs. We recognise that some of the remaining actions will take some time to implement as they include securing additional intermediate care bed facilities.

The plan is within the context of the System Resilience Group plan for improving patient flow the target is reflected in the CCG operational plans

The3.5% target is reflected in CCG operational plans. Although the CCG isn't asked to set a target in its operation plans, we are including this measure in the Quality Premium and this target will align to the BCF plan.

The SRG and commissioning intentions recognise the importance of an overall system approach to performance through collaborative working. This means that in addition to a focus on the desired Discharge Planning and onward care services plans to support a reduction in DToCs, there are also plans to reduce avoidable admissions through the commissioning intentions of the Out of Hospital Urgent Care response and on overall resilience which are multi-agency.

Out of hospital urgent care response plans focus on the 3 main urgent care access points (Urgent GP request to own practice, urgent walk-in (not emergency but currently going to A&E) and access via NHS111 and the NEL SPA). The community crisis response and the way it operates across all of these access demands is being shaped to consider 24/7 working and any agreed variations of service in the traditional out of hours period. These community crisis response plans focus on primary care and community service providers across all disciplines (health, adult social care, mental health, EoL and Therapies etc.).

The development of an urgent care centre, collocated with A&E is also planned to provide the same level of community crisis response but also change the assessment unit approach to ensure continuity of care and opportunity for an alternative to admission to be established in a primary care/community care

setting with access to diagnostics and consultant advice. In hospital management will require improvements to consultant review for those admitted and collaboration in implementing a process for estimated date of discharge and MDT discharge processes as part of the plan to assess from admission. Hospital review will also need to support a higher level of weekend discharges.

The DToCs reduction target is one of the key outcomes of the overall transformation plan that considers patient flow and includes the out of hospital crisis response (admission avoidance, attendance avoidance, and conveyance avoidance), urgent care centre (reducing A&E crowding) and transforming discharge planning and onward care. The role of the urgent GP response is built into these elements including GP out of hours.

The DToC plan is part of the area's overall transformation plan, which focuses on improving patient flow and experience across the whole system. A performance dashboard has been developed, which includes within it DToC information, as well as A&E performance, ambulance hand over times, etc to enable a system wide view to be monitored and reviewed at the SRG meetings, which all partners attend.

Under the 7 day service plan, SRG will have full oversight of the discharge plan.

Local risk sharing agreements with respect to DTOC

Due to our local arrangements of joint commissioning of health and adult social care, historically we have not used the penalties for delayed discharges. We have the Provider MOU which covers the risk sharing remit.

As provider collaboration develops, risk sharing arrangements will be considered by NEL SRG/CCG though accountable care models described earlier reduce the need to do this in future.

The detailed plans are reaching a stage of maturity through publication of the commissioning intentions and as oversight of these plans and others is managed through the SRG where discussions and agreements will continue in the coming months. The SRG has representation from all relevant providers and will be accountable for delivery and oversight of work streams, holding each to account, monitoring the overall DToCs performance trajectories and other measures and assurances required by each work stream.

National guidance and best practice, including the eight 'high impact interventions' that were agreed by ECIP

The five priorities for transforming discharge planning are fully inclusive of national guidance and imperatives:-

- Care Act *(Joint working, notifications and charging)*

- NHSE Guidance on best practice in discharge planning *(Joint working, Discharge to Assess)*
- NHS "Safer, Better, Faster" guidance on implementing Urgent & Emergency Care *(Intermediate Care, EDD, MDT and review process)*
- NHS Commissioning Standards for Integrated Urgent Care *(Admission Avoidance)*
- SRG 8 High Impact Interventions/7 day services *(weekend and midday discharge targets)*

The guidance has been interpreted in the local context of significant collaboration and joint working already in place.

