



North Lincolnshire Integrated Adults Partnership **STRATEGIC COMMISSIONING PLAN** **2020/24**

SLIDE 3

Foreword: Chair and Vice Chair of the Integrated Adult’s Partnership

SLIDES 4 to 7

Strategic Framework

Organisational Model

Outcomes

Emerging Themes

SLIDES 8 to 11

Priorities ‘Shine a Light’

Priority Focus

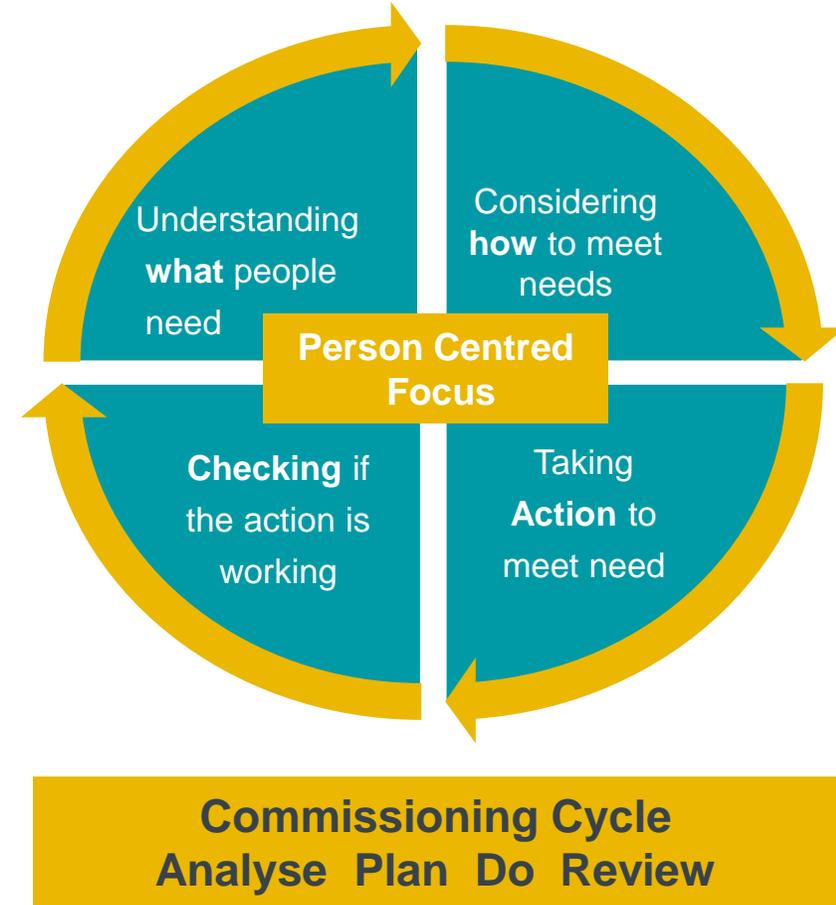
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On behalf of the Integrated Adults Partnership, we are pleased to introduce our North Lincolnshire Integrated Commissioning Strategy for Adults 2020/24 which clarifies our integrated approach and commissioning intent in relation to health and social care for adults in North Lincolnshire.

Our ambition is for North Lincolnshire to be best place to live, work, visit and invest where people are safe, well, prosperous and connected. We will achieve this through implementation of our shared strategic priorities and these are

- Enabling Self Care;
- Care Closer to Home;
- Right Care Right Place;
- Best use of Resources.

- This strategy is to enable Health and Social Care Services working with Adults, Families and Carers to have a shared understanding and ambition for the people of North Lincolnshire.
- It signals an intent to work together and integrate both services and our commissioning functions where these improve outcomes and to prioritise those where they have additional need.
- The strategy will inform Adults, Families and Carers stakeholders and others of our commissioning intent, the intent being based upon national and local guidance, data and intelligence and the views of Adults, Families and Carers as well as from practice wisdom and best practice.
- The strategy will form the work of and be monitored by the Integrated Adults Partnership and provide a conduit between this, the Place Partnership and the Health and Wellbeing Board.



