Leicestershire County Council

Meeting: **Health and Wellbeing Board**

Date/Time: **Thursday, 5 May 2016 at 2.00 pm**

Location: **Guthlaxton Committee Room, County Hall, Glenfield**

Contact: **Mrs. R. Palmer (Tel: 0116 305 6098)**

Email: **rosemary.palmer@leics.gov.uk**

Membership

Mr. E. F. White CC (Chairman)

John Adler	Rick Moore
Karen English	Mr. I. D. Ould CC
Lesley Hagger	Cllr. P. Posnett
Ch. Supt. Sally Healy	Cllr. P. Ranson
Mr. Dave Houseman MBE, CC	Toby Sanders
Dr Andy Ker	Mike Sandys
Dr Satheesh Kumar	Trish Thompson
Dr Mayur Lakhani	Jon Wilson

AGENDA

Item		Report by	
1.	Minutes of the meeting held on 10 March 2016 and Action Log.		(Pages 3 - 12)
2.	To advise of any other items which the Chairman has decided to take as urgent elsewhere on the agenda.		
3.	Declarations of interest in respect of items on the agenda.		
4.	Position Statement by the Chairman.		
5.	Carillon - Radio for Wellbeing. There will be a powerpoint presentation for this item.	Jon Sketchley Station Manager HermitageFM Radio	

Strategy.

6.	Sustainability and Transformation Plan.	West Leicestershire Clinical Commissioning Group	(Pages 13 - 24)
7.	NHS Quality Premium 2016/17.	West Leicestershire and East Leicestershire and Rutland CCG	(Pages 25 - 38)
8.	Better Care Fund Plan Final Submission and Assurance.	Director of Health and Care Integration	(Pages 39 - 128)
9.	Approach to Social Prescribing	Director of Public Health	(Pages 129 - 132)

Performance.

10.	Update on Discharge Arrangements.	Director of Adults and Communities	(Pages 133 - 140)
11.	Suicide Prevention.	Director of Public Health	(Pages 141 - 146)

Governance.

12.	Outputs from the Health and Wellbeing Board Development Session - 10 February 2016.	Director of Health and Care Integration	(Pages 147 - 170)

13. Date of next meeting.

The next meeting of the Health and Wellbeing Board will be held on Thursday 7 July 2016 at 2.00pm.

14. Any other items which the Chairman has decided to take as urgent.

Agenda Item 1

Minutes of a meeting of the Health and Wellbeing Board held at County Hall, Glenfield on Thursday, 10 March 2016.

PRESENT

Leicestershire County Council

Mr. E. F. White CC (In the Chair)
Mr. Dave Houseman MBE, CC
Mr. I. D. Ould CC
Lesley Hagger
Mike Sandys
Jon Wilson

Clinical Commissioning Groups

Dr Andy Ker
Prof Mayur Lakhani
Toby Sanders

Leicestershire Partnership NHS Trust

Dr Satheesh Kumar

University Hospitals of Leicester NHS Trust

John Adler

Healthwatch Leicestershire

Rick Moore

Leicestershire District/Borough Councils

Cllr Pam Posnett
Cllr Pauline Ranson

In attendance

Jane Chapman, East Leicestershire and Rutland CCG
Sarah Theaker, NHS England

260. Minutes and Action Log.

The minutes of the meeting held on 7 January were taken as read, confirmed and signed.

The Board also noted the Action Log, which provided an update on actions agreed by the Board at its previous meetings.

261. Urgent Items.

There were no urgent items for consideration.

262. Declarations of interest.

The Chairman invited members who wished to do so to declare any interest in respect of items on the agenda for the meeting.

No declarations were made.

263. Position Statement by the Chairman.

The Chairman gave a position statement on the following matters:-

- Antibiotic Prescribing: Antibiotics Awareness Campaign and Resources;
- Local Developments;
- National Developments and Publications.

Board members were encouraged to promote the messages regarding antibiotic prescribing and to ensure that the messages were consistent.

A copy of the position statement is filed with these minutes.

264. Better Care Fund Refresh 2016/17 Overview.

The Board considered a report from the Director of Health and Care Integration which provided assurance on the work in progress to refresh the Better Care Fund (BCF) plan for Leicestershire, including the refreshed spending plan, metrics and narrative so that the plan can be approved by local partners and assured by NHS England in line with the national timetable. A copy of the report marked 'Agenda Item 5' is filed with these minutes.

It was noted that the University Hospitals of Leicester NHS Trust (UHL), Leicestershire Partnership NHS Trust (LPT) and the Clinical Commissioning Groups (CCGs) were co-producing a plan for capacity and demand management in the health service. It would be important for this to be aligned with the BCF as well as with contractual processes.

One of the unresolved issues for the BCF at the time of this meeting related to the level of funding available for Disabled Facilities Grants (DFG). There had been a late policy and funding decision nationally which removed the social care capital grant within the BCF and replaced this with an uplift to the DFG allocation within the BCF. Locally this had an impact of £1.3m within the BCF. This matter would be subject to further discussions in the coming weeks with district councils

Due to the delay in national BCF guidance being issued, the timetable for final BCF submissions has been extended to 25 April. The Board discussed whether an extraordinary meeting of the HWB Board should be held to approve the final documentation, or whether this could be achieved through the Integration Executive meeting on 19 April.

RESOLVED:

(a) That the Better Care Fund refresh update report be noted;

(b) That each organisation represented on the Health and Wellbeing Board be requested to authorise its representative on the Integration Executive to approve

the Better Care Fund refresh for submission to NHS England on its behalf at its meeting on 19 April 2016, noting that the Integration Executive itself has no formal delegated powers;

(c) That the Better Care Fund refresh be submitted to the Health and Wellbeing Board at its meeting on 5 May for assurance.

265. Update on the Development of the Sustainability and Transformation Plan.

The Board considered a report from the Better Care Together (BCT) programme which set out the latest information available on the development of the Sustainability and Transformation Plan (STP), proposed governance arrangements and a draft timetable for its completion. A copy of the report marked 'Agenda Item 6' is filed with these minutes.

It was confirmed that the STP built on the BCT programme and was seen locally as the second phase of BCT. The first phase had focused on some specific system reconfiguration changes whereas the STP would enable Leicester, Leicestershire and Rutland to focus on broader areas which were likely to present a challenge in terms of sustainability or viability in the medium term including the wider determinants of health and wellbeing. To that end, the STP was expected to address the following areas:-

- The operating model for General Practice;
- Demand pressures in social care for both adults and children;
- Prevention and the wider determinants of health and wellbeing
- Bed reconfiguration in sub-acute services and community hospitals;
- Enablers such as IT and the use of estates.

It was also confirmed that Toby Sanders would be the Senior Responsible Officer for the STP in LLR.

The refresh of the Joint Health and Wellbeing Strategy would be aligned to the STP. In addition, a prevention workshop for the BCT programme held a couple of weeks earlier had confirmed that prevention would be more explicit within the programme and that it would tie in to the work being done by local authorities in this area.

RESOLVED:

That the update on the development of the Sustainability and Transformation Plan be noted and that there be an on-going dialogue with the NHS locally regarding the Plan.

266. Parity of Esteem for People with Serious Mental Illness.

The Board considered a report from East Leicestershire and Rutland CCG which summarised progress to date in achieving parity of esteem for people with serious mental illness, opportunities and proposed a plan to make further impact. A copy of the report marked 'Agenda Item 7' is filed with these minutes.

There was support for the broader approach to parity of esteem, including access to services as well as the physical health status of mentally ill people. It was suggested that a stronger focus on prevention was needed within existing initiatives such as making every contact count. More focus was also needed on suicide prevention, which was linked to all mental illness not just those that were severe and enduring. It was felt that the parity of esteem agenda should also encompass common mental illness, not just serious mental illness, although it was acknowledged that a key driver for making

improvements in this area was the mortality rate and physical health status of people with severe and enduring mental illness.

The report proposed the establishment of a group to take stock of the existing arrangements and see if they met the requirements of the parity of esteem initiative. It was suggested that a representative from children's social care should be included in this group.

With regard to a recent issue that had arisen related to the funding for the plan to transform children and adolescent mental health services, it was confirmed that, due to difficulties in identifying the funding within the CCG baseline budgets, the Collaborative Commissioning Board had requested business plans for the discrete pieces of work in this area. Discussions were also ongoing with NHS England regarding the allocations, ahead of finalising CCG operating plans for 2016/17.

RESOLVED:

(a) That it be confirmed that the local definition of 'Parity of Esteem' includes parity of access to a range of appropriate services as well as addressing physical health dimensions;

(b) That the proposal to commission a Leicester, Leicestershire and Rutland wide group led by Leicestershire County Council's Public Health Department to take this work forward, reporting to the multi-agency Mental Health Partnership Board be supported;

(c) That a report be submitted to the Health and Wellbeing Board in July setting out a timed and quantified plan for addressing issues related to Parity of Esteem.

267. Adult Social Care Commissioning Strategy and Market Position Statement.

The Board considered a report of the Director of Adults and Communities which set out the current status of the Adult Social Care Strategy 2016-20 and the associated Commissioning Intentions and Market Position Statement and provided details of current work and intentions to deliver the aims and objectives of the Strategy. A copy of the report marked 'Agenda Item 8' is filed with these minutes.

It was noted that the related Workforce Strategy was still being developed.

RESOLVED:

That the Adult Social Care Strategy, associated Commissioning Intentions and Market Position Statement be noted.

268. Supporting Leicestershire Families Sustainability.

The Board considered a report of the Director of Children and Family Services which provided an overview of the Supporting Leicestershire Families (SLF) programme, presented the case for continued partnership resource to the programme for a period of three years and provided an update on the progress towards continued sustainability. A copy of the report marked 'Agenda Item 9' is filed with these minutes.

It was noted that the NHS (initially through the Primary Care Trusts and now through the CCGs) had been a significant contributor at the start of the SLF programme. However, although outputs and impact on the NHS, such as being registered with a GP and the uptake of appropriate health care services, could be identified, more work was needed to demonstrate the health outcomes of the programme. Despite the programme's success, these had proved difficult to quantify. The CCGs would therefore support the SLF programme for a further year whilst a robust analysis of the health impacts was undertaken. It was expected that this support would be confirmed at the Integration Executive on 29 March. This would not impact the operational business of the programme.

Concern was expressed that the payment by results element of the programme was based on 60 percent of the target being met. However, it was confirmed that the programme aimed to achieve 100 percent of the target and had already achieved over 60 percent for this financial year.

The need for strengthened governance arrangements for the SLF programme was acknowledged but concern was expressed that these arrangements did not accurately reflect the partners involved in the programme. The Board was assured that it was the right body for the programme to be accountable to as it ensured the focus was on family wellbeing.

RESOLVED:

(a) That the report be noted;

(b) That the case for a continued health contribution to complete the partnership resources to the programme for a period of three years from 2016/17 be supported.

269. Sexual Health Strategy.

The Board considered a report of the Director of Public Health which set out the draft sexual health needs assessment and strategy and sought views on the proposed future direction for health services across Leicestershire. A copy of the report marked 'Agenda Item 10' is filed with these minutes.

Arising from discussion the following points were raised:-

(i) The strategy needed to reflect concerns regarding the sustainability of the primary care workforce in general, as the strategy recognised and relied on the contribution of primary care professionals to elements of delivery of the strategy. The strategy would also benefit from some contextual information linking it to the local health and care system as a whole.

(ii) With regard to the audit of long acting reversible contraception (LARC) retention rates in primary care and the integrated sexual health service, it was confirmed that this would be a separate audit to the ones completed by practices that had signed up to the LARC community based services. The LARC retention audit would be completed with the integrated sexual health service and a small sample of practices. The audit work would be primarily completed by the public health department with support from practices to access records.

(iii) During 2016/17, chlamydia screening would change from low prevalence mass screening to an online full STI screening service that would available to all age groups (not just 15-24 year olds). This formed part of the commissioning intentions related to the future of the service and would therefore have an impact on service providers.

(iv) It was expected that there would be further changes to the commissioning of sexual health services as a result of the strategy. The implications of these changes were not yet known but it would be important to engage with affected parties on an ongoing basis including engagement and communication with providers and all Health and Wellbeing Board partners once the implications had been worked through in more detail.

RESOLVED:

That the comments now made be submitted to Leicestershire County Council's Cabinet for consideration at its meeting on 19 April.

270. 'Your Voice Matters' Report.

The Board considered a report and presentation from Healthwatch Leicestershire which presented the approach to its refreshed priorities and the emerging findings from the 'Your Voice Matters' Survey. A copy of the report marked 'Agenda Item 11' and the slides forming the presentation is filed with these minutes.

The Board felt it was encouraging that the most important issues for those who responded to the survey related to prevention and early intervention as this reflected the direction of travel for the local health and care system. It was also a key feature of the County Council's Adult Social Care Strategy and the Healthy Schools Programme. Healthwatch would use the findings of the survey to inform its work programme and priorities for the coming year, particularly with regard to supporting partners with the promotion of key messages relating to these priorities.

The emerging findings from the survey reinforced the importance of General Practice and supported the proposed development of a sustainable long term service model for primary care which would form part of the Sustainability and Transformation Plan.

Further analysis of the findings from the survey would be undertaken, particularly with regard to responses relating to care in the community, where further insight into the views of patients and the public would be useful.

RESOLVED:

That the approach to Healthwatch Leicestershire's refreshed priorities and emerging findings from the 'Your Voice Matters' survey be noted.

271. Better Care Fund Quarterly Performance Report.

The Board considered a report of the Director of Health and Care Integration which provided assurance on the quarterly reporting requirements for the Better Care Fund including the pay for performance element of the fund which was linked to achieving reductions in emergency admissions. A copy of the report marked 'Agenda Item 12' is filed with these minutes.

RESOLVED:

That it be noted that the fourth quarterly return was approved by members of the Integration Executive on 23 February and submitted to NHS England and submitted to NHS England on 26 February 2016.

272. Quarterly Performance Report.

The Board considered a joint report of the Chief Executive of Leicestershire County Council and the Commissioning Support Performance Services which provided an update on health performance issues at the end of quarter 3 of 2015/16. A copy of the report marked 'Agenda Item 13' is filed with these minutes.

Performance of the emergency care system remained a key issue for the area. It was reported that the level of activity and demand continued to be high. However, the Board was pleased to note that the number of hours lost through delays in ambulance handovers had reduced by 31 percent between January and February 2016. This was a result of the relentless focus on performance in this area and the work undertaken to improve processes between providers. It was acknowledged that there were still problems relating to flow through the Leicester Royal Infirmary (LRI) which were affecting ambulance handover times. The first phase of the new Emergency Floor at the LRI would open in March 2017 and, although it would not reduce demand on the system, it would deliver further improvements to process and reduce the impact of surges in demand.

As a result of reductions in the Public Health Department's budget, the fee paid to GPs for health checks would be reduced for 2016/17, although it would still be slightly above the national average. This had understandably created some disquiet amongst GPs, however it was confirmed that the changes were also intended to prioritise payment for the uptake of health checks rather than paying for invites, in order to focus on the area which would help most in meeting the performance target.

RESOLVED:

That the performance summary, issues identified this quarter and actions planned in response to improve performance be noted.

273. Update on Actions from the Health and Wellbeing Board Development Session on 10 February.

The Board considered a report of the Director of Health and Care Integration which provided assurance that the actions arising from the Board Development Session held on 10 February 2016 were being acted upon. A copy of the report marked 'Agenda Item 14' is filed with these minutes.

Arising from discussion the following points were raised:-

(i) The Sustainability and Transformation Plan would not be a Health and Wellbeing Strategy for Leicester, Leicestershire and Rutland. It would focus on ensuring sustainability within the health system. In terms of improving health outcomes for the local population it was expected that the Health and Wellbeing Board would be

the system leader with a specific focus on the wider determinants of health in the medium term

(ii) With regard to improving clinical engagement with the Health and Wellbeing Board, this would be taken forward with support from the Board's GP representatives. Consideration would be given to how to engage with secondary care providers as well as GP federations.

(iii) It was confirmed that careful consideration would be given to the appropriateness of circulating reports for information only. Any Board member who wished to discuss an information paper could request that it be added to the agenda for the next meeting.

RESOLVED:

(a) That the proposals for the development of the Health and Wellbeing Strategy set out in paragraphs 7 – 10 of the report be approved;

(b) That the actions to make the Board more effective and timescales outlined in paragraph 13 of the report be approved;

(c) That the outcome of the discussions relating to system leadership by the LLR Chief Officers Group and the Better Care Together Partnership be noted.

274. Date of next meeting.

The next meeting of the Board would take place on Thursday 5 May at 2.00pm.

2.00 - 3.40 pm
10 March 2016

CHAIRMAN

No.	Date	Action	Responsible Officer	Comments	Status
176(e)	12/03/15	The Director of Public Health to establish a formal relationship with NHS England for developing the commissioning plans for pharmaceutical services.	Mike Sandys	A request has been sent to NHS England but a response has not yet been received.	AMBER
219(d)	17/09/15	Circulate the Healthwatch signposting directory to members of the Board.	Vandna Gohil	The Directories are not available as yet - the publishers have advised that they are awaiting input from CCGs. HW will distribute copies once it receives them.	AMBER
252(c)	07/01/16	Hold a development session in March to consider the prioritisation of issues for the Joint Health and Wellbeing Strategy once the mapping exercise is complete.	Jackie Mould	The Health and Wellbeing Board Development Session will take place on 21 June following engagement with individual members of the Health and Wellbeing Board s to confirm and challenge the shortlist of priorities.	GREEN
252(e)	07/01/16	Submit regular progress reports from the JSNA/JHWS Steering Board on the development of the strategy to the Board.	Jackie Mould	The first progress report is scheduled for the Board meeting in July 2016.	GREEN
254(e)	07/01/16	Receive progress reports on the CAMHS Transformation Plan, including performance information with regard to the outcomes framework on a quarterly basis.	Lesley Hagger	First progress report is scheduled for the Board meeting in July 2016.	GREEN
256(b)	07/01/16	Submit the outputs of the local self-assessment against the eight high impact changes for Delayed Transfers of Care to the Health and Wellbeing Board in March 2016.	Jon Wilson	Report is scheduled for the Board meeting in May 2016.	GREEN
264(b)	10/03/16	Request each organisation represented on the Health and Wellbeing Board to authorise its representative on the Integration Executive to approve the Better Care Fund refresh for	All	Integration Executive is to consider the BCF refresh on 26 April - representatives are authorised to approve on behalf of their organisations.	GREEN
264(c)	10/03/16	Submt the Better Care Fund refresh to the Health and Wellbeing Board at its meeting on 5	Cheryl Davenport	Report is scheduled for the Board meeting in May 2016.	GREEN

No.	Date	Action	Responsible Officer	Comments	Status
265	10/03/16	On-going dialogue to take place with the NHS locally regarding the Sustainability and Transformation Plan.	Cheryl Davenport/ Mike Sandys/ Toby Sanders	Cheryl Davenport and Mike Sandys represent the County Council on the STP working group	GREEN
266(c)	10/03/16	Submit a report to the Health and Wellbeing Board in July setting out a timed and quantified plan for addressing issues related to Parity of Esteem	Jim Bosworth/ Mike McHugh	Report is scheduled for the Board meeting in July 2016	GREEN
269	10/03/16	Submit comments on the Sexual Health Strategy to the County Council Cabinet on 19 April	Mike Sandys	The Board's comments have been reported to the Cabinet	GREEN
273	10/03/16	Improve the effectiveness of the Board	Cheryl Davenport/ Rosemary Palmer	There is an update on the agenda for the Board in May setting out the improvement actions that have been taken so far.	GREEN

Agenda Item 6

HEALTH AND WELLBEING BOARD: 5TH MAY

REPORT OF LLR SUSTAINABILITY AND TRANSFORMATION PLAN LEAD

Purpose of Report

1. The purpose of this report is to provide an update on the progress and development of the Sustainability and Transformation Plan submission from 18th April first checkpoint.