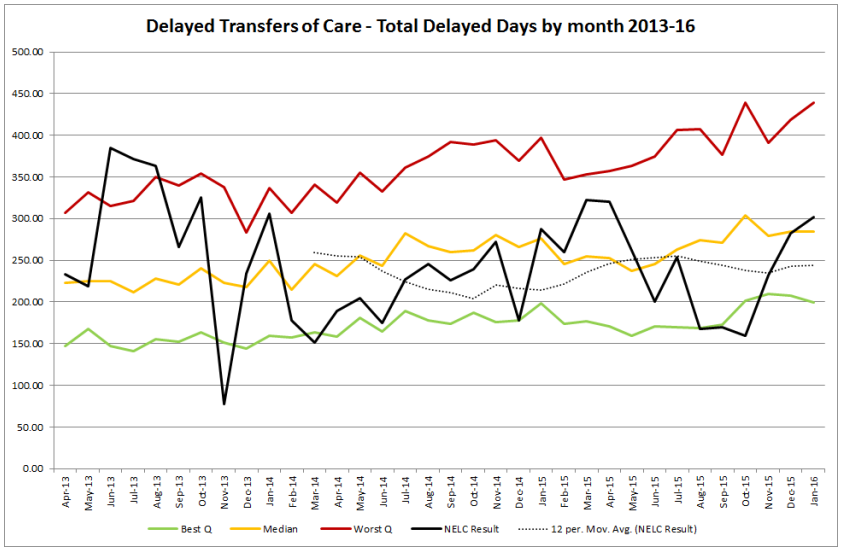
Engagement with the independent and voluntary sector providers

Through the SRG and via conversations with executive officers of the provider organisations, the CCG has engaged the acute trust, community trust and other relevant individual providers to determine the actions required to address the DToC position for inclusion in the overall transformation plan. The reduction has been built into the local acute trust activity plan.

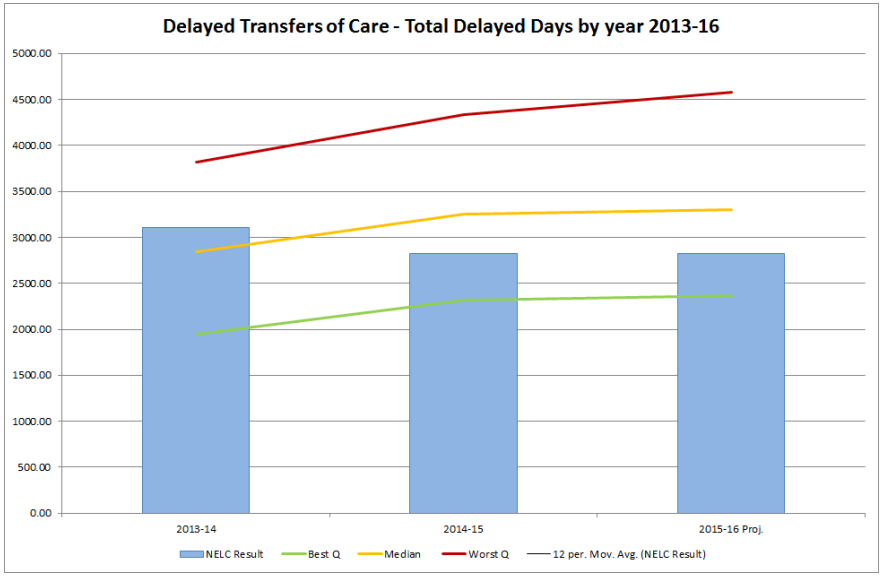
The NEL SRG has engaged with the local alliance of voluntary/independent providers and agreed that closer working and involvement in the design of home based services is paramount. As a result, the SRG has invited the voluntary sector alliance to be represented permanently on the SRG and partake in the relevant aspects of system transformation. The plans will require further input from the voluntary sector to secure additional home support for patients being discharged. Contributions from the voluntary sector include ensuring that there are the food basics at home for when someone is discharged.