Alex Seale
Chief Operating Officer
North Lincolnshire
Clinical Commissioning Group
Chair of
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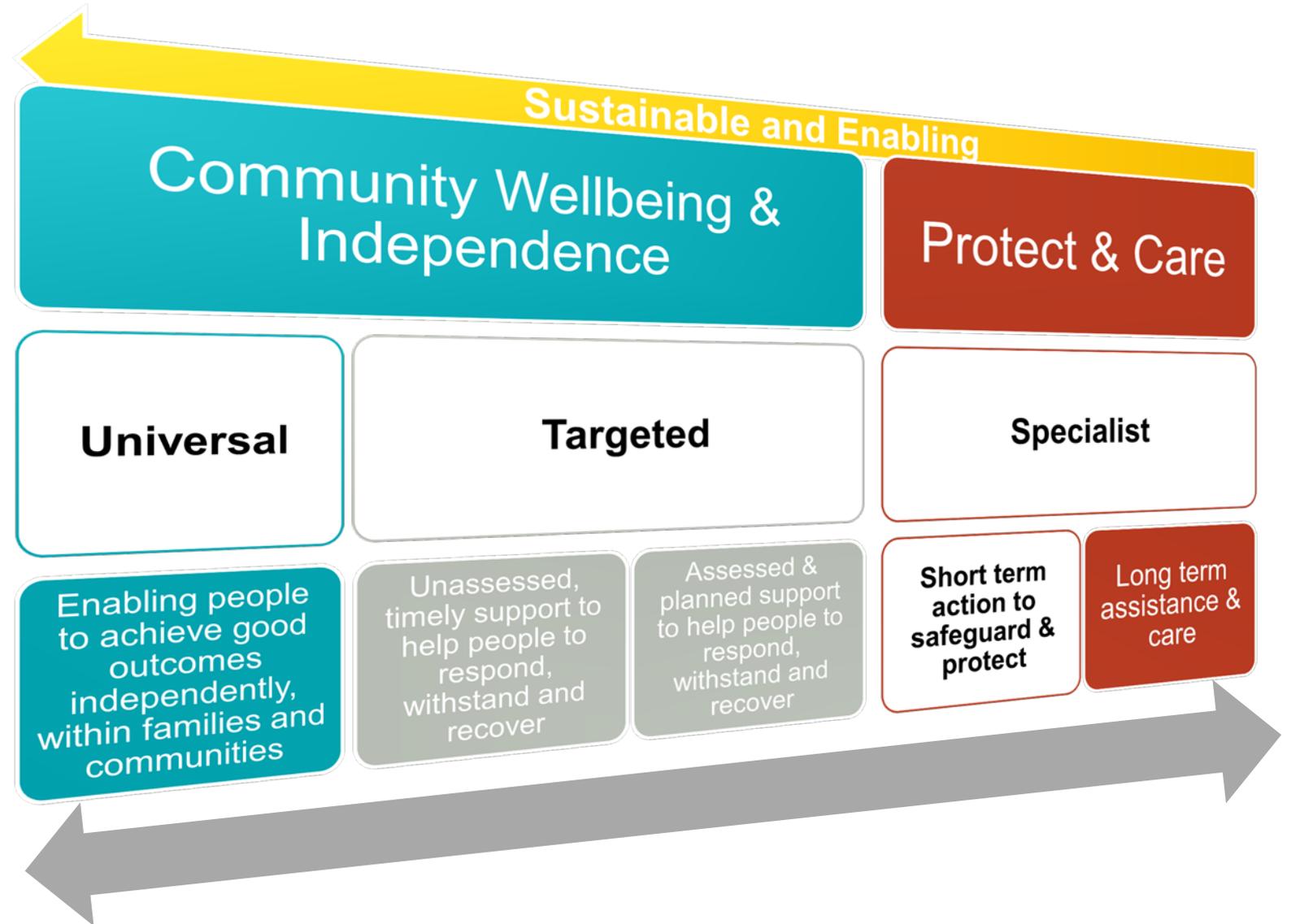


Single organisational model - meeting need at the lowest level

Universal
Self Help and Enablement

Targeted
Focused and preventative

Specialist
Protection and long term



SAFE

- **Where people:**
- are safe in their own home, at work and in their local communities;
- are encouraged to manage their own health through community hubs and within alternative health services such as pharmacists;
- are able to access more community capacity through further development of our local assets;
- are supported to withstand adverse impacts and change behaviours;
- are empowered and supported to identify and develop their strengths and aspirations;
- are able to die in their place of choice;
- are central to the quality assurance of their services.

