

North East Lincolnshire integrated health and care market position statement 2017 – 2020

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1.0 Introduction

Welcome to the second market position statement for North East Lincolnshire covering the period 2017 – 2020. The purpose of this document is to set out the way in which North East Lincolnshire (NEL) clinical commissioning group (CCG) wishes to see the development of the local market of integrated health and social care provision to meet the needs of its population. This is set within the context of a number of complex transformational programmes across North East Lincolnshire and its wider sustainability and transformation plan footprint. Throughout the document we will make explicit links to these plans and highlight the implications for the health and social care market.

This document provides an over-arching framework for the way in which the CCG will work with providers to secure the health and adult social care services that the people of North East Lincolnshire need over the next 3 years. There are thirteen areas of service covered.

1.1 What is a market position statement?

Local areas need to consider how they meeting their requirements under the Care Act 2014 to 'promote diversity and quality in the provision of services'. Good practice in market facilitation suggests that commissioners develop a common and shared perspective of supply and demand for care services. We also need to ensure sufficiency of provision and that the local care market is sustainable and fostering continuous improvement. These outcomes cannot be delivered without the active cooperation of providers and without clarity over their strategic approach. These functions are likely to be considerably helped by the development of a market position statement (MPS).

The MPS aims to:

- Present a picture of demand and supply now, what that might look like in the future and how strategic commissioners will support and intervene in a local or regional market in order to deliver this vision.
- Be a brief, analytical document that is clear about the distinction between description and analysis. It will allow providers to come to their own judgements about where and in what amount to invest in a market. Providers not only need to understand the direction the local area is taking but also why is it going in that direction and based on what evidence.
- Support its analysis by bringing together material from a range of sources such as JSNAs, surveys, contract monitoring, market reviews and statistics into a single document which presents the data that the market needs to know and use if providers are to develop effective business plans.
- Cover all potential and actual users of services in the local area, not just those that receive funding from commissioners offer a start to, not the end point of, a process of market facilitation.

Consequently, the MPS is the basis for strategic commissioning and is a document which we will review and update regularly.

We increasingly recognise that the local health and care workforce needs to be grown from within the local community as there are shortages of skilled workers in almost every area of health and care support. Through the sustainability and transformation plan (STP) we aim to work with regional partners to increase the supply of workers. Moving forward, as we transform local care and support services there are requirements for a different mix of skills and we have described how we see the workforce of the future. We are keen to have a dialogue with our providers to ensure that we work collaboratively in developing the workforce that is needed for the new environment.

<http://www.northeastlincolnshireccg.nhs.uk/data/uploads/hcv/humber-coast-and-vale-sustainability-and-transformation-plan.pdf>

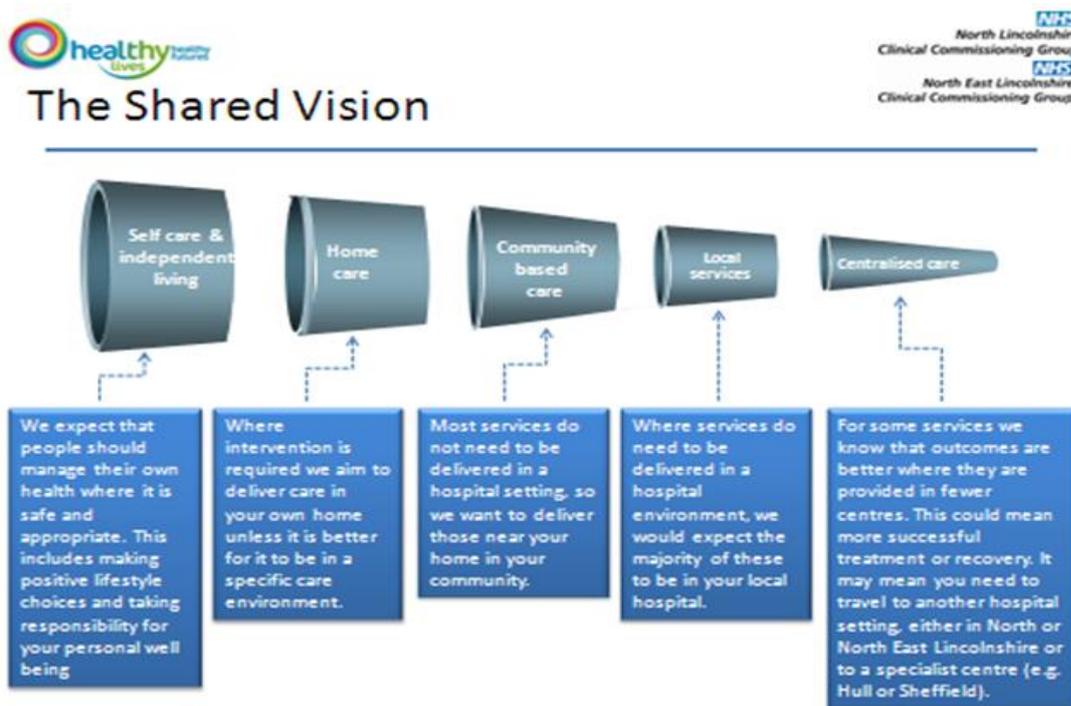
2.0 What are our plans to transform North East Lincolnshire by 2021?

North East Lincolnshire has a strong history of partnership working. In 2007 the partnership between the local NHS and Council progressed and was expanded to

include adult social care, public health, and children’s services, underpinned by a Section 75 Agreement (s75).

Over the past 10 years the partnership has continued and developed into a strong and lasting one, built upon a strong sense of place, with a proven ability to work together to deliver innovation, and confidence to implement further change. We continue to develop ways of involving people who can benefit from service improvement and have a strong commitment to making changes that best fit the local context and experiences of community members. Progress continues because we believe integrating service delivery across organisations provides the best opportunity for sustainable finances, improved outcomes for citizens and realisation of aspirations for growth and prosperity for North East Lincolnshire.

We have aligned adult social care to the wider vision for health and wellbeing locally, focusing on prevention, putting the community at the centre of service redesign, and supporting people to take responsibility for their own health and wellbeing. Our whole system model aims to deliver the right care in the right place by the right people, as close to home as possible; it seeks to release the capacity and innovation in our community which will promote healthy living, self-care and prevention, and reduce the risk of problems escalating and/ or lead to unplanned hospital admissions.



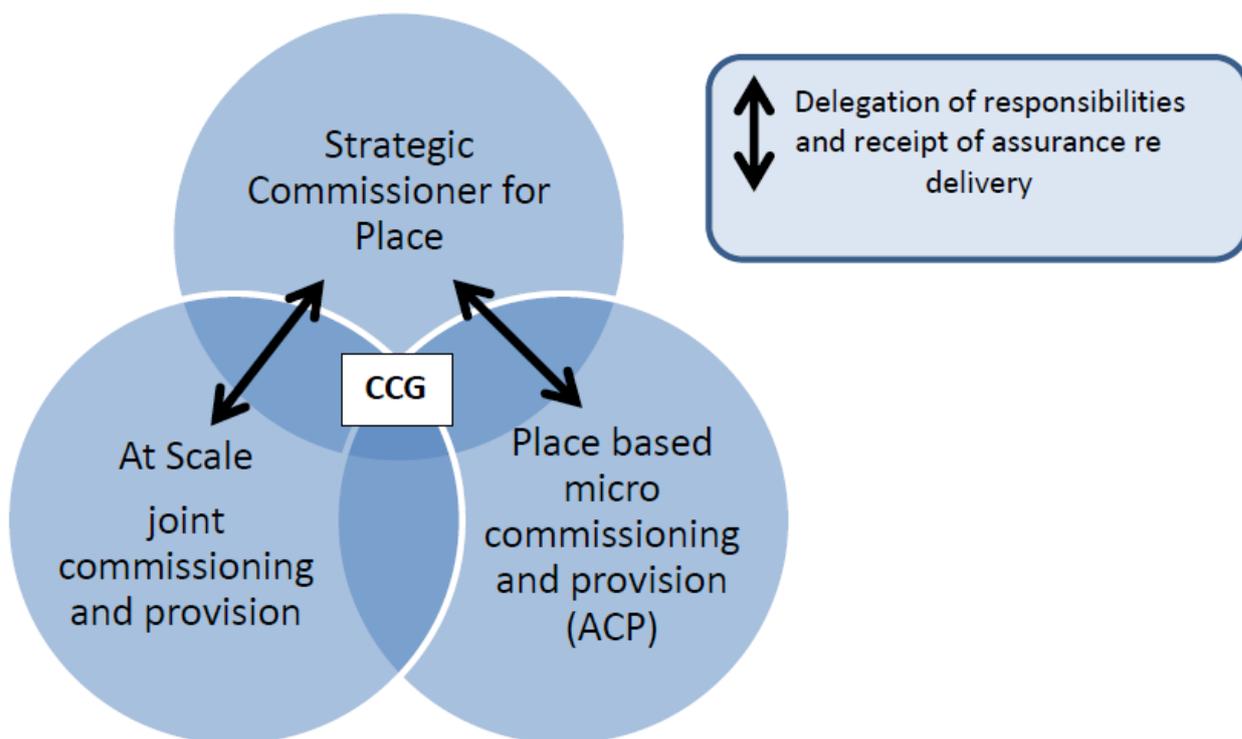
It is clear there is a need to move away from traditional models of service delivery and organisational boundaries towards reorganising services around people, communities and their needs. The universal offer of ‘one size fits all’ has many limitations, especially for citizens who have grown to see personalisation and customisation as a ‘given’ through the growth of digital technologies. Through partnership working and building community assets and capabilities, there is an opportunity to re-shape public services to ensure they meet the financial challenge head on and deliver on outcomes for citizens.

To support delivery of our ambitions we are moving forward with changing the way we commission and provide health and care services in North East Lincolnshire.

We are clear that improving health and wellbeing relies on considering and addressing a wide range of issues beyond just health & social care – economic growth and prosperity, learning & skills, housing and many more are all key contributors.

We plan to deliver our vision through enhanced partnership arrangements which will drive and support strategic commissioning, integration of services through an Accountable Care arrangement and positive engagement, participation and influence within all of the wider regional solutions which are emerging.

2.1 Future landscape



2.2 Strategic commissioner for place

NELC and the NELCCG are the two largest public sector 'spenders' across North East Lincolnshire. Closer integration of the work of the 2 organisations would appear to offer the best opportunity of securing the right strategy and interventions for economic, community and well-being benefit for the local population.

This will be delivered through the establishment of a “Union Board” through which the majority of health and council decisions will be taken.

2.3 Place based micro commissioning and provision - accountable care partnership (ACP) and alliance contract.

The ACP will work co-operatively to reshape pathways, redesign delivery models and radically realign resources to ensure people receive responsive, consistent, high quality care. This will allow faster progress to an integrated system which uses the current provider contracts and relationships through an alliance contract. This newly defined alliance contract (which must be in association with the standard NHS contract) sets out clear accountability, finance and governance arrangements which parties must be bound by when developing an accountable care system.

It allows more flexibility in how and which providers can work together especially primary care and its federations. The alliance agreement does not replace individual services contracts (i.e. contracts between the commissioner and the provider for delivery of care). Instead it brings providers together around a common aspiration for joint working across the system. It sets out a number of shared objectives and principles, and a set of shared governance allowing providers to come together to take decisions.

The commissioner still has to fulfil its obligations under the Public Contract Regulations over the alliance so consideration as to procurement and provider selection options still needs to be part of the development of the system under an ACP.