Situation Analysis

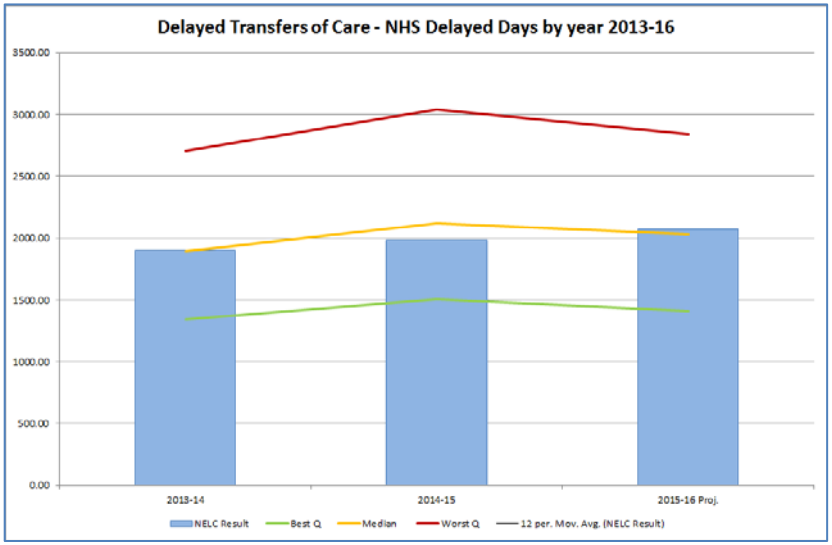
Overall Performance

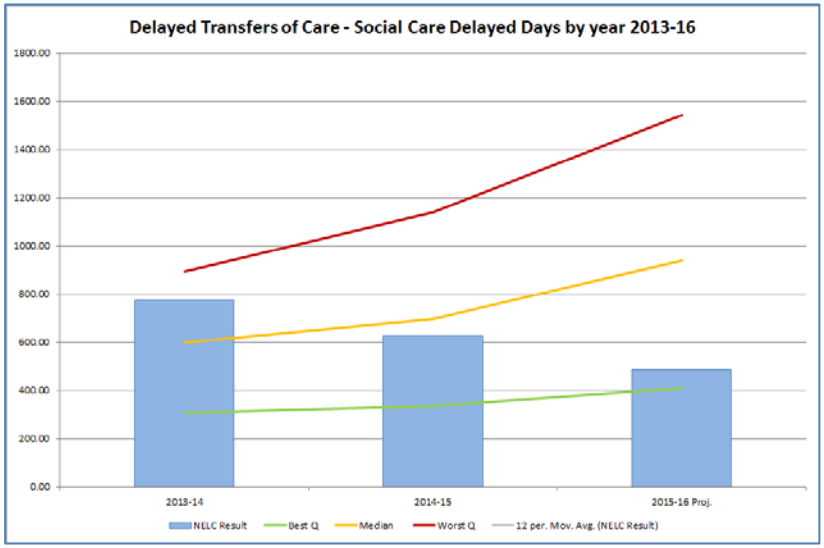


For the last two years, average overall performance has been between the median and best quartile performance however notable degraded performance on a month by month basis occurs at times when the local health and care system was under extreme pressure, notably Easter 2015 and the current winter period.



On a year by year basis, NEL performance has improved since 2013/14 against a national worsening quartiles picture. The following similar graphs split out those delays attributed to adult social Care or NHS care and show that the balance and movement to be the NHS attributable delays to require the main focus for our improvement plans. These have worsened against a backdrop of national improvement whereas adult social care attributable delays have improved against a backdrop of national worsening. Underlying monthly analysis shows the NHS care performance to be a result of prevailing pressure on the whole system.





Analysis - underneath the reported numbers

Particularly at times when there is most pressure in the whole system (Q4), there are two clear onward paths that have the highest number of patients regularly present on a daily basis (Note here an assumption that this translates into the largest number of DToC bed days) :-

1) Patients waiting for "The Beacon" bed based rehab services

   This is subject to a (limited) SRG escalation process dependent on resources and often reduces but not eliminates the queue

2) OOH patients requiring assessment or hospital/care placement – in particular Louth Hospital

   These appear as a significant contribution on daily data – **Note – these OOH patients do not appear on the NEL data however are a key cause of lost bed days.**

Waiting for assessment across all disciplines is the next ranked issue. Summed together this is significant. Next is waiting for a care package. There is a margin for error here in terms of assessing the detailed contribution of this across the teams as there is some room for interpretation between the daily unreported delays and the translation into nationally reported SITREP. This is an area that is being targeted for further analysis to confirm assumptions. Other regular, but less significant causes are waiting for specialist equipment and Care Home repatriation.