WELL

- **Where people:**
- are a healthy weight and live active lives;
- enjoy positive emotional wellbeing and mental health;
- are empowered to lead a healthy lifestyle through Making Every Contact Count approach;
- receive the health care and support they need in their community where possible;
- receive end of life support that meets their needs;
- are able to access volunteering, employment and befriending services;
- are able to access assessment and care planning services, that work collaboratively across levels of need to enable consistency of practise.

PROSPEROUS

- **Where people:**
- are empowered and enabled;
- have access to a consistent offer of health and care;
- are able to manage their health & social care needs through a personal budget;
- achieve their potential (including the most vulnerable);
- are able to access care and support in the most appropriate setting, for the right amount of time, to meet their needs;
- receive a holistic response to their needs;
- access the support and skills they need;
- Access consistent care journeys that reduce unwarranted variation in outcomes.

CONNECTED

- **Where people:**
- are able to access information, advice and guidance easily in easy read format;
- are empowered and enabled to participate, have equality of opportunity and access to creative and flexible support at the earliest point, in the right place by the right people;
- have greater choice and control over the care and support they receive through implementation of a single assessment and support planning framework;
- benefit from engaging in positive activities;
- build resilience and find resolutions for themselves;
- are able to transport themselves around the area.

We will demonstrate our success in improving outcomes for our adult population through performance monitoring, voice and practice wisdom

Key themes which have shaped and influenced our commissioning intents and priorities

Our shared ambition:

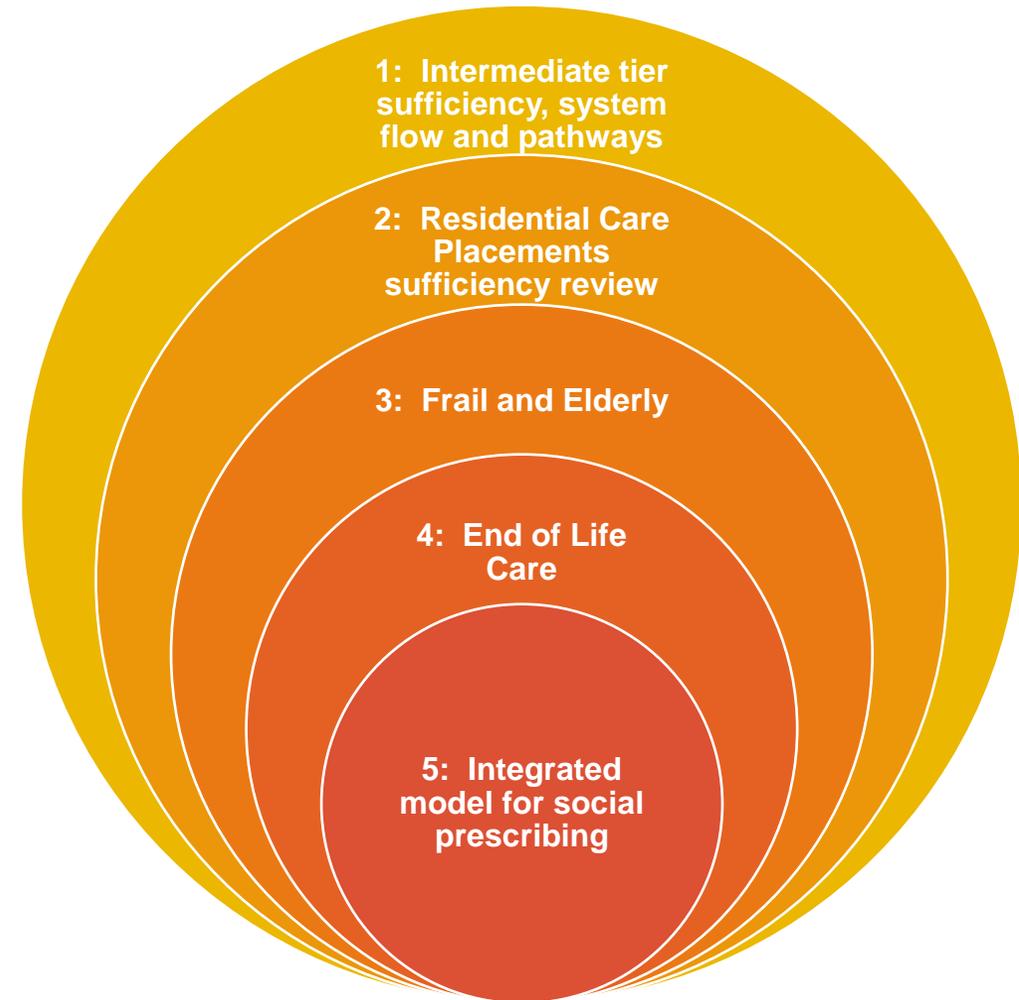
Our shared ambition to support people through good customer care is demonstrated through the following 'I' statements:

