

North East Lincolnshire

Integration and Better Care Fund

Narrative Plan 2017/19

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Contents

Background and context to the plan..... 3

What is the local vision for and approach to health and social care integration? 7

Evidence base and local priorities to support the plan for integration 11

Better Care Fund plan 14

Risk..... 19

Overview of funding contributions 26

National Metrics 29

Delayed transfers of care (DTC) plan 32

References 38

Approval and sign off..... 38

Introduction/ foreword: a mature system of integration

Over the past 10 years, North East Lincolnshire Council and North East Lincolnshire Clinical Commissioning Group ('the Partners') have developed a strong and lasting partnership with a proven ability to work together to deliver innovation. We have gained confidence that we can implement further change. As a mature system we have expressed an interest in the graduation from Better Care Fund (BCF) and this narrative plan is prepared to provide clarity of direction and articulate further plans to build on the work already in progress.

All BCF initiatives continue to demonstrate their contribution to on-going transformation and the goals set out within the Northern Lincolnshire transformation programme, Healthy Lives Healthy Futures (HLHF), local strategies for adult social care and health and wellbeing, and the Partners' strategic plans.

North East Lincolnshire's (NEL) pre-BCF arrangements represented more advanced integration of health and social care than anywhere in the country. Formal arrangements between North East Lincolnshire Council (NELC) and North East Lincolnshire Clinical Commissioning group (NELCCG) began in 2004 with mental health service commissioning; provision was expanded in 2007 to include adult social care, public health, and children's services, underpinned by a Section 75 agreement.

We have aligned adult social care to the wider vision for health and wellbeing locally. The delivery of an enhanced out of hospital model which enables health and care professionals to provide more joined up services within communities forms the basis of our system wide model of care.

Our whole system approach enables local realisation of the NHS Five Year Forward View, depicted by the below 'funnel of transformation' (shifting health and care provision closer to home wherever possible: see Figure 1). We set out within this narrative plan the way in which we are developing our model, to underpin the vision set out in our previous BCF plans.

We envisage more innovative and collaborative ways of commissioning services appropriate to economies of scale, enabling improved quality for service users and more flexibility to move resources to where they are required to meet the overall strategic objectives.

Integration in NEL is not dependent on BCF; integration will continue because we believe that integrating public service delivery across organisations provides the best opportunity for sustainable finances, improved outcomes for citizens and realising aspirations for growth and prosperity.

Background and context to the plan

Our developing integration model

Historically, local arrangements may have been described as a lead commissioner model (based on delegation of functions by each partner – NELC/ NELCCG - to the other); this has been supported by specialism based commissioning such as mental

health, community and intermediate care. In fact, our developing model has expanded beyond its original parameters, and now incorporates elements of other models outlined in the BCF policy framework.

Developments since the inception of NEL's integration in 2007, which form the background and context to our burgeoning plans, may be divided as follows:

- Developments via Healthy Lives, Healthy futures (HLHF)
- Developments via the accountable care partnership (ACP)
- Developments via the enhanced partnership between NELC/ NELCCG (union).

HLHF

BCF is reflective of the aims agreed via the HLHF programme, to invest in the further integration which will help shift emphasis and activity away from hospital and other commissioned settings. Intrinsic to the HLHF vision is that people should be enabled to get back to managing their own health as quickly as possible.

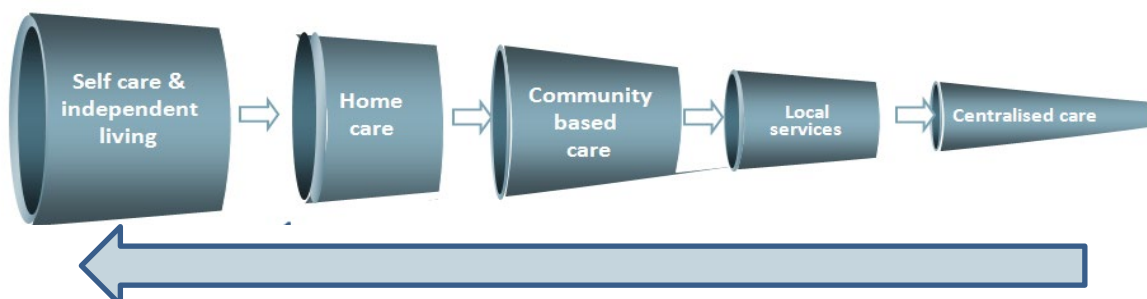
HLHF offers an alternative approach in which the people of NEL are enabled to live independent healthy lives, to support one another, and to take control of their own health. When they do need health and care services however, these are targeted as follows:

- 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
- Easier access to relevant services 24/7 through the implementation of seven day working at a 24/7 single point of access (SPA).

NEL's adult social care approach is aligned to the HLHF vision for health and wellbeing, focusing on prevention, putting the community at the centre of service re-design, and supporting people to take greater responsibility for their own wellbeing.

The HLHF vision is represented in the below 'funnel of transformation'. This vision, set out in our previous BCF plans, remains key to current and future planning.

Figure 1. The funnel of transformation



Accountable care partnership (ACP)

A more recent development is the creation of an ACP, which will enable providers to develop more seamless service pathways under a capitated budget, facilitating better use of resources for people with multiple conditions.

Led by local providers, a legally binding agreement has been created between organisations committed to working co-operatively within a legal structure: an ACP. Together (North East Lincolnshire) Ltd is a community benefit society comprising NEL's key providers NLaG, Care Plus Group, Navigo and focus CIC independent adult social work. Together Ltd is the vehicle through which the objects of the ACP will be delivered, including delivery of key elements of the overall place plan for NEL. Other providers who are key to delivery of this local vision (e.g. general practice federations), are taking part in regular meetings and planning to join Together Ltd.

The ACP will enhance providers' ability to influence the delivery of BCF, and to have a more direct impact over the implementation of service changes and improvements, leading to better system integration. The ACP will work co-operatively to reshape pathways, redesign delivery models and radically realign resources to ensure that people receive responsive, consistent and high quality care.

By April 2020 the strategic commissioner (the Partners) will establish a single long term contract with a weighted capitation budget, with the ACP. The ACP will then make or buy services to deliver outcomes set out within the contract. Work streams and detailed project plans are being created to support the ACP's development. A new approach to strategic commissioning will revise the partners' roles and responsibilities. Initial priorities for the ACP have been agreed as:

- Support to nursing and residential care
- Urgent care and
- Dementia care

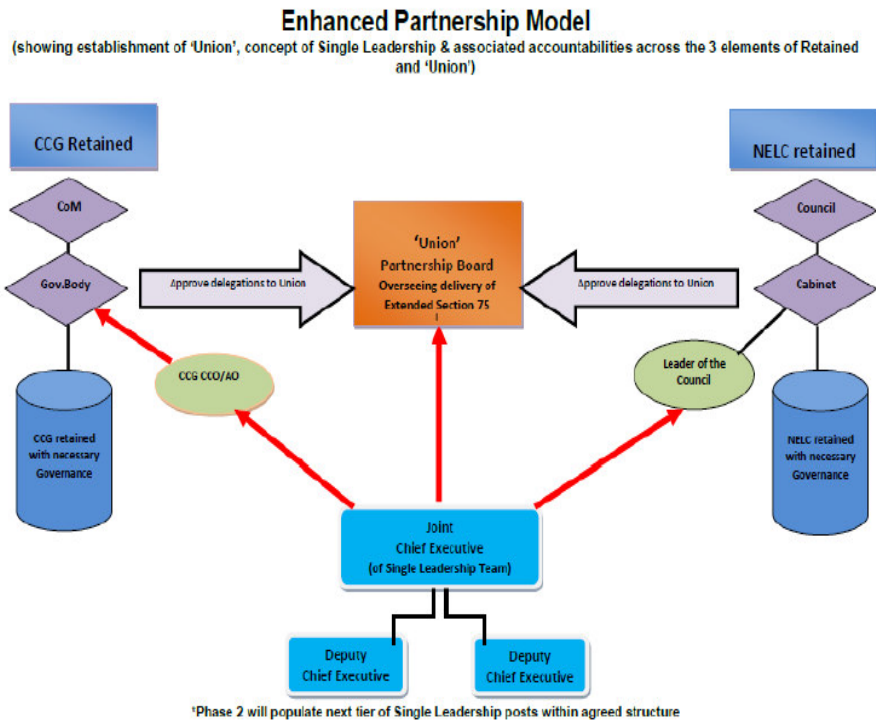
Council and NELCCG union

Consideration has been given to the shape of further integration, and to the Partner's management structure set out within our last BCF plan (see page 15). Following an options appraisal, it is agreed that an enhanced partnership with single leadership team best supports shared ambitions. This model, now formalised by NELC's cabinet and NELCCG's governing body/ council of members will operate in shadow form with effect from 1st September 2017 with a formal "go live" date of April 2018. A joint chief executive was appointed in July 2017.