Capacity

The local system (in common with others) exhibits an annual flow issue in Q4. Flow through the hospital is compromised which brings DToCs into focus as each lost bed day adds to the problem. This period also brings with it deterioration in A&E performance and handover delays. Whilst DToCs contribute to this pressure and should be eliminated as a factor, it is neither the cause nor the entire solution to the Q4 flow problem. There are clear capacity limitations within the onward care pathway – esp. bed based rehab services and domiciliary care package delays. The former is usually considered a bed base limitation as queues are evident however the solution is not framed as additional bed capacity but on a consideration as support at home, discharge to assess (home), IC at home etc.

Resilience across the 12 months should be based on an improved model of capacity and demand and due reference to how, when care at home is optimised, additional capacity can be added to the system on-demand. Discharge to Assess has not yet been implemented formally and national lessons are clear that this should not simply move a problem elsewhere. There needs to be a clear process for identifying those patients who would benefit from an assessment of future care needs post discharge, how support at home would differ from what is available now and if there is a case for step-down community capacity to support this. Areas that have implemented this well seem to have focused on specific cohorts.

Current Schemes in place to reduce delays

In addition to the on-going capacity and demand considerations of service providers and assessors involved in discharge planning, specific initiatives/schemes established to reduce delays include integrated community assessment teams supporting hospital operational centre. Adult social care and intermediate tier have both established in-reach teams supporting the assessment of patients for complex discharges. This team works closely with the hospital operational and bed management team on a daily basis to optimise planning and to consider process and referral issues – including notifications. The home from home step-down ward (dementia & confusion) has been established to enable early supported discharge for patients meeting the service criteria. A key element is the aim to transfer the end stage of acute care to the unit allowing for hospital discharge into the “community” facility and onward management home.

Resilience schemes agreed and adopted by NEL SRG include the use of resilience funding to support short term placements of those fit for discharge but waiting for bed based rehabilitation services – this is particularly relevant to winter resilience where demand for the bed based rehab services can be significantly higher than the average. Additional capacity for domiciliary care providers ensures responsiveness in starting/re-starting home care packages for those being assessed as requiring such on discharge.

The assisted living centre supports the early and timely provision of equipment including for those whose discharge is being planned.

There has been an overall reduction in the average level of delayed bed days over the last two years compared to 2013. Peaks occur where the whole system is under pressure, especially during the winter period. The above mechanisms are thought to have contributed to reducing delays, however, the plan considers further schemes and arrangements aimed at reducing delays. The focus of plans is to ensure the whole system has systematic improvements but also that the NHS care pathways are improved. Any risk sharing agreements will be defined under developing provider cooperation arrangements.

The situation analysis has considered national comparators however this is not seen as a significant driver to extend targets as a zero tolerance approach is the necessary basis for considering all factors that contribute to delayed transfers. Taking possible measures and negative pressures of increased activity into account the target extends the trajectory set in previous years and is aligned with the CCGs transformation targets for total bed day DToC reductions.

Accountability arrangements

These are to be agreed through the SRG

Is there read across to other local plans which will improve patient flow and support local performance?

Yes - the DToC reduction plan is one element of the overall transformation plan which considers patient flow from the point of crisis episodes, hospital avoidance schemes and discharge planning/onward care.

Analysis of local capacity and requirements

The SRG is currently holding a series of multi-agency workshops that will produce an agreed set of demand/capacity and workforce models, based on improved collaborative working and the reshaping of local services to deliver the required improvements.

The principles of the DToC plan have now been agreed by the NEL SRG.

Analysis of how capacity can best be used across health and social care to minimise DTOC and meet evolving need?