2.4 At scale commissioning and provision

There are some services which require a population footprint larger than NEL to be both commissioned and provided effectively. For these services the strategic commissioner and ACP will work with colleagues across the STP to ensure that those services are commissioned and provided in appropriate settings as close to the place of NEL as possible.

2.5 Programme alignment:

There are seven programmes that form the basis of the work being carried out in North East Lincolnshire which sits within the context of the wider STP:

To make the greatest impact on population health, efficiency and quality we have identified 3 areas where we will have the greatest outcomes:

- Long Term Conditions
- Urgent and Emergency Care
- Valuing difference and supporting vulnerability

We will be working towards implementing the national priorities within the Five Year Forward View and particularly:

- Five Year Forward View for Mental Health
- National Cancer Strategy
- General Practice Five Year Forward View

To underpin the vision we will be working across all areas to shift population culture and attitudes, workforce, digital transformation and estates.

2.6 What are we planning to achieve?

Our objectives include:

- Improving the outcomes for those living with long term conditions
- Redesign the future provision of urgent and emergency care , with a particular focus on the delivery of urgent care in North East Lincolnshire
- Increasing the expertise and support in the community to reduce the need to attend hospital
- Improving outcomes for the population with a particular focus on
 - Mental health in line with the 5YFV for Mental health
 - Learning disabilities
 - Frailty
 - Cancer Services
- Shaping the future of health and care services through enhanced partnership arrangements between the CCG and Council with a shared leadership team
- Integrating provision of services through providers working together in an Accountable Care Partnership (Together) moving towards the creation of an Accountable Care System
- Implementing the GP5YFV and strengthening GP access
- Shifting population and workforce attitudes and culture to empower and support individuals to take control
- Ensuring we are changing the way we use technology and digital services
- Developing our workforce
- Ensuring our estate is fit for purpose

- Ensuring we are making the best use of the available resources (£, people and buildings)
- Ensuring that high quality services are provided for our population

3.0 What would success look like?

Our vision for the area is that:

“We want people to be informed, involved, 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”

The vision is underpinned by five key outcomes which all partners in North East Lincolnshire have signed up to. These are:

All people in North East Lincolnshire 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

More information about the context within which we work in North East Lincolnshire can be found in the following documents, some of which are currently under development:

- North East Lincolnshire Better Care Fund Plan
- Humber Coast and Vale STP
- North East Lincolnshire public health annual report 2016
- North East Lincolnshire joint strategic needs assessment

4.0 Our local population

Our plans build from the joint strategic needs assessment (JSNA)

<http://www.nelincsdata.net/JSNA> which highlights a growing elderly and increasingly frail population. The proportion of older adults in North East Lincolnshire will continue

to increase, 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.

North East Lincolnshire'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, significant health inequalities associated with poverty and poor living standards with a consequent impact and dependency on services.

Our local health economy is facing significant challenges in terms of its financial resilience, the availability of suitably trained and skilled workers and the need to meet care quality expectations.

Local services will go through a process of transformation over the next five years with the whole health and social care economy needing to deliver savings against increased growth.

4.1 Our local demographic challenges

North East Lincolnshire 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 can be difficult to attract and retain the workforce needed across a range of sectors including health and care.

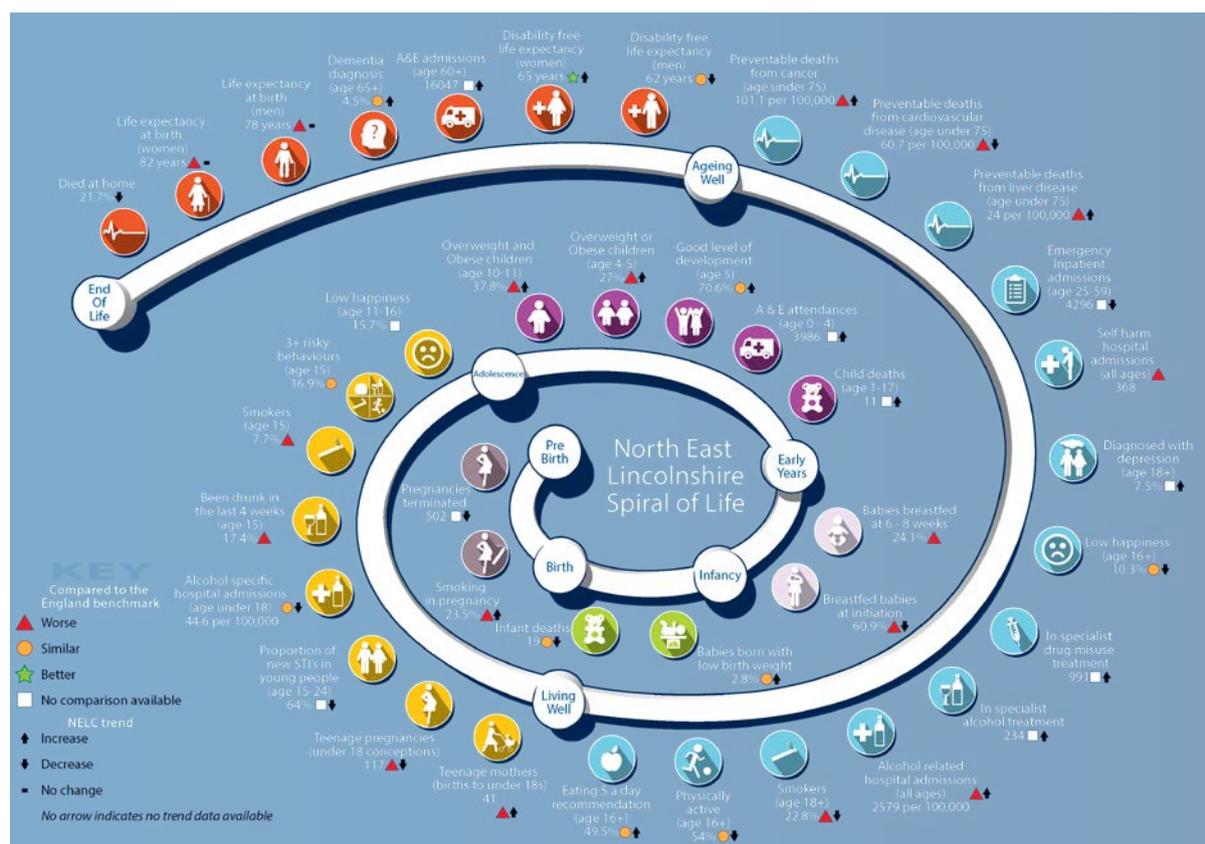
An estimated 159,803 people live within the borough which is an increase of 1.1 per cent in the 10 years since 2004¹. Latest projections indicate an overall rise in the population of 2.4 per cent between 2012 and 2037 with the number of people over the age of 85 predicted to double and those under 16 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

16/03/18

more women (22 per cent) than men (18.2 per cent) having a disability⁵. As an area, North East Lincolnshire'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 care for 50 hours or more per week (5, 993 residents or 29.8 per cent) than seen regionally (24.5 per cent) and nationally (23.1 per cent). This means that there is a higher proportion of people in the locality who may be at risk of social isolation due to caring responsibilities and who may have limited opportunities to pursue work or social interests.



<https://www.nelincs.gov.uk/wp-content/uploads/2016/02/before-and-after-life-Infographic-final.pdf>

4.2 Deprivation and health

Findings from the English indices of deprivation⁶ show that North East Lincolnshire has high levels of deprivation particularly within the East Marsh, West Marsh, and South wards. Comparing changes over time shows that North East Lincolnshire has an increasingly deprived overall picture relative to other local authorities. It is ranked the 31st most deprived local authority in England.

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 per cent more likely in North East Lincolnshire 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 reduced level of disability free life expectancy.

Older and frail elderly people 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, are less likely to adopt health seeking behaviours and are 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 terms changes to the population and reducing demand for treatments or other interventions.

4.3 Economy and health

The rate of unemployment in North East Lincolnshire is decreasing with a 2 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 were claiming out of work benefits. In 2014 the average national full time pay was 13.8 per cent higher than in North East Lincolnshire. The proportion of working age population who have no qualification reduced by 3.3 per cent from 2010 to 2014 to be at a slightly lower than seen regionally or nationally, and 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 generations of unemployment.

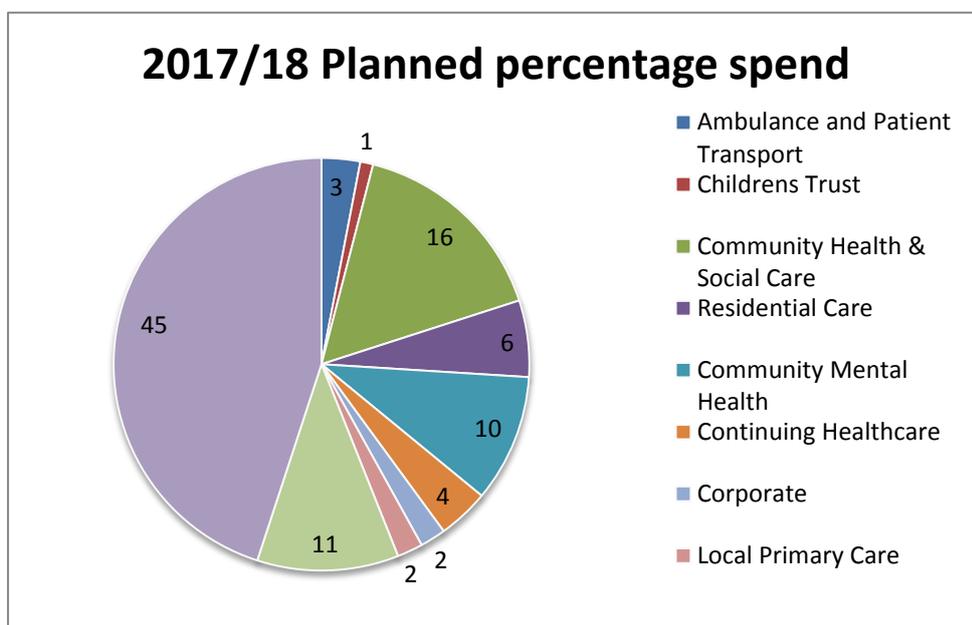
4.4 Housing and health

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 ensure 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.

5.0 Financial context – what services do we contract for?

The CCG enters into contracts with a range of providers to deliver an integrated health and social care system within North East Lincolnshire. In 2017/18 the CCG will invest a total of £267m in the health and care economy (£227m health funding, £40m adult social care) to commission services for the people in North East Lincolnshire. Services commissioned include secondary care, local primary care services, continuing healthcare and transport services together with preventative and wellbeing services, community mental health and care services. The detailed nature of the services contracted for are described in the relevant sections within this document.

The chart below shows the planned expenditure as proportions of the 2017/18 total budget envelope of £267m.



6.0 Framework for the MPS and definitions

We have structured this document in such a way as to provide a ‘directory’ of the services we buy. In doing this, and to ensure that current spend can be identified, we have necessarily structured the document in line with current budgetary and contractual commitments. This should not, however, be taken to mean that this breakdown of services is the best for the future. New ways of describing, organising and therefore funding services that cuts across traditional boundaries may be appropriate in a number of service areas.

Because of the reliance that people place on the services we commission we have described them in a number of different ways:

1. Some services are '*restricted*', i.e. we will always need to buy these services from a particular organisation. This does not, however, mean that the most stringent quality, consistency and innovation will not be expected and that the amount of these services might not change.
2. Some services are '*protected*', i.e. only a certain number or type of organisations might ever be suitable to provide these services. This might mean limited 'competition' for services.
3. Some services are '*open*', i.e. where a wide range of providers might be invited to tender.