Link to the local Health and Care System

2. The Sustainability and Transformation Plan.

Recommendation

3. The HWB is asked to note the content and process of the Sustainability and Transformation Plan and comment on the 11 suggested priority areas for LLR to confirm that these are the appropriate priorities for our system.

Background

4. All areas of the country required to produce an STP by the end of June 2016.

Appendix

Checkpoint Submission

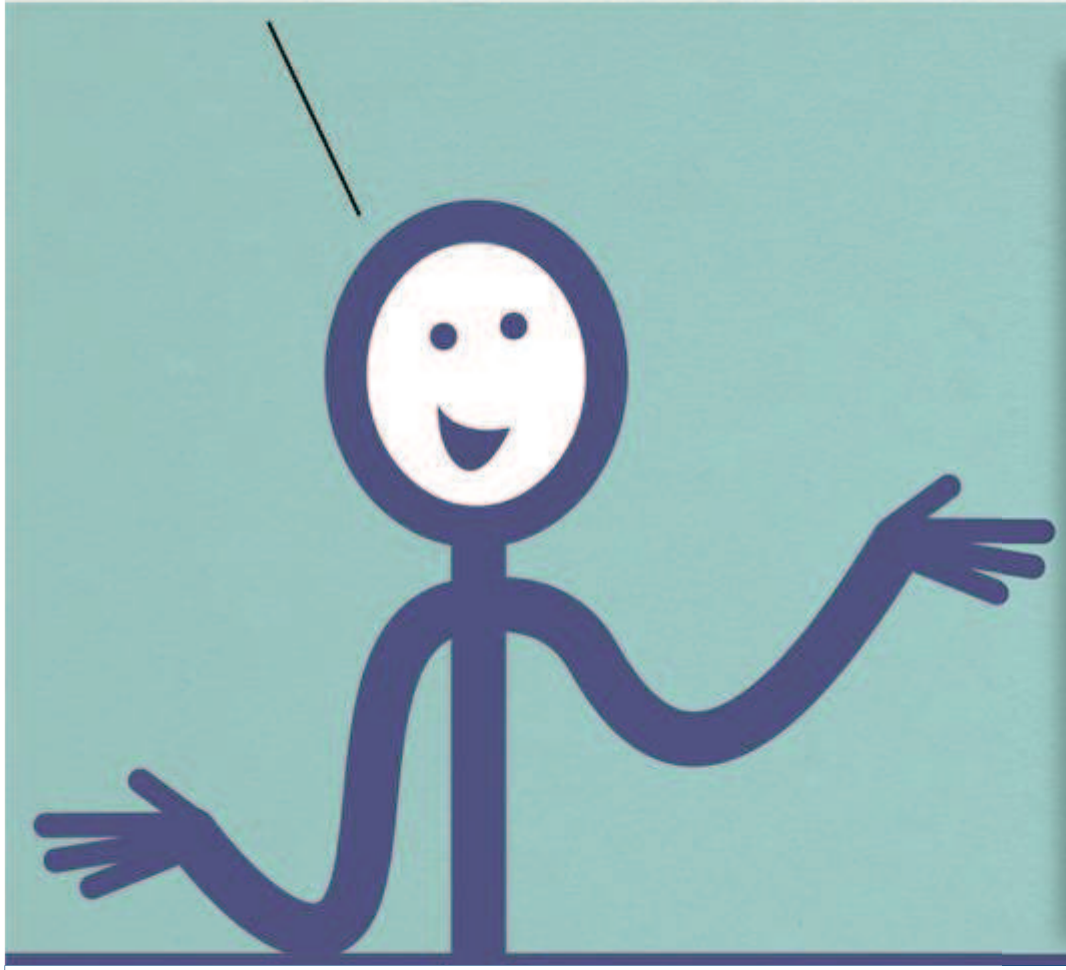
Officer to Contact

Toby Sanders, MD West Leicestershire CCG and STP Lead for LLR
Telephone: 01509 567740
Email: toby.sanders@westleicestershireccg.nhs.uk

This page is intentionally left blank

'It's about our life, our health, our care, our family and our community'

Better care together
Leicester, Leicestershire & Rutland health and social care



STP Footprint:

Leicester, Leicestershire & Rutland (No.15)

Region: Midlands & East

Nominated Footprint Lead:
Toby Sanders, Chief Officer, NHS West Leicestershire CCG

Contact details:
toby.sanders@westleicestershireccg.nhs.uk
Tel: 01509 567740

Organisations within footprint:

University Hospitals of Leicester NHS Trust
Leicestershire County Council
Leicester Partnership NHS Trust
NHS East Leicestershire and Rutland Clinical Commissioning Group
NHS Leicester City Clinical Commissioning Group
NHS West Leicestershire Clinical Commissioning Group
East Midlands Ambulance Service NHS Trust
Rutland County Council
Leicester City Council

LLR context

Better care together
Leicester, Leicestershire & Rutland health and social care

- Leicester, Leicestershire and Rutland has a well established whole system strategic transformation programme in place called Better Care Together (BCT)
- This health and care programme was stimulated by the nationally supported Challenged Health Economy work in 2014 and is now in its third year
- LLR has been externally recognised as having made huge progress over recent years in strengthening relationships and system leadership
- On 10 March senior representatives from the BCT partners came together to review progress to date and identify next step areas of focus:

✓ Strong partner support
✓ Clear work streams with clinical & patient involvement
✓ Good early delivery in some areas (e.g. BCF & reducing DTOC)
✓ Clear proposals for acute reconfiguration
✓ And difficult choices re number and configuration of community hospital inpatient wards
✓ Aiming for formal public consultation summer 2016

× Some early implementation not having anticipated impact (e.g. LRI UEC)
× Some work stream plans not clear (e.g. older people) or ambitious enough (e.g. shared records/care plans)
× Decision making and governance complicated
× Pace of implementation generally too slow, impacted on by organisational position and funding
× Some issues not adequately addressed (e.g. model of general practice)
× Some opportunities not fully exploited (e.g. public sector estate)

- Strong local consensus that the BCT programme is already addressing some of our systems underlying and long standing issues (e.g. acute hospital configuration) but that there is much more to do and the scale of the challenge has increased given the public sector financial climate
- Therefore collective agreement to approach STP development as BCT 'Phase II'

1. Leadership, Governance and Engagement

Better care together
Leicester, Leicestershire & Rutland health and social care

Collaborative leadership and decision making:

- The LLR STP is being developed through our existing BCT leadership and decision making arrangements. These include:
  - An overarching Partnership Board, independently Chaired, and including senior clinical, patient, managerial and lay/NED input from all partner (NHS, LA and Healthwatch) organisations
  - A Clinical Leadership Group which brings together senior medical and nursing leads to shape clinical service models
  - A Chief Officers Group with executive authority for managing development of the programme
- Our STP lead is supported by a nominated CCG strategy exec lead (Sarah Prema), the BCT Programme Director (Mary Barber) and PMO. Wider partner support is provided through a new fortnightly STP Task Group comprising senior managerial input from all organisations
- Decision making arrangements are being strengthened by moving the Commissioning Collaborative Board to being a formal Joint Committee of each of the 3 LLR CCGs with delegated authority to enable decisions to be taken post consultation

An inclusive process:

- The initial shape of our emerging STP has been developed through an open and inclusive conversation across the system
- Individual STP discussions, focused on identifying the key local challenges that the STP needs to address, have been held during April with Board/exec teams/strategy groups of NHS and LA partners
- STP development will build on existing patient and wider community involvement mechanisms including an active Patient Involvement Group, Equalities Group and voluntary sector forum
- Initial areas of focus have been shaped by recent Healthwatch intelligence (e.g. 'Your Voice Matters' survey)

Local government involvement:

- The three upper tier local authorities in LLR are all active partners in the BCT programme and governance
- All 3 LAs have been involved during April in the initial thinking around the shape and areas of focus of our STP
- HWB Chairs are Partnership Board members and we have agreed that wider formal member engagement will be through the 3 HWBs supplemented by using scheduled informal member and political briefings
- Health is not currently a main focus of local devolution proposals for Leicester and Leicestershire but there is the potential for this to broaden through the STP process (see section 4)

Engaging clinicians and NHS staff:

- The BCT work streams are clinically led and have input from a range of acute, community and primary care health and care professionals
- STP thinking around new models of care was the focus of a major local Kings Fund supported event on 6 April attended by c.200 clinicians, patients, lay members and managers

2a. Improving health and wellbeing

Better care together
Leicester, Leicestershire & Rutland health and social care

Issues

- Variation in health outcomes, deprivation levels and health inequalities across the system
- CVD, Cancer and Respiratory disease are the main causes of death and premature mortality
- More than 50% of the burden of strokes, 65% of CHD; 70% of COPD; and 80% lung cancer are due to behavioural risk
- Variation in the early detection rates for cancer across the system and tumour sites
- Variation in the prevalence rates of diseases compared to expectation
- Infant mortality rates in the city are significantly higher than the national average
- Limited exploration of community assets and social prescribing to support prevention, self-care and resilience
- Not exploiting the strength of the NHS workforce in being advocates for healthier life styles

Getting it right in the NHS and social care:

- Develop and embed what we know works in primary and secondary prevention
- Support the NHS workforce to be healthy exemplars
- A step-change in patient activation and self-care including expansion of existing programmes such as Personal Health Budgets, Making Every Contact Count

Making the most of the local government contribution to prevention, building on the work of public health and the role of HWBs:

- Support local councils to build health into the local environment, making healthy behaviour the norm
- Clear pathways to local integrated lifestyle services (smoking, healthy weight, physical activity, mental well-being)
- Redesign public health commissioned services to provide better integration with primary care and community initiatives
- Build on existing services (e.g. 0-19 integrated children's public health service) renewed focus on 6 high impact areas & multi agency LLR programmes of work

Through the STP process develop plans to maximise the joint contribution of health and local government:

- Build local platforms to communicate effectively with the public, building on approaches such as PHE's Sugar Swap campaign
- Utilise risk profiling to target communities and places with the worst health to close the health gap & reduce health inequalities
- Harness the strength of communities to provide social support, through community asset based approaches, drawing together health and local government through integrated approaches to social prescribing
- Implementation of the Diabetes Prevention Programme (June 2016)

2b. Improving care & quality of services

Better care together
Leicester, Leicestershire & Rutland health and social care

The Leicester, Leicestershire and Rutland health and social care system have identified the following as the key challenges that contribute to our care and quality 'gaps':

- Rising demand for all forms of health and social care, which is creating an imbalance between demand and capacity
- Sustainability of urgent and emergency care in the context of rising demand
- Focus is on individuals rather than pathways which leads to lack of service integration between health and social care for complex and frail older patients
- Clinically unsustainable acute service configuration e.g. maternity, children's, intensive care services
- Sustainability and funding of social care, particularly in the context of supporting people to remain independent and to help with hospital discharge
- Sustainability of primary care, particularly in the context of growing demand both from patients and service redesign, workforce issues and reduced share of NHS funding
- Inappropriate clinical variation across all sectors which impacts on outcomes for patients
- Improving the integration of mental health services with physical health
- Continued growth in demand for CHC services and impact of current model on recovery and re-ablement outcomes
- Transition between settings of care which often lead to patients telling their story more than once and poor outcomes
- Information sharing – being able to have access to information no matter what care setting a patient is presenting in
- Acute adult mental health pathway which results in too many patients being placed out-of-county
- Acute child and adolescent mental health care pathway requiring a better crisis response and improved local inpatient capacity
- Unsustainable community hospital inpatient configuration across eight county town and city sites
- Insufficient dementia capacity which will not secure a two thirds diagnosis rate for people with dementia, diagnosis within 6 weeks of referral, and improved post diagnosis treatment and support
- End of life services which offer limited patient choice of services and have insufficient capacity to enable people to choose to die at home
- The management of an increasing number of people who have long term conditions and co-morbidities
- Developing a workforce that can respond to the challenges faced in health and social care and the transfer of services from the hospital to community settings

2c. Improving productivity and closing the local financial gap

Better care together
Leicester, Leicestershire & Rutland health and social care

Financial challenges	Current financial solutions identified
• Previous modelling (2014 EY, updated 2015) developed an five year 'do nothing ' model for LLR which produced a financial gap of c.: - £0.5 billion for the NHS - £0.2 billion for Adult Social Care This is being updated post allocations and 16/17 contracts to inform the development of the STP • Current 'structural deficit' at UHL supported in 16/17 through £23m national STF	Currently identified plans to deliver savings through: • BCT system wide work: pathway redesign in eight clinical and six enabling work-streams and reconfiguration of acute services • Organisational CIP and QIPP for example through primary care prescribing; theatre utilisation and length of stay improvements • Local authority MTFS plans to achieve savings, including a 2% council tax precept for social care
Opportunities	**Current plans that support sustainability – note some of these are subject to the outcome of formal public consultation**
• Reduce the need for and reliance on inpatient care by stemming admission growth by increasing the community and home offer and reducing length of stay • Focus financial growth and investment in out of hospital and primary care services • Developing new models of care that support integration and reduce duplication in the system • Improve the utilisation and rationalise the public sector estate – "one public estate" • Manage the growth in CHC • Focus on prevention and promote a self-care culture to ensure longer term sustainability • Work towards a place based control total • Commissioner /Provider collaboration to reduce overheads • IM&T solutions that improve care quality and efficiency • Supporting carers to reduce reliance on social care services • Improving access to information and advice, enabling people to help themselves • Utilising support from families and the community before resorting to support from formal public services	• Acute hospital footprint reduced from three to two sites • Consolidation of community hospital estate and increased hospital at home services • Reconfiguration of maternity services • Improved support for people with Learning Disabilities to live in community settings and reduction in inpatient beds over time • Improved mental health services for all focussing on prevention, resilience and improving crisis services • Development of dementia services to improve quality of life • Improve the quality and choice of end of life services • Working with individuals to deliver cost effective, personalised care and maximise independence • Working with local communities and providers to develop local community based support • Develop an integrated housing offer, to support individuals in their own home

3a. Emerging thinking - areas of focus

Better care together
Leicester, Leicestershire & Rutland health and social care

Major local challenges	3 'gaps'		
	Health and Wellbeing	Care and Quality	Finance and Productivity
Implementing BCT Phase 1	• Shift of all age mental health to prevention and resilience • Secondary prevention and primary care upskilling for LTC's	• Maternity consolidation • Increasing community support for people with learning disabilities • CAMHS transformational plan • Redesign integrate urgent care offer (Vanguard) • Configuration of intensive care	• Acute site consolidation (3:2) • Community hospital reconfiguration • Efficiencies and lowest cost settings for planned care
Current issues where plans are insufficient	• Cancer prevention and early detection • Services for frail older people • Physical and mental health integration • Self care support • Employers offer for staff health and wellbeing (public and large private sector employers)	• End of life services • Access to and variation in general practice • Variation in care home quality • Acute adult mental health pathway • Community response to mental health crisis • Shared records and care plans	• In balance between demand and capacity across all sectors • LRI Urgent Care service model • CHC model and demand • Reducing inappropriate clinical variation/duplication • Capacity in out of hospital services to absorb left shift in activity • Collective culture and approach to service improvement
Potentially unsustainable in 2020	• Public expectations and approaches to accessing health and care services	• Dementia capacity for treatment and support • Care home and domiciliary provider market • Workforce supply (capacity and skill mix) • Urgent and emergency care service 'designation'	• Viability of adult social care model/funding • Model and viability of general medical care services (workforce, finance , business model) • Configuration of specialised services
Potential opportunities to enable transformation	• Capitalising on community and voluntary sector assets to support primary prevention • Place based approach across public sector services and workforce	• Exploiting advances in technology, science and treatment to enable patients to remain well and support independence • New 'paramedic at home ' and wider EMAS clinical delivery model	• New models of care (integrated health and social care teams) • Acute provider networks • Placed based control total • Integration of commissioning between health and social care • Collaborative commissioning arrangements • IM&T interoperability and paperless (Digital Roadmap) • One public sector estate (utilisation and consolidation) • Carter review (productivity)

N.B. some of these 'propositions' will be subject to formal public consultation

3b. Emerging thinking – Top Priorities

Better care together
Leicester, Leicestershire & Rutland health and social care

1. **BCT Phase I service reconfiguration** - acute and community hospitals
2. **Public sector efficiency** – within and across providers (Carter) and commissioner collaboration/integration
3. **Prevention** – community asset base, risk targeted and staff wellbeing
4. **Urgent and emergency care** – integrated urgent care, LRI services , designation and EMAS delivery model
5. **Mental health** – acute pathway, all age crisis and dementia
6. **Integrated place based community teams** - multi-specialty and health/care supporting LTCs and older people
7. **Primary medical care** – quality variation, workforce and business model/scale
8. **Digital technology** – shared records/care plans, patient monitoring and self care
9. **Public sector estate** – utilisation, co-location, consolidation and condition
10. **Health and care workforce** – supply, skill mix, flexibility and settings of care
11. **LLR place based system approach** – collective leadership, single control total, 'One LLR' OD/quality improvement way

3c. Emerging thinking – LLR delivery model

Better care together
Leicester, Leicestershire & Rutland health and social care

Addressing current system limitations

- Acute hospital focused
- Illness not wellness
- Disease not prevention
- Individual not population
- Organisational not pathway
- Misaligned financial incentives and regimes
- Isolated, separated small primary care units
- Fragmented community teams

By working through these new models

- Harnessing community / voluntary sector assets
- Greater patient self care/activation
- 'Federated' general practice working together at scale
- Provider integration of health and social care teams (specialist and generalist) at locality level
- Acute networks (regional/national)
- Commissioner collaboration across CCGs and with LAs

In order to generate a new LLR way of doing things

- Operating as one integrated system of health and care, delivering improved population level outcomes through a single place based approach and budget

4. Support we would like

Better care together
Leicester, Leicestershire & Rutland health and social care

Asks:

- Approval to proceed to formal public consultation on current BCT proposals after the EU Referendum
- Access to capital funding to enable site/service reconfiguration proposals to be implemented
- Planning rules flexibility to allow an element of CCG 1% non-recurrent funding (c.£1.5m) to be committed now to support BCT programme delivery & STF from 17/18
- Empower specialised commissioners to engage on a more local level with STP footprints
- Early conversation about moving more rapidly towards place based control total across LLR NHS organisations and alignment of national regulator oversight/assurance of this
- Input from national clinical and technical expertise to challenge thinking/ambition (e.g. IM&T, older peoples care)
- Consideration of potential models for transferring estates assets from NHS Property Services to local public sector vehicle to support reconfiguration and reinvestment (potentially part of wider devolution deal?)