The principles underpinning the enhanced partnership model, or "union", include:

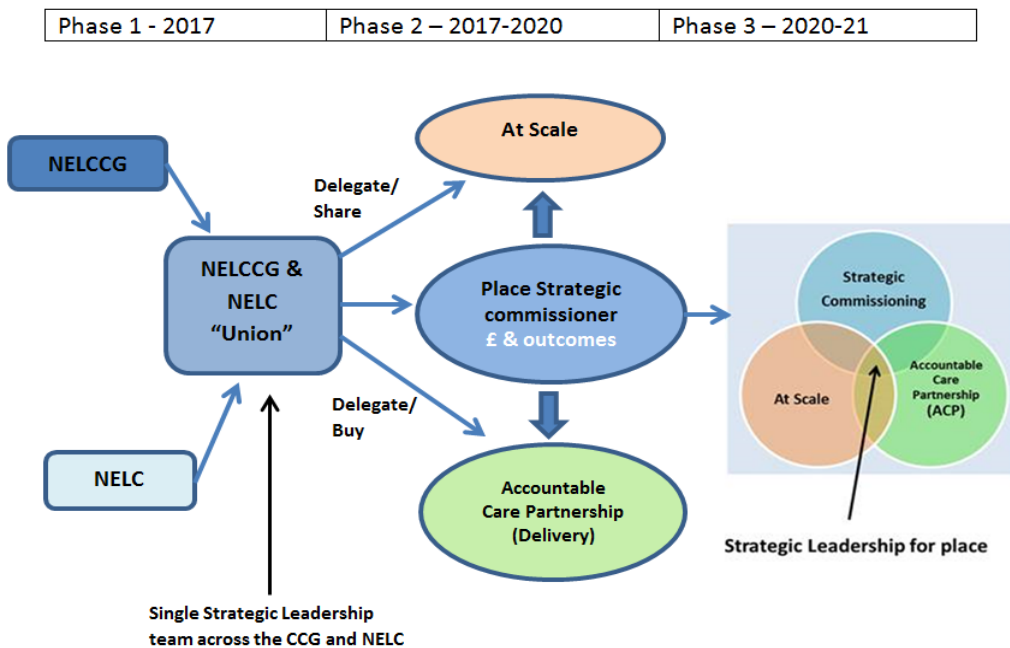
- Continuance of the two statutory organisations (NELC and NELCCG) which will discharge their retained responsibilities and necessary statutory governance and assurance mechanisms – no new organisation is being created
- Formalisation of arrangements via an extended Section 75 agreement to include as much as statute permits, so the Partners can better shape/ manage pooled duties and resources and harness greater commissioning power
- Development of robust and unambiguous governance arrangements designed to add value, and reduce the burden of governance, process and delivery
- Creation of a powerful 'single voice' during the wide scale reform represented by the development of the ACP and sustainability and transformation plan (STP). The STP's complementary aims remain as set out at page 11 of our last BCF plan.

Figure 2: the enhanced partnership or “union” model



The ACP and “union” of NELC and NELCCG will enable a stronger place based focus. Diagram 3 below shows how the model will operate within the wider context of the STP footprint to achieve wider system efficiencies and benefits.

Figure 3: interaction between the union, ACP and STP (commissioning ‘at scale’)



The benefits we envisage from the “union” model include:

- Whole system approach to health, wellbeing and planning across the life course
- More efficient use of estate
- More effective use of combined workforce and skill-set
- Improved access to key levers and decision makers across the system, to allow more proactive and informed decision making.

The Partners will further their plans in the current year to align management and commissioning as described at figures 2 and 3.

What is the local vision for and approach to health and social care integration?

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 development of our vision can be tracked across the HLHF programme, creation of the ACP and union. Via HLHF, we adopted a system wide approach to delivering integrated and sustainable services intended to produce better quality outcomes for our local population within available budgets. Further integration via the ACP and union will create additional efficiencies, improve cooperation and coordination across the system and enhance patient/ service user experience.

This alignment of this vision and approach with other plans (such as the health and wellbeing strategy) continues as previously set out. However, the biggest change since our previous BCF plan is the Partners' increasing focus - including via development of the ACP - on a place-based approach for the benefit of NEL as a whole. The union is intended to provide a firm foundation for achievement of the previously adopted outcomes framework and shared vision. The framework and vision are wider than, but crucial to, delivery of health and care integration.

The place-based approach is underpinned by five key outcomes which all partners in NEL have signed up to. These are that all people in NEL will:

- Enjoy and benefit from a strong economy
- Feel safe and are safe
- Enjoy good health and wellbeing
- Benefit from sustainable communities
- Fulfil their potential through skills and learning

In terms of the impact our approach seeks to effect, the Partner's shared vision for the people of NEL is:

“We want people to be informed, capable of living independent lives, self-supporting and resilient in maintaining/improving their own health. By feeling valued through their lives, people will be in control of their own wellbeing, have opportunities to be fulfilled and are able to actively engage in life in an environment that promotes health and protects people from avoidable harm. Access will be made available to safe quality services that support and restore people back to optimal health or support them to a dignified end of life, as close to home as safety allows: services that are part of a sustainable health and social care system which directs resources according to need.”

Two examples may illustrate the practical application of our vision:

- **Information and advice:** by ensuring that all citizens can access the advice, information and help they need, we aim to support people to keep well, directing them to preventative services wherever possible. We are working to strengthen the local public health offer – which includes provision of information and advice and a wellbeing service - by ensuring that this is focused on prevention and early intervention, rather than treatment services. Performance measures have been developed against which to measure an integrated information and advice offer, along with creation of a charter, to which it is hoped all local providers of information and advice will shortly subscribe (across the health, care and voluntary sectors).
- **Assessments and resource allocation:** as noted on page 29 of our previous plan, we use an integrated assessment approach which is asset based, focusing on wellbeing and prevention. By promoting individual and community capital, it is intended that the assessment approach will produce better outcomes and value for money. Our previous plan also makes reference (at page 6) to our revised policy on micro-commissioning, the aim of which is to encourage a focus on resilience and wellbeing in all front line assessment and care planning (social care, mental health and continuing healthcare). A programme of public and staff engagement has been delivered with regard to this policy, to support development of the cultural change required to embed a strengths-based approach across the sector.

Progress to date

All BCF schemes work collectively with other initiatives within NEL to deliver our overall objectives for health and social care.

Assisted Living Centre (ALC – community based equipment service): the continuing development of the ALC has enabled more people to access equipment and technology, supporting them to live safely at home and to seek help when needed. Footfall in 2016/2017 further increased to a total of 4157 people (professionals and community members) visiting throughout 2016/2017. 100% of low level assessments are undertaken at the time of presentation at the service. Self-purchase items in 2016/2017 totalled £5,469, 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. User feedback remains positive; in 2016/17, all accessing wheelchair services via the ALC were 'extremely likely' or 'likely' to recommend the service. In quarter 1 (2017/18), 100% of wheelchair users were extremely likely to recommend the ALC.

Extra care housing (ECH): NEL's first scheme has featured as a positive national case study in the housing learning and improvement network. Outcomes for residents are proving to be beneficial in terms of improved wellbeing and fewer non-elective admissions.

Further schemes are in development although their delivery has been delayed due to difficulty in identifying suitable land in the right locations for the schemes. Additionally, there is very little appetite for housing providers to work with councils in

the climate of uncertainty around changes to housing benefit. Proposed welfare reforms are likely to impact not just the overall ECH scheme viability, but also the appetite of local housing providers to engage with and manage such schemes.

The Partners are also exploring other routes to delivering extra care and specialist housing. NELC is currently in the process of developing a policy to ensure that the local housing allowance will be strategically aligned to the provision of future supported housing. We have been working to develop a new housing strategy for the borough which will not only recognise the needs of an increasing number of older, frail and vulnerable people in the community, but will also ensure that alignment of local planning, resources and policies enables specialised and adopted housing to be more seamlessly delivered, for the benefit of the whole community.

Just checking: Evidence suggests that the just checking scheme continued to offer financial savings and improved qualitative benefits both for service users, and the domiciliary staff seeking to support them. Building on the learning from just checking, we are developing a new model for domiciliary care. We believe that through working differently with our domiciliary care providers we can make better use of the care and support staff working within the community and ensure that the service overall is more productive, by focusing effort on outcomes for clients rather than the traditional time and task model.