- I have access to a range of support that enables me to live the life I want and remain a contributing member of my community.
- My parents/carers say they feel supported and enabled to have a good quality of life.
- I have the information, and am enabled to use it, that I need to make decisions and choices about my care and support.
- Taken together, my care and support help me live the life I want to the best of my ability.
- I am as actively involved in discussions and decisions about my care, support and treatment as I want to be.
- When I move between services or care settings, there is a plan in place for what happens next.



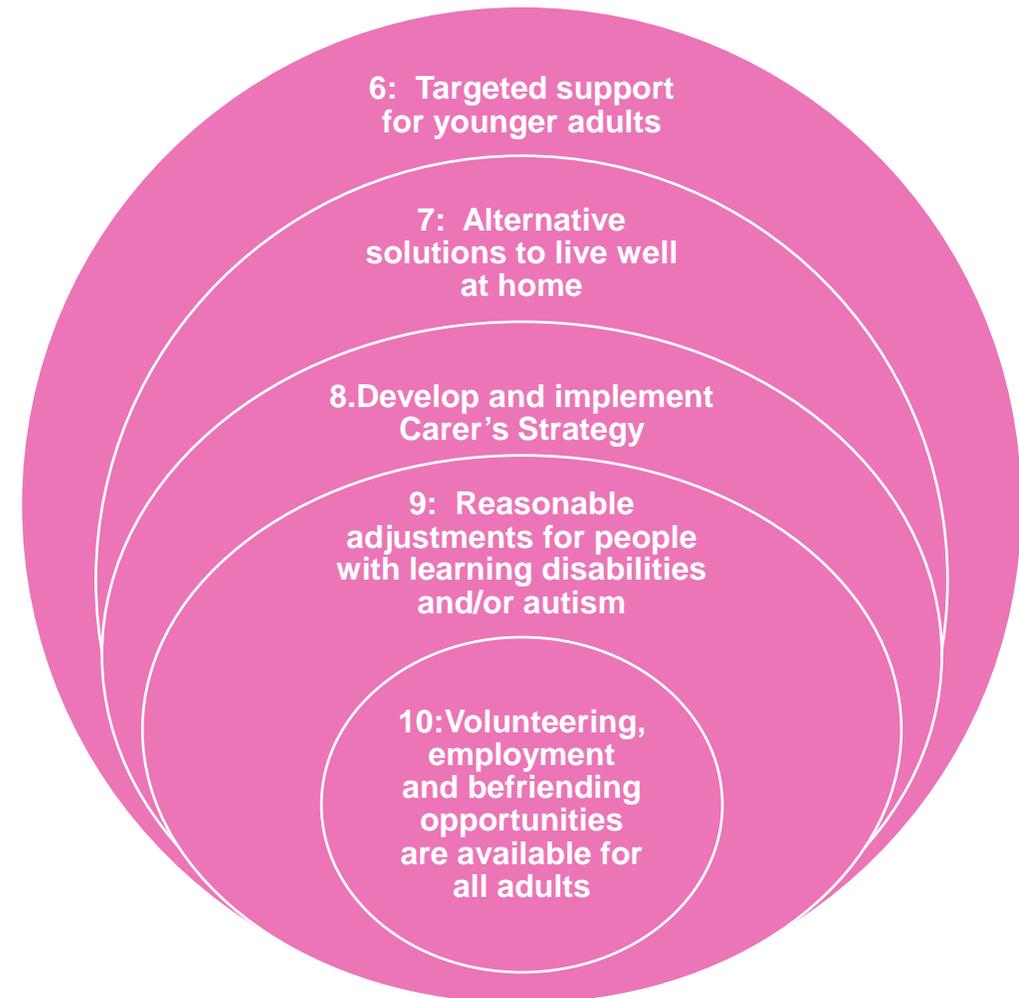
We shall do this by implementing robust performance and governance frameworks, compliance and professional best practice, specifications to include corporate responsibilities and social value outcomes, investment in personal and professional development