Offers:

- BCT journey - sharing our experience and lessons learned on collective system leadership over last three years
- BCF implementation – sharing our experience of bringing together local authorities, CCGs and NHS providers to develop, own and implement a successful programme

Key risks:

- Delivery capacity (clinical and managerial) to develop and implement transformation
- Lack of local financial 'headroom' to invest in new models and transition costs
- Access to capital to support service reconfiguration proposals
- Workforce availability and skill mix
- Impact of local authority funding (adult social care, public health & children's services)

Agenda Item 7

NHS West Leicestershire Clinical Commissioning Group

NHS East Leicestershire and Rutland Clinical Commissioning Group

HEALTH AND WELLBEING BOARD

REPORT OF WEST LEICESTERSHIRE & EAST LEICESTERSHIRE & RUTLAND CCGS

NHS QUALITY PREMIUM 2016/17

Purpose of Report

1. The purpose of this report is to provide the H&WBB with information on specific indicators that relate to the Quality Premium 2016/17 and confirm specific indicators, where choices have been made in agreement with NHS England.

Link to Better Care Together

Workstream	Relevance	Workstream	Relevance
Maternity, neonates, children and young people		Mental health	✓
Long term conditions	✓	Frail and older people	✓
Urgent care	✓	Planned care	✓
Learning disabilities		End of life	

Policy Framework and Previous Decisions

2. West Leicestershire CCG & East Leicestershire & Rutland CCG Operational Plans 2016/17.
West Leicestershire CCG & East Leicestershire & Rutland CCG Commissioning for Value Packs

Background

3. The Quality Premium for 2016/17 has been published, and is intended to reward CCGs for improvements in the quality of the services that they commission and for associated improvement in health outcomes. This premium will be paid to CCGs in 2017/18, and covers a number of national and local priorities. Monies will be awarded for the achievement of the following:

- Improving anti-biotic prescribing in primary care 10%
- Cancer diagnosed at early stage 20%
- Increase in the proportion of GP referrals made by e-referrals 20%

- GP Patient Survey 20%
- Three local measures 30%

There are also a number of NHS Constitution indicators that will also impact on the Quality Premium. Monies will be deducted for non-achievement. These are:

- Referral To Treatment incomplete - 92% standard
- Maximum four hour waits for A&E departments – 95% standard
- Cancer 62 Day Wait – 85% standard
- Maximum 8 minutes responses for Category A (Red 1) ambulance calls – 75% standard

There are choices and decisions that Health and Wellbeing Boards should be made aware of. The choice of these indicators will be submitted, with the agreement of NHS England, on 29th April 2016. Given the timeframe of information being supplied by NHS England this is the first opportunity the CCGs have had to submit to H&WBB.

Proposals/Options

4. There are a number of indicators that CCGs are able to choose as part of their Quality Premium. It should be noted that at the time of writing this paper (15th April 2016) these are subject to confirmation by NHS England.

The H&WBB members are asked to support the following:

3 Local Priorities:

WLCCG:

- Mental Health - The number of people on Care Programme Approach per 100,000 population aged 18+
- Respiratory - Emergency COPD admissions relative to patients on disease register
- Delayed transfers of care from hospital per 100,000 population aged 18+

These priorities will contribute and help with reducing the current health and social care issues in these areas and are areas where West Leicestershire is deemed to be an outlier when comparing similar CCGs in the latest Commissioning for Value packs. They are also areas where there is scope to improve, and data can be reported either monthly or quarterly. As in previous years, the three local priorities will be reported to the WLCCG Quality & Performance sub group as part of the monthly Performance report.

Discussion has taken place on these and other potential indicators at WL's Planning and Delivery Sub-Group Meeting on 22nd March, with further discussion and agreement reached on the 3 priorities at the Extraordinary Board Meeting on 29th March.

ELRCCG:

- Cancer - % of lung cancers detected at an early stage (1 or 2)
- Mental Health - Access to IAPT services: People entering IAPT services as a % of those estimated to have anxiety/depression
- To be confirmed and with agreement from NHS England

Improving the early detection of Lung cancer will have an impact on improving outcomes for Potential Years Life Lost (PYLL).
ELR recognise the need to focus on Parity of Esteem. Increasing IAPT referrals is critical to maintaining people accessing the service and serving the population of ELR, and the service has been proactive in disseminating information to the public, community groups and voluntary organisations.
At the time of writing this paper (21st April) the third indicator is yet to be confirmed with the CCG and NHS England.
As in previous years, the three local priorities will be reported to the ELRCCG Quality & Performance sub group as part of the monthly Performance report.

Consultation/Patient and Public Involvement

5. *N/A*

Resource Implications

6. *N/A*

Timetable for Decisions

7. *N/A*

Conclusions/Recommendations

8. H&WBB are asked to support the options made by ELR & WL CCG in Section 4.

Background papers
https://www.england.nhs.uk/resources/resources-for-ccgs/ccg-out-tool/ccg-ois/qual-prem/

Officers to Contact

Yasmin Sidyot
Head of Planning & Strategic Commissioning
East Leicestershire & Rutland CCG
0116 295 6768
yasmin.sidyot@eastleicestershireandrutlanddccg.nhs.uk

Ket Chudasama
Assistant Director – Corporate Affairs
West Leicestershire CCG
01509 567739
Ket.Chudasama@WestLeicestershireCCG.nhs.uk

Appendix

UNIFY submission for ELRCCG & WLCCG

Equality and Human Rights Implications

9. N/A.

Partnership Working and associated issues

10. ELR & WL CCGs, UHL, EMAS, LPT & Leicestershire County Council

This page is intentionally left blank

Planning Round 2016/17 - Quality Premium

V1.0

Please select your CCG:

Select CCG: NHS EAST LEICESTERSHIRE AND RUTLAND CCG - 03W

CCG Details:

CCG Name: NHS EAST LEICESTERSHIRE AND RUTLAND CCG
CCG Code: 03W

Quality Premium Notes

The local element of the 16/17 Quality Premium (QP) focuses on the RightCare programme, with CCGs expected to identify three measures from their Commissioning for Value (CfV) packs, each worth 10% of the QP. In selecting the local indicators CCGs and Regional Teams (local offices) should refer to the 16/17 QP guidance on the QP website.
CCGs will need to work with their NHS England Regional Team (local office) to agree the local indicators for the QP scheme, and the levels of improvement needed to trigger the award.

CCGs and Regional Teams (local offices) will be required to submit an assessment of performance on the local measure in **September 2017**, therefore CCGs and Regional Teams (local offices) should select indicators where data will be available that will allow them to make a robust assessment of performance. Appendix 3 "Identification of RightCare metrics" of the QP guidance contains an assessment of the timeliness and suitability to inform indicator selection.

CCGs should select from the dropdown list of 80 indicators contained in Appendix 3. Where the CCG and Regional team (local office) feel there is an alternative indicator from the wider RightCare set that will bring greater benefit, then this could be used instead, subject to robust and timely data being identified.

To complete this return CCGs should:
1) Select from the drop down list the relevant metrics for local measures 1, 2 and 3. Each metric from Appendix 3 of the guidance is listed, numbered 1-80, and number 81 is "other".
Where "81-other-other" is selected a text box will appear that should be completed with the indicator design and source of data for assessment.
2) The CCG should provide detail of the level of improvement agreed with the Regional Team for each measure.

This information will be stored in Unify, and used to populate a template that will be issued to CCGs and Regional Teams (local offices) in September 2017, so that CCGs and Regional teams can carry out a local assessment of performance to be submitted to the National Team.

How to upload this template:

Once you have completed the workbook and saved it onto your hard drive, please upload your data into Unify 2.
To do this, login to Unify2 http://nww.unify2.dh.nhs.uk/unify/interface/homepage.aspx

[If you are a CSU acting on behalf of a CCG and have logged in using a CSU account, at this point you will need to follow an extra step before continuing - see CSU Guidance. If logged in as a CCG, continue to step below]

Once logged in click on 'Data collection & management'
.....then 'NON DCT Home Page'
...and select the Upload option for the return '**PlanQPC**'

Then click 'Browse' and select (or drill down to) the location of the completed workbook on your hard drive (the file path will be displayed below)

CSU Guidance:

If you are a CSU acting on behalf of a CCG and have logged in using a CSU account you will first need to 'impersonate' the CCG for whom you are uploading the template

- In the top right corner of the screen, click where it reads 'You are signed in as xxx as XXX COMMISSIONING SUPPORT UNIT'
- Select the correct CCG from the organisation dropdown list
- Click 'Impersonate'
- Follow the remaining steps above, from 'Once logged in click on Data collection and management'

Further Information:

For queries related to this template and its submission to Unify2 please email PAT@dh.gsi.gov.uk

CCG Code:	CCG Name:
03W	NHS EAST LEICESTERSHIRE AND RUTLAND CCG

Validations
All Questions Completed
Character Limits Passed

TEMPLATE READY FOR UPLOAD

Quality Premium Local Measure 1

Please select a measure from the drop down below

7 - Cancer - % of lung cancers detected at an early stage (1 or 2)

QP Local Measure 1 - Locally agreed target

Please provide the agreed level of improvement - 704 characters remaining.

Currently 21% of all identified lung cancer cases are detected at Stage 1 or 2. In 2012 this level was 24%. Therefore suggested target is to stretch to 25%. This equates to an extra 8 patients (44 Stage 1 & 2 in total)

This data will be available annually from the Cancer Commissioning Toolkit

Quality Premium Local Measure 2

Please select a measure from the drop down below

37 - Mental Health - Access to IAPT services: People entering IAPT services as a % of those estimated to have anxiety/depression

QP Local Measure 2 - Locally agreed target

Please provide the agreed level of improvement - 567 characters remaining.

Stretch target to achieve 15.5% of the total number of people who have depression and/or anxiety disorders by the end of March 2017. The number of people accessing the service should be 4277 to achieve this during 16/17 which represents an increase of 511 from levels in Jan 16. It represents an increase of 137 patients from the national target of 15%.

This is reported monthly from ArdenGEM BI team, using national data systems.

Quality Premium Local Measure 3

Please select a measure from the drop down below

36 - Mental Health - Mental Health - Reported numbers of dementia on GP registers as a % of estimated prevalence

QP Local Measure 3 - Locally agreed target

Please provide the agreed level of improvement - 745 characters remaining.

Target to achieve 67% of estimated dementia prevalence (65+ Only). The number of people diagnosed (65+) should be 3081 by the end of March 17, this is an overall increase of 337 patients from Feb 16 levels. This is reported monthly using data from HSCIC.

Planning Round 2016/17 - Quality Premium

V1.0

Please select your CCG:

Select CCG: NHS WEST LEICESTERSHIRE CCG - 04V

CCG Details:

CCG Name: NHS WEST LEICESTERSHIRE CCG
CCG Code: 04V

Quality Premium Notes

The local element of the 16/17 Quality Premium (QP) focuses on the RightCare programme, with CCGs expected to identify three measures from their Commissioning for Value (CfV) packs, each worth 10% of the QP. In selecting the local indicators CCGs and Regional Teams (local offices) should refer to the 16/17 QP guidance on the QP website.
CCGs will need to work with their NHS England Regional Team (local office) to agree the local indicators for the QP scheme, and the levels of improvement needed to trigger the award.

CCGs and Regional Teams (local offices) will be required to submit an assessment of performance on the local measure in **September 2017**, therefore CCGs and Regional Teams (local offices) should select indicators where data will be available that will allow them to make a robust assessment of performance. Appendix 3 "Identification of RightCare metrics" of the QP guidance contains an assessment of the timeliness and suitability to inform indicator selection.

CCGs should select from the dropdown list of 80 indicators contained in Appendix 3. Where the CCG and Regional team (local office) feel there is an alternative indicator from the wider RightCare set that will bring greater benefit, then this could be used instead, subject to robust and timely data being identified.

To complete this return CCGs should:
1) Select from the drop down list the relevant metrics for local measures 1, 2 and 3. Each metric from Appendix 3 of the guidance is listed, numbered 1-80, and number 81 is "other".
Where "81-other-other" is selected a text box will appear that should be completed with the indicator design and source of data for assessment.
2) The CCG should provide detail of the level of improvement agreed with the Regional Team for each measure.

This information will be stored in Unify, and used to populate a template that will be issued to CCGs and Regional Teams (local offices) in September 2017, so that CCGs and Regional teams can carry out a local assessment of performance to be submitted to the National Team.

How to upload this template:

Once you have completed the workbook and saved it onto your hard drive, please upload your data into Unify 2.
To do this, login to Unify2 http://nww.unify2.dh.nhs.uk/unify/interface/homepage.aspx

[If you are a CSU acting on behalf of a CCG and have logged in using a CSU account, at this point you will need to follow an extra step before continuing - see CSU Guidance. If logged in as a CCG, continue to step below]

Once logged in click on ‘Data collection & management’
…..then ‘NON DCT Home Page’
...and select the Upload option for the return ‘**PlanQPC**’

Then click 'Browse' and select (or drill down to) the location of the completed workbook on your hard drive (the file path will be displayed below)

CSU Guidance:

If you are a CSU acting on behalf of a CCG and have logged in using a CSU account you will first need to ‘impersonate’ the CCG for whom you are uploading the template

- In the top right corner of the screen, click where it reads ‘You are signed in as xxx as XXX COMMISSIONING SUPPORT UNIT’
- Select the correct CCG from the organisation dropdown list
- Click ‘Impersonate’
- Follow the remaining steps above, from ‘Once logged in click on Data collection and management'

Further Information:

For queries related to this template and its submission to Unify2 please email PAT@dh.gsi.gov.uk

CCG Code:	CCG Name:
04V	NHS WEST LEICESTERSHIRE CCG

Validations
All Questions Completed Character Limits Passed

TEMPLATE READY FOR UPLOAD

Quality Premium Local Measure 1

Please select a measure from the drop down below

46 - Mental Health - The number of people on Care Programme Approach per 100,000 population aged 18+

QP Local Measure 1 - Locally agreed target

Please provide the agreed level of improvement - 654 characters remaining.

Supports delivery of parity of esteem
Data available on actual number of WL people on CPA from April 14 - Nov 15. Baseline (Nov 15) is 760 people on CPA.
Extending the increasing trendline through 16/17, target set at 800 people by end of March 17.
Data can be reported monthly by ArdenGEM BI team, using HSCIC monthly MHLDMDS activity reports.

Quality Premium Local Measure 2

Please select a measure from the drop down below

52 - Respiratory - Respiratory - Emergency COPD admissions relative to patients on disease register

QP Local Measure 2 - Locally agreed target

Please provide the agreed level of improvement - 435 characters remaining.

Current plans in place through BCT LTC workstream and CCG specific GP QIPP aimed to reduce admissions and increase prevalence.
Work undertaken locally to calculate the rate of emergency admissions by registered COPD patients.
13/14 - Rate of 0.101
14/15 - Rate of 0.111
Given the extensive work in place in 15/16 and planned in 16/17, suggest a 17% reduction from 14/15 baseline to March 17, giving a target of 0.092.
Prevalence data available annually from national data source. Admissions data available from ArdenGEM BI team, suggested on a quarterly basis.

Quality Premium Local Measure 3

Please select a measure from the drop down below

75 - Cross-cutting - Delayed transfers of care from hospital per 100,000 population aged 18+

QP Local Measure 3 - Locally agreed target

Please provide the agreed level of improvement - 602 characters remaining.

Leicestershire BCF target. Due to the improvements already made in 2015/16, the target has been based on reducing the number of non-acute delays per quarter by 0.5%, while maintaining the 2015/16 rate of acute delays.
16/17 target: Q1 16/17 - 714
Q2 16/17 - 699.7
Q3 16/17 - 647.7
Q4 16/17 - 662.1
Currently DTOC is reported to Leicestershire County Council to Integration Exec on a monthly basis.

This page is intentionally left blank

Agenda Item 8

HEALTH AND WELLBEING BOARD: 5TH MAY 2016

REPORT OF LEICESTERSHIRE INTEGRATION PROGRAMME

BETTER CARE FUND REFRESH 2016/17

Purpose of report

1. The purpose of this report is to provide an update to the Health and Wellbeing Board on the Better Care Fund (BCF) Plan that has been submitted to NHS England, in line with the national timetable.

2. This report provides an overview of the spending plan and outcome metrics for 2016/17.

Policy Framework and Previous Decisions

3. The BCF policy framework was introduced by the Government in 2014.

4. NHS England published a revised policy framework for 2016/17 on 8th January 2016 which was accompanied by a revised technical guidance document published on 23rd February 2016, both of which have been used to prepare the 2016/17 BCF plan.

5. The production of Leicestershire's refreshed BCF plan for 2016/17 was directed by the Leicestershire Integration Executive between November 2015 and May 2016, and considered by the Health and Wellbeing Board on 10th March 2016.

6. At the Health and Wellbeing Board on 10th March 2016, it was agreed to delegate responsibility for signing off the BCF Plan to the Integration Executive on behalf of the Health and Wellbeing Board.

7. On 30th March 2016 the Health Overview and Scrutiny Committee also received a report on the Better Care Fund plan refresh.