We are also looking to see how we can improve recruitment and retention to care work by improving working conditions and creating a more diversified workforce to focus on a more complex range of tasks for clients.

Preventative services market development board (PSMDB): significant investment has been made into community based services. In the year to December 2016, the PSMDB attracted an additional £601,560 of funding to NEL; it has attracted £790,187 since its inception in the summer of 2013 - clearly, progress is still being made.

Seven day services: there are a number of 7 day services in place: GP out of hours' services (for urgent care), community nursing (adults and paediatric), crisis response services and the SPA.

Whilst NEL does have some extended opening hours across general practice, it is not consistent and available across the whole population up to 8pm every day, and weekend provision is not currently in place. As part of the GP forward view there is a plan to have 8am to 8pm access across weekdays, and weekend provision available to 50 per cent of the population by April 2018, with the remainder covered by April 2019. The local pilot testing out a model for seven day access to general practice, which covers half of the population, has been completed. The pilot has been valuable in terms of generating a number of findings which can be taken into account within the design of extended access arrangements across NEL.

Investment in primary care is a key priority, as it is recognised that good primary care plays a pivotal role in supporting individuals to remain well and to ensure they get the right care at the right time in the right place. One of the main areas of investment will be in supporting general practice to work collaboratively to develop services

across a larger footprint, creating more resilient and specialised services, and creating an infrastructure that supports other services to integrate more effectively with general practice. Implementing enhanced long term condition management across the networks is a key priority; this will provide a more responsive and resilient service to individuals, support proactive care and reduce the reliance on acute services. Plans to offer extended access to general practice through these collaborative arrangements will include routine / planned appointments and will incorporate long term conditions management services.

The following are 7 day services which are currently in place and are reflected in our planning template:

Crisis bed

Extra care housing static worker

Long term care management in primary care

Adult community nursing

Mental health out of hours SPA

GP 'front ending' in A&E, out of hours

Hospital discharge Hospital In-reach Team

Single point of access (SPA): the SPA continues to respond to a demanding level of calls. There has been a slight decrease within the year 2016-17 in social care related calls, but an increase of around 12% in health related calls during that same period. The Govmetric system enables callers to leave instant feedback about their experience, and feedback remains consistently good. Out of hours mental health access is now delivered via the SPA. A SPA Facebook page has been developed, via which SPA staff are accessible 24/7. A clinical advisory service is also in development, concentrating initially on improving the transfer between NHS 111 and SPA, supporting access to GP availability (extended hours) and supporting care homes.

Plans to develop the SPA further are led via the SPA board. A SPA performance framework/ case study template is being developed in conjunction with NHSE – Better Care North of England.

Support to care homes: our vision for enhanced support to care homes is to ensure multi-disciplinary support to the most vulnerable and frail clients within health and social care. This approach will ensure that individual care homes and clients are supported by a single multidisciplinary team able to ensure that health and care support is tailored to the range of complex needs. Further, the programme of work will enable care home staff to deal confidently with presenting conditions.

Our enhanced support to care homes project has had early success in recruiting six homes within the borough to work to the new model. We are aiming to extend this approach to all care homes within NEL and are exploring the applicability of the model to other settings such as supported living and ECH.

At the same time we have reviewed and enhanced the expectation of our long term care contract to ensure better quality of care and better support for residents to remain within the setting when there is a health problem.

Dementia pathway: further work is required and is underway via the ACP to remodel the dementia pathway, to ensure that dementia patients are able to access appropriate quality support within the community wherever possible. Additional capacity and specialist support has been identified as a need for dementia patients.

Training and workforce development: NEL's training and development offer encompasses workers across the sector, e.g. from community nursing to domiciliary care providers. Training currently in process includes (by way of example) lawful decision making (particularly around the allocation of resources amongst individuals), in accordance with public law principles, and understanding and application of the Mental Capacity Act 2005 (MCA) across health and social care.

Development currently in process is focused on (by way of example) creation of shared policies and procedures for application across all health and social care settings e.g. in relation to capacity assessments and best interests decisions made under the MCA, and consideration of the role of the ACP in leading on coherent workforce development activity across health and social care providers.

Summary

Progress on BCF conditions/ metrics can be summarised as follows:

- The national conditions have been met
- Delivery of expenditure is in line with planned expenditure
- We have been successful in achieving our targets in relation to non-elective hospital admissions. The rate of permanent admissions to residential care or nursing homes has been improved by more effective working with clients' families and carers and we are achieving top quartile performance on the proportion of people still at home 91 days after admission
- Though we perform well when compared regionally and nationally, there has been no overall improvement in delayed transfers of care (DToCs). We believe there is scope for further improvement through the application of the high impact change model (areas for further development include investment in intermediate tier, trusted assessor model and discharge to assess). We also believe that we can make better use of disabled facilities grant (DFG) funding to speed up access to adaptations that will not only improve client outcomes but will also improve hospital discharges, and contribute to reducing the cost of care at home
- There has been a slight decrease in (social) call volumes, however outcomes remain constant (see Appendix A). There was been an increase in health related calls
- The data in relation to people feeling safe within care and support services is an annually collected measure and was not available at the time of this submission.

Evidence base and local priorities to support the plan for integration

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 NEL will continue to increase placing additional demands on services. NEL also contains 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.

Demography presents some key local challenges for NEL, which is a small unitary authority area with the majority of residents living in the towns of Grimsby, Cleethorpes and Immingham. It is somewhat geographically remote from larger centres of population and it is therefore difficult to attract, and retain, the workforce needed across a range of sectors including health and care.

An estimated 159,803 people live within the borough which is an increase of 1.1 per cent in the 10 years since 2004¹. Latest projections indicate an overall rise in the population of 2.4 per cent between 2012 and 2037 with the number of people over the age of 85 predicted to double and those under 16 and of working age predicted to decrease². This represents significant growth in demand to be met from the reduced resources available to the health and care economy within the borough.

The overall population of ethnic minorities at the time of the 2011 census was estimated at 4.6 per cent which is significantly lower than the regional (14.2 per cent) and national (20.2 per cent) comparators³. However the school census suggests that there is more diversity in the younger age groups⁴. Our local services need to be more sensitive to cultural needs and the changing patterns of demand which may arise from different community characteristics.

In the 2011 census 9.3 per cent of the resident population stated that their daily activities were significantly limited due to a health condition or disability. Around 20.1 per cent of the working age population (aged 16-64) have a known disability with more women (22 per cent) than men (18.2 per cent) having a disability. As an area, NEL's population has a greater dependency on public services as a result of the impact of disability within the community.

Locally there is a higher proportion of people who provide informal care for 50 hours or more per week (5,993 residents or 29.8%) than seen regionally (24.5 per cent) and nationally (23.1 per cent). This means that a higher proportion of people in the locality may be at risk of social isolation due to caring responsibilities and who may have limited opportunities to pursue work or social interests.

Deprivation and health

Findings from the English indices of deprivation show that NEL has high levels of deprivation particularly within the East Marsh, West Marsh, and South Wards. Comparing changes over time shows that NEL has an increasingly deprived overall picture relative to other local authorities. It is ranked the 31st most deprived local authority in England and over time NEL's position in the indices of deprivation rankings has worsened relative to other local councils.

The NEL population presents with a significant gap in life expectancy between NEL 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 per cent more likely in NEL when compared to the England average. Mortality from cancers is 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 levels 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.

As outlined above the implications are that the population has higher levels of poor health, is less likely to adopt health seeking behaviours and is more likely to be exposed to multiple risk factors leading to adverse health outcomes, with the consequence of higher levels of premature death or development of complex conditions. A lower disability free life expectancy means that some segments of the population will require state funded care and support for longer. Earlier intervention and preventative wellbeing services are therefore an essential component of making long term changes to the population and reducing demand for treatments or other interventions.

Economy and health

The rate of unemployment in NEL is decreasing with a two per cent drop from 2013 – 2014 but it remains higher than the regional or national rate.⁷

In November 2014, 13.9 per cent of the working age population was claiming out of work benefits. In 2014 the average national full time pay was 13.8 per cent higher than in NEL. The proportion of working age population, who have no qualification, reduced by 3.3 per cent from 2010 to 2014 and is at a slightly lower level than seen regionally or nationally. Within the same period, the proportion of those with level 4 qualifications and above, increased by 2.4 per cent but remains lower than comparator groups⁷. This means that by comparison with other areas we have a population that is less able to earn the levels of income that are required to live well.