These **COMMISSIONING INTENTS** articulate the areas of focus that the Integrated Adults Partnership will **'SHINE A LIGHT'** on for partnership action and system change to contribute to our adult population being **SAFE, WELL, PROSPEROUS** and **CONNECTED**



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Strategic monitoring and oversight - Without evidence, we don't know what is working well and what could work better.

For areas in which we want to **'SHINE A LIGHT'** there are identified lead officers to drive forward partnership action and system change.

As part of this, lead partnerships will be responsible for identifying, monitoring and progress reporting to the IAP, underpinned by relevant **performance data and analysis, practice wisdom, voice and engagement and reviews/reports.**

COMMISSIONING INTENT	PARTNERSHP ACTION AND SYSTEM CHANGE
<p>1 – Intermediate tier sufficiency, system flow and pathways</p>	<ul style="list-style-type: none"> ➤ Intermediate tier review including reflections on learning during Covid -19 period and changes to services required/implemented ➤ Integrated single point of access (Gateway to care) ➤ Improved system flow and integrated pathways on discharge, for those that need rehabilitation or are unable to return home at that point. ➤ Full implementation and impact measurement of Early discharge planning, pre-operative discharge planning, discharge to assess and trusted assessor.
<p>2 – Residential Care placements sufficiency review</p>	<ul style="list-style-type: none"> ➤ Residential Care: Improved relationship with care home providers, acknowledging value and breaking down organisation barriers. Increased quality of care and using clinical evidence to support changes. ➤ Short Stay placements review to support assessment and enablement provision that is genuinely short-stay ➤ Improvements in how some independent sector care is commissioned for mental health service users.
<p>3 – Frail and Elderly</p>	<ul style="list-style-type: none"> ➤ Align to Humber Acute Services Review Out of Hospital Programme. ➤ Development of integrated frailty strategy, proactive and reactive frailty pathways and integrated care services.
<p>4 – End of Life Care</p>	<ul style="list-style-type: none"> ➤ Review of End of Life strategy. System wide action plan development across Primary Care, Community Services and Hospices. ➤ Implementation plan for RESPECT model and EPaCCs (Electronic Palliative Care Coordination System)
<p>5 – Integrated model for social prescribing</p>	<ul style="list-style-type: none"> ➤ Development of Primary Care link roles and Capacity Builder to support development of voluntary sector capacity to meet Social Prescribing needs.

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COMMISSIONING INTENT	PARTNERSHP ACTION AND SYSTEM CHANGE
6 – Targeted support for younger adults	<ul style="list-style-type: none"> ➤ Review of commissioned services and development of communications and engagement to support younger adults to access services
7 – Alternative solutions to live well at home	<ul style="list-style-type: none"> ➤ Implement the Independent Living Centre ➤ Development of the domiciliary care market to support people to remain in their homes
8 – Develop and implement Carer’s Strategy	<ul style="list-style-type: none"> ➤ Carer’s strategy engagement review to ensure co-production ➤ Integration with support for young carers
9 – Reasonable adjustments for people with learning disabilities and/or autism	<ul style="list-style-type: none"> ➤ Specialist care and support for people with learning disability and/or autism. ➤ Housing needs for all disability groups with a range of provisions ➤ Consideration of adjustments required across commissioned services to support all people to access them
10 – Volunteering, employment and befriending opportunities are available for all adults	<ul style="list-style-type: none"> ➤ Establish a local volunteer hub with support to enable all people to access ➤ Review the role of the voluntary sector