There are also sometimes differences in how we expect to buy services, and whether it is intended that this should change in the future. For example, will we pay for outcomes (results for users) rather than inputs, and we are expecting to move away from 'block' contracts and pay for activity in future. There will also be some areas where what we have commissioned in the past on behalf of groups of people will become the subject of individual budgets, where the market will be made up of a number of individual purchasers.

Finally, even when there is no intention to change what we buy in future there is a requirement to ensure we continue to get the best possible quality of care and support. Where this quality falls below acceptable standards the CCG reserves the right to undertake a review and re-commission such services as necessary.

6.1 Coverage of the document

- Wellbeing and prevention services
- Primary care
- Community assessment and micro commissioning
- Community services
- Intermediate care services
- Secondary care services
- Mental health
- Learning disability specialist services
- Long term care
- Tertiary services
- Carers' support
- Domiciliary care
- Housing and housing related support
- Rehabilitation and re-enablement

7.0 Wellbeing and prevention services

Wellbeing and prevention services play a vital role in the overall strategy and market development approach. Approximately £6.6m is already spent in this area including a wide range of services contracted with the independent and voluntary sector. These include Carelink, St Andrews Hospice, Alzheimer's Society, The Stroke Association, Red Cross and over 23 other contracts with voluntary groups amounting to just over £2.3m purchased by the CCG.

The CCG will work to stimulate this market to provide an increasingly effective first line of support at a local community and neighbourhood level. The primary partners in this will be the independent and voluntary sector who will be supported to develop their capacity and capability. This will be achieved through:

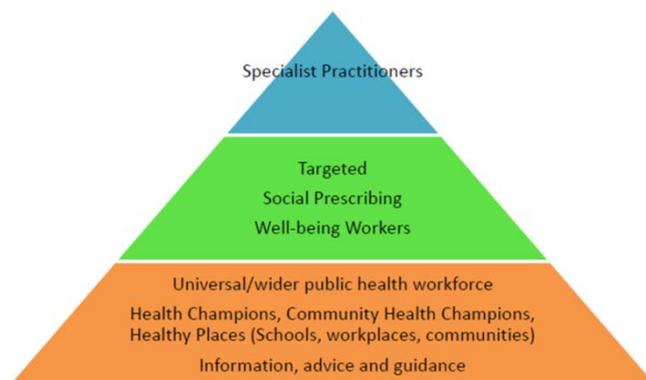
1. Grant funding from the preventative services market development board to set up priority 3 services (see appendix) with suitable guarantees of targeted spend.
2. For these targeted prevention services the ability to charge clients a maximum of £10 per hour.
3. The opportunity to raise funds through charitable and other fund raising activities and to manage costs through the use of volunteers where appropriate.

Alongside these wellbeing and prevention services the council contracts for around £4.8m of services including drug and alcohol services, substance misuse and sexual health services. The CCG informs the commissioning of these services through its participation in the health and wellbeing board.

The vision for North East Lincolnshire is for a health and social care economy that enables its citizens to care for themselves wherever practicable therefore all service providers will be required to demonstrate how they are promoting wellbeing and independence in the way in which they deliver their services.

7.1 Public health wellbeing service

The current wellbeing service is a part of the public health team within North East Lincolnshire council and has recently been reconfigured to ensure alignment with the council's desire to promote wellbeing and independence wherever practical, and more specific targeted support in areas of health inequality within the borough. The focus for this service is on the delivery of integrated wellbeing support which serves North East Lincolnshire's adult population. The service is structured across three levels of delivery dependant on client and community need and is set out in the model below.



Staff use a coaching approach to support people with their health and wellbeing with an emphasis on the wider wellbeing agenda. There is also the ability to support partners and other service providers delivering health and wellbeing related activity to adopt a similar approach. The aim is to foster a standardised approach to health and wellbeing engagement within NEL and create a consistent model for delivery. The council and CCG are in an ideal position to champion this approach across NEL and encourage partners and providers to adopt a similar way of working.

7.2 Online wellbeing tool

We are currently in the process of developing an online wellbeing tool that is accessible to people in NEL and can be completed with or without support from a professional. This tool will include an engaging and simple online questionnaire and health check to enable individuals to self-assess and signpost to appropriate information to make positive changes in their lives. The tool will be available across the life course starting with a version for adults and could eventually be used by a variety of services/ stakeholders, such as family hubs, health visitors/ school nurses, academies, local employers, the fire service, voluntary sector etc. There will be a phased approach to the development of the tool starting with an adult version with a basic sense check questionnaire covering all the potential domains that make up a person's life. These domains will give real focus to the holistic wellbeing approach and include the following topics:

- Money
- Daily routine
- Where you live
- Physical health
- Mental and emotional health
- Learning
- Relationships

We envisage that the tool/wellbeing approach could be used by health and care providers to deliver a self-reported wellbeing assessment for the clients they work with as part of developing a standardised and consistent wellbeing intervention.

7.3 Making every contact count – (MECC)

The wellbeing service currently delivers a programme of work that is centred on up -skilling the wider health and wellbeing workforce to have opportunistic health and wellbeing conversations in a standardised and consistent way based on the local ethos and approach to wellbeing and using a coaching approach. We would therefore encourage all of our providers to access this support from the wellbeing service to ensure that every opportunity to engage with service users and patients results in a meaningful conversation about healthy lifestyles and improved outcomes.

7.4 Healthy Places – traded service

Healthy Places is a trading arm of North East Lincolnshire council which has been formed as a health and wellbeing training and support provider. Healthy Places was born out of a strategic move to implement commercial growth within the authority, the goal being to establish the council as the “go-to” provider for health and wellbeing support within North East Lincolnshire.

Key objectives for the service:

- To promote health and wellbeing across North East Lincolnshire through targeted support to close the gap in health inequalities within the borough
- To increase the capability of the wider health and care workforce in being able to promote and support a public health-led approach to deliver improvements in health through training, support, advice and consultancy

This service is ideally placed to support the workforce development of all health and care providers both in promoting health and wellbeing for the clients being supported, and also to ensure that the provider’s own workforce is supported within a “healthy workplace” ethos.

8.0 Primary care

Primary Care services are commissioned by both the CCG and NHS England currently; however, the CCG has applied to take on delegated responsibilities from NHS England for the core general practice contracts from April 2018, which will streamline the commissioning arrangements for local general practices.

NHS England’s planned expenditure on GP medical services (core contract essential services) in 2017/18 amounts to £28m. This covers a total of 27 GP practices, with

registered list sizes ranging from 1300 to 21000. The CCG commissions a broad range of enhanced services from general practice (services delivered over and above core contract), predominantly delivered at individual practice level and this expenditure amounts to approximately £3.6m. Enhanced services generally support the delivery of care outside of a hospital setting.

Examples include:

- Post-operative care
- Management of anticoagulation drugs
- Initiation of insulin and minor surgery.

However, not all services are delivered by all practices and there are therefore inequities in the level of service delivered across NEL. There are a small number of services that are delivered by groups of practices or individual practices that are provided to the whole population of NEL, such as skin cancer excisions and a micro-suction service. More latterly, the CCG has commissioned services for more enhanced chronic disease management from groups (federations) of practices, working together collaboratively to share more specialised roles and ensure provision across the whole population.

In addition to these services the CCG plans to spend £28m in 2017/18 in relation to prescribing within primary care.

8.1 Future needs and demand analysis

There are growing demands on general practice, which are creating significant pressures. These include increases in the number of patients accessing services, rising public expectations, an increasing older population, greater numbers of patients with multiple and more complex needs and recruitment difficulties, particularly for GPs and nurse posts. This rate of growth in demand has been greater than the growth in funding into general practice services and this has resulted in national plans for increased investment into the allocation for general practice services. However, there are still expected to be continued challenges in meeting demand and increasing expectations.

The registered population of North East Lincolnshire is set to increase to 170,074 by 2020, which represents a growth of 586 from the October 2017 registered list position of 169,488. Based on the average of 6.3 consultations for each patient on the total registered list (taken from a local data collection exercise undertaken in October 2016), this equates to an additional 3692 consultations per year across North East Lincolnshire. This just focuses on the additional workload as a result of increased list size, and does not take into account additional activity that would be generated by new care models and an increase in workload as a result of a shift of care from a hospital to primary care / community setting.

8.2 Strategic direction

The CCG recognises that general practice plays a pivotal role in the care system, and it is seen as the foundation of a more integrated health and social care system. Sustainability of general practice is therefore a high priority. Whilst maintaining viable individual practice provision for core general practice services, the CCG will be seeking greater collaboration and delivery of care across a larger footprint for enhanced services. This is to ensure equality of service provision, sharing of more specialist resources and greater resilience of those services. The CCG's local GP Forward View delivery plan, in line with NHS GP five year forward view, aims to support this direction of travel and covers the following main objectives:

- Develop the resilience and sustainability of general practice services
- Improve access to general practice services for the local population
- Develop the extended services delivered from and embedded within general practice to provide more proactive care and better support patients with long term conditions

8.3 What we are looking for from the market

The CCG is looking to maintain viable, resilient and good quality general practice. As well as commissioning core services from individual practices which are able to cope with the increasing expectations regarding access, it is looking for providers of general practice to be willing and able to work collaboratively with other practices and local health and social care providers. As part of the local integrated accountable care system within NEL, the CCG is looking for general practices to work within a federated model across population sizes of around 30,000 to 50,000 to provide an infrastructure for extended services which are most effectively delivered at this population size, on the basis of the ability to ensure specialist skills and resilience of services are maintained and delivering economies of scale.

The CCG expects that providers of general practice services will expand the workforce to support GP workload, adopting new practice-based professional roles such as Clinical Pharmacists and Physician's Associates, and up-skilling other members of the team, such as Receptionists, to take on new roles. Improving access is a key priority, and it is expected that general practice will enhance the methods by which patients can seek advice, such as telephone, online consultations, email, and skype consultations.

9.0 Community assessment and micro-commissioning

The council and the CCG entered into a partnership agreement to deliver integrated health and care. Our community assessment and "micro-commissioning" or care planning functions are primarily delivered by focus independent adult social work, a community interest company. Around £4.1m is spent on the statutory social work functions related to assessment and case management of adults who need care or support. These functions are also included in the delivery of the single point of access, a multi-disciplinary team which provides:

- Assessment, financial assessment and care planning
- The integrated health and social care response to urgent need
- Complex care management
- Signposting and advice
- Access to preventative services
- Adult safeguarding services and
- Continuing health care hub.

This approach is governed by a clear policy entitled "ethical and pragmatic decision making" which sets out the shared principles and values intended to inform the micro-commissioned activity undertaken on the CCG's behalf across social care, CHC and FNC provision, its purpose is to:

- a) ensure provision of the best possible quality of care for those for whom the CCG is responsible, distributed on a transparent, equitable and affordable basis
- b) Improve consistency and quality of decision making across micro-commissioned provision, through knowledge and application of public law principles.

9.1 Future needs and demand analysis

As indicated in the opening to the market position statement North East Lincolnshire is experiencing growth in the number of older people with multiple complex care needs in addition to which more younger clients with long term disability will need to be supported.

9.2 Strategic direction

Practice is focused on an asset or strengths based approach which looks holistically at the health and care needs of the people we need to support. Working in an integrated system will require health care professionals and social workers to develop integrated care packages that focus on improving or maintaining wellbeing, independence and the enjoyment of life within the community of North East Lincolnshire.