By focusing on generating more employment opportunities and increasing the supply of good quality jobs for local people we will be able to reverse the cycle of intergenerational worklessness.

Our local health economy is facing significant difficulties in terms of its financial resilience, with the acute hospital trust having recently gone into intervention measures. Supporting the trust to manage these challenges is a priority.

Housing and health

Housing and health are inextricably linked. As a borough we have a low value housing market, which on the one hand enables home ownership, but on the other makes it a difficult area for housing developers to generate appropriate levels of return on new build housing. We are also aware that there is a need for a more diversified housing stock able to support the changing needs of an ageing and increasingly frail population. New housing developments need to make certain that services and support are appropriately accessible to ensure that all people can access what they need, when they need it and without having to rely on personal transport. We are developing a local housing strategy and a more co-ordinated

approach to the delivery of housing initiatives that will help people to live in a safe, connected and supportive community.

Priorities

NEL's priorities are "stronger economy and stronger communities". These priorities have arisen out of a desire to see sustained longer term change for the population which has historically been characterised by economic decline, and significant health inequalities associated with poverty and poor living standards, with a consequent impact and dependency on services.

Our priorities may be summarised as supporting people to –

1. Stay well and be independent for as long as possible
2. Avoid unnecessary admission to hospital or care homes
3. Where such admissions cannot be avoided, reduce the stay as far as is safe and appropriate
4. Get well and return to independence as quickly as possible.

Delivery of these priorities is underpinned by four key 'enablers', which may be summarised as –

1. Data collation and analysis
2. Data sharing
3. Workforce development
4. Information and advice provision.

The plan set out below, building on the plans set out within our previous BCF submissions, offers further detail regarding how our priorities will be addressed.

Better Care Fund plan

The HLHF programme helped us to work across the Northern Lincolnshire health and care system to develop new approaches and learn from emerging practice. Our transformation 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 following are some of the key actions and improvements within our current strategic and future BCF/integration plans that will help to manage the demographic challenges, tackle the health inequalities we have highlighted and help to ensure that the health and care needs of the population can be sustainably managed:

- 1) Preventative approaches which help to keep people well, for example the PSMDB (which exists to generate a range of services within the community), the health and wellbeing service including the older people's health check, asset based assessment and care planning
- 2) Avoiding hospital and residential care admission via the delivery of:
 - a. The "Pause" programme
 - b. The enhanced support to care homes project
 - c. The delivery of extra care housing to provide greater choice to residents (and an alternative to residential or nursing care) which can promote independent living in the community for longer
 - d. Assisted living centre services which enable access to adaptations and technologies that promote independence

- e. Re-modelling domiciliary care services to focus on the achievement of outcomes for users rather than the time and task approach traditionally employed
 - f. Remodelling access to GP services
- 3) Actions to facilitate timely and safe discharge from hospital
- a. Implementation of the discharge to assess and trusted assessor model
 - b. Developing seven day hospital services which reduce length of stay and support discharge from hospital
 - c. Additional intermediate tier bed based capacity and intermediate care at home service review
 - d. IT investment to facilitate information flows and data sharing
 - e. Review of DFG services and realignment of allocation to ensure focus on strategic initiatives
- 4) Maximising rehabilitation and re-enablement following crisis or hospital admission
- a. Review of the assisted living centre to ensure optimum service delivery including the use of new technologies/equipment
 - b. Review of rehabilitation and re-enablement services

Enablers of integration

To support our vision and to create sustainability we are investing some of our BCF and wider resources to secure the 'enablers' of integrated delivery – i.e. data collation and analysis, data sharing, workforce development and information and advice provision.

Data collation and analysis

At present the Partners and commissioned providers across health and care collect and analyse data for a variety of reasons. We recognise the imperative to take an holistic look at how best to use data/ intelligence, with two aims a) to support identification of which areas of activity are securing best value, and b) to ensure coordination and targeting of resources to greatest need.

To deliver the aims at a) and b) above, the following actions are proposed:

- Review what data/ intelligence is collected by whom, and for what purpose
- Understand gaps and duplication in collection; streamline where possible
- Create mechanisms for ensuring that useful data/ intelligence regarding population need is collected, analysed and shared by the Partners – this should include information gleaned via complaints and relevant annual surveys
- Ensure clarity of contract terms requiring providers to share the data/ intelligence identified as useful during above review, or otherwise.

Data sharing

By improving data sharing between partner organisations, the ability to provide real time access to key care records becomes possible, facilitating the integration of services by ensuring that key information is visible to the care giver at the

appropriate time. In turn, the ability to deliver enhanced, integrated, cross-discipline care models to the citizens of NEL becomes achievable.

The NHS number is as a mandatory field used across all health and care providers, providing consistency. Where NHS number look up functionality is not already integrated into a system, data quality auditing services are used to ensure high data quality on NHS Numbers.

To ensure all staff are empowered to support data sharing between care settings:

- All staff undertake mandatory information governance training, explaining to them the fundamental principles of data sharing and their associated responsibilities. All providers have completed their IG Toolkit Level 2
- Through staff briefings all front facing staff have a clear understanding of their responsibility in regards to the data sharing consent model
- The organisations involved in delivering care have a nominated and appropriately trained Caldicott Guardian, engaged in working practices within their organisation
- There is organisational HR mechanisms in place to proactively monitor and check that all sharing and security principles are being adhered to
- To help with partner provider engagement, a number of cross organisational structured workshops are planned to ensure that stakeholders 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.

The wider Humber care community is working towards implementing its agreed shared local Digital Road Map (LDR). In the first instance access to view the enriched summary care record (eSCR) will be rolled out across care partners. The eSCR is a NHS Digital product available nationally which will provide a view of the GP held record to all appropriate care partners subject to service user consent. Within the current financial year the LDR will also start to deliver improved electronic referral mechanisms, electronic discharge information from secondary care to both community and social care and the sharing of CPIS information across all parties. The LDR are also investigating options for wider community sharing options. Commissioners and major providers have signed up to the principles required to deliver the LDR. By working at a Humber community scale we can make sure that the right information is available to clinicians, in a standard way, when required.

To support extended hours and community based services, the health and care community is committed to providing shared access to records within wide ranging care settings. To facilitate this, a number of initiatives are complete or are underway:

- The majority of local primary care providers, the key adult social care provider and community care providers use SystemOne, allowing for an electronic shared health record
- A sharing portal is being developed which will provide a shared view of social and health care records
- 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 2017
- 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. The initial roll out phase is complete and further installations are available on request.

By providing shared electronic records, the flexibility to run services from more locations increases allowing for a more dynamic and scalable care service

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 appropriate service users
- Visual advertising campaigns, e.g. posters and leaflets in strategic locations
- Pamphlets delivered in the local press
- Direct conversation with service users at entry to, or point of, care.

Improved data sharing will impact on the integration of services with key outcomes for NEL including:

- An agreed consent sharing model, reflecting the particular requirements of the eSCR 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 from a single signposting mechanism supporting the 'No Wrong Door' approach to public engagement
- Short term improved utilisation of existing data views to bridge any data sharing gaps until integrated systems are online
- Social care records being readily available to health professionals electronically for the first time, and vice versa.

Workforce development

The health and care community as a whole lacks an adequate supply of suitably trained and qualified workers which in turn has an impact on the ability of the system to meet care quality expectations. We intend that the following actions should support delivery of a longer term workforce plan:

- Map the staff required by the Partners and consider where efficiencies might be made/ capacity released:
- Map the staff required across the sector as a whole, with provider input (including most significantly, from the ACP)
- Build on the approach planned via HLHF, to:
 - create a strategic approach to workforce recruitment and development, drawing on NELC's Outcomes Framework Lead for Skills and Learning and tools such as <http://worksmartlivewell.co.uk/>
 - ensure that strategic considerations are reflected in the development of the ACP (in terms of ensuring a sufficient and adaptive workforce able to meet increased and changing demand across organisational boundaries)
- Amend contracts and contract monitoring practices to create the following expectations:
 - Providers work with the Partners in a coordinated way to consider how we can support them to generate quality staff
 - Providers work with the Partners to coordinate training where needs across providers are similar and training could be cost effectively shared
 - Providers' workforce plans are collated and analysed to support identification of trends and forecasting for the benefit of NEL as a whole
 - All providers, irrespective of their organisation, share an approach which
 - ❖ focuses on signposting, prevention and creating resilience
 - ❖ fosters value-driven practice based on the NHS constitution, the Human Rights Act 1998, Mental Capacity Act 2005 etc
 - ❖ is driven by best value thinking, in service delivery and decision making
 - ❖ uses the same policies and tools wherever possible, to create consistency.