8. On 29th March and 5th April the CCG Governing Bodies considered the BCF plan at their respective Board meetings.

9. On April 26th 2016 the final BCF submission was approved by the Integration Executive, as directed by the Health and Wellbeing Board on 10th March.

Background

10. The purpose of the BCF is to transform and improve the integration of local health and care services, in particular to:

    - Reduce the dependency on hospital services, in favour of providing more integrated community based support, such as reablement, early intervention and prevention;

- Promote seven day working across health and care services;
- Promote care which is planned around the individual, with improved care planning and data sharing across agencies.

Resource Implications

11. The BCF spending plan totals £39.4m in 2016/17. This comprises of minimum contributions from partners of £39.1m as notified by Government (compared with £38.3m in 2015/16), and an additional locally agreed £0.3m allocation from the Health and Social Care Integration Earmarked Fund.

12. The BCF is operated as a pooled budget under section 75 of the NHS Act 2006. The Leicestershire BCF agreement is a rolling agreement approved in July 2014. Assurance is required that the section 75 has been extended for a further 12 months, by June 2016, to meet national BCF requirements.

13. More detail on the funding arrangements is given in paragraphs 22 to 31 of this report.

BCF Assurance Process

14. The assurance process for the refreshed BCF plans has involved regional and national submissions from each Health and Wellbeing Board area to NHS England. These have taken place between February and May 2016.

15. Regional and national assurance is based on assessing the comprehensiveness and quality of the plan against the "key lines of enquiry" assessment tool. There is also an assessment of the risk to plan delivery based on the risks within the local health and care economy.

16. The outcome of the assurance process for the BCF has specific definitions as follows: *Approved, Approved with Support, or Not Approved.*

17. The national timetable for submissions and assurance has been subject to several changes, first caused by an eight week delay in the publication of the national guidance for the BCF for 2016/17, and latterly by adjustments made to the timetable for CCG operating plan submissions (which are aligned to BCF plan submissions).

18. Following initial submissions to NHS England on the 2nd and 21st March, the final stage submission takes place on 3rd May with a view to finalising the section 75 agreement by 30th June.

BCF Narrative Plan

19. The initial draft of the narrative plan was submitted to NHS England on 21st March. Following feedback from the assurance process, a revised plan was submitted to NHS England on 18th April.

20. The narrative provides an overview of the refreshed BCF plan, demonstrating how the national conditions and metrics for the BCF will be achieved in 2016/17 with assurance on how plans have been co-produced and approved by all partners.

21. A copy of the detailed BCF Narrative Plan is provided in appendix 1.

BCF Spending Plan

22. Leicestershire's BCF allocation for 2016/17 has been confirmed as £39.1m, an increase of £0.8m (2%) from 2015/16.

23. An initial refreshed spending plan has been developed through co-production across partners. Evaluation work across the BCF plan to inform the spending refresh was led by the Integration Operational Group, with recommendations reported to the Integration Executive between December 2015 and February 2016.

24. The spending plan has been refined further during February and March between Leicestershire County Council, East Leicestershire and Rutland CCG and West Leicestershire CCG, so that the initial BCF submissions demonstrates a balanced plan.

25. The technical guidance included a section on risk pool arrangements. It states that where local partners recognise a significant degree of risk associated with the delivery of their 2016/17 plan, for example where emergency admission reductions targets were not met in 2015/16, it is expected local areas will consider a risk pool.

26. On 26th February 2016, Leicestershire County Council and CCG representatives met to consider the spending plan refresh including the trajectories for the BCF schemes for admissions avoidance, the level of assurance on delivery of these schemes, and the level of investment being made in the schemes.

27. The outcome of this meeting was a recommendation of a risk pool of £1m which will be accessed if the planned reduction of emergency admissions is not achieved, and a further £1m for general contingency.

28. The risk pool and contingency are reviewed on a quarterly basis to ensure that they remain appropriate to the level of financial risk.

29. Work was undertaken with the CCGs to ensure that relevant BCF schemes are captured in CCG commissioning intentions and that schemes are contractualised with specification and are reflected consistently in CCG operating plans, including QIPP plans where applicable.

30. The work to refresh the BCF plan has generated a number of actions to be followed up in course of 2016/17. This work will be led by the Integration Operational Group.

31. A copy of the final spending plan is available in appendix 2.

Summary of Metrics and Trajectories for the 2016/17 BCF Plan

32. The following table explains the definition of each of the BCF metrics, and the rate of improvement partners are aiming for in each case. Some metrics rely on data produced annually or quarterly, hence the narrative indicates the likely position based on most recent data available.

National Metric (1)	Definition	Trajectory of improvement
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	This is a nationally defined metric measuring delivery of the outcome to reduce inappropriate admissions of older people to residential care.	The target for 2016/17 has been set at 630.1 per 100,000 based on the 2015/16 target of 670.4 per 100,000 and a 90% confidence level that the trajectory is decreasing. Current performance is on track to achieve the target for 2015/16. As part of the development of a four year adult social care strategy, detailed analysis of this metric has taken place and the target set accordingly. In 2014/15 there were 710.5 permanent admissions per 100,000 people. In 2015/16 this is likely to reduce to 669.6 per 100,000 people.

National Metric (2)	Definition	Trajectory of improvement
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	This is a nationally defined metric measuring delivery of the outcome to increase the effectiveness of reablement and rehabilitation services whilst ensuring that the number of service users offered the service does not decrease. The aim is therefore to increase the percentage of service users still at home 91 days after discharge.	The target for 2016/17 has been set at 84.2%, based on the expected level of 82.6% being achieved in 2015/16 and a 75% confidence interval that the trajectory is increasing. The lower confidence interval has been chosen to ensure that the target is realistic and achievable. Performance is currently on track to meet the 2015/16 target of 82.0% As part of the development of a four year adult social care strategy, detailed analysis of this metric has taken place and the target set accordingly. In 2014/15 83.8% of reablement service users were still at home after 91 days. In 2015/16 this is likely to reduce to 82.6%. Due to the introduction of a Help to Live at Home scheme planned for November 2016, a conservative target has been set.

National Metric (3)	Definition	Trajectory of improvement
Delayed transfers of care from hospital per 100,000 population (average per month)	This is a nationally defined metric measuring delivery of the outcome of effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults. The aim is therefore to reduce the rate of delayed bed days per 100,000 population.	Recent reductions in delays have focussed on interventions in the acute sector. We have therefore set a target based on reducing the number of days delayed in non-acute settings by 0.5%, while maintaining the rate of days delayed in acute settings at its current low level. The targets are quarterly and are 238.0, 233.3, 215.9, 220.7 for quarters 1 to 4 of 2016/17 respectively. As part of the development of a four year adult social care strategy, detailed analysis of this metric has taken place and the target set accordingly. Substantial improvement in the rate of days delayed has been achieved – the annual rate has dropped from 4,753 per 100,000 in 2014/15 to a probable 2,730 per 100,000 in 2015/16.

National Metric (4)	Definition	Trajectory of improvement
Non-Elective Admissions (General & Acute)	This is a nationally defined metric measuring the reduction in non-elective admissions which can be influenced by effective collaboration across the health and care system. Total non-elective admissions (general and acute) underpin the payment for performance element of the Better Care Fund.	In 2014/15 there were 58,479 non-elective admissions for Leicestershire residents, In 2015/16 it is likely that there will be 59,957. The proposed target for 2016/17 is 726.38 per 100,000 per month, based on a 2.49% reduction on the probable number of non-elective admissions for patients registered with GP practices in Leicestershire for 2015/16 (allowing for population growth). This equates to no more than 58,836 admissions in 2016/17. This assumption has been aligned with final CCG operational plan targets. All existing admission avoidance schemes have been subject to evaluation in 2015/16, and the

		results reflected in the development of a trajectory of 1,500 avoided admissions from these schemes in 2016/17.

National Metric (5)	Definition	Trajectory of improvement
Improved Patient Experience	Selected metric for BCF Plan from national menu: - taken from GP Patient Survey: "In the last 6 months, have you had enough support from local services or organisations to help manage long-term health condition(s)? Please think about all organisations and services, not just health." The metric measures the number of patients giving a response of "Yes, definitely" or "Yes, to some extent" to the above question in the GP Patient Survey in comparison to the total number of responses to the question.	It is proposed to set this target at 63.5% for 2016/17 (data will be released February 2017). This is based on the 2015/16 target (data due for release July 2016) and a 2% increase in the number of positive replies. Current performance of 61.6% (January 2016) is below the England average of 63%.

Local Metric (6)	Definition	Trajectory of Improvement
Injuries due to falls in people aged 65 and over	This is a locally defined metric measuring delivery of the outcome to reduce emergency admissions for injuries due to falls in people aged 65 and over.	It is proposed that this target is set at 1742.9, based on holding the number of admissions for injuries due to falls steady for the 65-79 age group (a reduction in the rate per 100,000 from 678.9 to 664.0) while lowering the rate per 100,000 for the 80+ age group from 7,919.1 to 7,523.1 (this equates to 25 fewer admissions in the year despite the increase in population) The latest published data (2014/15) shows Leicestershire as having a directly standardised rate significantly better than the England average for the whole age 65+ cohort and for the separate 65-79 age group and the 80+ age group.

33. The following should be noted with reference to the emergency admissions metric:

    a. Refreshed trajectories have been developed for the emergency admissions avoidance schemes implemented in 2015/16 based on learning to date.

    b. The assumption for the existing schemes is that only uplifted activity achieved in 2016/17 will count towards the trajectory.

    c. Trajectories have been developed for any new admissions avoidance scheme for 2016/17, for example the pilot of the new Ambulatory Pathway on CDU scheme at Glenfield Hospital.

    d. The current estimation is approximately 1,500 avoided admissions for 2016/17 are to be achieved through the BCF.

    e. This assumption will be reflected in CCG operating plans, apportioned by CCG by scheme.

BCF National Conditions

34. The BCF plan must demonstrate how it will delivery on the following national conditions:

- Delivery against five national BCF metrics and a locally selected metric;
- How a proportion of the fund will protect adult social care services;
- How data sharing and data integration is being progressed using the NHS number *(the NHS number is the unique identifier for each individual which is used on all NHS records);*
- How an accountable lead professional is designated for care planning/care coordination;
- Delivery of Care Act requirements;
- How a proportion of the fund will be used to commission care outside of hospital;
- How seven day services will be supported by the plan;
- That the impact on emergency admissions activity has been agreed with acute providers;
- That there is a locally agreed proactive plan to improve delayed transfer of care from hospital;
- That Disabled Facilities Grant allocations within the BCF will be used to support integrated housing solutions including the delivery of major adaptations in the home (see note below, para 36 and 37);
- Approval of the BCF plan by all partners being assured via the local Health and Wellbeing Board.

35. Assurance has been given that the Leicestershire BCF plan delivers against all the national conditions.

Disabled Facilities Grants Allocations

36. In terms of the Disabled Facilities Grant (DFG) allocations the BCF plan confirms the commitment to passport a £1.7m DFG allocation to District Councils for 2016/17, the same as the arrangement in 2015/16.

37. The additional £1.3m DFG allocation which replaced the social care capital grant within the BCF is being retained within the BCF pooled budget. This is because it is already committed on a range of essential services that benefit all partners and the communities they serve, including other elements of housing related support (for example assistive technology and the housing discharge support schemes at the Bradgate Unit and Leicester Royal Infirmary). The position will be reviewed following consideration of the Lightbulb Business Case with District Councils later in 2016.

Recommendation

It is recommended that the approval of the BCF plan by the Integration Executive at their meeting on 26th April and submission of the plan to NHS England be noted.

Officer to Contact

Cheryl Davenport, Director of Health and Care Integration (Joint Appointment)
Telephone: 0116 305 4212
Email: Cheryl.Davenport@leics.gov.uk

List of Appendices

- Appendix 1 – BCF Narrative Plan
- Appendix 2 – BCF Spending Plan 2016/17 (appendices mentioned within the BCF plan have not been circulated but copies can be made available to members upon request).

Relevant Impact Assessments

Equality and Human Rights Implications

38. Developments within the BCF Plan are subject to equality impact assessment and the evidence base supporting the BCF Plan has been tested with respect to Leicestershire Joint Strategic Needs Assessment.

39. An equalities and human rights impact assessment has been undertaken which is provided at http://www.leics.gov.uk/better_care_fund_overview_ehria.pdf

Partnership Working and associated issues

40. The delivery of the BCF Plan and the governance of the associated pooled budget is managed in partnership through the collaboration of commissioners and providers in Leicestershire.

41. Day to day oversight of delivery is via the Integration Executive through the scheme of delegation agreed via the Integrated Executive's terms of reference which have been approved by the Health and Wellbeing Board.

42. The delivery of the Leicestershire BCF ensures that a number of key integrated services are in place and contributing to the system wide changes being implemented through the five year plan to transform health and care in Leicestershire, known as Better Care Together http://www.bettercareleicester.nhs.uk/.

This page is intentionally left blank

Leicestershire Better Care Fund Plan – 2016/17

Local Authority	Leicestershire County Council
Clinical Commissioning Groups	West Leicestershire CCG
	East Leicestershire and Rutland CCG
Boundary Differences	East Leicestershire and Rutland CCG spans populations within both Leicestershire County Council and Rutland County Council. East Leicestershire and Rutland CCG have also co-produced the Rutland BCF plan with Rutland County
Date agreed at Health and Well-Being Board:	10th March 2016 19th April 2016
Date submitted:	Narrative Interim Submission March 21 Narrative Final Submission April 25
Minimum required value of BCF pooled budget: 2016/17	**£39,103,965**
2016/17	**£39,290,965**

Authorisation and signoff (to complete for April 25 Submission)

Signed on behalf of East Leicestershire and Rutland Clinical Commissioning Group	
By	Karen English
Position	Managing Director
Date	21st March 2016

Signed on behalf of the West Leicestershire Clinical Commissioning Group	
By	Toby Sanders
Position	Managing Director
Date	21st March 2016

Signed on behalf of the Leicestershire County Council	
By	John Sinnott
Position	Chief Executive
Date	21st March 2016

Signed on behalf of the Leicestershire Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Cllr Ernie White
Date	21st March 2016

CONTENTS

SECTION 1: OUR VISION FOR HEALTH AND CARE INTEGRATION

1.1 Our Vision

Our vision remains as set out in our original Better Care Fund (BCF) plan submission in 2014

> We will create a strong, sustainable, person-centred, and integrated health and care system which improves outcomes for our citizens.

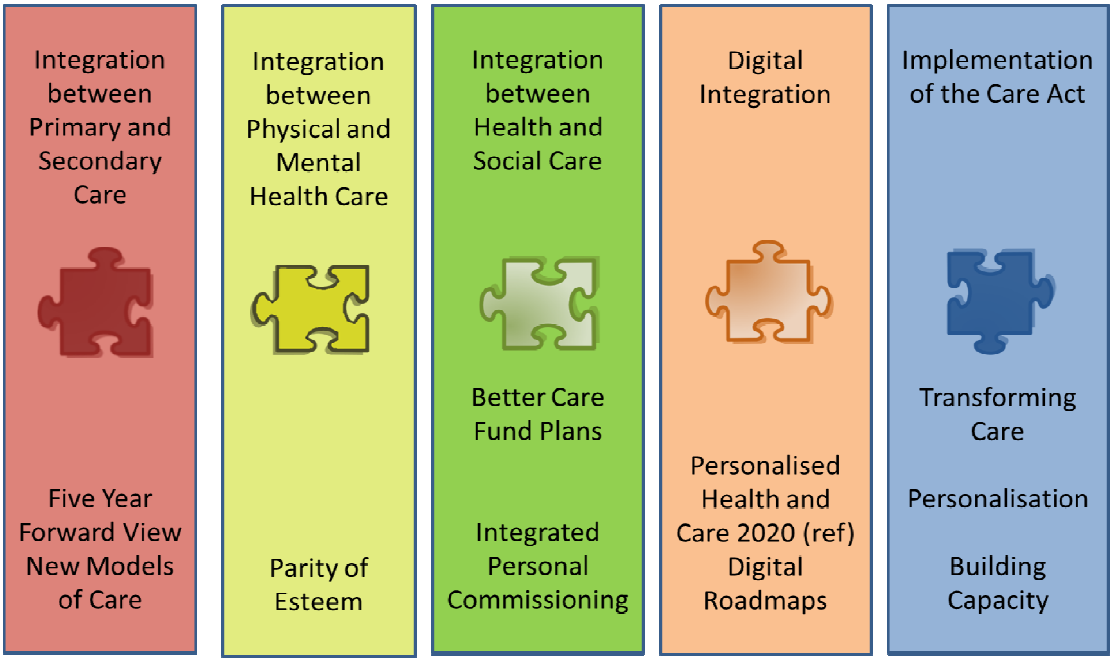
Our vision in 2014 was built upon four fundamental strategic drivers, two of which are local drivers, and two of which are national, all of which still continue to be fundamental to our integration plans from 2016/17 onwards.

BETTER CARE TOGETHER 5 YEAR STRATEGY: LEICESTER, LEICESTERSHIRE AND RUTLAND http://www.bettercareleicester.nhs.uk/information-library/better-care-together-plan-2014/	**LEICESTERSHIRE'S JOINT HEALTH AND WELLBEING STRATEGY** http://www.leics.gov.uk/healthwellbeingboard.htm
Better care together Leicester, Leicestershire & Rutland health and social care	 
THE KING'S FUND: INTEGRATED, PERSON CENTRED CARE http://www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population	**NATIONAL VOICES: PRINCIPLES FOR INTEGRATED CARE** http://www.nationalvoices.org.uk/principles-integrated-care http://www.england.nhs.uk/wp-content/uploads/2013/05/nv-narrative-cc.pdf
	National Voices People shaping health and social c

1.2 The Impact of Medium Term Policy and Planning Developments

Over the last 18 months the policy landscape for health and care has continued to evolve at pace and is complex. We have developed the diagram below to show the main "pillars" of national policy that are promoting and driving integration, recognising there are many other contributing factors.

How National Policy Developments are promoting and driving integration



Through the implementation taking place nationally within these policy pillars, the health and care system is currently implementing and testing:

- New models of care
- New ways of delivering integrated care
- New approaches to integrated commissioning at both personal and population levels
- New approaches and flexibilities for pooled budgets, contracting and tariffs
- New opportunities and flexibilities for devolution
- New digital technologies and data sharing capabilities
- New approaches to workforce development.