There is an expectation that social work practice works in partnership with the CCG and providers to strengthen integrated practices and ensure that the health and care system is easy to navigate and is delivering appropriate outcomes for users.

9.3 What we are looking for from the market

At the present time we are not looking to re-commission this service. However we would welcome examples of good or innovative practice from other areas in order to develop our local model.

10.0 Community services

Care Plus Group is contracted to provide a range of integrated community health and social care services with a value of around £19m. A key component of this spend is accounted for with the provision of an integrated intermediate tier of services. The value of Care Plus contracts accounts for nearly 50 per cent of the CCG's community spend with the remainder being made up of domiciliary and day care, direct payments and supported living. The community services commissioned from a range of providers includes:

- District nursing

- Health visiting
- School nursing
- Specialist nursing
- Palliative care nursing
- Continence nursing
- Community learning disability services
- Community physical disability services
- Community older people's services
- Services for people with mild to moderate mental health needs
- Domiciliary care
- Social care transport services
- Community meals
- Housing with support
- Tele-care and tele-health
- Carers' support
- Involvement and engagement.

10.1 Current Contract(s)

The following provider(s) are delivering commissioned services in this area?

- Care Plus Group (CPG)
- Yarborough Clee Care (YCC)

The above contracts are until March 2019

The annual value of the current contract(s):

£19.04m CPG

£1.22m YCC

The CPG contracts are operated under block arrangements for a variety of community services available to the population of NE Lincolnshire. The YCC operates district nursing services for the population of six primary care practices related to approximately a quarter of the registered population of the CCG.

There is a range of performance criteria related to the services for both health and adult social care. These are made up of standard national CQUINS, plus a number of local KPI's relating to performance on the individual services. Any provider would need to deliver all these standards at scale. Any contract will have negotiated performance targets in line with national standards and best practice and include those referred to service and triaged, prevalence of pressure sore and damage, incidents and complaints.

The community providers must have close working relationships with GP practices and primary care locally, secondary care, hospice, mental health and adult social care. Closer working in this area and coming together in alliance and joint

arrangements is a strategic aim in order to reduce the conflicts within the system for patients and improve patient pathways.

10.2 Future needs and demand analysis

There is currently adequate supply to meet the demand within the area for community care. What is scarce is funding to meet the overall demand and the requirement on the system is to improve efficiency within the structures currently commissioned to deliver savings which can be then used to improve patients' care and delivery. Recruitment of suitable staff continues to be a risk to delivery across all sectors.

Demand for community services activity is always increasing due to the nature of an aging population. The strategic aim is to focus on improving how patients' best manage conditions, and to move services and support into community settings to try and provide community support to avoid unplanned admissions which have a substantial impact on resources. The community providers will allow earlier discharge of patients and support in the community, with rapid response teams helping to avoid unplanned admissions.

10.3 Strategic direction

Reduced funding and challenges of sufficiency of supply within the labour market coupled with higher demand for services mean that commissioners and providers have to work closely together to ensure resources targeted where required, making efficiencies and economies. The CCG expects providers to work collaboratively under aligned incentive contracts and accountable care partnerships (ACPs) which involve a number of providers working together to meet the needs of a defined population. These providers take responsibility for a budget allocated by a commissioner or alliance of commissioners to deliver a range of services to that population. ACPs work under a contract that specifies the outcomes and other objectives they are required to achieve within the given budget, often extending over a number of years.

10.4 What is the CCG looking for from the market?

The CCG is interested in encouraging the market to form an accountable care partnership to operate within an alliance contract structure. The intention is for local organisations to take responsibility for resources and activity to ensure care is carried out in the most appropriate setting and most cost effective manner within the objectives set by the CCG as strategic commissioner of place. Providers whilst holding contracts in their own right must demonstrate how they will support the wider NHS and the wider community to avoid "cost shunting" between different parts of the

system under the alliance arrangement. It is also important to ensure that providers work to design the service around the needs of the service user in a holistic way.

11.0 Intermediate services

Intermediate tier services are concerned with client or patient re-habilitation following episodic illness or crisis and is most often best described as a “half-way home” service provided on hospital discharge. Intermediate care can also provide for patient recovery as a “step down” from hospital or urgent community response and has the potential to intervene to prevent hospital admissions by means of swift interventions at home or using a short term “step-up” bed.

Services are currently arranged as follows:-

- Intermediate Care (rehabilitation/re-enablement) - this service is provided in community beds (The Beacon) or as intermediate care at home. The majority of referrals are for patients being discharged from hospital however some patients are referred from the community. Spot purchased residential care beds may be used to support flexible capacity arrangements.
- Telephone triage - as an element of the NEL single point of access (SPA), this service is integrated health, social care and Mental Health triage function for callers to the SPA that advises, signposts and initiates an urgent care response if required, including a rapid response service.
- Rapid response - this service provides a rapid response to a patient at their normal place of residence for their rapid assessment, treatment and onward referral. The service is accessed via the NEL SPA, this service may also place into short term step-up beds.
- Discharge liaison - working as part of a developing integrated discharge team to support the timely assessment and onward care arrangements for complex discharges.

11.1 Financial Context

The CCG Commissions intermediate tier services through its contract with Care Plus Group, our main community services provider. The integrated intermediate tier service is jointly funded through contributions from both health and adult social care, totaling around £8m in 17/18.

The implementation of intermediate care services nationally is inconsistent and varied as demonstrated by the recently established national audit regime (NAIC) though there is clearly a significant drive to provide the services and outcomes as described by the guidance. The CCG will continue to develop intermediate tier services to minimize the dependency on long term care and hospital services through a variety of intermediate service mechanisms.

11.2 Current supply

Care Plus Group (CPG) is the lead provider commissioned to deliver intermediate care services in NEL. As lead provider CPG has entered into an integrated partnership arrangement with Northern Lincolnshire and Goole hospital trust (NLaG - acute provider) for the delivery of therapy services that includes allied health professionals services for intermediate care. There is currently a variety of arrangements for the supply of intermediate tier bed facilities with CPG's own facilities, their own contracted supply from community nursing homes and the CCG's direct arrangements with community facilities and NLaG. CPG also works with focus CIC on integrated call handling arrangements through the NEL single point of access (SPA).

11.3 Future needs and demand analysis

Demand for intermediate tier services is predicted to increase both through demographic factors and in that step-up, rapid response and hospital avoidance services have a clear role in the transformation of care services and any shift from hospital to community based care. Further, the opportunity to expand the scope and improve outcomes for re-enablement and rehabilitation will be constantly examined.

11.4 Strategic direction

We aim to further develop the seamless, integrated nature of intermediate tier service delivery as part of the wider NEL integration approach. We aim to ensure that capacity meets projected demand and that performance is optimised in terms of individual outcomes and to minimize delayed transfers of care associated with the hospital setting. We wish to develop step-up/ hospital avoidance, further shifting to care at/ nearer home where hospital specialist care is not appropriate. By focusing on rehabilitation and re-ablement outcomes we aim to reduce long term care and potentially increase individuals' ability to live independently at home.

The commissioning principles with respect to intermediate care are to ensure that services are delivered in the most appropriate setting, are outcome focused, are high quality, cost effective and patient centered.

In line with the strategic direction and in conjunction with the developing provider network we will need to include the establishment of enhanced hospital avoidance step - up services.

11.5 How the CCG expects the market to respond

In the context of the NEL approach to integration, and the seven day working pilot, providers are expected to work together through the alliance and with the CCG to

contribute to the development of improved, integrated, value for money intermediate tier services.

Contract KPI and provider performance data reporting covers a significant dataset on activity and outcomes across the range of services.

11.6 Current Contract(s)

Care Plus Group is currently delivering services in this area and the contract is with an annual value of £8m which is part of a larger block based contract with CPG.

Provider performance data reporting covers a significant dataset on activity and outcomes across the range of services. Activity measures include volume of clinical activity in health triage, rapid response and rehabilitation services. Contractual performance requirements include reporting on a wide range of commissioner measures including CQUINS, patient satisfaction, outcome measures through specific services, call handling timing requirements etc. The contract will be reviewed in April 2018.

The key intersections in terms of integrated service delivery are:

- Service level agreement with NLaG for the delivery of therapy services as a key element of patient assessment and therapy service delivery in the hospital (assessment for discharge), in bed based and home based rehabilitation services.
- Single point of access. Working with focus CIC and NAViGO (adult social care and mental health provision) to provide an integrated “phone first” service for advice, signposting and access to urgent care services
- Integrated discharge team. Working with focus to provide an integrated approach to hospital discharge assessment and arrangement of onward care.
- Provision of a clinical nurse as part of the primary care stream co-located with the Diana Princess of Wales Hospital accident and emergency services

11.7 Supply and Demand

Intermediate tier services are currently arranged as follows:-

- Intermediate care (rehabilitation/re-enablement)
This service is provided in a community bed (The Beacon) or at home (IC@Home). The majority of referrals are for patients being discharged from the step-up bed based service (part of rapid response pathway)
- Telephone triage
As an element of the NEL SPA, this service is the health triage function for callers to the SPA that advises, signposts and initiates an urgent care response if required, including a Rapid Response service.
- Rapid response

This service provides a rapid response to a patient at their normal place of residence for their rapid assessment, treatment and onward referral. The service is accessed via the NEL SPA, this service may also place into short term step-up beds.

Activity in each of these intermediate tier services areas has risen in recent years through demographic growth and through the planned strategic aims of increasing the number of patients being offered rehabilitation/re-enablement and increasing the number of patients where accident and emergency attendance and possible admission are avoided by improved community response.

Demand is expected to rise through both demographic and strategic (care system re-design) reasons.

In future we need to:

- Ensure that capacity meets projected demand.
- Ensure performance is optimised in terms of individual outcomes.
- To minimise delayed transfers of care associated with access to intermediate care services.
- Develop rapid response capacity and step-up/hospital avoidance, further shifting to care at/ nearer home where hospital specialist care is not appropriate.

11.8 What we are looking for from the market

A key challenge is workforce, especially nursing led functions, as demand for nurses nationally and recruiting to NEL is presenting difficulties. Innovation in service delivery and commission will be required to ensure that services can continue to meet demand and improve patient outcomes. Accountable care models will be developed to support this. It is not yet clear how the development of services on a broader geographical footprint will impact on either the definition of services or the scale of provision by specific providers.

12.0 Secondary care

Acute services in North East Lincolnshire are subject to a separate market position statement which is being developed for acute services in line with the North Lincolnshire 'sustainable services' programme. The major part of the acute spend is with NLaG (£99m) but significant sums are also spent on ambulance services, other local acute services and further afield on specialist services. A relatively small but important part of this spend, particularly on tertiary or specialist services, is the responsibility of the NHS Commissioning Board.

As described earlier in the context section our provider covers three hospital sites (Diana Princess of Wales (Grimsby), Scunthorpe and Goole). We are also engaging with GP's, community services, social enterprises and social care providers to achieve high quality care in centres of excellence, to reduce mortality rates and to achieve a rebalancing of care across the local area and between hospital and community services.

12.1 Current Contract(s)

- Northern Lincolnshire and Goole NHS Foundation Trust
- Hull and East Yorkshire Hospitals NHS Trust
- Other NHS providers commissioned further afield
 - Leeds Teaching Hospital
 - Sheffield Teaching Hospital
 - Sheffield Children's Trust
 - United Lincolnshire Hospitals Trust
- Non NHS Commissioned providers
 - Virgin Care (dermatology)
 - Newmedica (ophthalmology)
 - St Hugh's Hospital – number of elective services
 - Spire Health – number of elective services

NHS Provider contracts are for two years

Other provider contracts range from two to five years dependant on when the contract was established.