These COMMISSIONING INTENTS articulate the areas of focus that the Integrated Adults Partnership will have a **LINE OF SIGHT** on to shape and influence partnership action and system change (and which may be the responsibility of other partnerships and planning frameworks)

SAFE

- Commissioning services to meet the individual needs of **mental health** service users
- Manage the impact of changes to the **Liberty Protection Safeguards**
- Develop a joint approach to supporting people who are **frail**
- Implement the **Integrated Care Service**
- Development of the integrated **Home Care Framework**
- Specialist care and support for people with **learning disability and/or autism**.
- **Housing needs for all disability groups** with a range of provisions
- Implement **Multi Agency Resilience and Safeguarding (MARS)** arrangements.

WELL

- Appropriate support for people with **dementia** and/or have had a **stroke**
- Identify alternative **housing** provision for people living with **dementia**
- Specialist support for people who are **frail and/or elderly**
- Develop an integrated model for **social prescribing**
- **Reasonable adjustments** for people with **learning disabilities and/or autism**
- **Autism diagnosis** and development of an **autism aftercare model**
- Implement the **Independent Living Service**
- Develop and implement **Carer's Strategy**

PROSPEROUS

- Ensure sufficient **intermediate tier** capacity
- **Care home contract and framework**
- **Care home sufficiency**
- Undertake **review of intermediate tier**
- Improved **system flow** and **integrated pathways** on discharge
- Improved **system performance**
- Implement the Humber **Acute Services** review, including the **Out of Hospital Transformation** workstream
- **Volunteering, employment and befriending opportunities** are available for **vulnerable adults**
- Explore opportunities for **integrated commissioning** (NHS North Lincolnshire CCG & North Lincolnshire Council)
- Establish a local **volunteer hub**
- **review the role of the voluntary sector**. E.g. specialist services

CONNECTED

- Transform **digital solutions** to improve access to information and resources
- Develop **total transport solutions** to meet all needs
- Develop a **Joint Section 117 protocol**
- Develop an integrated single point of access (**Gateway to Care**)
- **Primary Care Networks (PCNs)** to be configured and agreed service model in place
- Identify and implement **models of care and support** to align services to PCNs. E.g. Mental Health, social care
- **Integrated case management** for complex needs
- Engage with our community through **People's Voice**
- Implement the **discharge to assess digitalisation project**

We shall do this by robust performance and governance frameworks, compliance and professional best practice, specifications to include corporate social responsibilities and social value outcomes, investment in personal and professional development

Our shared ambition to support and enable our workforce:

- We work together through the 24hr period.
- We are proactive and more options are available in the community.
- We are all enabled to work together as we have joined up protocols.
- We are all able to access joint resources to help people.
- We help people easily move between settings in a timely way.
- We are more efficient as we reduce duplication at every opportunity.
- We support people in their homes and families bringing specialist services in the community.



WORKFORCE ENGAGEMENT STRATEGY

Will be achieved by...	Being agile in thinking and working practises	Enabling flexible, agile leadership at all levels	Involving the workforce at all levels in decision making	Valuing and recognising achievement	Behaving true to our values - valuing each other
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We shall do this by robust performance and governance frameworks, compliance and professional best practice, specifications to include corporate social responsibilities and social value outcomes, investment in personal and professional development

People, Families, Carers and Communities are at the heart of all we do and by making use of their strengths, assets, views and experiences and by engaging with and working together as partners and with other key stakeholders across the partnership, including the voluntary and community sector, we will co-produce local services and support which meet the needs of local people and help to achieve positive outcomes.