Information and advice

Significant work has been undertaken to understand current experiences of accessing and providing information and advice across health and social care in NEL. We are now using what we have learned to create plans for improvement. Developing the information and advice agenda across health and care draws together other related initiatives, including the citizen access work stream as part of the NHS digital roadmap.

Our ambition is to ensure that, delivered via borough-wide coordinated mechanisms, local people can access good quality information and advice to maximise their wellbeing: they will be provided with the help they need or accurately signposted to where they can access it. Staff supporting local people to access information and advice will be enabled to do so.

Further work is underway and/ or planned to

- Agree an information and advice model, the principles that will underpin it, and a charter for signature by providers of information and advice
- Agree the roles of contributors to the model, including lead agencies for key issues e.g. mental health
- Agree a navigation hub with links to satellite hubs such as the 'Transport One Stop Shop'
- Create a local single point of information.

Our information and advice plans are linked to the No Wrong Door approach referred to under the heading of data sharing, above.

Risk

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

- a) Usual contractual processes
- b) Each scheme's own management mechanism (e.g. A&E delivery board).

Where risks appear to be escalating these are challenged via usual contract monitoring and/ or via the project governance mechanisms and scheme lead.

Where appropriate, risks are highlighted by the BCF lead via line management and/ or drawn to the attention of senior management as part of our routine arrangements in managing an integrated system.

NELCCG's corporate risk register also contains an overarching BCF risk. The risk register within the previous BCF plan has been refreshed and is attached. We can confirm that risk sharing arrangements do not put any element of the minimum contribution to social care or iBCF at risk.

The key high level risks to the delivery of the BCF plan are:

- 1) Financial sustainability of the health and care system in NEL given that the acute hospital trust is under severe financial pressure and that NELC needs to operate independent of revenue support grant by 2020. The hospital trust is subject to intervention measures which may impact on the ability of the trust workforce to fully engage with the BCF plan
- 2) The availability of an adequate supply of suitably trained workforce across the health and care system capable of meeting the needs of an elderly, frail population
- 3) Financial sustainability of the domiciliary care market and the residential care market and their ability to meet quality expectations given the workforce challenges that are apparent in the borough
- 4) Uncertainty over welfare reform measures which may impact on the future viability of alternative housing schemes such as extra care housing and intermediate care and the willingness of housing providers to enter into long term arrangements for such schemes.

There is a risk that:	How likely is the risk to materialise?	Potential impact	Overall risk factor	Mitigating Actions
<p>Effectiveness of re-ablement</p> <p>a. We are unable to offer sufficient re-ablement capacity to meet demand</p> <p>b. We are unable to identify those with sufficient re-ablement capacity. Our current top quartile performance worsens.</p>	3	4	12	<p>The performance of re-ablement services is closely monitored through contract performance and KPIs, including measures of occupancy levels and length of stay (bed based services), achievement of re-ablement goals and service user satisfaction. Along with data on DToCs for those in hospital and assessed as appropriate for re-ablement services and national comparative data, there is an on-going commissioner/provider analysis of the demand versus capacity and adjustment made in conjunction with providers. Historically our figures indicate good results from our approach to DToCs.</p>
	3	3	9	
<p>We are unable to reduce delayed transfers of care</p> <p>a. Current performance worsens.</p> <p>b. We are unable to reach the target we have set.</p>	3	4	12	<p>Monthly analysis of DToCs is undertaken in order to monitor the different cause/reasons and the professional groups responsible for assessment and service readiness delays. Where capacity is identified then adjustments have been and can be made and process improvements have been identified in liaison with hospital operations centre and the disparate community services that enable timely discharges. Under joint working developments and winter planning considerations, providers have been incentivised to make performance</p>
	2	3	6	

				improvements. The SPA will continue as the focus for community coordination.
Risk to Commissioners of non-achievement of financial plan within agreed timescales	3	5	15	Increased demand due to demographic characteristics combined with a significant restraint in NELC's overall budgets going forward presents a significant risk to project and routine service delivery – close monitoring and review will mitigate this risk. We also have medium term financial planning processes in place which ensures an ongoing focus on efficiency and improvement in cost-performance
Partnership working does not develop the required level of maturity required to deliver system benefits				The ACP and the enhanced partnership working between NELC and NELCCG will take time to establish new ways of working, including overcoming organisational barriers and developing a common culture and language focused on delivering shared objectives. To mitigate this risk we are planning to invest in workforce development initiatives and in a programme of activity which will enable the simplification/unification of key policies and processes to support organisational development and integration. In addition, we have recently refreshed our market position statement, and will be hosting a provider event in the coming months, to ensure that the statement offers a useful foundation for both commissioners and providers.

National Conditions

National condition 1: jointly agreed plan

The plan has been initiated, developed and agreed within the new integrated management arrangements between NELC and NELCCG and builds on existing projects and plans that have already been developed and are in the process of being operationalised.

NELC, in its capacity as the local housing authority, is joint author and co-signatory to the plan; the local housing strategy is currently in development and will reflect the need for the development of specialised and supported housing which mirrors the needs of the population. We are in the process of refreshing our approach to extra care housing delivery.

In the preparation of our plan we have engaged with the Together Board to ensure that the plans are fully integrated into the ACP's initial programme of work and to ensure local system oversight of delivery. The A&E Board has also been involved in discussing our BCF plans; detailed plans have been shared in particular with NLaG and the chair of the A&E Board. We have provided an initial flavour of our plans via the Community Forum which consists of members of the community and voluntary sector organisations. We have facilitated some detailed discussion of our plans via NELCCG's membership body ACCORD, particularly in relation to iBCF spend; key points of interest centred around provision of domiciliary care, urgent care, and building pride in professional care careers. Useful suggestions were made by community members, such as the greater systemic use of voluntary befrienders. We will be further engaging our community representatives in confirming and challenging the plans at an engagement event during September 2017.

We have made a plan to review the DFG pathway to ensure the process is lean, fit for purpose and operating as efficiently and effectively as possible to be supportive to the achievement of client outcomes as well as delivery of the health and social care system. Another aspect of work will look at the DFG budget allocation to ensure the budget is being deployed in the most appropriate way to support all clients whether in their own homes, extra care housing or supported living to live as independently as possible. This will ensure that we minimise DToCs and reduce reliance on high cost care packages. In broad terms, our plan in relation to DFG is –

- Short term – develop a full understanding of the DFG pathway and process and implement process improvements to ensure adaptations are delivered to priority cases in the shortest time possible.
- Medium term – develop a full understanding of the issues evident in the DFG process and recommendations for further action including greater integration of the service offer with the assisted living centre and policies which ensure alternative approaches to the delivery of adaptations are in place.

- Long Term – implement recommendations to secure an efficient, effective and client led adaptations service linked to a more integrated home options/integrated housing service, rehabilitation services and care link function

This BCF plan will be signed off by the health and wellbeing board, and the NELCCG partnership board.

National condition 2: social care maintenance

The area has benefited from the application of the local precept which has helped to raise additional revenue to meet essential costs such as meeting the cost of the national minimum wage.

Since the inception of the section 75 agreement between NELC and NELCCG, the partners have pooled significantly more resources than has been specified as the BCF minimum contribution. Our well established working relationship and partnership arrangement enables effective risk sharing and mitigates the risk of “cost shunting” between organisations since the resources are managed collaboratively and as a pooled resource. Closer working between the Partners via the union will help to ensure that the local markets are not de-stabilised.

Additionally, further investment from the iBCF allocation is welcomed and timely to support the on-going transformational activity that will generate sustained benefits in the future. We have local agreement to use iBCF for stabilising the local social care market, specifically in relation to domiciliary care provision.

There is still a need to ensure that the systems supporting the allocation of social care resources operate effectively and efficiently. Packages of support must promote and sustain independence wherever possible and make best use of other resources and services availability within the community to ensure that social services can be deployed to greatest need.

A programme of work has been developed to enable the Partners to manage demand for services within a three year planned budget envelope (17/18 through to 2020). The expected contributions from the NELCCG will be maintained as per the planning templates issued to local areas for the years 17/18, 18/19 and 19/20.

Some of the actions planned to support sustainable service provision include:

- 1) Review our approach to domiciliary care provision to focus on the achievement of outcomes for users, moving away from the traditional “time and task” model. In year one of the plan (17/18) we are piloting an approach which allows greater provider flexibility in deploying care workers within the community and therefore making better use of the time and capacity available to support service users. In year two of the plan we will investigate

opportunities to develop and diversify care roles within the workforce and to strengthen the range of skills and capabilities that can be delivered within the home. We are seeking to invest in a more capable workforce to address recruitment and retention issues within the sector.