All contracts are assessed on an activity payment by results basis.

- Northern Lincolnshire and Goole NHS Foundation Trust £99m
- Hull and East Yorkshire Hospitals NHS Trust £7.4m
- Other NHS providers commissioned further afield
- Leeds Teaching Hospital £525k
- Sheffield Teaching Hospital £784k
- Sheffield Children's Trust £370k
- United Lincolnshire Hospitals Trust £352k

Non NHS commissioned providers:

- Virgin Care (dermatology) £1m
- Newmedica (ophthalmology) Nil Value
- St Hugh's Hospital – number of elective services £7m
- Spire Health – number of elective services £325k

Each contract has a significant range of national and local KPI's CQUINS which cannot be identified in this market position statement. Any contract will have

negotiated performance targets in line with national standards and best practice. National performance criteria for secondary care includes 18 weeks referrals, 62 day wait cancer treatment, four hour accident and emergency waiting time, electronic referral and advice and guidance requirements. Contracts are reviewed annually and when contracts are becoming due for extension or re provision.

The secondary care providers have close working relationships with GP practices and primary care locally, community providers, mental health and adult social care. Closer working in this area and coming together in alliance and joint arrangements is a strategic aim in order to reduce the conflicts within the system for patients.

12.2 Future needs and demand analysis

There is currently a review of supply to meet the demand within the area for secondary care. However there are critical staff shortages in key disciplines which impacts on service performance and quality.

Demand for secondary care activity is always increasing due to the nature of an ageing population and the ability of technology and treatments to offer additional options for patients. The strategic aim is to focus on improving referrals in primary care, advising patients on how best to manage conditions, move services and support into community settings and implement advice and guidance to clinicians from consultants in secondary care to reduce referral activity and manage patients in other settings. The demands on non-elective emergency activity are to try and provide community support to avoid unplanned admissions which have a substantial impact on resources.

12.3 Strategic direction

The pressures in the system around funding and levels of activity mean that commissioners and providers have to work closely together to ensure resources are targeted where required, making efficiencies and economies. The CCG will be looking across the area for providers to work collaboratively under aligned incentive contracts and accountable care partnerships to deliver services; given the limited resources, cost shunt across the system cannot continue.

The NHS five year forward view and its refresh, demands of the service transformation plans and the financial plans of the CCG have identified a need for these changes

Demand needs to be managed to where it is clinically appropriate to do so to ensure people with greatest need get the services they require. There will be an expectation that all providers will work together if they wish to maintain their engagement in the local economy to reduce activity, costs and support the issue of staff shortage across

certain skill groups. The CCG will always look for opportunities to ensure effective and safe services are provided in the secondary care sector and will be looking for services to move to community settings as out of hospital care is established. This may be working with the current provider or other parties dependant on capacity and ability to deliver modern safe cost effective services.

12.4 What we are looking for from the market

Secondary care provision locally is facing significant challenges in relation to the quality of service delivery and in being able to operate within financial limits. There is a shortage of staff for safe delivery of services and a significant proportion of staff are agency or locum staff operating at premium costs. That must be reduced in order to afford the delivery of care under tariff. We have good provision for elective care from voluntary sector and non NHS providers which will support the delivery of care to patients locally

The vision of the future will be impacted on by the changes in NHS structures, relationship with councils and the STP which may take an 'at scale' strategic overview which will change the requirement of services delivered locally or further afield. The challenged health economies locally mean that resources may be diverted to sustain a wider footprint than NEL so that decisions have to be made at a higher level. All this will mean longer term decision making about significant service changes will be difficult to make in isolation of the wider system and contracts for specific elements of service not integrating into the wider health and social care system will be limited or even non-existent.

13.0 Mental health services

Mental health and learning disability services total around £24m of expenditure. Whilst significant contributions are provided to supporting people with mental health needs or learning disability by the independent and voluntary sector, the element of spend for specialist support is predominantly contracted from Navigo. The CCG wishes to develop a diverse market for care and wellbeing offering real choice for people with mental health difficulties. To achieve this vision the CCG recognises that we need to know how best we can influence, help and support the local market to achieve better outcomes and value for people. This market position statement is an important part of that process, initiating a dialogue and relationship with our providers in our area, in which we will:

- Meet the Government's requirements as set out in the Care Act 2014 and the financial challenge facing the health and social care system.
- Meet the requirements of the Mental Health 5 Year Forward view
- Commit to provide choice and control to people and to work with providers to ensure we are transparent about the way we intend to strategically

commission and influence services in the future in order to meet the personalisation agenda for both health and social care.

- To meet the requirements of the Transforming Care agenda, in collaboration with other partners in the Humber Transforming Care Partnership.

13.1 Current Supply

One in four people in the UK will suffer a mental health problem in the course of a year. The cost of mental health problems to the economy in England has recently been estimated at £105 billion, and treatment costs are expected to double in the next 20 years. Mental health is high on the government's agenda, currently illustrated by the mental health five year forward view. This identifies a five year programme of priorities for local areas to implement. A formalised partnership of providers, such as an accountable care partnership, is seen as the way to ensure the challenges are met locally.

13.2 Future needs and demand analysis

A wide range of social, economic and environmental factors influence the health and wellbeing of individuals and populations, and these factors can be used to provide an indication of the potential for mental illness and related conditions.

In North East Lincolnshire (NEL) we expect demand for mental health services to be increased due to by:

- An ageing population
- Social deprivation
- Unemployment

13.3 Strategic direction

Understanding how the market in mental health works is critical to ensuring we have a clear approach to developing effective commissioning arrangements, examining how a more level playing field for providers might be achieved, and exploring how community and voluntary sector organisations may better work together with larger providers to provide improved network of care – particularly in the fields of prevention and resilience.

Increasingly the CCG's geographical footprint means that it is not economic to provide some of the more specialist services within the borough. The CCG is increasingly working in partnership with other CCGs and councils at scale, specifically the Humber sub region, and Humber coast and vale STP "footprint." The direction of travel for mental health and learning disabilities is described within the [Humber coast and vale STP plan](#).

13.3 Our view of the current state of supply

Overall, the mental health provider market in NEL is dominated by statutory NHS provision, delivered through Navigo, a social enterprise. Most focus and resource is on acute needs; those elements of the market concerned with the early identification of emerging problems and community-based support for those with ongoing problems are less well developed.

Services can be categorised as follows:

- Services for people with common mental health problems
- In-patient, crisis and home support
- Community and acute mental health and memory service: services for people with dementia
- Support in the community
- Employment and training

There needs to be more choice given to people requiring long term care, especially with an emphasis on support and enablement as opposed to residential care. Personalisation needs to be more actively promoted to people with mental health issues in order that they can have control over their recovery. Priority has been placed on developing and stabilising access and crisis response for adult mental health services, and also developing solutions for individuals with complex needs to enable them to return to the area from out of area placements.

As part of the national direction all mental health services were required to implement payment by results (PBR) for all mental health services from 2015. The set-up entails assessing service users into one of 21 clusters; for example '(6) non-psychotic disorders of overvalued ideas' or '(19) cognitive impairment or dementia (low need)'.

Within these a 1-4 scale indicates the seriousness of the condition, and clusters are linked to various maximum review periods ranging from four weeks to annual. Each cluster is linked to a care package – under PBR this is what commissioner's pay for, as opposed to the traditional 'block contracts' that are commonly used to fund care.

The theory is that resources follow the patient. We are working with Navigo to ensure the pathways remain integrated by providing patients an enhancement of care which will keep integration at the heart of our mental health service. It is our intention to explore other funding mechanisms to better facilitate the flexibilities of an integrated health and social care system.

Part of the CCG's strategy is to better manage demand to ensure the right professional responds to situations at the right time. To help deliver this vision we

are currently working with NAViGO and Rethink to find ways of better integrating mental health into our single point of access arrangements. We believe there are huge benefits from having mental health workers (say) alongside community nurses, social workers and other care professionals. This will support the development of one single access point for all in NEL, regardless of the need.

The CCG tries to ensure that care for its residents is provided as close to NEL as possible, within the context of affordable services. To this end we will use partnership arrangements, such as STP and Transforming Care Partnership, to ensure high quality care is available to the people of NEL.

Over the last five years we have been working with the providers appointed on a framework to support them to develop services for people with long term support needs that are fit for purpose. This has involved reviewing and remodeling residential care and undertaking a review of all people under the age of 65 currently in residential care and looking at moving people on to more supported living services.

The care market is now in a much better place to meet the demands of people requiring long term support with much more focus on enablement and independence. This is the model of choice in NEL for people in the Transforming Care cohort, where small discrete units with bespoke care centred on the individual has enabled people with complex mental health and/ or learning disability needs to return to NEL. This model of care is how we intend to continue to meet the needs of this cohort and others with long term complex support needs.

We will be focusing on preventive and implementing the government's policy on "no health without mental health". Providers need to be in a position to offer people choice and control and look at ways of supporting personalisation in order for people to have a market in which they can purchase person-centred care.

Widening opportunities for accessing psychological therapies through development of integrated Improving Access to Psychological Therapies (IAPT) will form a better facility for people with common mental health difficulties to have the treatment they need to tackle their issues before they build up to crisis point. This will see greater partnership working between IAPT provider and primary care, and enable access to quality IAPT provision within primary care centres.

Looking to the areas of prevention and resilience building, we would welcome 3rd or voluntary sector providers to engage with initiatives such as social prescribing, seeking to support people to address core issues such as occupation and loneliness which are often a precursor to poor mental health.

Providers within the area are expected to plan, work, and deliver outcomes together through partnerships both within and extending outside of NEL – playing to the strengths of each organisation - to better enable a good quality care experience for the local population.

The CCG is currently reviewing the contract for the primary care provision to ensure that any in-house service is able to work closer with the IAPT provision. Wherever possible tender procedures have and will continue to include service users and community members to guide the process and choice of provider to win the tender. The CCG will ensure that the any qualified provider procurement model will aim to reduce barriers to entry for potential providers, and so improve patient choice and access, and deliver value for money. For larger provision this must be considered in the context of the ACP.

13.4 Current Contracts

NEL has one main integrated health and social care provider, which is a social enterprise organisation known as NAViGO. It works with the voluntary and community sector to deliver a range of pathways across mental health. Services can be categorised as follows:

Services for people with common mental health problems across the payment by results clusters and pathways:

- In-patient, crisis and home support
- Community and acute mental health and memory service – (services for people with dementia)
- Support in the community
- Employment and training

One of our priorities has been to develop more supported accommodation for people to live independently. This has involved working with Navigo whilst reviewing all out of area placements and looking at pathways to return people closer to home. We have developed several supported living schemes as alternatives to residential care, in which people have remained more settled. We have remodelled both the acute care pathway and our unlocked rehabilitation pathway, in order for people to have a much clearer step down provision from both secure and acute care.

13.5 Financial context:

Currently our actual spend on mental health and learning disability services within NEL is set out below:

Category	Health spend	Adult social care spend
IAPT	£1.5m	-
Liaison psychiatry	£2.1m	-
Community mental health and physical health checks	£4.7m	£3.4m
Other adult mental health	£13.2m	-
Residential mental health		£0.8m
Specialist and community learning disability	£1.6m	-
Learning disability community (and housing related support)	-	£8.7m
Learning disability residential and nursing	-	£5.2m
Dementia	£1m	£1m

We currently operate within payment by results within our mental health service and have recently experienced significant pressures in the system to manage crisis and working more jointly with the single point of access (SPA) and Rethink. We are now in a position to respond much better to people who require support and who feel they are experiencing crisis by developing a fully integrated SPA. The number of calls to SPA between April 2016 and March 2017 was 115,962.