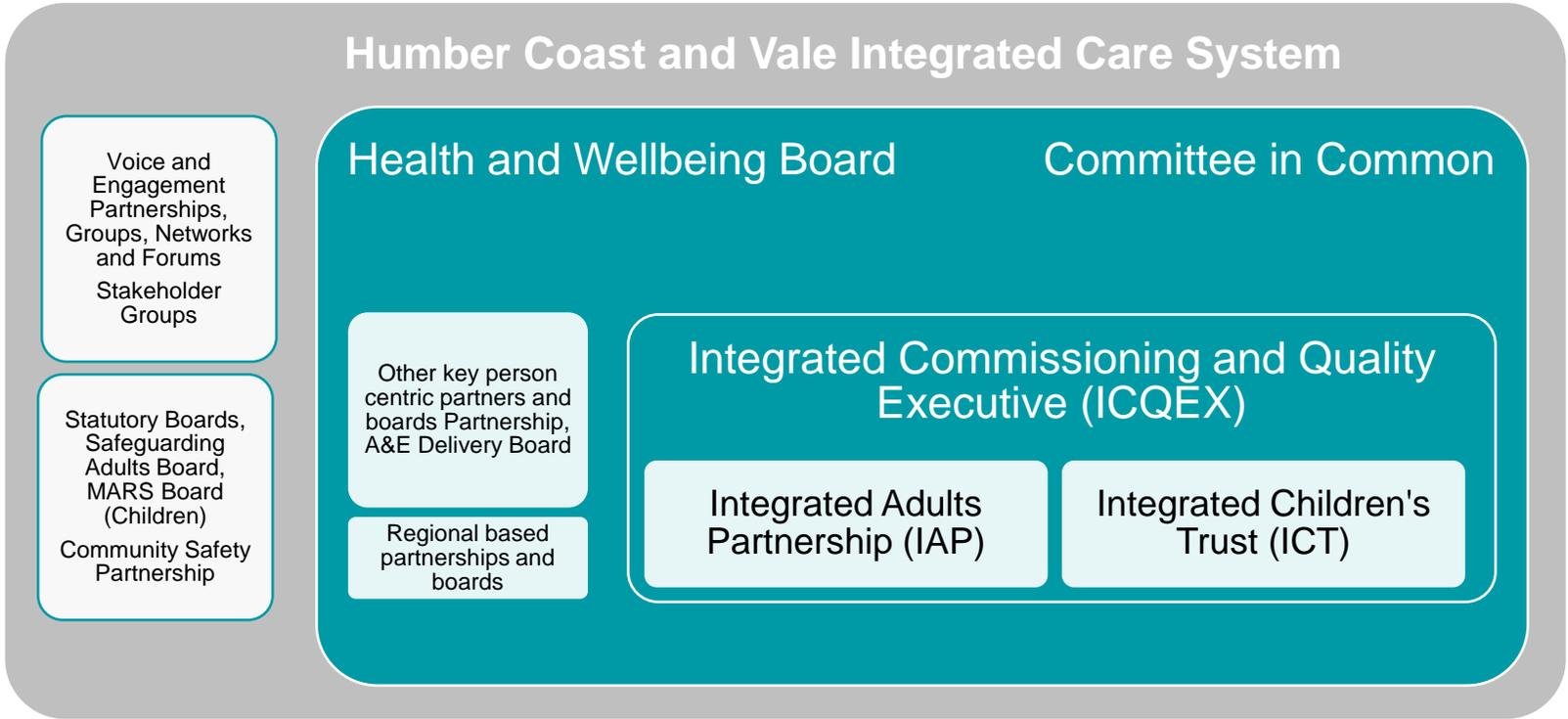
This will be underpinned in our stakeholder engagement which clarifies our commitment and mechanisms for engagement at all levels.

Along with People, Families, Carers and Communities themselves, key partners and stakeholders include the Council, the CCG, health providers, police and the voluntary and community sector.

Lead Partnership – Integrated Adults Partnership.



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Monitoring and Oversight: Priorities – Shine a light