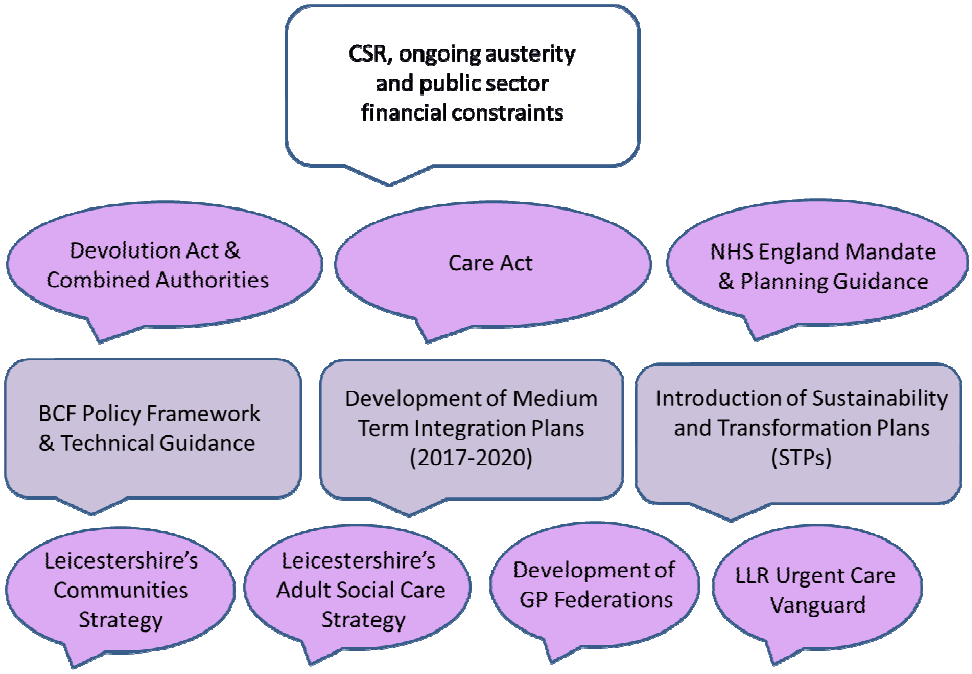
Learning from the outputs of these developments nationally, regionally and locally and rapidly adopting good practice, as well as continuing to innovate is essential to delivering integration in the medium term.

Translating this national policy context into the practicalities of setting a local integration vision and delivering a plan to achieve this vision is also a complex task.

In order to refresh our BCF plan for 2016/17 we have reflected on the impact of the policy pillars on our local vision and approach, our progress to date and the milestones we still need to achieve. We have also considered how related local developments connect with our

BCF plan and how our BCF plan contributes to system level delivery within Leicester, Leicestershire and Rutland (LLR).

The diagram below illustrates how a combination of national and local factors have been considered in refreshing our local integration vision and delivery plan.



During 2016/17 there are some new policy and planning requirements affecting the NHS and Local Government which are referred to in the diagram above – in particular:

- A new place based five year sustainability and transformation plan (STP) - for our local area the planning footprint for the STP will be LLR. The STP will incorporate our existing five year strategy for transforming health and care (the Better Care Together plan), but will also be expected to cover broader elements, such as the wider determinants of Health and Wellbeing including prevention.

- The planning guidance also articulated the need for medium term integration plans (guidance is pending for this), for demonstrable progress to be made in implementing the five year forward view new models of care, in our case this relates to progress on the LLR Urgent Care Vanguard Redesign, and national requirement for a digital roadmaps for each local area.

- National submissions related to combined authorities and devolution deals.

Our Health and Wellbeing Board Development Session in February 2016 focused on system leadership and place based planning and provided an excellent opportunity to co-produce our strategic approach and shape these complex developments within our local place.

1.3 The Better Care Fund Plan and the Sustainable and Transformation Plan (STP) for Leicester, Leicestershire and Rutland

In 2015/16 the Leicestershire County BCF provided for £38m of health and care service which were commissioned jointly through our BCF pooled budget to drive better integration of health services and improve outcomes for patients, service users and carers.

The progress made in the first year of delivery of our BCF plan provided the foundation and catalyst towards our vision for a modern model of integrated care. In 2016/17 we will build on our locally designed model of integrated care which places the focus on promoting health, wellbeing, prevention and independence rather than illness. By 2018, we will have used the BCF as a key enabler to mobilise a fully integrated care model that will significantly reduce the demand for hospital services.

The picture below shows how the BCF plan will be incorporated in the wider system plan, and reflected within the overarching STP for LLR. The BCF is therefore a key enabler in the implementation of our STP.

The development of the STP signals a move away from an annual planning process that has delivered incremental, organisational-specific improvement to a longer-term view that delivers transformational change across organisational boundaries.

The co-production of the five year STP will enable the health and social care community across LLR to continue to plan together with confidence and set out the work of Better Care Together alongside the Better Care Fund and emerging new models of community placed based care in a way that demonstrates collaboration of partners across organisational boundaries. It will represent the combined strategy of East Leicestershire and Rutland CCG (ELRCCG), West Leicestershire CCG (WLCCG), Leicester City CCG, the three Leicester, Leicestershire and Rutland Health and Wellbeing Boards and in doing so set the framework for joint working across health, social care and public health.

1.4 Key Challenges for the Leicestershire Better Care Fund for 2016/17

Urgent Care

- The demands on the acute care system are the local health and care economy's greatest risk to sustainability. Total emergency admissions in Leicestershire have risen again over the past 12 months. In 2014/15 there were 58,479 non-elective admissions for Leicestershire residents, and in 2015/16 the forecast out turn is 62,286. Analysis by the LLR Urgent Care Board shows that a proportion of the growth in 2015/16 has occurred in the 0-10 and 20-40 age groups. Further analysis is underway to establish the detailed reasons behind the increase.
- In the meantime it can be demonstrated that three of the four emergency admissions avoidance schemes in Leicestershire (GP seven day services pilots were the fourth) have delivered measurable impact in 2015/16 in terms of admissions avoidance in the BCF target cohort (older people).
- This is evidenced in falls non conveyance figures for example, data from Care and Healthtrak, clinical audit and independent academic evaluation outputs which support/triangulate these findings.
- In terms of hospital admissions avoidance, the 2016/17 BCF plan includes further improvements to the models of care and pathway redesign for the four existing schemes implemented in 2015/16, based on our evaluation findings.
- A further admissions avoidance scheme is being implemented in 2016/17 targeted to adults with cardio/respiratory conditions who attend at the Glenfield Hospital site, which will deliver a consistent ambulatory pathway to prevent a large number of short stay admissions.
- Sustaining our good DTOC performance achieved in 2015/16 relies on existing interventions continuing to maintain their impact, and any additional actions to be prioritised locally from the eight high impact changes self-assessment tool recently published by the Department of Health.
- A more rigorous implementation plan for falls prevention is being implemented in 2016/17 as part of a new LLR wide falls strategy. The Leicestershire BCF will continue to be an important part of the delivery plan for this strategy.
- Developing an integrated approach to housing solutions by mobilising a range of housing support (including DFGs) to deliver measurable health and wellbeing benefits will be a key feature of our workplan in 2016/16, through the development of the Lightbulb Service business case in conjunction with District Councils.

Financial Constraints

- Financial allocations and the scale of financial pressure and savings required across the partnership impact on the ability of partners to commit to new initiatives, unless funds are reallocated between existing commitments, schemes are decommissioned or transformation funds can be accessed, especially for delivering ROI within a one to three year horizon.
- Despite this, partners must maintain delivery across the BCF plan metrics and national conditions as well as deliver a medium term view of transformation for years three to five. To do this even more rigour to benefits realisation, with more sophisticated, integrated and co-produced methodologies for predictive modelling and measuring impact will be required and greater alignment will be needed between the local BCF plans, the medium term integration plan (to 2020) and the LLR-wide five year plan/STP.
- The 2016/17 BCF plan will include a focus on developing a commissioning framework for integrated commissioning across LA and NHS partners – more details of this can be found on page 64. This will have emphasis on seeking further savings and value for money for joint commissioning, as well as assuring quality and driving further innovation in models of integrated provision.

Data Integration

- Although progress has been made on data integration using the NHS number and Care and Healthtrak in 2015/16, further work is needed on the integration of records and data across agencies for direct care and case management in community settings. This will be a focus of the 2016/17 BCF plan in conjunction with the LLR IM&T workstream.

1.5 Our Ambition for Integration for 2016/17 and Beyond

During 2015, Leicestershire's Integration Executive developed our ambition of integration beyond March 2016, and set out a number of priorities (see summary slides at Appendix 1).

This product set the strategic direction for the BCF refresh and in summary was concerned with the following:

1. Embedding the model of integrated provision being developed in locality hubs; and
2. Integrated Commissioning including:
    a. Setting an outcomes framework for integrated commissioning.
    b. Proposing what should be in scope for improving integrated commissioning beyond March 2016.

1.6 Aims of the Leicestershire BCF Plan 2016/17

The aims of the Leicestershire BCF plan have been refreshed in light of the strategic policy context and the work to develop our vision and ambition post March 2016.

The revised aims are as follows:

1. Continue to develop and implement new models of provision and new approaches to commissioning, which maximise the opportunities and outcomes for integration.	**2. Deliver measurable, evidence based improvements to the way our citizens and communities experience integrated care and support.**	**3. Increase the capacity, capability and sustainability of integrated services, so that professionals and the public have confidence that more can be delivered in the community in the future.**
4. Support the reconfiguration of services from acute to community settings in line with: • **LLR five year plan** • **New models of care.**	**5. Manage an effective and efficient pooled budget across the partnership to deliver the integration programme.**	**6. Develop Leicestershire's "medium term integration plan" including our approach to devolution.**

The work already undertaken by the Integration Executive on refreshing our vision and aims for integration provides a good foundation for the further work to be completed during 2016/17 as part of STP production.

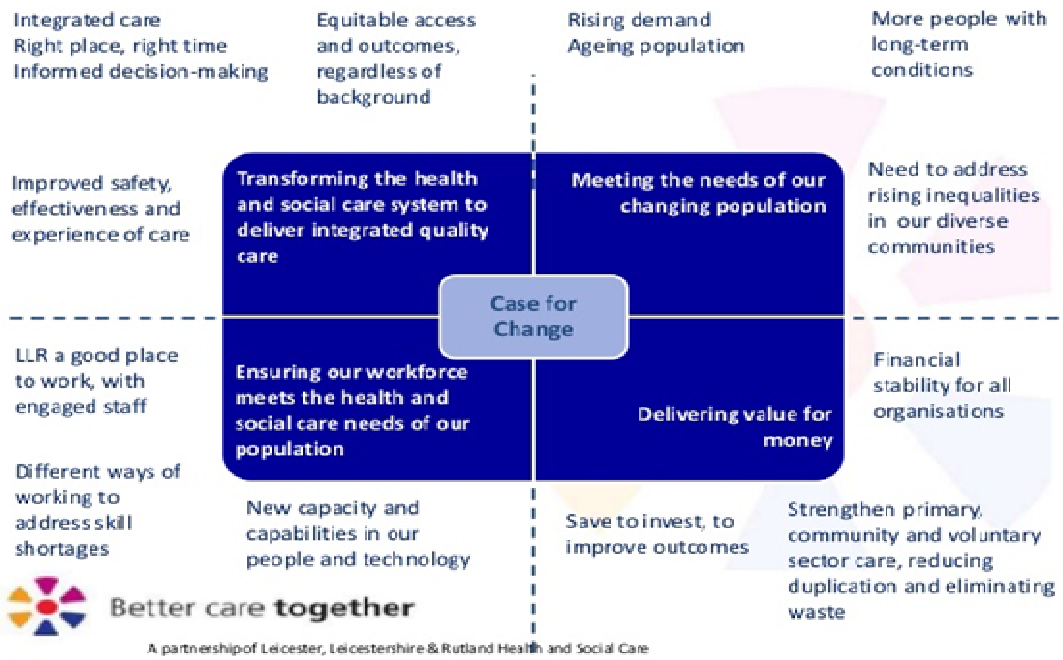
SECTION 2: LOCAL CASE FOR CHANGE

2.1 Summary Overview of Case for Change Analysis

A number of existing documents provide a consistent analysis of the case for change in the local health and care economy in LLR. In terms of the BCF refresh for 2016/17 we have therefore summarised and signposted to these as follows:

- **Leicestershire's 2014 BCF submission** - where the analysis focused for example on the specific needs of older people, the over use of the urgent care system, the improvements still needed in the proactive case management of people with long term conditions (LTCs) and frailty, the problems being experienced with hospital discharge. We considered the case for change and a range of evidence underpinning each theme of our of our BCF plan - the supporting materials can be found at this link: http://www.leics.gov.uk/leics_county_bcf_submission_template_1_sept_19.pdf.
  A summary of the evidence base used to develop the 2014 BCF is available in the Annex 1 documents at this weblink. http://www.leics.gov.uk/bcfsubmission.

- **The Better Care Together LLR-wide five year plan** - which considers the overall sustainability of our health and care system and the reconfiguration opportunities in LLR, in particular the left shift of care from acute to community settings and how improvements in priority care pathways could drive this reconfiguration. The case for change for the BCT five year plan in summarised in the summary diagram below and the BCT blue print document at this weblink:
  http://www.bettercareleicester.nhs.uk/EasysiteWeb/getresource.axd?AssetID=31818&servicetype=Attachment?AssetID=31818



- **Leicestershire's Joint Strategic Needs Assessment and Leicestershire's Joint Health and Wellbeing Strategy** - which consider the specific health outcomes where improvements are still needed for the local population including for example improving mental wellbeing. Our JSNA 2015 refresh includes a range of infographics interactive webpages, which show the profile of Leicestershire's population per the priorities in our Joint Health and Wellbeing Strategy https://public.tableau.com/views/CoredatasetMASTER_All_Infographics/BestStartinLife-County?:embed=y&:display_count=yes&:showTabs=y&:showVizHome=no#3.

- **Public Health Summary Needs Analysis 2015** - we have updated the 2014 BCF summary needs analysis in conjunction with public health, to reflect 2015 data where available. This is provided at Appendix 2 to this document for assurance.

- **The Urgent Care Vanguard Value Proposition** which focuses on the gap between the current model of urgent care operating in LLR and what a redesigned urgent care system based on best practice could deliver. A diagram summarising the proposition can be found at Appendix 3.

- We have refreshed our **Population level risk stratification** using 2015 data through Care and Health Trak - the outputs of this analysis are at Appendix 4. In summary this shows that, from April 2015 to December 2015, 44% of all emergency admissions at University Hospital Leicester (UHL) for Leicestershire residents have been for patients aged 70 and over. For those aged 70 and over, length of stay tends to be longer, and admissions for this age group account for 60% of the bed days, and 56% of the health service costs. The analysis also shows the profile healthcare costs of Leicestershire's population with LTCs in the over 70 age group. This shows that most of the costs (63%) for emergency admissions to UHL for those aged 70 and over are for patients with between two and four long-term conditions. This amounts to over £13.5 million of costs for April - December 2015. In Leicestershire in 2015, almost 62,000 (46% adults aged 65 or over were predicted to have at least one limiting long-term illness (JSNA 2015). Of these, hypertension is the most costly long term condition and 78% of the costs for this condition can be attributed to patients aged 70 and over.

2.1 Summary of Customer Insight Analysis that has informed the BCF Refresh

- Service user metrics have been analysed to assess improvements in the experience of local people using integrated care and support across settings of care in Leicestershire, including the quality of life score in the Adult Social Care Outcome Framework, support for people with LTCs via the GP survey, and experience of coordination of care and support on discharge from the CQC inpatient survey.
- The BCT Frail Older People customer insight survey undertaken in 2015 identified a number of important themes which indicate carers feel unsupported and isolated in our health and care system.
- Findings from the engagement with service users undertaken for the introduction of the "Help To Live At Home" domiciliary care services have been used to shape the outcomes and service model.
- Findings from the engagement with service users undertaken during the evaluation of the emergency admissions avoidance schemes, with Loughborough University, have been used to shape service redesign within the BCF in 2016/17.
- Findings from the customer insight analysis undertaken for the Lightbulb Housing Project are being used to design the service model for the Lightbulb Service business case, which is currently being prepared.

- Findings from engagement with service users on integrating customer services points of access across health and care have been used to inform the future options and solutions for an LLR wide operating model.

Other Reference Sources of Data and Analysis that underpin our BCF plan

- NHSE Benchmarking data (e.g. readmissions within 30 days)
- LLR Utilisation Studies
- Urgent Care Board Analysis
- ACG Risk Stratification data from Primary Care
- LA Benchmarking: e.g. on permanent admissions to residential care
- Customer Insight Survey Analysis and findings from Service User engagement in service redesign activities
- Adult Social Care Performance Reports and Dashboards
- Regional and National BCF analysis from the Central team
- Findings from the Dr Ian Sturgess review of our Urgent Care System and the focused action plan/RAP arising from this - led by the Urgent Care Board
- The "learning lessons" (mortality review)
- Outcomes and action plans arising from recent CQC inspections
- The detailed analysis completed for the recommissioning of Leicestershire's domiciliary care services across health and social care
- A self-assessment against the high impact changes for DTOC
- Independent evaluations and clinical audits of the emergency admissions schemes within the Leicestershire BCF.

These outputs have further informed the process of setting system level priorities for quality assurance and quality improvement, and where applicable have also been considered in refreshing our BCF plan.

2.2 How the Leicestershire BCF Plan Responds to the Case for Change

There is an ongoing need to focus community based interventions on those with LTCs, frailty and the growing population of over 70s - to reduce the level of activity and costs associated with acute care in favour of a left shift into proactive and preventative care in community settings.

Theme 1 of the Leicestershire BCF (Unified Prevention Offer) provides local area coordination to support vulnerable people with low level support to avoid escalating need/demand management, and offers a range of improved support to carers and housing needs.

Theme 2 of the Leicestershire BCF (Long Term Conditions) is directed to improving the identification of people with LTCs and providing integrated and proactive case management across health and social care.

Theme 3 of the BCF (Integrated Urgent Response) contains seven schemes targeted to reducing emergency admissions by 3% in 2016/7. These include a community based assessment service for frail older people, case management for the over 75s including via seven day services, a new falls service to avoid unnecessary admissions for older people, extends the seven day services offer within primary care, and provides an improved ambulatory pathway for people with respiratory and cardiac problems.

Theme 4 of the BCF (Hospital Discharge and Reablement) is targeted to improving reablement and supporting hospital discharge more effectively including through:

- A proactive and effective multiagency plan for sustaining good DTOC performance which includes:
- Follow up service for home care packages two weeks after discharge Housing offer targeted to improving hospital discharge (Theme 1)
- Improved LTC case management in localities (Theme 2)
- A range of community based care alternative pathways to avoid admission/readmission
- A new domiciliary care service “Help to Live at Home” being implemented from November 2016.