Our mental health provider delivers integrated health and social care. It is therefore required to meet the quality and performance standards set by NHS England and the adult social care outcome framework measures (ASCOF).

The only two measures currently falling below expected levels of performance are:

- DAC4090 IAPT access rate:
- DAC6120 IAPT recovery rate:
-

NAVIGO has continued to perform well with IAPT recovery, although marginally below the 50 per cent target in March 2017. The overall percentage for quarter 4 of 2016-17 was 50.8 per cent. The increased performance appears to be continuing into 2017-18 with April 2017 performance currently at 53.8 per cent.

We meet with the mental health provider on a monthly basis to review performance on the existing contract and the value is annually negotiated, working in partnership with Navigo to improve services all the time. The current contractor will be part of the ACP approach this year.

Navigo continues to work with other providers and community and voluntary organisations like Rethink and care4all. This year remodelling the dementia pathway will be a focus for the ACP.

13.6 Supply and Demand

The current financial climate creates a significant challenge to all those who are involved in commissioning, providing or using health and social care services. We have an ageing population and more younger people with complex conditions who will transition to adult services. Our provider has significant demand on the service and we are working with them to respond to people in much smarter ways and ensure people are discharged from the appropriate pathways as appropriate.

13.7 What strategic direction is the CCG taking in this area?

The NHS five year forward view for mental health is the focus. Our priority is to ensure we invest in our wellbeing and preventative services. By delivering targeted support early, the correct intervention may prevent an individual from developing a severe and enduring need, or stop a crisis from occurring in the future.

National guidance and the mental health strategy “no health without mental health” sets out four key domains related to mental health:

1. Preventing people from dying prematurely
2. Enhancing quality of life for people with long term conditions
3. Helping people to recover from episodes of ill mental health and following injury
4. Ensuring people have a positive experience of care.

By working in preventative manner we are enabling people to live as independently as possible and ensuring access to support is available for them and their families.

We have recently being successful with a regional bid to focus on developing more of our IAPT (improving access psychological therapies) to people with long term conditions.

We are setting priorities across the STP to focus on some specialist areas to support people with complex mental health needs. These will include out of area placements and support to people with dementia.

13.8 What we are looking for from the market

One of our challenges in NEL is how we change culture to ensure mental health is embedded in all services and make mental health everyone's business, by embedding mental health into existing pathways and support networks. We are working with public health to look at ways to educate schools and workplaces to recognise mental health and respond. Housing remains a big challenge for vulnerable adults, and with our unique partnership working with the council we are developing a more co-ordinated approach which enables us to respond more quickly to people who require accommodation.

14.0 Learning disability Services

14.1 What we are currently commissioning

We are currently commissioning a range of specialist learning disability services; which includes the intensive support team, health and wellbeing workers specialist nurses currently from Care Plus Group. This multi- agency team merged into one in order that they are in a better position to respond people with a learning disability support and their families in managing complex health care and support. They also offer a significant amount of support to providers in order to maintain the individual within their own home during times when the person's behaviour deteriorates.

We have worked hard in North East Lincolnshire to develop a range of supported living services in order that people with complex needs can live independently as possible, offering a person centred support from a range of providers on the framework.

People with a disability are supported into employment where appropriate and we also commission a range of day occupation both from Care Plus Group and the third sector,

Transforming care

Humber transforming care partnership (TCP) has been established for transforming care and services for people with a learning disability and/or autism, especially those who also have, or are at risk of developing, a mental health condition or behaviours described as challenging. This includes people of all ages and those with autism (including those who do not also have a learning disability) as well as those people with a learning disability and/or autism whose behaviour can lead to contact with the criminal justice system.

The Humber TCP was established to work on a wider footprint than our usual learning disability planning partnerships, with consequent increased scope for economies of scale and greater opportunities for learning from the experience of other areas and organisations. This three year transformation plan is written in response to building the right support and the national service model published in October 2015, which set out a national vision for a radical shift in the delivery of care and support for people with learning disabilities and/or autism.

Our plan describes our intention to improve the quality of care and life experience of people with a learning disability and/or autism in order to reduce our reliance on inpatient care to the following

Due to the market reshaping North East Lincolnshire doesn't have any inpatient beds, but a number of people will be moving from low secure services and we are planning for person centred services.

The TCP is committed to improving safe care and treatment to make sure that Children, Young People and Adults with a learning disability and/or autism have the same opportunities as anyone else to live satisfying and valued lives and are treated with dignity and respect.

We continue to work with children's services to identify people who will need support into adulthood we have reviewed the transition pathway in line with the Children and Families Act in order that people are clear of the process and each person has a health/care/education plan

15.0 Long term care

Long term care and continuing NHS healthcare (CHC) represent a total of £24.9m annually. These two elements of spend are jointly commissioned by the CCG and should be seen as supporting overlapping needs and will in future be increasingly integrated. The individual circumstances for each person with long term or CHC needs means that this commissioning activity involves working with a wide range of providers both locally and further afield. A more detailed market position statement outlines the approach envisaged in these services.

15.1 Current Contract(s)

Details are included at appendix 1. All contracts are rolling contracts which are continually reviewed against set standards. A new contract and specification will be in place by April 2018.

As of 27/3/17 the annual costs are as follows:

DESCRIPTION	Total expenditure £'000	Number of clients that are out of area placement
Learning disability nursing	193	4
Learning disability residential care	4,627	32
Total learning disability long term	4,820	36
Mental health residential	778	7
Total spend on mental health long term	778	7
Older people nursing	513	1
Older people residential care	10,724	8
Enhanced dementia care	606	0
Total spend on older people long term	11,843	9
Physical disability nursing	54	0
Physical disability residential care	635	6
total spend physical disability long term	689	6

The table below summarises the amount of service placements currently needed.

	Permanent residents		Short Stay Placements
CCG Funded	533		35
CHC Funded	130		30

Outcomes are identified in the service specification and backed up with a quality awards framework. The specification has been piloted from 1st April 2017 and will be fully implemented subject to community consultation by April 2018. Individual provider contracts are reviewed on a rolling basis with on-going monitoring against the quality criteria.

The existing quality award is based around three levels (bronze, silver and gold). Each level has the same key areas but an award is based on level of compliance/attainment. As a result of the Care Act 2014, the quality framework is being redesigned and the contract specification enhanced. The quality framework now covers four prescribed domains and one that can be self-defined.

The intersections are between nursing care, CHC and domiciliary care.

15.2 Future needs and demand analysis

Registered beds	Permanent residents	Short stay placements
1631	1095	77
CCG Funded	533	35
CHC Funded	130	30
Self-funded	369	11
Other local authority funded	63	1

This represents a 72 per cent occupancy rate. There is a good level of supply in this area offering a range of choice however this can lead to issues where low occupancy becomes problematic for individual provider sustainability. The present concern is that there could be oversupply in the market leading to pressure in smaller providers where bed occupancy could be at a more critical level.

15.3 Strategic direction

We are actively seeking to move the market forward by developing a much more detailed specification that is Care Act compliant and developing a revised quality framework that is based on outcomes and the needs of the residents. This builds on three years' worth of development of the existing quality framework.

Our aim is that people in residential care receive care appropriate to the complexity of their conditions and are encouraged to be as active as possible. Care homes should be able to provide appropriate responses to ensure management of conditions within the home. We are working to develop our enhanced support to care homes model with a wraparound package of care to prevent avoidable hospital admissions.

This will allow payments to be made against the quality framework in a similar way to CQUINS allowing a more stable income stream and focusing on the needs of residents

There is a need for all providers to work in accordance with a Care Act complaint specification. Those that are not doing so will be required to develop a plan to meet the contracted standards. The revised quality framework and the ability to tailor the care outcomes to residents, means that homes may be able to develop and deliver localised unique selling points. In conjunction with all other provision described within this market position statement, care homes provide a critical part of the care pathway and providers will be expected to collaborate across the health and care system to ensure that health, wellbeing and independence outcomes for service users are the focus of the care setting and that hospital admissions/ hospital lengths of stay are minimised.

15.4 What we are looking for from the market

There is a need to attract new workers to the care workforce to ensure quality and stability of care provision. There is also a need to ensure that there is an adequate supply of good quality care managers within the workforce.

Our priority is to support people to maintain independence within the home wherever possible; this is partly due to stated preferences by service users and partly to ensure that resources are used to best effect.

16.0 Tertiary services

Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) provides acute secondary health care services to residents of North and North East Lincolnshire, East Riding of Yorkshire and East and West Lindsey, Lincolnshire and community services in North Lincolnshire. Networked services are provided in collaboration with Hull and East Yorkshire Hospitals NHS trust as the Trust's main adult tertiary service provider, and the trust hosts pathology services for Northern and Greater Lincolnshire (there is currently a review of pathology services across the Midlands). NLaG employs approximately 6000 staff, with an annual turnover of £310m.

Diana Princess of Wales hospital has approximately 400 beds and currently provides a full range of emergency and secondary health care services including an emergency care centre, intensive and high dependency care. Scunthorpe general hospital with around 338 beds provides a full range of emergency and secondary health care services including an emergency care centre with an integrated model. Goole and district hospital has approximately 55 beds and provides a minor injuries unit, and a range of outpatient and diagnostic services. It also houses a specialist rehabilitation service offering general and medical rehabilitation.

Sheffield Children's NHS Foundation Trust provides specialist children's services. Outpatient clinics are undertaken by Sheffield consultants in the Diana Princess of Wales hospital and Scunthorpe general hospital for paediatric surgical and medical specialties. All specialist children's surgery, surgery for children under the age of 2 and children's cancer services are provided by Sheffield Children's NHS Foundation Trust. Neonatal care for babies of less than 27 weeks gestation is also provided by Sheffield with plans in place to increase the gestational age for transfer to 28 weeks. Transfers are undertaken by EMBRACE (a specialist paediatric transport service). Leeds Cancer Centre delivers a comprehensive range of treatments, for Leeds, Yorkshire and the North of England.

17.0 Carers' support

The following providers deliver support to carers in NEL:

- Carers' support centre
- NAViGO
- Care Plus Group
- Carelink
- Foresight

The lengths of contract are as follows:

- Carers' Support Centre – 3 years +1 +1 (contract to be reviewed January 2018)
- NAViGO – 1 year (contract to be reviewed January 2018)
- Care Plus Group – 1 year (contract to be reviewed January 2018)
- Carelink - 3 Years +1 +1 (contract to be reviewed January 2018)
- Foresight - 1 year (contract to be reviewed November 2017)

With annual values of:

- Carers' Support Centre - £325k
- NAViGO - £38k
- Care Plus Group - £58k
- Carelink - Circa £12k (depending on demand)
- Foresight - £5k

The expected outcomes of all carers support services are:

- Delivery of a high quality, culturally sensitive and inclusive carer led service that is delivered by appropriately trained staff and volunteers to meet individual and collective carers' needs.

- Carers of all ages, and the people who work with them, are well informed about the information, support and services available for carers.
- Effective partnership working with all local carers' forums and wider carer participation from all carer groups to gain a strong collective carer voice that informs the development and improvement of local services.
- Effective strategic partnership and working relationships with relevant organisations and agencies across the statutory, voluntary, community and independent sectors to improve the overall health and wellbeing of carers residing in North East Lincolnshire.
- Development of a carer--aware and friendly community through robust publicity, promotion, outreach and engagement activities.
- Carers of all ages including those from hard to reach carer groups are identified and encouraged to register with the carers' support service/ GP.
- All carers, professionals and community members are able to access a wide range of advice and information.
- Registered carers are able to access a range of information, specialist advice and carers support services which are responsive and sensitive to their individual needs.