- 2) We are reviewing the pathway of support which enables the deployment of equipment and adaptations within the community. We are aiming to expand the range of equipment that can be deployed quickly to support hospital discharge as well as ensure that packages of care can be reduced wherever safe and practical to do so. We are intending to use some of our DFG allocation for strategic projects to enhance supported living and to meet the above aims. We are also going to undertake a “lean” review of the DFG process to minimise delays in receiving adaptations. A workshop has recently been delivered to clearly articulate the full DFG pathway/ process, look at what is working well and to identify issues/ pitfalls in the pathway causing inefficiency/ delays/ poor outcomes. This intelligence will be collated into a DFG service review paper which will articulate recommendations for action.
- 3) We have refreshed our policy framework to enable social workers and health care professionals to make decisions in relation to packages of care; the principles underlying the policy are that needs can be met in a variety of different ways, opening up the opportunity to link clients to alternative support such as voluntary and community organisations. This approach is helping to ensure that formal commissioned services can be more appropriately used, helping to manage demand and sustain the health and care market.

Our schemes all have an emphasis on promoting health and wellbeing and as such have a health benefit to service users. For example, the wrap around support for residential care homes is in part designed to ensure better management of complex health conditions.

National condition 3: NHS commissioned out-of-hospital services

To complement the work we are undertaking in relation to hospital discharge planning, the maintenance of individuals’ independence and the safe reduction of packages of care we are planning to invest in intermediate care services. This will involve:

- 1) The creation of additional bed based capacity to speed up hospital discharge, rehabilitation and re-enablement
- 2) A greater focus on the effectiveness of community rehabilitation and re-enablement services
- 3) A review to ensure appropriate staffing/skill mix of “at home” teams.

We also plan a continuance and expansion of the enhanced support to care homes project which will ensure a roll out of the scheme to all residential care settings within the borough to reduce non-elective hospital admissions and ensure that residential care staff are more confident in supporting residents with complex conditions. We

would envisage a similar model being applied to all accommodation based care settings in the future, including supported living and ECH.

This work has been complemented by raising commissioner expectations of the quality of care in long term care settings through a review of the residential care specification and the quality scheme.

In relation to contingencies, we have made reference to this in the risk log. We have made no specific contingency funding within BCF as risk sharing forms part of our overall partnership arrangements.

National Condition 4: Managing Transfers of Care

Across the health and care system we are working to ensure that hospital admissions can be avoided by the availability of community based support. Specific examples of work we are doing to reduce hospital admissions include:

1) Investment in the “Pause” programme

The purpose of “Pause” is to prevent the damaging consequences of children being taken into care each year.

Pause works with a cohort of women who have experienced – or are at risk of – repeated pregnancies that result in children needing to be removed from their care. The programme gives women the chance to pause and take control over their lives, by offering an intense programme of therapeutic, practical and behavioural support through an integrated and systemic model. Each woman has a bespoke programme designed around their needs, breaking a destructive cycle that causes both them and their children deep trauma and avoiding hospital admissions resulting from the presenting issues associated with substance misuse and domestic violence.

It offers an intensive, flexible programme of support, tailored to individual needs, to tackle destructive patterns, develop new skills and avoid further trauma. This helps the women involved set in place strong foundations on which they can build a more positive future for themselves.

2) ECH

We have been working to ensure an adequate provision of ECH within the borough as a means of diversifying the choice available to residents, diverting some of the demand away from traditional residential care homes and providing an accommodation based solution which focuses on maintaining independence. We completed our first 60 unit scheme in 2015 and have a requirement for up to an additional 440 units. Despite the delay in delivering further ECH schemes in NEL, our current scheme is showing that hospital admissions can be reduced.

High impact change model

We have undertaken a self- assessment using the high impact change tool to evaluate our progress in our DToC plan. Our conclusion is that we have partially implemented the majority of changes but these are not all fully embedded. The DToC plan section heading summarises the current activity and plan in the context of the High Impact Change Model.

Overview of funding contributions

The funding contributions for the BCF have been agreed as follows:-

		2017/18	2018/19
		£'m	£'m
Core BCF allocation	NELCCG	11.4	11.6
DFG Grant	NELC	2.4	2.6
i BCF	NELC	4.1	5.6
Minimum Required Contribution		17.9	19.8

It should be noted that whilst only the minimum required contribution is part of NELs formal BCF arrangements this funding is an integral part of the wider partnership arrangements between NELC and NELCCG.

As demonstrated in the excel Planning Template, funding has been identified specifically for:-

- Care Act duties
- Re-ablement
- Carers' breaks

The funding set aside for all these areas is as per 2016/17 uplifted by 1.79% / 1.90% respectively.

Programme Governance

Outcomes from the BCF schemes are described in the project initiation documents (PIDs) attached to our previous plan. The PIDs also set out the intended impact of each scheme.

All schemes designated within our previous plans have again been scored and evaluated utilising the BCF planning and evaluation self-assessment tool previously provided. 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. Any underperformance is addressed via the relevant board, steering group or contact monitoring meetings.

BCF programme governance is managed as part of the overall partnership governance programme that exists between the Partners via its Section 75 arrangements.

The development of the BCF plan is undertaken by the financial programme board with oversight by NELCCG's senior team catch up meeting and signed off by the Health and Wellbeing Board. Progress against delivery of the overall plan will be monitored via NELCCG's delivery assurance group which is a committee of the Partnership Board which includes the portfolio holder, plus one other councillor, the DASS and the director of public health, together with NELCCG's deputy chief executive, clinical chief officer and director of quality and nursing.

The Pooled budget manager is NELCCG's Chief Finance Officer.

The BCF plan will be delivered by the integrated health and social care teams that exist within NELCCG. The overall lead for the plan is the director of adult services which is a joint post across NELC and NELCCG, who will be responsible for ensuring that all of the individual projects are appropriately managed and delivered.

As previously noted, the Partners are developing a closer union and have appointed a Joint Chief Executive who will oversee the working of both organisations and leadership teams; in time this will develop into a single leadership team covering the full range of services required to support both organisations.

The Partners frequently contribute to regional and national events on integration (e.g. our BCF lead contributes examples of good practice at North Yorkshire and Humber BCF Network meetings, and our director of adult services spoke at the April BCF West Midlands regional networking event in Birmingham and has presented to the North East commissioning academy on collaboration to achieve integration). We regularly respond to requests for advice and information.

Last summer we hosted a visit from the department of health (DoH)/ department of communities and local government designed to understand local arrangements and best practice; we facilitated their attendance at our SPA, supported living and extra care housing units, and organised a focus group meeting with health and care staff. We are working with DoH on the revision of a national template for s75 agreements to support other areas in ensuring that their s75 is as flexible as possible, so allowing them to integrate without unnecessary barriers. Uniquely, having begun the 'integration journey' earlier than others, NEL has ten years' of experience, learning and commitment to share.

Assessment of Risk and Risk Management

Given that the focus of the BCF schemes is building on existing joint working between the Partners, the overall risk level is assessed as low.

No specific contingency funding has been set aside within 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 in NEL. These are set out within the s75 agreement and risks are monitored and managed as part of NELCCG's partnership governance arrangements.