All of which are targeted to support people to be maintained in the community following a hospital admission, and avoid or delay permanent admission to residential care.

Section 5.9 and 5.10 of this document provide:

- A scheme level breakdown of the plan mapped to each BCF theme, the Better Care Together Workstreams in LLR, along with the BCF National Metrics and BCF National Conditions.

- A summary of the impact the BCF will have in 2016/17 in response to the case for change.

SECTION 3: OUR TRACK RECORD OF DELIVERY IN 2015/16

3.1 Progress Achieved by the 2015/16 BCF Plan

The Leicestershire BCF Plan is delivered under four themes. The themes are designed to group together related activity/projects so that:

- These are managed and governed effectively within the local integration programme.
- Their contribution and outputs are connected effectively to LLR-wide governance, where applicable.

BCF THEME 1: Unified Prevention Offer	**BCF THEME 2: Long Term Conditions**
• Integration of prevention services in Leicestershire's communities into one consistent wrap-around offer for professionals and services users. • Improved, systematic, targeting, access and coordination of the offer.	• Integrated, proactive case management from multidisciplinary teams for those with complex conditions and/or the over 75s. • Integrated data sharing and records, for risk stratification, care planning and care coordination.
BCF THEME 3: Integrated Urgent Response	**BCF THEME 4: Hospital Discharge and Reablement**
• Integrated, rapid response community and primary care services 24/7 • Working together to avoid unnecessary hospital admissions, supporting people at home wherever possible.	• Safe, timely and effective discharge from hospital, via consistent pathways, reducing length of stay • "Home First" philosophy, focused on reablement and maintaining independence.

3.2 Progress by Theme

Implementation of the integration programme in Leicestershire continues at pace.

The following table is a summary of our achievements to date:

Unified Prevention Offer	**Integrated, Proactive Care for those with Long Term Conditions**
✓ Launched Local Area Coordinators in eight localities to support vulnerable people and extend the availability and uptake of our community based assets. ✓ Implemented the Lightbulb Housing Offer with pilots operating across three localities targeted to improving health and wellbeing. ✓ Redesigning adaptation processes with district council partners and designing a new "housing MOT."	✓ Rolled out integrated locality working between community nursing and social workers so that they jointly respond and manage their caseloads using shared operational practices and procedures – organised to support both planned care and urgent care cases in each locality. ✓ Adopted NHS number onto 94% of adult social care records.
Integrated Urgent Response	**Hospital Discharge and Reablement**
✓ Implemented the frail older people's assessment unit at Loughborough Hospital with 540 people referred and 377 avoided admissions between January to December 2015. ✓ Trained 81% of paramedics in the falls risk assessment tool so that an average of 37% people per month are now not conveyed to hospital; but receive care and support at home instead. ✓ Implemented Night Nursing so that our existing Integrated Crisis Response Service can operate 24/7, with 470 referrals and 437 avoided admissions achieved in the Night Nursing service during 2015. ✓ Piloted seven day services in primary care across both CCGs with evaluation findings informing models and admissions avoidance assumptions for 2016 onwards. ✓ Achieved 1,581 avoided admissions from the above schemes between 1st January 2015 and 31st December 2015, against a target of 2,041.	✓ High impact interventions prioritised for 2015/16 BCF funding for improving DTOC, which ensured we achieved the DTOC target in Q1 (for the first time since 2011) and sustained good performance throughout 2015/16. ✓ Introduced dedicated housing support to acute and mental health inpatient settings to support hospital discharge, (featured in the HSJ in October). ✓ Redesigned domiciliary care service resulting in business case and joint specification for NHS and LA partners to commission a new service with effect from 2016/17.

3.3 Progress with BCF Enablers in 2015

Progress with BCF Enablers in 2015
• Implemented Care and Healthtrak – the new data integration tool for LLR. Care and Healthtrak is now a business as usual tool for measuring the impact of Better Care Together and BCF/integration developments in LLR. • Introduced the safe minimum transfer data set for hospital discharge. • Individual trajectories developed for each of the emergency admissions avoidance schemes with ongoing performance management. • Evaluated the emergency admissions avoidance schemes in conjunction with Loughborough University, Healthwatch Leicestershire and SIMUL8 to inform commissioning intentions for 2016, and with a view to publishing and disseminating our findings and methodology regionally and nationally in 2016. • Emma's story animation published (https://youtu.be/AU8CK-LT3dU) highlighting the approach to emergency admissions avoidance in Leicestershire, featured in the national Better Care Exchange Bulletin. • Social isolation campaign being launched in early 2016. • Integration Stakeholder Bulletins published quarterly featuring our progress and case studies (www.leics.gov.uk/healthwellbeingboardnews#hcibulletins). • Work of the Integration Programme promoted via @leicshwb twitter feed.

3 4 How we refreshed our BCF Plan for 2016/17

A systematic approach has been undertaken.

Leicestershire's (multiagency, director level) Integration Executive considered the vision and ambition for integration from March 2016 onwards, and engaged with the Health and Wellbeing Board about this during their development sessions in 2015. The product of this work has set the strategic direction for this refresh.

Detailed work to evaluate the performance of the BCF plan to date has been led by the Integration Operational Group. This is a multiagency group of commissioners and providers reporting into our Integration Executive.

The BCF plan was divided into three elements for the refresh:

- Elements of the plan which are now considered embedded and business as usual, some of which date back to the original health transfer monies allocations in 2011/12 which preceded the BCF. The refresh process ensured partners could discuss and agree which schemes should be in this category.
- Elements of the plan which were new in 2015 and subject to evaluation.
- Elements of the plan which were emerging for 2016/17.

The Integration Operational Group concentrated their efforts on the new elements implemented in 2015 and emerging elements for 2016/17 and compiled evidence from a range of sources including the findings of formal evaluations being undertaken, site visits, emerging business cases/proposals, and routine performance and service information gathered via existing governance processes.

The group directed actions and clarifications over a six to eight week period and then assessed existing schemes, with a RAG rating and narrative using the national evaluation tool (see results of this process at Appendix 5). They also sought clarification on the assumptions of a number of the existing schemes where scoping or early proposals were already available. Initial recommendations from these outputs were made to the Integration Executive at their meeting in January 2016 to inform the first cut of the BCF refresh.

In parallel with the above:-

- A full financial refresh was undertaken, profiling the plan for 2016/17.
- A review of Adult Social Care protection was undertaken.
- A review of additional pressures affecting CCGs and adult social care in the context of local allocations and savings targets was undertaken.
- A review of the threshold for the reserve/risk pool within the plan was undertaken in conjunction with CCG Finance Directors.
- Trajectories for existing and proposed emergency admissions avoidance schemes were refreshed/developed using the learning and findings from our implementation experience and evaluations undertaken in 2015 – confirm and challenge was applied to these trajectories on a multiagency basis.
- Annex 1's from the original BCF submission in 2014 which summarise the components in each theme of the BCF, were refreshed. http://www.leics.gov.uk/bcfsubmission
- A refresh of the programme delivery resources in terms of the management support available to deliver the plan, both within the core BCF delivery team and via matrix working across our partnership.

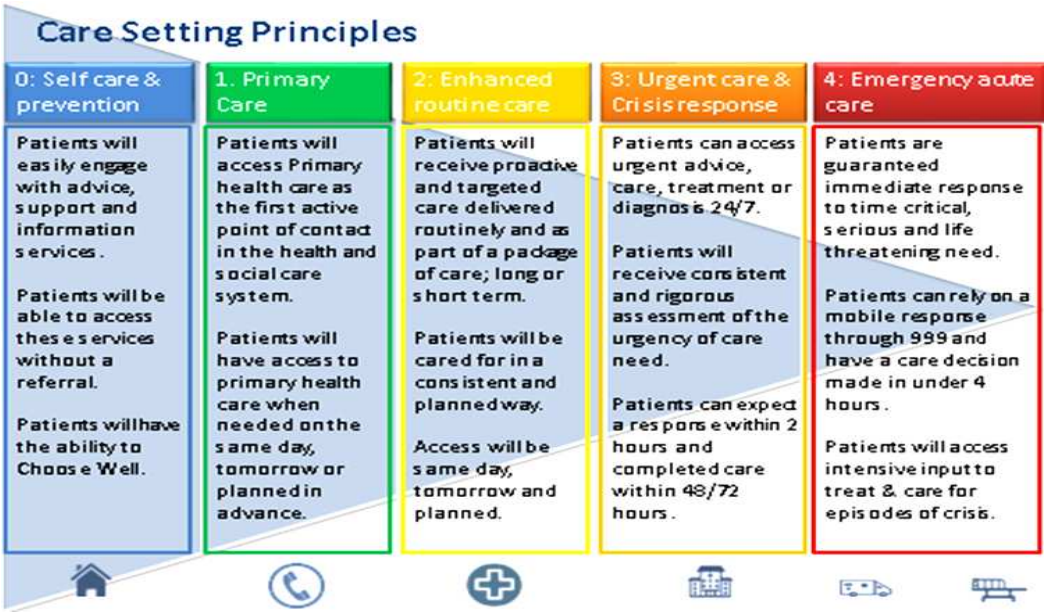
SECTION 4: OUR PLANS FOR 2016/17

4.1 Our Model for Integrated Care in Localities

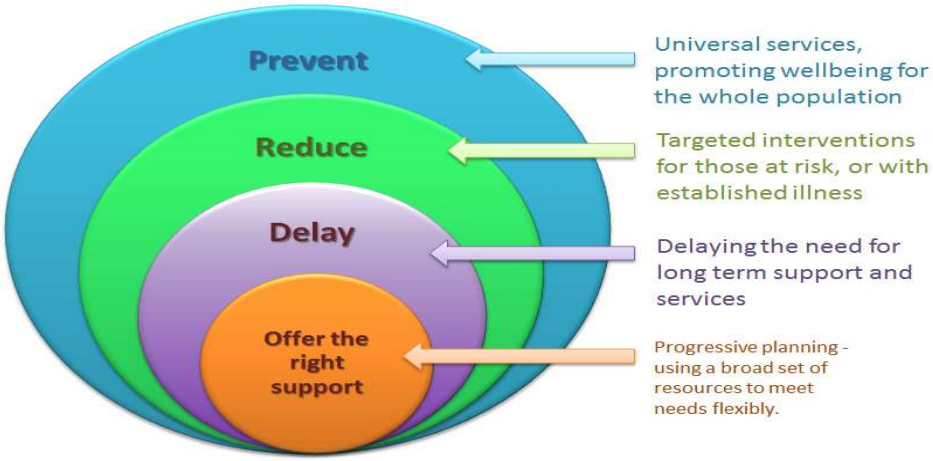
New models of integrated care are being designed via co-production and collaboration in Leicestershire, using some important design principles. In summary these are:

a) King's Fund and National Voices principles for Integration (see page 5 of this document).
b) Care setting principles per the Keogh review (see below)
c) Prevent, Reduce, Delay, as reflected in the Leicestershire Adult Social Care Strategy (see below)

Keogh Care Setting Principles Reference Diagram



Leicestershire Adult Social Care Strategy Reference Diagram



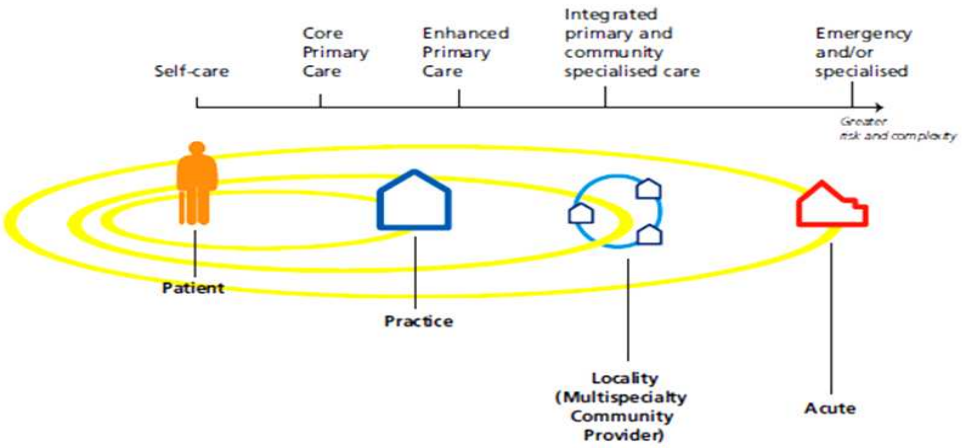
By applying these principles we are designing a new model of integrated care for Leicestershire's localities. During 2015 we have started to put in place the foundations of this model, and during 2016 we will be consolidating it.

The model places the patient or service user at the centre, with the GP as the primary route for accessing care. The GP is also the designated accountable care coordinator for the most complex or vulnerable patients in community settings.

Our model of integration wraps around the patient and their GP practice, extending the care and support that can be delivered in community settings through multidisciplinary working, with the aim of reducing the amount of care and support delivered in acute settings, so that only care that should/must be delivered in the acute setting will take place there in the future.

This "left shift" of activity into community settings is essential for the whole of LLR to deliver a sustainable health and care economy in the future and forms the basis of our LLR-wide five year plan *Better Care Together.*

The diagram below illustrates how the model of integrated care in localities has been designed.



Critical to this model, in terms of the contribution from the BCF are:

- **Multidisciplinary services that are configured on a locality basis and wrap-around clusters of GP practice**. Examples would be our integrated health and care teams who case manage vulnerable people such as those with long term conditions or frailty, and our new domiciliary care services, which are being jointly commissioned between CCGs and the LA in 2016, and which will be delivered on a locality basis.
- **Community based alternatives for urgent care**, being implemented in conjunction with the LLR urgent care vanguard, to avoid unnecessary hospital admissions.
- **Ensuring those being discharged from hospital are received safely back into local community services,** with the right level of coordination and planned support to promote reablement and prevent readmission.
- **Shifting demand into non-medical support where appropriate**, providing a broad and consistent range of social and preventative services, such as our housing offer, support to carers, and lifestyle support. The Leicestershire BCF has a whole theme dedicated to

co-producing this prevention model, creating a new platform of services which will be consistent and easy to access and navigate for both professionals and the public.

4.2 Our Framework and Workplan for Integrated Commissioning

A new strand of work for the BCF plan in 2016/17 will be to develop an outcomes framework for integrated commissioning with a work plan that focuses on a small number of priorities. The basis of this framework is outlined in this document.
http://www.birmingham.ac.uk/schools/social-policy/departments/health-services-management-centre/news/2015/02/commissioning-for-better-outcomes-a-route-map.aspx

At the time of this submission the priority services to be applied to the framework are in the process of being scoped however through the involvement of local partners in the Commissioning Academy there is already agreement that taking a joint approach to commissioning nursing and residential care placements should be one of the main areas of the work plan in 2016/17. This will build on the existing BCF funded quality assurance team for this care sector, and lessons learned through our work in 2015/16 to jointly commission domiciliary care services "Help To Live At Home". Other areas of focus area are likely to include: Integrated Personal Budgets and High Cost Placements. This work will:

- Involve researching other best practice, seeking further opportunities to achieve value for money, improve service user outcomes and quality assurance, using a shared outcomes framework.
- Help shape the market and commissioning intentions for integrated provision, improve commissioning intelligence, and how integrated services can be specified and procured across the health and care system.
- Involve improving oversight of all the existing Section 75 agreements within Leicestershire, so they are brought into the governance of the integration programme.

The performance of all of the following pooled budgets will be assessed quarterly in the Integration Finance and Performance Group, which includes representatives from Leicestershire County Council and the County CCGs:

- BCF Plan Section 75/pooled budget
- Community Equipment Section 75/pooled budget
- Learning Disabilities Section 75/pooled budget
- Help to Live at Home (domiciliary care) Section 75/pooled budget (from November 2016).

SECTION 5: DELIVERY OF THE BETTER CARE FUND NATIONAL CONDITIONS

5.1 Maintaining Provision of Social Care Services

Within the 2015/16 BCF plan we agreed a number of investments where specific types of packages of care and other social care services were protected. In the 2015/16 BCF plan this totalled £16m of the £38m pooled budget.

The prioritisation and type of resource to be protected has been reviewed for 2016/17 and determined by analysing:

- The population demand profiles/projections for adult social care.
- The impact of the savings target in adult social care for Leicestershire County Council.
- The protection that can be seen through the allocation of growth funding applied in the Council's, Medium Term Financial Strategy (MTFS).
- The delivery requirements of the local care system, including changes to models of care being driven by the BCF.
- Specific requirements linked to BCF Metrics and National Conditions, for example for the Care Act and Delayed Transfers of Care.
- The service and financial pressures that are still to be addressed in the medium term.

5.1.1 Impact of LLR-wide system changes on Adult Social Care

There are multiple pathway and system changes being implemented within the LLR five year plan for the local health and care economy, with an overall ambition to achieve a left shift of care into community settings.

At the time of this BCF submission work is being completed as part of the five year plan (Better Care Together) to model the impact of these wider system changes on the provision of adult social care, across all three councils in LLR.

It is recognised by all partners that the protection of adult social care services within the BCF, and the incremental changes already being made to integrated care delivery through the BCF, are a crucial part of maintaining system delivery while the longer term system changes are implemented, and the implications of the Better Care Together programme on adult social care can be assessed and addressed in more depth.

Leicestershire County Council is required to make a total of £78m budget savings between 2016-20. The Council recognises the need to protect adult social care and accordingly has allocated some resource for demographic growth pressures over the next four years. The Council is sourcing a higher proportion of savings from non-Adult Social Care Council services to mitigate some of the service reductions that would need to be made otherwise.

The Council's 2016/17 MTFS shows an increased financial allocation for growth totalling £23m in Adult Social Care for the next four years with £5.7m towards meeting increased demographic pressures in 2016/17.

The funding proposed from the BCF will in part meet increasing demand and cost and continue to protect social care services.

The protection identified within the BCF plan does not resolve all aspects of the increased demographic pressure, nor does it address the wider LLR system changes that are still to come, however priority has been given to areas where insufficient social care support will be detrimental to the delivery of the BCF plan's aims and metrics, in particular:

- To reduce emergency admissions.
- To ensure a more streamlined and responsive health and care system supporting hospital discharge seven days a week.
- To provide sufficient social care support for frail older people and those with LTCs to remain in their community for as long as possible.
- So that the existing social care resource can be redesigned to integrate more effectively with community services and primary care services.

The table below summarises the packages/activity type and investment levels that have been agreed for 2016/17 in order to protect Adult Social Care in support of the BCF plan. The investments include all previous protection elements which have been re-confirmed and are being carried forward into 2016/17.