17.1 Future needs and demand analysis

It is estimated that there are around 16,000 carers in NEL. Many of these carers are unregistered/ unrecognised as many carers remain hidden from formal support. Current capacity in the above service provision meets the current demand. As further work is undertaken to raise the profile of carers, create a carer friendly NEL and improve pathways to registration and support, it is hoped that many more carers will come forward for support. In addition, as people live longer with life-limiting conditions, the number of people who are carers will grow and the burden on those carers will increase – as a result it is anticipated that there will be year on year growth in demand. This is particularly the case for NEL as we have an aging population compared to other areas so an increase in the numbers of carers is expected.

17.2 Strategic Direction

Please find the carers' support strategy at the link.

We have just refreshed our local carers' strategy, vision and forward plan for the next three years. The areas of priority are to ensure carers are:

- Identified at the right time

- Provided with appropriate advice and information throughout their caring journey
- Supported to identify their needs and responded to appropriately
- Supported in their caring role and have a life outside of caring and beyond
- Recognised as expert care partners and are involved in care and support planning for the cared for
- Involved in service design, delivery and monitoring

Supporting carers is part of our strategic agenda to promote preventative interventions i.e. by offering carers' 'easy-access' lower level support via the North East Lincolnshire carers' support service. We hope to support carers to sustain the caring relationship wherever possible, have a life outside of caring and perhaps reduce access to more expensive commissioned services necessitated by avoidable crises. The CCG understands the role carers play in our local community and the vital contribution they make to the local health, social care and wider economy. The CCG therefore wants to clearly set out its priorities with its partners on supporting carers now and in the future. This direction also fits with wider CCG strategic decision making to ensure the creation of holistic joined up services, secure economies of scale and supports the shift to the left (we support carers to enable them to support the cared for persons to stay in their own home for as long as possible).

The carers' strategy is carer-led. Extensive consultation occurs regularly on a service and wider carers' agenda basis, carers are included and involved in commissioning decisions and support the quarterly monitoring of carer contracts. NEL's tradition of cooperation and integration evidences that services are more effectively commissioned in partnership. Results of strategy engagement demonstrate carer feedback corroborates our strategic direction. In addition, supporting carers is extremely cost effective and an effective method for supporting whole families.

17.3 What we are looking for from the market

All carers' support services are currently delivering to their contract and in many areas adding value. There are very few concerns/ complaints raised across all of the carers' support services and feedback on services is exceptionally high.

We constantly review (quarterly) carers' support contracts to ensure they are compliant with legislation, best practice and continue to meet carers' needs. In addition the NEL carers' strategy action plan aims to address any wider carers' agenda developments/ gaps to ensure continued support to carers in NEL. We would favour models of practice which promote client and carers' independence, self-care and overall family wellbeing.

18.0 Domiciliary care

The services are provided as follows:

- Willow Homecare – lead provider
 - Lincolnshire Quality Care Services (LQCS) – lead provider
 - HICA – lead provider
 - Hales Group – approved provider
 - Aspects Care – approved provider

Contracts are for three years plus a two year extension with a total annual value of £5,734,807 at an hourly rate of £13.12.

Provider	Adult social care hours	Number of service users	CHC patients	Total service users/patients
Willow	1953	221	11	232
LQCS	1546	156	7	163
HICA	1866	194	8	202
Hales	1472	148	18	166
Aspects	48	7	3	10

Individual outcomes are monitored by care practitioners, these are not collated as yet. It is something we are looking to build into new model of working between 17-18 and something we will ask providers to report on as part of monitoring.

The key performance criteria are detailed in the table below:

KPI		Descriptor	Data Capture	Tolerance level
1a	Timeliness and reliability	The percentage of care visits which are delivered	Missed calls (ECM)	90%
1b	Timeliness and reliability	The percentage of care visits which are delivered by the designated care workers in accordance with the support plan	Late calls (ECM)	80%
1c	Timeliness and reliability	Number of cases in the locality area which were not picked up by the lead provider	Quarterly performance monitoring	90%
1d	Timeliness and reliability	Percentage of care packages re-initiated within agreed timescales following discharge from hospital	Quarterly monitoring	80%
1e	Timeliness and reliability	Percentage of new care packages initiated within agreed timescales	Quarterly monitoring	80%
2a	Person-centred Care	Percentage of service users receiving evening/overnight service	Rolling basis to understand demand for night support	90%
2b	Person-centred care	Number of care packages which have reduced in support hours as a result of intervention	Quarterly performance monitoring	Individual case-by-case basis
3a	Appropriate Care	Number of times <i>Just Checking</i> has been utilised which may have otherwise resulted in an emergency response (including intermediate tier) or hospital admission	Qualitative and quantitative data	Review periods
3b	Appropriate	Proportion of service users who are still at	Quarterly	95%

	Care	home 14 days after discharge from hospital	performance monitoring	
4a	Quality of service	Percentage of service users registered with ECM	Rolling annual improvement threshold	80% increasing to 90% after 12 months
4b	Quality of service	Friends and Family Test (FFT)/Patient Satisfaction	FFT or Survey	85%
4c	Quality of Service	Safeguarding referrals, complaints, concerns and incidents are resolved and acted upon with lessons learnt informing changes to organisational processes	Professional feedback/ action plans/ reduction	80%
5a	Skilled workforce	Percentage of staff who have completed mandatory training (who have been employed for longer than 12 weeks)	Quarterly performance monitoring	100%
5b	Skilled workforce	Number of staff who have received specialist training appropriate to service user needs	Qualitative and quantitative data	90%
6a	Equality and Diversity	Equality opportunities monitoring data collated for service users and staff members	Equality and diversity Monitoring Template	100%

Domiciliary care is an integral part of the care pathway and of the support needed to maintain service users leading independent lives at home. Key interfaces are with:

- Ensuring timely hospital discharge.
- GP's
- Care homes
- Continuing health care
- District nursing

18.1 Future needs and demand analysis

The current time/task model of working is being reviewed. Feedback from providers, discussions with commissioning colleagues and national press infer that it is not fit for purpose. Locally it has resulted in very limited capacity particularly around the times of 8am, 12 noon and 4pm. The model that has been in place in NEL since 2015 is geographically split into 3 main areas with one provider servicing each (lead provider) and two approved providers picking up those packages that lead providers are unable to. This has subsequently been split into four lead areas.

This model will be reviewed when planning for the new contracts in 2018 or 2020. Due to the demand at key times (8am, 12 noon and 4pm) often packages cannot be sourced as soon as we would like with some delays of up to two weeks. We have built in two hour "tolerances" around these times, but do feel that this is not servicing people's needs adequately. The geographical model does help in that providers can resource accordingly with less travel time, as well as working together to support one another but they are reacting to the assessed packages and times with little control over co-ordination. i.e. filling slots.

We are introducing a new model moving away from time task, into neighbourhood/community teams with defined staff serving named groups of service users in a flexible manner that is not time specific. For example if someone was not feeling well enough to rise in the morning, the team would make the person comfortable and return at a later time.

We have been operating a pilot in one area (Humberston) comprising 60 service users since April 17. While actual delivery of services has not changed significantly (people still like the set times) the setting up of zones and teams has freed capacity up for HICA and relieved the pressure for other providers. We are monitoring the pilot, and expecting to roll it out further into HICA's area to include Cleethorpes.

Demand will increase with fewer resources and staff available to deliver services; a new way of working is therefore essential.

18.2 Strategic direction

We are looking at remodelling the service around flexible neighbourhood teams to respond to demand while delivering person centred outcome based support. We will extend the current contracts until 2020 with a view to rolling out the new way of working fully in 2018.

The perceived lack of capacity is causing pressure in the sector for all, including hospital discharge teams, care practitioners and not least provider staff, both in co-ordinating packages and care staff delivering these packages. Recruitment and retention is a major issue in the sector. The new model will address the capacity issue while allowing teams to support as required on a daily basis and not purely deliver the tasks required which sometimes leaves the person feeling “done to”. The teams will have the flexibility to respond to demand i.e. a new package can be incorporated into the team, rather than as now individual staff being identified according to their rota and fitted in. The staff member’s role will change; it will be much more responsive and less pressured which should aid recruitment and retention.

Complaints and concerns from service users and professional staff were increasing and our analysis of data and demand patterns led us to a conclusion that a new model of service is needed to ensure that services can be sustainably delivered.

The teams will have the ability to “soak up” new packages, resulting in almost immediate responses to new packages. The providers will discuss packages with new service users and agree how the service will be delivered after receiving the needs and outcomes (not times) from the practitioner. This will free up practitioners and providers to respond more effectively.

18.3 What we are looking for from the market

As mentioned above capacity is the ultimate priority, to enable all providers to manage their own staff according to need rather than to prescribed times. Reducing travel time and allowing teams to “soak up” extra packages and increases will provide a more responsive service.

Recruitment and retention into the sector is a major concern. Allowing teams to respond to the needs of individuals rather than on a strict time task rota basis will help to improve working conditions and attract new staff. Longer term staff could be employed on a shift basis.

Our priority is to support people to maintain independence within the home for longer wherever possible. The risk of this is a sharp rise in demand outstripping capacity even with the team based responsive approach above.

In addition to this, the approach above does have the added risk of an increase in time spent with Individuals, in the move away from time and task. Close monitoring

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and review of packages is required, Finance need to identify variations in service delivery, which needs to be closely monitored against any care plan with comprehensive contract monitoring against commissioned hours.

19.0 Housing and housing related support

The following provider(s) deliver commissioned services in this area:

- Longhurst and Havelok Homes
- Doorstep
- YMCA
- Salvation Army
- Women's Aid
- Creative support
- Humber care

The contracts are for two years + 1 + 1 + 1 (from July 2016) with an annual value of £2,175,594 for the whole programme

Contract Name	Contract Value (Annual)	Current Provider	Clients supported at any one time
Accommodation based and floating for offenders	£60,372.00	Longhurst and Havelok Homes	22
Accommodation based for multiple and complex needs	£73,788.00	Longhurst and Havelok Homes	22
Accommodation based general needs over 25 yrs	£136,500.00	Salvation Army	35
Accommodation based and floating Domestic Abuse	£167,700.00	Women's Aid	65
Accommodation based for young people 16 - 25	£283,065.00	YMCA	103
Accommodation based for young people 16 - 26	£308,100.00	Doorstep	79
Floating Support for young people 16 - 25	£98,280.00	Doorstep	45
Floating Support for Singles and Families	£472,914.00	Longhurst and Havelok Homes	235
Floating Support for Older People	£335,400.00	Longhurst and Havelok Homes	650
Floating Support for Mental Health	£239,475.60	Longhurst and Havelok Homes	119

Clients are measured against 9 performance outcomes and providers' performance in achieving these aims is measured:

- managing money and bills;
- accessing education, training and employment;
- daily living skills;
- numeracy and literacy;
- physical and mental health;
- personal behaviour (if applicable);
- ability and confidence to access other services;
- family and relationships;
- moving on to independent living.

In addition, length of time in service, positive move-on, and client satisfaction are also monitored for each service, and the services are compared against each other and good practice shared.

These services complement, support and assist in many other areas, as secure and stable housing is a basic need of every resident to ensure their health and wellbeing.