Risk sharing arrangements have also been established as part of the aligned incentive contract that has been put in place between NELCCG and Northern Lincolnshire and Goole NHS Foundation Trust

National Metrics

We have used a scale of 1-5 to judge the relative impact of the schemes in terms of the performance metrics where 1= low impact and 5= high impact

Metric	Schemes which contribute to metric	Strength of contribution to metric
<p>Non Elective Admissions</p> <p>NEL currently has a non-elective admission rate within the lowest (best) quartile nationally which is more than 15% than the national average. More telling is that it is the lowest of its peer group which has an average rate of admission 37% higher than NEL.</p> <p>In 2016-17 NELCCG realised a 5.5% reduction in admissions against the backdrop of a 2.4% increase nationally. This reduction has continued in to the early part of 2017-18 and is reflected in our level of ambition in our BCF trajectory.</p> <p>Our BCF schemes have facilitated this reduction in recent years and there is an expectation that they continue to contribute to this measure.</p>	<p>The support to care homes project (enhanced health in care homes) will significantly contribute to this metric because one of the key philosophies and intended outcomes of the project is to reduce care home residents attendance/ presentation at A&E in a number of ways:</p> <ul style="list-style-type: none"> - Improving the coordinated, wrap-round support function (improved communication/ joint working) to care homes and their residents to ensure the appropriate and timely intervention supporting residents to maintain or enhance their wellbeing - Improved primary care support to care homes to ensure timely clinical support and decision making – medication/ intervention for an episode of ill-health - Improved training of care home staff to make informed decisions about a resident’s health and wellbeing - Falls prevention scheme to reduce the number of falls within care homes - Improved training, coaching and enhanced practice around advanced decision making <p>The above will lead to:</p> <ul style="list-style-type: none"> - Decreased number of emergency calls outs – 	<p>It is felt that the support to care homes project may reduce A&E presentations by about 20% (as a significant proportion of presentations at A&E are from care homes) - this would obviously reduce admissions to hospital as less people are presenting because they have been supported elsewhere in the system and hopefully much earlier meaning they are not in need of acute care. This is one of the key projects supporting the reduction of admissions.</p> <p>Impact rating 4</p>

	<p>rapid response/ ambulance</p> <ul style="list-style-type: none"> - Decreased conveyance to hospital via ambulance - Reduced presentations to A&E - Reduced admissions 	
<p>Admissions to residential and care homes</p> <p>NEL has significantly reduced admissions to care homes since it integrated commissioning of adult health and social care services down to levels in line with the national average. It is felt that given the previous reductions and the challenging demographics of NEL that the trajectory will be set to maintain current levels of admissions rather than reduce them further. However in view of the ever growing demands from the aging population (NEL has a much greater proportion of older people than both England and Y&H), amongst other pressures, this should be seen as a “real” reduction as there is an anticipated rise in demand of around 2% in the next year alone.</p>	<p>Discharge to assess will support a shift to ‘home first’ and assessment within the most appropriate environment away from hospital – this will support a culture of what the person can do, re-enablement and focus on the abilities/ capabilities of the individual in an appropriate setting – maximising their potential. This should have the result of focusing less on respite/ short stay and more on supporting people to return home.</p> <p>Support to care homes project – those in short stay/ respite will receive a much better experience of re-enablement/ recuperation and are therefore more likely to regain their skills, confidence and independence and return home.</p>	<p>While discharge to assess and the support to care homes project may not significantly reduce the number of short stay/ respite placements, it is hoped they will reduce the number of people having extended periods of short stay and therefore reduce the number of people becoming permanent residents.</p> <p>Impact rating 2</p>
<p>Effectiveness of re-ablement</p> <p>NEL has historically been a high performer against this measure</p>	<p>The support to care homes, discharge to assess, trusted assessor model and ECH will all contribute to this metric by providing a dedicated and multi-disciplinary support team tailored</p>	<p>One of the key priorities in the discharge to assess project is to undertake a gap analysis of community provision (i.e. blockages</p>

<p>and this continued in to 2016-17 with the area having the fourth highest rate of performance across all local authorities in England. Through the BCF plans NEL is seeking to maintain performance within the top quartile at 88.6% or above.</p>	<p>to the needs of the individuals. The principle of all of these schemes is to support a person to improve their health and wellbeing wherever possible, maintain or regain maximum re-ablement and live as independently as possible.</p> <ul style="list-style-type: none"> - ECH – community inclusion/ social interaction/ supportive environment with the housing manager and care agency intervention - improved discharge processes – repatriating people to the most appropriate setting to support recovery/ recuperation and re-ablement - timely assessment of care home residents needing to be repatriated to a care home once medically fit to do so (with the correct care plan/ medication/ support) 	<p>in the system) therefore depending on the gaps identified (capacity in domiciliary care/ capacity in intermediate residential based care and intermediate care in the community/ lack of therapy support in the community) and the action taken to address these gaps it could potentially have a huge impact on the opportunity and ability to support re-enablement.</p> <p>Potential impact rating 4</p>
<p>Delayed transfers of care</p> <p>Again NEL's performance here is currently in the lowest (best) quartile of local authorities nationally with a reduction achieved in 2016-17 of 2.6% on the previous year despite an increase nationally of 24.5%.</p> <p>This current level of performance means that NELCCG is below the 3.5% national ambition for September but has a two year trajectory to</p>	<p>The discharge to access project and the trusted assessors model will ultimately reduce DTocCs by ensuring appropriate and timely assessment of people on admission to the acute trust, who are effectively monitored and given an expected date of discharge. This will lead to appropriate timeframes to source and secure appropriate care once the person is medically fit/ over their need for acute care/ intervention.</p>	<p>Impact rating 4 - 5</p>

reduce DToCs further.		
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Delayed transfers of care (DToC) plan

With the NEL relative position on DToC benchmarking and on the position relative to the national percentage reduction targets, the NEL DToC plan remains targeted at a 3 year trajectory from April 2016 of an overall reduction in total DToC bed days of 20 per cent.

All partners agreed a metric for planned reductions in delayed transfers of care across the HWB and this is at least as ambitious as the overall HWB target for reductions of DToC by November 2017. The metric is in line with the expected reductions in DToC for social care and NHS attributed reductions for the HWB area set out in the DToC template. The narrative sets out the contribution that the BCF schemes will make to the metric including an analysis of previous performance and a realistic assessment of the impact of BCF initiatives in 2017/19 towards meeting the ambition set out in the local A&E improvement plan. All relevant NHS and social care providers have been involved in developing this narrative.

The national high impact change model encompasses the key best practice initiatives in support of reducing DToCs, however the key driver of DToC numbers in NEL is associated with NHS delays in further non-acute care – in particular Intermediate care capacity and the processes associated with timely transfers of care. These initiatives and those of the High Impact Change model are summarised together as follows:-

High Impact Change Model

- Change 1 – Early Discharge Planning
- Change 2 – Systems to monitor patient flow
- Change 3 – Multi-disciplinary/multi-agency discharge teams, including the voluntary and community sector

The integrated discharge team was established in 2016 and has made progress in streamlining the discharge process and interworking with the acute trust bed management and operations centre. In particular, information sharing has improved and Board rounds have been established to ensure planning for patients begins at the earliest opportunity and that timely attention is given to those patients where delays occur. In addition to emergency admissions, new processes are in place to improve the planning for elective patients. As these processes show benefit there will be engagement with how community and primary care are bought into this earlier planning activity.

In year there has been ECIP support for the acute trust which has further highlighted the need for improvement in critical “flow” processes, including the use of the SAFER principles for consultant review which will include the adoption of Expected Date of

Discharge being declared within 48hrs. This will further enhance early discharge planning in the coordination of consultant review and the integrated discharge team.

Progress has been made with understanding patient flows, both in respect of in-hospital (length of stay, outliers, red/green days etc.) and the key bottlenecks in the community and services relating to delays in assessment and in the provision of onward care which contribute to DToCs. Some measures are already in place to match capacity with demand however more work is planned to ensure domiciliary and residential care providers play an increasing role in early planning. Work is underway to update the home care and intermediate care pathway to provide resilience to peaks of demand.

Change 4 – Home first/ discharge to access

We are working collaboratively to develop a model to deliver the nationally mandated best practice of discharging to assess, in conjunction with the changes we are proposing with regard to enhanced re-enablement and intermediate care delivery. Improved joint working processes on discharge planning and improved onward care access following a hospital admission will not only support improved patient pathways, but will also support a further reduction in our DToCs.

Under the national mandate, home first/ discharge to assess has the oversight of the Northern Lincolnshire A&E Delivery Board. With ECIP support, a model has been developed which is common to the two acute district general hospital sites that are in two different CCGs. In line with best practice implementations, three pathways have been defined for complex discharges: home, bed based step-down and residential care. In NEL, the plan and current activity is to focus on the “medically optimised” and the determination of both the potential activity and service gaps for the three pathways, with the key premise that rehab or long term care assessments will not be undertaken with the patient in an acute bed. The audit work is led by the acute trust identifying the medically optimised and the integrated discharge team is supporting in the identification of why this cohort cannot currently be transferred to a more appropriate setting under discharge to assess principles. Further there is primary care in-reach support to assist in the identification of medically optimised through the improved use of primary care and community knowledge of patients. With ECIP support, a PDSA 30/60/90day cycle approach is being used to support rapid change, though it is recognised that the service gap solutions may take time to commission and embed.