There are also two new areas of investment which have been included for 2016/17. The result of this is an overall uplift in the level of adult social protection within the 2016/17 BCF plan, totalling £17,025,927, representing an increase of £970,727.

The breakdown of adult social care protection shown in the table below corresponds with the detailed BCF spending plan shown in the NHSE BCF Submission Template at Appendix 6.

Service Area	Description	Risk if not protected / protection reduced	2015/16 Protected Amount £000's	Other Adjustment £000's	2016/17 Protection £000's
Nursing Care Home Packages	Ongoing provision of c300 nursing care packages enabling these high dependency service users to remain safely in stable placements.	Service user needs not adequately met which could result in a deterioration in condition and admission to hospital and or need of more costly services.	3,361	0	3,361
Home Care Services	The provision of home care services to vulnerable adults is a cost effective way of meeting service user needs in their own home and helps to maintain their independence in the community. Demand for this service is increasing as more community based services are being commissioned. The funding ensures the delivery of c740,000 hours of home care to 1,420 service users.	Service users are not adequately supported in the community which may result in the need for more costly services, for example residential care. Unmet needs could have an impact on a service user's health needs leading to additional demands on primary, community or acute health care services.	10,312	432	10,744
Residential Respite Services	Ongoing provision of residential respite care for c20 service users per week. This service provides support to carers of service users with complex and challenging needs, giving them a break from their caring responsibilities.	Increased risk of carer breakdown which could result in the need to provide more costly services to support service users that would otherwise be undertaken by the carer.	743	0	743
Social Care Assessment and Review	Dedicated social work teams based across Leicestershire and in acute hospitals to ensure that service users and carers are assessed or reviewed in an appropriate timescale ensuring that needs are identified and, where appropriate, services are commissioned to meet outcomes.	Reduced capacity in this area may result in delays in assessing service user needs which could adversely impact on DTOCs. Reductions in review staff may mean that areas of over commissioning are not identified which would result in capacity issues in the market place.	1,640	0	1,640
Increased demand for Nursing Care Placements (New for 2016/17)	Demand growth in nursing placements equivalent to 750 bed weeks.				238
Increased demand for Community Based Social Care Services (New for 2016/17)	Leicestershire has an ageing population and as a result, greater numbers of residents are in need of support from Adult Social Care. This allocation will allow for a provide community based support for an additional 40 service users to enabling them to remain safely in their own homes, reducing the likelihood of admission to permanent residential care.				300
			16,056	**432**	**17,026**

5.1.2 Progress on Implementation of the Care Act

The Care Act 2014 introduced significant changes to Social Care legislation in April 2015. The changes implemented included the introduction of a national eligibility threshold; a new duty to carry out assessments for all carers regardless of the level of care provided, and an expanded role in market shaping. Responsibilities were also broadened to include assessments and support for adult prisoners and people in approved premises as well as the introduction of a universal deferred payment scheme.

All the required statutory requirements were implemented in April 2015, and a post implementation review has been completed confirming compliance with the Act.

Further changes were due to take effect from April 2016, namely the introduction of a cap on charges payable by service users; an increased threshold before service users start paying and free social care to anyone entering adulthood with a disability. Due to their significant cost, at a national level, these changes have now been postponed until 2020.

5.1.3 Leicestershire's Care Act Allocation

Local Authorities have received confirmation of their specific allocation from a national investment of £138m for the implementation of the Care Act in 2016/17. This forms one of the elements of the overall BCF financial envelope for each Authority and its partners.

We have identified our proportion of the £138m for the implementation of the Care Act which equates to £1.39m for Leicestershire and this has been incorporated and applied to the BCF plan in the areas identified in the table below.

Additional funding of £5.6m was made available in 2015/16 to cover the increased cost relating to the Care Act. Of this, £2.9m related to the on-going cost of phase one. Although the Government had indicated that the cost of implementation would be fully funded for 2016/17, the main Care Act grants have been included in the local government settlement, which due to significant reductions to that funding, has the effect of removing any additional allocation. This leaves the BCF as the only potential source of Care Act specific funding (£1.38m in 2015/16).

The funding shortfall will be partially mitigated by reviewing the approach to the phase one requirements and the financial impact of lower than expected demand from carers, following the introduction of changes in eligibility for assessments. However staffing resources and contracts that were expected to be funded from dedicated Care Act funding will need to be reduced or funded from savings elsewhere within Adult Social Care. To support the transition to a lower level of funding un-spent Care Act funding in 2015/16 will be used, through movements in earmarked reserves, in 2016/17 to allow time to transition to the lower level of funding.

5.1.4 Summary Data on Implementation of the Care Act 2015/16

The following data was used to populate the last Care Act National Stocktake and shows the amount spent on carer specific support during the first half of 2015, showing the numbers of people who have benefited and other outcomes/data.

	In 2014/15	From 1 April 2015 to 30 September 2015
Total number of adult social care assessments (this includes reviews)	17,854	8,039
Total number of assessments where the eligibility threshold was met	3,506	3,191
Total amount your council spent on social care assessments (this includes reviews)	8,662,066	4,222,482

	In 2014/15	From 1 April 2015 to 30 September 2015
Total number of carers who were given information and advice and/or signposted to other universal services	1,530	719
Total number of carers who were assessed for care and support	1,113	1,464
Total number of carers who were assessed for care and support who met the eligibility threshold	Carers eligibility not previously recorded / reported	868
Total number of carers who received council funded services	1,552 grant allocation 146 people receiving sitting services for carers	444

	In 2014/15 £	From 1 April 2015 to 30 September 2015 £
Total amount your council spent on assessments for carers	539,984	768,996
Spend on respite care. This metric measures total spend on building-based respite care (i.e. either in residential care or in the service user's own home), set against a 2014/15 baseline. Respite care is an important service for carers and a high cost service - any significant increase will therefore impact strongly on council finances. All respite care costs should be included, even if they are recorded in your systems against the individual who is being cared for.		
	In 2014/15 £	**From 1 April 2015 to 30 September 2015 £**
Total amount your council spent on respite care (as defined above)	3,972,656	2,213,423

	In 2014/15 £	From 1 April 2015 to 30 September 2015 £
Total amount your council spent on direct payments to carers	297,067	119,185
	In 2014/15 £	**From 1 April 2015 to 30 September 2015 £**
Total amount your council spent on services for carers (excluding assessment costs)	697,277	511,347

	From 1 April 2015 to 30 September 2015
Total number of people for whom an independent advocate was arranged under the Care Act	184 (excluding IMCA and IMHA)

	People
Total number of people who had a deferred payment as at 1 April 2015	219 (plus an additional 97 finalised cases where payment has not been received prior to April 2015)
Total number of people for whom a deferred payment agreement was agreed during the period 1st April to 30 September 2015	Forms for completion sent to 118 people 86 cases in progress 5 cases agreed and signed off
Total value of deferred payment loans made by your council in 2014/15	2,972,772
Total value of deferred payment loans made by your council between 1 April 2015 and 30 September 2015 (*This should include loans secured against property as well as against non-property assets)*	Total deferred element of all deferred payments between 30/3/14 and 13/9/15 = 1,192,408

Better Care Fund Resubmission (September 2014) – CARE ACT IMPLICATIONS

Scheme	BCF Scheme Ref	Total BCF Commitment £'000
Carers Support. In some cases carers will be entitled to receive services. The BCF includes funding for the Carers Support Fund, GP referral support service, access to advocacy and funding for respite provision provided by the independent sector.	UP02	778
Safeguarding. The Care Act requires that Local Authorities set up safeguarding Adults Boards in their area. Leicestershire already has such a board in place which is funded outside of the BCF. The BCF plan does include funding for a number of safeguarding posts.	LTC3	55
Assessment & Eligibility. The Care Act includes provision for a national minimum threshold for eligibility to receive services. This is to be set at substantial and critical. As Leicestershire's eligibility threshold is already set at this level and any additional cost will be absorbed in the protection of social care already included in the BCF submission.	LTC4	288
Continuity of care for movers. When a service user moves home within England, they will continue to receive care on the day of their arrival in the new area meaning that there will be no gap in care and support when people choose to move. This will also be absorbed in the protection of social care already built into the BCF Plan.	LTC4	45
		1,166
Two elements of the DH Local Reform and Community Voices Grant are now to be funded from the Better Care Fund:		
1) Veterans in receipt of guaranteed income payments (GIP). When financially assessing social care service users to determine the charge they pay for the service received, if a service user/veteran is in receipt of a GIP through the Armed Forces Compensation Scheme, that income cannot be taken into account and reduces the charge that the Council can make.	EN02	17
2) Independent Mental Health Advocacy (IMHA). The responsibility for the provision of Independent Mental Health Advocacy (IMHA) services transferred to the local authority in April 2013 from PCTs.	EN02	85
DWP Policies. The introduction of pension auto enrolment for providers is likely to result in additional costs. In addition to this, the 1% cap on benefits (against the previous increases in line with inflation) will see reduced income generating capacity for the provision of social care services. This forms part of the protection of social care already included in the BCF Plan.		120
		1,388
Other elements (including Law Reform, information and advice Support) to meet Care Act requirements are included in Local Authority core funding through existing commissioning rather than BCF)		

5.2 Seven Day Services across Health and Social Care

There is a national requirement to deliver against a set of 10 clinical standards for seven day services (7DS) http://www.nhsiq.nhs.uk/media/2638611/clinical_standards.pdf which NHS organisations are expected to meet by 2017. The standards include delivery of 7DS improvements within acute settings including diagnostic availability, and delivery of improvements in 7DS across other system wide settings such as primary, community mental health, and social care.

These developments aim to improve clinical outcomes and patient experience, reduce the risk of morbidity and mortality, and provide consistent NHS services across seven days. Specifically the following outcomes are intended to be delivered as a result of implementing the 10 standards:

- Reduced admissions
- Reduced variation in:
    - Length of stay by day of week
    - Mortality by day of week
    - Re-admittance by day of week (variation 1.8% between highest and lowest number across 7 days from Q2 2016)
    - Access to diagnostics (achievement of clinical standards 2, 5, 6 & 8)
- Reduced delays in clinical decision making
- Reduction in decompensation especially for the elderly
- Reduced risk especially for longer lengths of stay e.g.; falls, HAI rate.

5.2.1 Local Progress

University Hospitals of Leicester (UHL) is an Acute Trust Early Implementer for Seven Day Services (7DS), and the LLR health and care economy is one of the national Urgent Care Vanguard sites.

An active programme of work is therefore already in place to address the standards, both in terms of the contractual delivery of specific clinical standards within UHL and delivering a redesigned, resilient health and care system on a seven day basis across organisational boundaries and settings of care.

The governance route for assuring this delivery is via the LLR System Resilience Group and the LLR Urgent Care Board.

Services commissioned via local BCF plans are already contributing to the progress being made across LLR on 7DS.

A number of specific BCF investments were made in 2015/16 within the Leicestershire BCF in order to strengthen the provision of 7DS such as:

- The acute visiting service in primary care
- Seven day services pilots in primary care in ELRCCG and WLCCG
- Extended opening hours in primary care in ELRCCG and WLCCG
- 24/7 integrated crisis rapid response services – across LLR
- Adult social care seven day support to hospital discharge

The impact of these has been measured via BCF performance metrics for emergency admissions and DTOC, as reported quarterly to NHS England. Our emergency admissions avoidance schemes have also been evaluated in 2015/16 as part of the BCF refresh, in order to adapt and improve the alternative pathways to admissions on a seven day basis and to inform commissioning intentions for 2016/17.

The Vanguard programme is the vehicle for leading the LLR wide partnership work to establish a more comprehensive and resilient seven day service across the health and care system, and their work programme has been designed in line with achieving the national clinical standards and the new model of urgent care per the NHSE five year forward view.

Within the LLR Vanguard Programme, Workstream four focuses specifically on the delivery of 7DS and Workstream one focuses on Integrated Urgent Care in the Community. Together these workstreams will coordinate the delivery of 7DS developments spanning acute primary, secondary, social care and mental health care.

Appendix 3 shows the workplan and intended impact of the Vanguard workstreams, per the value proposition document recently submitted to the national team.

The Vanguard workstreams are at the early stages of development and delivery however commissioning intentions for 2016/17 have incorporated some of the early investments and redesign requirements for the new model of urgent care, including several elements linked to delivery of the 7DS standards.

At the time of this BCF submission CCG operating/financial plans and contracts with providers are still being finalised however it is anticipated delivery priorities for 7DS in 2016/17 will include the following:

- For UHL the focus will be on key clinical standards (CS) within Medicine, Surgery, Women's and Children's (patients on the emergency/urgent pathway) namely:
    - CS 02 - 90% of patients seen within 14 hours of admission by suitable consultant
    - CS 05 – timely availability of key diagnostic services
    - CS 06 - Key Interventions available 24 hours with timely access (as determined by speciality guidelines)
    - CS 08 – Patients admitted as emergencies to be reviewed every 24 hours 7 days a week where appropriate

Significant progress has already been made across Medicine, Surgery, Women's and Children's achieving CS02, CSO5 and CS06 – however the main challenge will be achievement of CS08. This will be addressed by completing a gap analysis to determine

what can be achieved within existing resources e.g. by redesign, and what will need additional investment.

Other key actions for UHL include:

- Variability analysis across seven days in key outcomes – e.g. readmissions / length of stay / deaths by day of admission.
- Audits of progress achieved across all standards in April and October 2016.
- Named Senior Management and Clinical Leads to drive implementation.

Actions Spanning Primary Care, Mental Health Care, Community Services and Social Care, examples include:

- Introduction of the Acute Visiting Service into ELRCCG
- Further Investment in Liaison Psychiatry and Mental Health Crisis Response to provide a more effective 7DS for responding to Urgent Mental Health Care needs (Adults and Children)
- New models of 7DS in primary care – for example WLCCG will be testing new models utilising a combination of home visiting, the Urgent Care Centre and face to face appointments, both in and out of hours, seven days a week.
- Implementation of the new “Help to Live at Home” domiciliary care service, facilitating discharge seven days a week
- The LLR redesigned Discharge Pathway three (residential reablement)
- The expansion of the Intensive Community Service (ICS) provided by Leicestershire Partnership Trust, which is a key enabler within the 24/7 urgent care system.

5.3 Better Data Sharing between Health and Social Care, based on the NHS Number

5.3.1 NHS Number as the Consistent Identifier

During 2015/16 the NHS number has been adopted on all Adult Social Care records in Leicestershire where a successful match has been possible (achieved 94%), via the NHS matching service (MACS). Good preparations have also been made for the switch over to the new Demographics Batch Tracing Service Bureau (DBSB) due to the imminent cessation of the MACS service.

The adoption of the NHS number has been a key dependency for the implementation of Care and Health Trak – see further detail on this development below.

In Q1 and 2 of 2016/17, aligned to our further ambitions for the deployment of Care and Healthtrak, we will be pursuing the adoption of the NHS number for children's social care records, the supporting Leicestershire Families Service and the Lightbulb Housing Service.

In Q3 of 2016/17 we will also be working with our new domiciliary care providers who will be coming on stream in November 2016 to ensure their activity data can also be identified with the consistency of the NHS number.

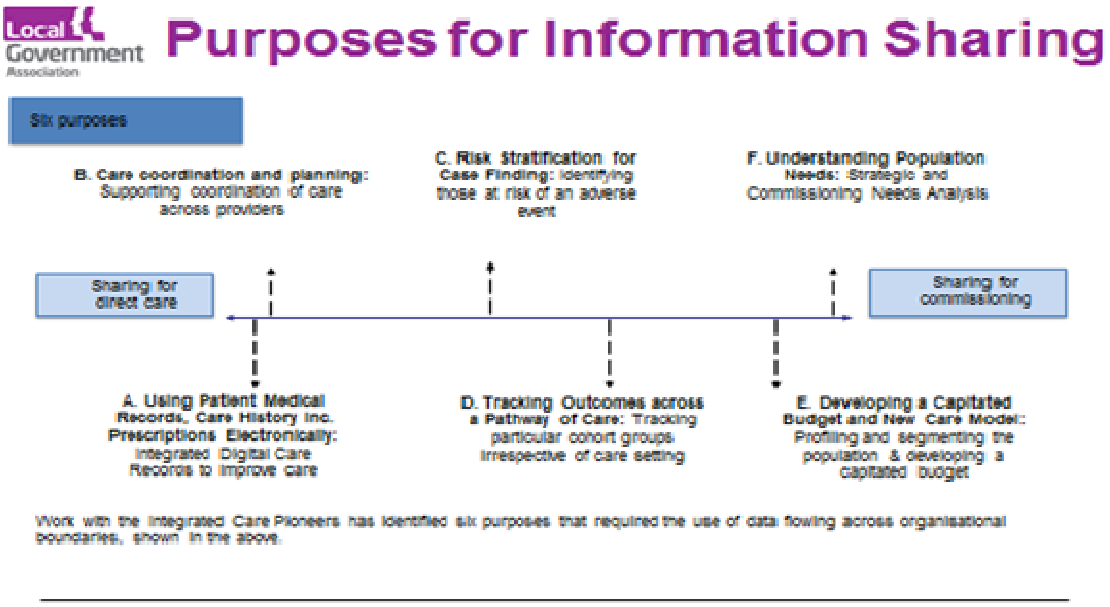
Some scoping discussions are also underway with other agencies including fire and police in terms of the applicability of the Care and Healthtrak tool when working collectively with vulnerable people.

The adoption of the NHS number is seen an upstream activity in the Leicestershire health and care system, to be captured at the point of initial contact or matched as soon as possible thereafter on a monthly basis.

In terms of risk, there remains a small core of residual service users who do not have an NHS number despite a lot of effort to match them. The mitigation plan relies on alternative ways to obtain the number, via personal contact/consent for example.

5.3.2 Data Sharing

The following diagram illustrates the six purposes for information sharing in relation to health and care integration:



During the preparations for the original BCF submission in 2014 we assessed our local approach to data sharing and benefited from the "how to" guides, workshops and webinars provided by the national BCF team which explored the information sharing purposes, national policy, legislative and IG issues, and encouraged local areas to seek solutions to the numerous challenges and barriers these issues present.

In Leicestershire we recognised the need to take a strategic approach to solving two key barriers to delivering our vision for health and care integration:

a. System level data sharing across health and care - for population level stratification, and tracking patient journeys and outcomes.

b. Records sharing at the point of care delivery, including for care coordination and care planning.

We are using the Leicestershire BCF as the lever to address item a., and are working with the LLR wide IM&T group to progress item b.