19.1 Future needs and demand analysis

Demand is currently exceeding supply, particularly in accommodation-based services where support is delivered in the home setting. It is anticipated that demand will continue to rise due to welfare reforms affecting homeless clients and their ability to secure suitable housing. Also clients are presenting with multiple and complex issues which require intervention from other complimentary services (e.g. adult social care, mental health, drug/alcohol services).

19.2 Strategic direction

We are committed to continuing to provide this vital support to clients to secure independence and wellbeing in order to achieve the wider council outcomes of stronger economy and stronger communities. Support enables clients to gain the confidence to actively participate in their communities, manage their finance, and access training and employment. The support for older people tackles social isolation and loneliness.

Housing related support prevents demands on other services (adult social care, health, police and probation for example). Housing related support also contributes to achieving the aims of the housing strategy in that everyone should have access to suitable, affordable housing.

External factors are more likely to impact on demand. We will need to consider carefully, upon reviewing the contracts, how we can maintain, increase or redistribute supply to certain client groups.

19.3 What we are looking for from the market

The strengths are that these services are well established and have the knowledge and track record in these areas that are required. Flexibility within the contracts allows for the most in need clients to receive more intensive support, and for support to be tapered for clients who are nearing readiness to move on.

We do this through contract management, performance monitoring, and maintaining cooperative and collaborative relationships with all providers.

We are currently working with Doorstep and YMCA to ensure a positive pathway through services for young people, with the aim of having a seamless transition through services.

We have not yet seen the full impact of various strands of welfare reform on young people or how the new Homeless Reduction Act will further increase demand on supported housing. In addition, any further funding reductions to these services are likely to lead to a reduction in numbers of clients supported as providers have, to their credit, dramatically reduced costs/ overheads in order to deliver the current contracts within the budget allowed. In addition, forthcoming changes to the way supported housing is funded could present a significant risk to the survival of these services.

20.0 Rehabilitation and re-enablement

The assisted living centre (ALC) aims to provide all of its users with accurate, up-to-date and timely advice, information and signposting with regards to all aspects of independent living. This includes clear advice on what items may be supplied and provided by the service, including alternatives which may be purchased, and/ or signposting to purchasable items. It includes a demonstration facility showcasing the range of adaptations for daily living available, including self-purchase defined items of equipment. The facility provides choice and improved access to equipment, helping to promote independence and wellbeing, and support self-care wherever possible.

Where adaptations have been prescribed by authorised professionals, the service aims to stock, supply, deliver, fit, install, adjust, repair/refurbish, collect, decontaminate and recycle/ dispose of adaptations requisitioned by authorised prescribers (where appropriate). The service also provides office space for allied health professionals, occasional disabled facilities grant (DFG) sessions, sensory

impairment drop in clinics and other activities of community benefit, to support the promotion of health and wellbeing for North East Lincolnshire (NEL) residents.

The core elements of the service are:

- A high quality, equitable and cost effective service for both adults and children.
- A public facing service which operates over 6 days of the week.
- Provision of relevant, concise and timely advice and information for all stakeholders.
- Demonstration facilities which showcase the range of home environments in which the equipment could be used and the types of equipment that are available via self-purchase or a commissioned service.
- Provision of a self-purchase model to allow members of the community to purchase or be signposted to aids and adaptations as a preventative measure or to offer greater choice.
- A referral and triage system for access to the service for those with eligible needs.
- Access to an assessment of need which leads to the prescription and loaning and/or self-purchasing of equipment at the time the client visits the service wherever possible.
- Bookable appointments for prescribers to use the ALC for timely, multiagency (where relevant), clinically based, comprehensive holistic assessment that also takes account of the carer's, parents' and family's abilities.
- Referral into the Community Therapy Team for a comprehensive holistic assessment at home where appropriate.
- A prescription (based on need)
- Information at the time of referral to enable the individual and their parents/carers to make informed decisions regarding care and requirements.
- Support, information and scheduled reassessments at the time of first assessment.
- Development and agreement of a personalised care plan where appropriate.
- Flexible and proactive services for those children and adults with rapidly deteriorating conditions.
- Provision of equipment on loan to all those with eligible needs as part of their care plan.
- Appropriate client education and training.
- Flexible and proactive follow up and review to identify changing needs and prevent avoidable deterioration.
- Provision of an efficient distribution, installation, collection and cleaning equipment
- An equipment service which is facilitated by specialist software and a multi-skilled workforce that operates over 7 days of the week.
- The maintenance and repair of equipment in line with manufacturing guidelines, including a service for emergency/ urgent repairs.
- Decontamination of equipment in line with infection control regulations.

- Reuse of equipment, where this is economically viable and appropriate.
- Recycling of equipment for scrap, where possible.
- Warehousing of equipment in line with health and safety and manufacturer's guidelines.
- Robust tracking and monitoring of equipment through specialist software

20.1 Current Contract

Northern Lincolnshire and Goole Hospitals NHS Foundation Trust (NLaG) provide services in this area under the NLaG block contract arrangement at a value of £1.4m annually. The contract is required to meet presenting need.

The expected outcomes are:

- A fully accessible service, easy for stakeholders to contact, fully compliant with all equal opportunities legislation and convenient for clients, carers and prescribers.
- A responsive service that meets national and local guidelines for the delivery and collection of equipment, has IT based, efficient stock control and storage facilities, robust infection control measures and delivery methods, and is flexible enough to meet changes in national or local policy requirements.
- A cost effective service that achieves good value for money on equipment purchases through buying power, achieves a high recycling rate and maximises reuse of equipment and collection rates.
- A quality service with high levels of customer satisfaction and an exemplary safety record with health and safety policies in place and implemented.
- A person centred service with regular stakeholder feedback, consultation systems and a robust complaints procedure.
- Service outcomes that reflect the clients agreed objectives in their assessment and/or integrated care plan and which encourages strong joint arrangements and local partnerships. This includes liaison and coordinating with other services which all contribute to the person-centred approach.

Health and Social Care Commissioners wish to see-

- An increase in the number of people who are enabled to remain living in their chosen home.
- A reduction in the number of people requiring admission to hospital, residential or nursing care.
- Evidence of efficient hospital discharges facilitated by a responsive ALC service.
- Evidence that the provision of appropriate equipment can in some cases prevent deterioration of a condition or the complications of additional health problems.

- A reduction in the need for more complex / costly interventions such as housing adaptations.
- A reduction on out of area placements for vulnerable adults

Key quality or performance criteria are:

- 95 per cent of low level assessments to be completed at the time of presentation at the ALC service
- 95 per cent of complex assessments to be undertaken within 28 days of receipt of referral, subject to client choice, unless in urgent cases (these should be within 2 weeks)
- 100 per cent of clients with a complex assessment to have a Personalised Care Plan
- 95 per cent of deliveries and collections to be made within the required timescales for standard referrals for standard stock items
- 95 per cent of deliveries and collections to be made within the required timescales for urgent referrals for standard stock items
- 85 per cent of 'special' stock items to be delivered within 6 weeks from receipt of the order at the service; the remaining 15per cent within 8 weeks
- 100 per cent of clients to have been reviewed in accordance with the Personalised Care Plan, or at least annually if they have on-going needs
- 100 per cent of clients to be offered a customer survey, with at least a 20per cent response rate. Of those, at least:
 - 90 per cent of clients to rate the service as good or excellent
 - 90 per cent of clients should feel valued and respected
 - 90 per cent of clients should report that their outcomes and goals have been met

Maintenance and repair standards

- 100 per cent of all planned maintenance to be completed within the required timescales
- 95 per cent of all non-urgent repairs to be made within 7 days
- 99 per cent of all urgent repairs to be made or an alternative provided within 4 hours

This service is reviewed in line with the wider NLaG block contract arrangement. quality and performance is reviewed on a quarterly basis. This service is part of the wider NLaG block contract; however it interfaces with Telecare provision, carers' support, allied health professionals, social care, intermediate care, disabled facilities grants team and with domiciliary care providers.

20.2 Future needs and demand analysis

Demand for the service is growing year on year, as people are living longer with long term conditions. In addition, now that the self-purchase model is furthering development, the reach of the service is growing to those with prevention and wellbeing needs, as well as those with eligible needs for prescribed equipment.

Future demand for the service will continue to increase, firstly due to NEL's demographics, but also because of our aspiration locally to support people in their own homes for as long as possible.

20.3 Strategic Direction

Further review on an on-going basis to ensure the service continues to be fit for purpose, now and in the future. Reviews will include wider assistive living options to further enhance and broaden service deliver – i.e. some work to include those with visual impairment needs and disabled facilities grant applications.

We would wish to see a fully inclusive 'assisted living service' that offers advice, information, guidance and assessment of an individual's needs and support and assistance where necessary to meet those needs.

As the remit and scope of the service broadens, the demand for the service will inevitably grow.

20.4 What we are looking for from the market

As the service has been extensively reviewed and re-modelled, the service is designed and is currently meeting local need. As demand increases for the service, there will inevitably be strain on the availability of equipment, staff capacity and timings of assessments/ provision of equipment.

Constant review of supply and demand will ensure that appropriate conversations can occur to ensure the correct level of investment is directed to the service.

We would like to see expansion of the wheelchair facility, providing advice and training sessions to enable people and carers to maintain their own wheelchairs appropriately and increased use of the centre by the public through on-site promotion and demonstration of equipment, leading to a rise in self-care and self-purchase.

Appendix 1 list of care home providers

3 Welholme Rd	Residential Care - MH
Bellamy's Cottage	Residential - LD
Bradley Apartments	Residential - LD
Carisbrooke	Residential - LD
Fairways Care Home	Residential Care - Older People
Garden House, The	Residential Care - Older People
Glynn Thomas House	Residential Care - Older People
Havenmere	Residential Care + Nursing
Homefield House	Residential Care - Older People
Kirklees	Residential - LD
Newgrove House	Residential Care - Older People
Old Vicarage, The	Residential - LD
Royal Court	Residential Care - Older People
Stanage Lodge	Residential Care - Older People
Waltham House	Residential Care - Older People
Carlton House	Residential Care - Older People
Meadows, The	Residential Care - Older People
College View	Residential Care - Older People
Old Library, The	Residential Care - Older People
Orchards, The	Residential Care - Older People
Ashlea Court	Residential Care + Nursing
Acorns	Residential Care - Older People
Alderlea	Residential Care - Older People
Anchorage, The (Residential Unit)	Residential Care - Older People
Anchorage, The (Enhanced Unit)	Residential Care - Older People
Ashgrove Care Home	Residential Care - Older People
Bradley House	Residential Care
Brooklands	Residential Care + Nursing
Cambridge Park	Residential Care - Older People
Chestnuts, The	Residential Care - Older People
Church View	Residential Care - Older People
Clarendon Hall	Residential Care + Nursing
Cloverdale	Residential Care - Older People
Cranwell Court Residential	Residential Care - Older People
Cranwell Court (Enhanced Unit)	Residential Care - Older People
Eastwood House	Residential Care - Older People
Eaton Court	Residential Care + Nursing
Grimsby Grange	Residential Care - Older People
Grimsby Manor	Residential Care - Older People
Grove, The	Residential Care - Older People
Kensington, The	Residential Care - Older People
Ladysmith Care Home (Enhanced Unit)	Residential Care - Older People
Ladysmith Care Home (Residential)	Residential Care - Older People
Lindsay Hall	Residential Care - Older People + Nursing
Ravendale Hall	Residential Care - Older People
Rivelin Care Home	Residential Care - Older People
St Margarets	Residential Care + Nursing
Stallingborough Lodge	Residential Care + Nursing
Sussex House	Residential Care - MH
Temple Croft	Residential Care - Older People
Yarborough House	Residential Care - Older People