Action	Deadline	Status
Establish governance arrangements	July 2017	Complete
Agree overall metrics	August 2017	
Develop high level definitions and comms for staff engagement	August 2017	
Agree lead provider for pathway implementation	August 2017	Complete

Audit delays for “medically optimised”	August 2017	
Agree capacity and model for bed based/step down pathway (as part of Intermediate tier winter planning and planned changes to IC facilities/capacity and usage)	Sept 2017	
Agree service gap model for home pathway (community assessment and short term intervention team – as an extension to intermediate care at home)	Sept 2017	
Agree model for bed based assessment for long term care pathway	Sept 2017	
Implement pathways	Oct 2017 – Dec 2017	

The reshaping of intermediate care (bed based and intermediate care at home) and domiciliary care will be done in the context of known issues of capacity/ demand but also specifically with the outcome of the activity generated by discharge to assess development in terms of the service gap analysis that will shape the home and intermediate care future requirements.

Action	Deadline	Status
Agree capacity and model for bed based/step down pathway (as part of Intermediate tier winter planning and planned changes to intermediate care facilities/capacity and usage)	Sept 2017	

The home first element further includes all of the initiatives that control admission demand through improved interventions before admission and the A&E Delivery Board (including ECIP recommendations) work plan includes these “assess to admit” initiatives:-

- Emergency Ambulatory Care Stream for A&E
- Primary Care Stream for A&E

Action	Deadline	Status
Launch PCS service at DPoW	July 12 th 2017	Complete
Review (PDSA) monthly and agree decisions on staffing and processes as they arise	August 2017 September 2017 October 2017	Complete
Agree on-going opening hours, GP, Nurse, HCA staffing and on-going model for resourcing acute streaming nurse function. Agree on-going reporting	November 2017	
DPoW to launch Emergency Ambulatory Care	August 2017	

In the community, work continues on the integrated urgent care response for those at home or in a residential care home. Specific work is planned to add further clinical advice (GP and access to other specialists) to the SPA and to reshape the community Rapid Response in order to support the avoidance of A&E attendance and with a specific aim to reduce inappropriate ambulance conveyance and consider additional capacity for responding to referrals from primary care. These enhancements are planned to begin in early 2018.

Change 5 – Seven day service

The 7 day services initiatives are broad ranging and inter-related and include the requirements for:

- Discharge and social care teams to operate 7 days
- Acute trust processes to discharge at weekends
- Transport arrangements for weekend discharges

A related initiative that will be a significant in improving flow, A&E performance and DToCs is the ECIP recommended work for the acute trust and discharge teams/ transport etc. to change all relevant processes to enable morning discharges and create bed capacity for that day's emergency intake.

Action	Deadline	Status
Agree on ASC weekend functions to support both SW support in A&E to prevent admissions and Integrated Discharge team.	August 2017	Complete
Agree 7 role of therapy services in support of weekend admission avoidance and discharge services	Sept 2017	
As part of winter plan agree on the resources required to implement agreed 7 day functions	Sept 2017	
Agree with NLaG the trajectory of the transition to moving to morning discharges as much as possible	Oct 2017(TBC)	
Employ acute ops centre PTS transport coordinator role to support PTS analysis and process improvement	August 2017	Complete
Adjust PTS planned/unplanned contracts to support discharge profile transition	Oct 2017	

Change 6 – Trusted assessors

In order to deliver on our DToC targets, improve patient flow and overall patient outcomes, we are implementing the trusted assessor best practice model for discharges to residential and nursing homes.

We are designing a safe trusted assessor model, where all care homes and relevant acute staff co-design and agree a memorandum of understanding for assessments,

documenting who can carry them out, what competencies are required, how they will be delivered, what the review mechanisms will be and what will happen if the receiving service judges that the assessment is inappropriate. The process will:

- Support and facilitate timely and safe discharges from hospital to care homes
- Undertake assessments and re-assessments on behalf of the care homes
- Ensure the discharge documentation is complete to accompany the resident on discharge
- Liaise with the care homes about the discharge arrangements to streamline processes
- Act as a point of contact when residents are admitted to hospital to monitor progress
- Work in partnership with care homes and the hospital to find solutions to current challenges.

The NEL model for trusted assessors will be to establish this function in the integrated discharge team rather than one provider assessing on behalf of others. Engagement with residential care providers will rapidly move this on in line with the national mandate and will select a cohort of care homes to work through the processes of transferring to a trusted assessor approach – initially for care home repatriations with discharge to assess picking up new placements under a revised assessment process. As with the national mandate, we have identified the timeliness of care home assessments as a process issue, as well as the ability for care homes to accept multiple repatriations on one day. This initiative will also be aligned with the NEL support to care homes project with the integrated discharge team ensuring that the clinical support teams aligned to care homes are engaged with the trusted assessment.

Action	Deadline	Status
Engage with care home provider group on options. Preferred model trusted assessor within integrated discharge team, other option being one current provider implementing trusted assessor function on behalf of others	August 2017	Complete
Agree cohort going forward to pilot process	August 2017	Complete
Initial workshop	August 2017	Complete
Design associated processes	Sept 2017	
Begin trusted assessor process for pilot using PDSA approach	Oct 2017	
Review/learn/adjust	Nov 2017	
Expand for all providers	Jan 2018	

Change 7 – Focus on Choice

Planning for discharges for elective patients, led by the integrated discharge team is beginning to improve the information available from the point of admission. A key piece of engagement work is planned directed at the voluntary sector agencies to determine the current status, gaps and opportunities to fully integrate the voluntary sector in the information and advice for discharge role.

Action	Deadline	Status
Link with VCSE Forum to discuss plans and scope of engagement with relevant groups/services/organisations	October 2017	
Carry out engagement with specific VCSE organisations to map current patient support networks	Dec 2017	
Link with NLaG and NELCCG PALS/Patient Experience team to obtain patient stories of IAG - before, during, and after hospital admission and discharge	Dec 2017	
Engagement with NLaG patient panel and NELCCG community representatives to co-design IAG pathway design associated processes	March 2018	

Change 8 – Enhancing health in care homes

This programme of work is linking single multidisciplinary teams (MDT) to residential/ nursing care homes within the borough to ensure better management of complexity within long term care settings. The model will improve the confidence of care home staff to help avoid hospital admissions. In the next year of the plan, the aim is to build on the work already started within six homes and to ensure the application of the model to all long term care settings.

Once the model is fully implemented it is expected that there will be:

- Confident and appropriately skilled residential and nursing care staff within the sector who remain in their employment
- A fully developed, co-ordinated wrap around support function (social care/ health/ pharmacy/ therapy/ mental health)
- Rapid primary care support where the identified need is agreed
- Effective use of technology to support care delivery
- Improved client access to community services
- Improved client wellbeing
- Improved client outcomes – independence, choice and control
- Reduction in inappropriate A&E attendances
- Reduction in inappropriate ambulance/ rapid response call outs
- Reduction in length of hospital stays
- Reduction in prescribing costs

Action	Deadline	Status
Extend roll-out of geographically aligned clinical support teams to remaining care homes	April 2018	
Deploy Summary Care Record Access	April 2018	

References

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 - <https://portal.nyhcsu.org.uk/documents/5665646/5860313/Adult+Social+Care+Strategy/461f6203-8bee-40fd-a0fc-5cd7e04028e7>

NB the above plans were attached to our first BCF plan 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 relationship between BCF plans and longer term sustainability and transformation plans was set out in our 2016-17 narrative plan at page 11. BCF planning remains in line with other plans such as the STP. The Humber, Coast and Vale STP can be found at - <http://www.northeastlincolnshireccg.nhs.uk/about-us/stp/>

1 ONS 2015 mid-year population estimates

2 ONS 2015 mid-year population projections 2012-2037

3 ONS 2011 census

5 Annual population survey NOMIS, <https://www.nomisweb.co.uk/default.asp>, Aprils 2012 to March 2013


6 The English Indices of Deprivation 2015,


<https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015>


7 ONS, annual population survey 12 months to December 2014


Approval and sign off

Further information regarding agreement to, and involvement in, BCF planning can be found under the sections detailing NEL's response to national conditions one and two. The Health and Wellbeing Board meeting at which the plans were signed off took place on 11 09 2017.

Signed on behalf of the Clinical Commissioning Group	North East Lincolnshire Clinical Commissioning Group 
By	Dr Peter Melton
Position	Clinical Chief Officer
Date	03/10/2017

Signed on behalf of the Council	North East Lincolnshire Council 
By	Rob Walsh
Position	Chief Executive
Date	03/10/2017

Signed on behalf of the Council	North East Lincolnshire Council 
By	Joanne Hewson
Position	Director of Adult and Children's Services
Date	03/10/2017

Signed on behalf of the Health and Wellbeing Board	North East Lincolnshire Health and Wellbeing Board 
By	Jane Hyldon-King
Position	Chair of the Health and Wellbeing Board
Date	03/10/2017