Under continuing local arrangements in NEL, health and social care is already jointly commissioned. Operational integration is in place and being developed further at points in the system where patients access urgent care, in the response and, should admission be required, in discharge planning and care coordination. Whilst capacity may need to be adjusted for planned demand and variation (resilience), the joint working approach supports the optimised use of available capacity. Longer term it is desirable that further support for efficiency and sustainability is delivered by moving to one form of the accountable care organisation model.

The role of the voluntary and community sector can play in supporting patients to remain in their own home or return there more quickly following a period in hospital

The SRG has acknowledged, based on engagement and best practice guidance, that additional voluntary and community sector support will play a vital role in supporting patients to remain at home or return quickly following a period of acute admission. The SRG has formally invited representatives of the voluntary sector to become permanent members of the SRG and the current series of SRG workshops considering capacity, demand and workforce will consider current gaps in home care that prevent people from remaining at home or having early supported discharge. The role of the voluntary sector will be central to considering how these gaps are resolved.

Scheme level spending plan

Does the narrative plan provide sufficient assurance that detailed plans are in place for each of the schemes set out in the spending plan?

Yes

Does the narrative plan include reference to how these plans are aligned with, and included in, CCG operating plans for 2016-17?

Yes

National conditions

Non-elective admissions (General and	Minimum	E.1.i	i. Has a target been set for this metric as part of the BCF Planning Return template?	BCF planning return	Confirmation from national team that KLOE has been met	

Acute)						
Non-elective admissions (General and Acute)	Minimum	E.1.ii	ii. Does the narrative plan include an explanation for how this target has been reached?	Main BCF submission	Approach to setting NEA plan set out	The approach to setting NEA plan aligns to the CCGs modelling of activity and takes in to account the view of NHSE on NEAs. It also considers the information in the IHAM model. The plan has been built on previous activity and analyses previous trends. Impact of initiatives has been modelled and sense checked with clinicians through the CCGs Council of Members and other groups.
Non-elective admissions (General and Acute)	Minimum	E.1.iii	iii. Does this include an analysis of previous performance and a realistic assessment of the impact of BCF initiatives on performance in 2016-17?	Main BCF submission	Previous performance and impact of schemes set out	
Admissions to residential and care homes;	Minimum	E.2.i	i. Has a target been set for this metric as part of the BCF Planning Return template?	BCF planning return	Confirmation from national team that KLOE has been met	
Admissions to residential and care homes;	Minimum	E.2.ii	ii. Does the narrative plan include an explanation for how this target has been reached?	Main BCF submission	Approach to setting residential admissions metric plan set out	The admissions to care homes plan has been set in conjunction with the Local Authority, CCG and Social Work Practice. Although looking to minimise admissions wherever possible and appropriate, NEL need to balance this with choice and budget management. This plan has considered previous performance, benchmarking information, planned changes to policies and the impact of the Care Act. It also takes in to account recent changes to definitions on this measure.
Admissions to residential and care homes;	Minimum	E.2.iii	iii. Does this include an analysis of previous performance and a realistic assessment of the impact of BCF initiatives on performance in 2016-17?	Main BCF submission	Previous performance and impact of schemes set out	
Effectiveness of reablement;	Minimum	E.3.i	i. Has a target been set for this metric as part of the BCF Planning Return template?	BCF planning return	Confirmation from national team that KLOE has been met	
Effectiveness of reablement;	Minimum	E.3.ii	ii. Does the narrative plan include an explanation for how this target has been reached?	Main BCF submission	Approach to setting reablement metric plan set out	The plan around effectiveness of re-enablement continues to be an area where NEL perform well and the plan set in the BCF looks to maintain performance in the best quartile of LAs.
Effectiveness of reablement;	Minimum	E.3.iii	iii. Does this include an analysis of previous performance and a realistic assessment of the impact of BCF initiatives on performance in 2016-17?	Main BCF submission	Previous performance and impact of schemes set out	
DToC						
Agreement on local action plan to reduce delayed transfers of care (DTOC)	Minimum	C.8.iv	This target is reflected in CCG operational plans?	Main BCF submission	Confirmation provided that this aligns to CCG plans	Although CCG aren't asked to set a target in their operation plans the CCG will be including this measure in the Quality Premium and this target will align to the BCF plan.