COMMISSIONING INTENT	LEAD OFFICER	Implementation Timeline			
		2020/21	2021/22	2022/23	2023/24
1 – Intermediate tier sufficiency, system flow and pathways	Head of Adult Social Care NLC	Model review and planning based on learning during pandemic period and changes to services required/implementation planning	Full implementation and impact measurement of Early Discharge planning, pre-operative discharge planning, discharge to assess and trusted assessor	Data and outcomes review in terms of rightsizing capacity to meet rehab and reablement demand, pathway and integration updates	Impact measurement and capacity forward planning
2 – Residential Care placements sufficiency review	Head of Social Work and Assurance NLC	Care Home Support plan in place. Sufficiency review with new contract for 3/21 implementation. Short stay assessment and enablement provision implementation	Full implementation of Care Home Framework and contract and impact assessment of Short Stay provision	Data and outcomes review in terms of rightsizing capacity to meet demand, pathway and integration updates	Impact measurement and capacity forward planning
3 – Frail and Elderly	Head of Strategic Commissioning CCG	Alignment of local plans to HASR Out of Hospital Programme. Transformation of frailty pathways. Development of integrated Frailty strategy and integrated frailty pathway. Integrated Care Centre business case	Implementation of Integrated Care Centre, impact assessment of Integration	Data and outcomes review, pathway and integration updates	Impact assessment, Data and outcomes review, capacity forward planning
4 – End of Life Care (EoLC)	Transformation Programme Lead CCG	Map new EoLC pathways, EoLC strategy update, implementation of RESPECT model and EPaCCs (electronic Palliative Care Coordination System), ongoing impact	Implement new EoLC pathways	Impact assessment, data and outcomes review	Review and refresh EoLC pathways
5 – Integrated model for social prescribing	Head of Participation and Achievement NLC	Full Implementation of model	Impact assessment, Data and outcomes review	Impact assessment, Data and outcomes review	Impact assessment, Data and outcomes review, capacity forward planning

COMMISSIONING INTENT	LEAD OFFICER	Implementation Timeline			
		2020/21	2021/22	2022/23	2023/24
6 – Targeted support for younger adults	Head of Social Work and Assurance NLC, Principal Manager Commissioning NLC, Head of Strategic Commissioning CCG	Service review and engagement including learning during pandemic period and changes to services required and implementation planning	Full implementation and initial impact measurement	Data and outcomes review, Impact measurement and capacity forward planning	Impact measurement and capacity forward planning
7 – Alternative solutions to live well at home	Head of Adult Social Care and Head of Social Work and Assurance NLC	Independent Living Centre implementation, Domiciliary Care Market development support strategy and implementation plan	Full implementation and initial impact measurement	Data and outcomes review, Impact measurement and capacity forward planning	Impact measurement and capacity forward planning
8 – Develop and implement Carer’s Strategy	Head of Adult Social Care, Principal Manager Commissioning NLC	Carer’s strategy development through co-production, integration with support for young carers	Full implementation and initial impact measurement	Data and outcomes review, Impact measurement and capacity forward planning	Impact measurement and capacity forward planning
9 – Reasonable adjustments for people with learning disabilities and /or autism	Head of Strategic Commissioning CCG and Head of Social Work and Assurance NLC	Specialist care and support pathway development and implementation, integration across services to support access	Full implementation and initial impact measurement	Data and outcomes review, Impact measurement and capacity forward planning	Impact measurement and capacity forward planning
10 – Volunteering, employment and befriending opportunities are available for all adults	Head of Participation and Achievement NLC	Full Implementation of model	Impact assessment, Data and outcomes review	Impact assessment, Data and outcomes review	Impact assessment, Data and outcomes review, capacity forward planning

We have a commitment to listen, learn, review and adapt and we will demonstrate our success in improving outcomes for our residents through **performance data and analysis**, **practice wisdom**, **voice and engagement** and **reviews/reports**.

Outcomes Based Accountability principles underpin our approach and five key questions inform our monitoring, evaluation and next steps planning:

1. What is the outcome we want for residents
2. What is the curve we want to turn – what does success look like
3. What is the story behind the baseline – where have we been and where are we headed
4. How much did we do, how well did we do it and is anyone better off (performance measures)
5. Are we making a difference (indicators, voice/experiences)

Progress relating to the areas of focus, where we will '**shine a light**', will be regularly presented to the **Integrated Adults Partnership** by the relevant leads.

For areas where there is a '**line of sight**', progress reports will be presented to the Integrated Adults Partnership on an exceptions basis at the request of or by agreement with the Integrated Adults Partnership.

An annual progress review of this strategy will be developed and presented by the Integrated Adults Partnership to the **Integrated Commissioning and Quality Executive** to consider the effectiveness of the commissioning intents and to shape and influence partnership action.

CONTACT US:

For any further information, comments or queries, please go to:

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