5.3.3 Implementation of Care and Healthtrak

During 2015/16 the Leicestershire BCF led the local implementation of Care and Healthtrak, a third party product from Pi Ltd. This tool was procured in April 2016 to provide a psuedonymised analysis of patient journeys across the health and care system. Implementation of this tool has been led via the Leicestershire BCF on behalf of the LLR Health and Care economy.

The tool was launched in October 2015 http://www.lsr-online.org/launch-event---14-october-2015.html. The tool includes two years of historical activity and costing data which is then updated routinely monthly from existing commissioner and provider systems within the NHS and Local Authorities.

Care and Healthtrak offers bespoke dashboards, costing analysis and source data for workforce analysis for the workstreams within the BCT programme across LLR.

26 members of the business intelligence teams in LLR have been trained to use the system with individuals assigned to partner organisations and BCT workstreams.

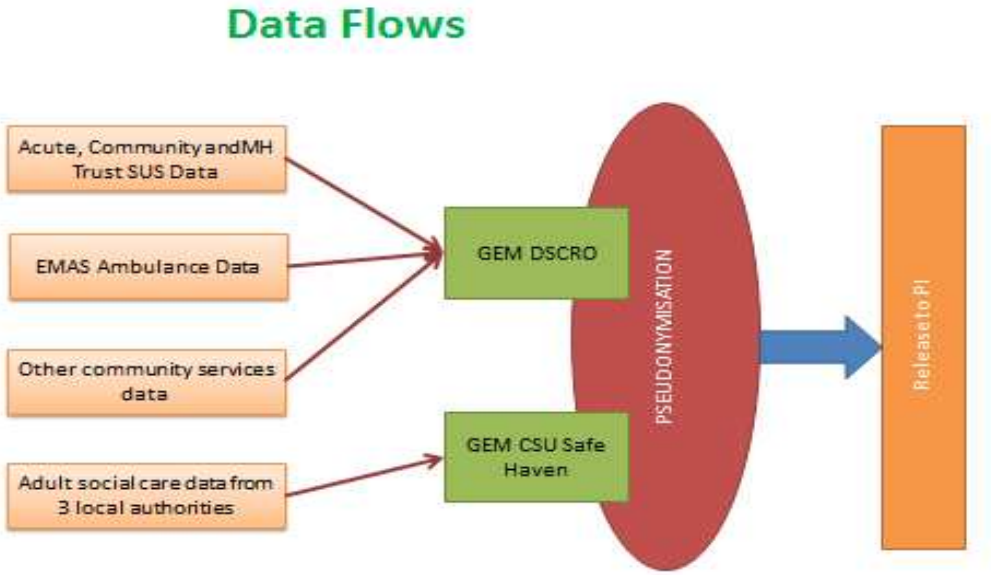
Dashboards and bespoke analysis are now being produced to analyse trends in how patients are using the health and care system and the impact of changes that are being made, such as the introduction of new elements of the urgent care system.

5.3.4 Information Governance and the Care and Healthtrak Tool

Achieving the appropriate information sharing agreements with information governance (IG) assurance, including from Caldicott Guardians were key dependencies for the successful implementation of Care and Healthtrak during 2015/16.

The PI Care & Health tool provides extensive data sharing between health providers and social care across LLR, using pseudonymised NHS number as the unique identifier. All appropriate IG controls are in place, authorised by the SIROs for the relevant data controllers, and overseen by the community of IG specialists who developed the documentation. The outputs of the PI tool however do not share personal confidential data.

This process relies on an SLA between the local Arden and GEM CSU and Pi Ltd and revised Caldicott principles relating to personal confidential data. Local Caldicott Guardians have been involved throughout. The diagram below outlines the data flows that support this process.



5.3.5 Care and Healthtrak Phase Two - Developments for 2016/17

Following agreement by LLR partners to continue with investment in the tool for a further 12 months, a strategy for its further deployment, and a workplan for the priority business intelligence activities for 2016/17, is currently being developed. The targeted workplan will provide analysis supporting key priorities from local BCF plans, the overarching Better Care Together programme and the LLR Urgent Care Vanguard.

Care and Healthtrak Phase two also involves the addition of NHS 111 number data, the potential addition of a pilot GP data set for the top 2% at risk of admission (from existing GP risk stratification systems), and the addition of data sets from out of county acute hospitals. As noted above, discussions are already in progress about the adoption of the NHS number into the Lightbulb housing service, and children's social care records so that an even a richer data set can be available within the tool in 2016/17.

5.3.6 Integrated data for Care Delivery

The LLR IM&T Group are in the process of developing a Local Digital Roadmap to define the IM&T strategy for LLR. This document needs to in place by June 2016. Per the work required on the NHS Digital Roadmap assurance, each of the main NHS providers (including EMAS and GPs) have been asked to provide an analysis against the digital maturity index, to give a baseline for LLR. To support the development of the Roadmap a number of workshops have been held.

Appendix 7 shows the LLR IM&T programme plan that will help to deliver the outcomes of the workshop. Appendix 8, shows the BCT Clinical Workstream IM&T requirements.

Key focus areas for 2016/17 are:

- Sharing care records (e.g. via the MIG)
- Population data analysis
- System wide efficiencies to improve integrated working
- Better Care Together Clinical Workstreams

The main priority of the LLR IM&T group in 2015 has been to develop a system wide summary care record (SCR) which can be viewed across NHS partner organisations. This has been developed and achieved through the MIG web based solution. In 2016/17, further scoping will consider which is the best platform for achieving SCR across NHS and LA settings, e.g.:

- If the MIG viewer can be used by both LA and NHS partners.
- If summary information via the MIG can include any LA information.
- If summary information viewed via the MIG can be edited.

Should the MIG not be a suitable solution for this capability, the LLR IM&T group will need to consider other case management systems/solutions such as TPP/SystmOne or other third party solutions being adopted in some other parts of the country. However it is recognised

that these can be prohibitively costly and difficult to implement, hence the efforts currently being made to develop a solution from local infrastructure. Having an integrated summary care record that can be edited by a multidisciplinary team is especially important in terms of integrated care planning and case management in the community including crisis response and palliative care where inputs spanning GPs, EMAS, social care and community nursing/therapy teams are involved.

5.3.7 LLR Integrated Points of Access Project

The business case currently being prepared on opportunities to integrate the various points of access (call centres) across the health and care system in LLR will also set out some of the technology opportunities and constraints in terms of call handling, scheduling of work and case management, which will also need to be considered as part of the next phase of the LLR IM&T strategy.

5.3.8 Assurance on Interoperability /APIs

Progress on achieving open APIs across the IT systems operating within the health and care economy is summarised below, recognising elements are at different levels of maturity.

- **GPs API** – All of our GP systems are using the GPSoC contract. Suppliers under the GPSoC contract have to commit to open APIs. Our GP clinical systems are either on TPP or EMIS. Following recent conversations with these companies they are focusing on API information sharing between the two companies before expanding this further. This is in pilot phase and will be rolled out towards the end of 2016. Data feeds that will be shared are all coded data with associated free text, appointments and tasks. To bridge the current interoperability gap between GP systems and secondary care providers the LLR health community have implemented the MIG that shares core components of the GP records to hospitals and community services. We are looking to further expand this to Social Care, Mental Health and Specialised Palliative care.

- **Hospital API** – Currently view GP data via TPP EPR Core and the MIG. They are currently in the process of implementing an EPR (subject to approval by the TDA). The new EPR (Cerner) will have API capabilities using their Health Information Exchange (HIE).

- **Social Care API** – Social Care systems are a mixture of Liquid Logic and Core Logic. Both systems have API capabilities but have not been exploited. The intention is for Social Care to have access to the MIG during 2016/17.

- **Community API** – Community are using TPP SystmOne. They have the ability to view the full GP record of a patient of patients that originate from a GP practice that has TPP. They also have the ability to view EMIS records via an API with MIG.

- **Mental Health API** – Are using Servelec Rio system that has API capabilities however the full capabilities have not been fully exploited.

- **Specialised Palliative API** – Our main provider LOROS is currently using TPP SystmOne. They have the ability to view the full GP record of a patient of patients that originate from a GP practice that has TPP. They will also have the ability to view EMIS records via the MIG or future development of GP Clinical System API's.

The next steps on IM&T interoperability will be reflected within the LLR Local Digital Roadmap that will be submitted to NHS England in June.

5.3.9 Assurance on Information Governance

We are committed to ensuring that the appropriate IG controls are in place.

Leicestershire County Council already utilises the IG Toolkit as part of connecting Public Health to the N3 network. Local organisations are committed to PSN connectivity.

NHS partners are committed to the IG Toolkit and N3 connections are covered by code of connectivity.

The majority of NHS systems are covered by the national NHS Registration Authority Chip and Pin access system which provides position based access control. The mental health IT system (from 2015), TPP SystmOne and the GP system EMIS all operate Chip and Pin, along with the theatre IT system in UHL. Those systems that do not operate chip and pin include the main clinical system in UHL, CLINICOM, and the therapy services IT system, TIARA.

The implications of this are that demographic data such as address, dob and the NHS number requires validation at operational service level and batch requests are made to extract/validate and add the NHS number to local records where needed.

CCGs are required to comply with the IG Toolkit standards and submit a level of compliance on an annual basis to the Health and Social Care Information Centre.

The IG Toolkit includes standards relating to the Caldicott principles and compliance with information governance regulations.

The IG Toolkit draws together all legal requirements and central guidance in relation to information processing and presents them as a set of 28 IG requirements. CCG's are required to achieve a minimum of level two across all of the relevant requirements,

For 2015/16 ELRCCG and WLCCG have achieved level three compliance across the majority of standards which is a positive position (the highest level of achievement being level 4). The CCG's Internal Auditors have independently reviewed the CCG's compliance levels across a range of identified standards to ensure that there is the required evidence to support the information governance requirements.

5.3.10 Engagement with the public regarding data sharing

In terms of the Local Authority, the following elements are in place

The *Privacy Notice* on the LCC website can be found at this weblink http://leicestershire.gov.uk/privacy-notice

Engagement via the "Have your say" feature for relevant consultations, (plus a short archive of previous engagements) at this weblink: http://leicestershire.gov.uk/have-your-say. Individual consultations make it clear about the use of responses and make it clear what happens to personal information. See example below

Please note: Your responses to the main part of the survey (Q1 to Q8 including your comments) may be released to the general public in full under the Freedom of Information Act 2000. Any responses to the questions in the 'About you' section of the questionnaire will be held securely and will not be subject to release under Freedom of Information legislation, nor passed on to any third party

In terms of Adult Social care and the use of personal data via assessment or review processes/forms the following is in place:

I understand that completing this form will lead to a computer record being made which will be treated confidentially. The Council will hold this information for the purpose of providing information, advice and support to meet my needs. To be able to do this the information may be shared with relevant NHS agencies and providers of care and support services. This will also help reduce the number of times I am asked for the same information. If I have given details about someone else, I will make sure that they know about this. I understand that the information I provide on this form will only be shared as allowed by the Data Protection Act.

Leicestershire's social prescribing single point of access "First Contact Plus" coordinates referrals across multiple agencies and their referral form has clear guidance on how data will be shared between NHS/LA and other agencies including fire and police

https://leicestershirecc.firmstep.com/default.aspx/RenderForm/?F.Name=uvn2gxn1eyk&HideToolbar=1

In terms of CCGs the following guidance summarises the use of personal data in GP practice and CCG settings

https://eastleicestershireandrutlandccg.nhs.uk/how-we-use-your-health-records/ or in PDF version here https://eastleicestershireandrutlandccg.nhs.uk/wp-content/uploads/2015/09/How_we_use_your_health_records_82247GEM.pdf

http://www.westleicestershireccg.nhs.uk/page/privacy

http://www.westleicestershireccg.nhs.uk/recordsharing

In 2013/14 local GP practices in Leicestershire publicised information in line with the care.data requirements, and a summary of these activities and how patients were engaged at that time can be found here: http://www.westleicestershireccg.nhs.uk/page/caredata

5.4 Accountable Professional for Case Management

Both local CCGs in Leicestershire have developed effective models of care to support people with LTCs to maintain the maximum level of independence and self-care possible.

Locality health and social care teams work with the high risk 2% of our local population (frail older people, and those with LTCs) who are identified through risk stratification. Risk stratification identifies those individuals most at risk of being admitted to hospital or those who are likely to experience a health crisis.

The model is now well established and has been successfully developed through the creation of "Virtual Wards." These are caseloads of patients in the community whose care is managed by locality based teams working with General Practice as an integrated service, using the established community and social care resources within each locality.

A proactive, integrated approach is followed where the individual and the health and care team work together to agree the support needed to manage their condition and identify the specific help they need. The engagement with the individual is ongoing and ensures the health risk is kept at bay while supporting the individual to self-manage their condition.

A care plan is then developed, with primary, community and social care based support planned around the patient, carer and family, using standard shared care plans. Care plans "step up" care when needed to support through a period of crisis or increased need and "step down" care when the person stabilises or needs decrease.

The named accountable GP is responsible for ensuring the creation of the personalised care plan and the appointment of a care co-ordinator as per the requirements of the Avoiding unplanned admissions: proactive case finding and patient review for vulnerable people 2015/16 DES.

The avoidable admissions DES was commissioned by NHS England in April 2014. All 49 practices within WLCCG have committed to this DES and 31 (out of 32) practices in ELRCCG have committed to this DES during 2015/16.

The practice must provide a back office number to other health and social care professionals who wish to discuss elements of the patients care. In addition, patients should also be offered on the day advice/consultation with their registered practice.

There are a number of specific commissioned services with named care coordinators/managers for patients, for example:

- Reablement Discharge Pathway three designed for patients no longer receiving acute care but unable to return home and require reablement and assessment within dedicated therapy based care facilities. For pathway three, a therapy-led, model of care will include: Case management of all patients transferred, leading the MDT meetings, therapy leading the discharge process in co-ordination with the wider MDT (which will include care home staff trained in reablement and that have supported/managed the patient)

- Weekend Access Service – patients at most risk of a hospital admission over the weekend period benefit from a “patient passport” where they can contact a clinically qualified person for advice or for onward referral to an on call GP, 999, secondary care or community services.

In terms of multispecialty community provider implications, the 2016/17 BCF plan demonstrates how we are moving into an even greater level of ambition for integrated care in localities. This will integrate the offer beyond core primary care, community nursing and social care to encompass other wrap-around preventative and social prescribing components such as housing support, domiciliary care and local area coordination.

5.4.1 Care Planning and Support to People with Dementia and their Carers

With regards to dementia, we will focus on the following key areas of work during 2016/17:

- Review and refresh the Joint Dementia Strategy for LLR to reflect the Prime Ministers Challenge 2020.
- Develop an LLR commissioning plan for the next three years (years three to five of the BCT programme of delivery) this will be part of the LLR STP — June 2016.
- The development of an Adult Social Care Strategy for 2016-2020, working together with partnership agencies to provide more ‘joined up’ health and social care services.
- Improve and maintain diagnosis rates to reflect the expected prevalence through:
    - Continue to implement the Shared Care Agreement in order to enable more people to be supported in primary medical care that in turn will reduce waiting times for diagnosis in memory clinics, through creating capacity. Further work is being taken forward to be able to discharge patients on Galantamine during 2016/2017 — ensuring that the drug costs stay the same in primary care as they are for our secondary health care providers.
    - Review and redesign the Memory Assessment Service in order to deliver an integrated service provision with primary care so that we can increase its capacity to support meeting the increasing need.
    - Continued working with our general medical practices through enhanced service provision, audit programmes and educational events in order to drive the dementia diagnosis target.
    - Implement the outcomes from the evaluation of the Hospital Liaison Scheme to Leicester Royal Infirmary and Glenfield Hospital sites.
    - Work with our voluntary sector organisations to provide integrated support for the patient, their family and carers.

Work with our voluntary sector organisations to provide integrated support for the patient, their family and carers. These services include:-

- Side by Side – a new initiative that allows people with dementia to choose a volunteer who will accompany them on out and about activities/hobbies
- Memory Support Service: The service will provide emotional support, information and guidance on living well with dementia and enable a better understanding of the condition

and support the development of self-management skills. The service also offers home visits for one to one support and telephone support.

- Singing for the Brain includes people with dementia, carers and family members.
- An information programme for South Asian families. This programme is for carers at the point of diagnosis
- Carers Information and Support Programme (CRiSP) aimed at family members and friends who support a person with a recent diagnosis of dementia

Supporting information can be found in Appendix 9 and 10.

5.5 Agreement on the Consequential Impact of the Changes Providers

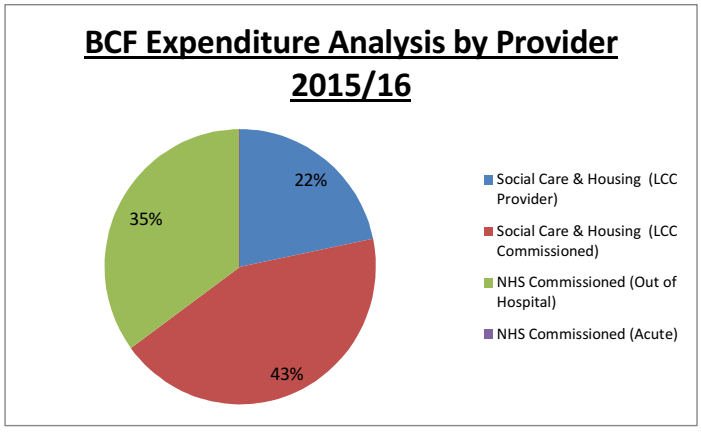
- Approval of the BCF plan by all partners, including agreeing the impact on providers and how BCF schemes are contractualised, is an essential part of the governance associated with the Leicestershire Integration Programme. In Section 8 of this document there is a summary of all the engagement undertaken in the refresh and approval process for the Leicestershire BCF 2016/17. It should be noted however that co-production with providers and with Healthwatch is a key feature of how we deliver our integration programme on a daily, weekly and monthly basis, as demonstrated in the governance narrative in Section 7 of this document.
- Triangulation of the BCF metrics and trajectories has been an important element of our work as partners between January and March 2016. Due to the delays in the BCF technical guidance and the impact this had on BCF submission dates it is recognised that CCG operating plan dates and BCF submission dates are now not aligned nationally, though this had been the original intention. To mitigate this we are working closely with CCGs to ensure iterations of activity plans are consistent and keep pace with adjustments being made between respective submissions.
- The impact of the BCF emergency admissions schemes trajectories on capacity planning and contract negotiations with our local acute provider have been shared transparently and feedback has been sought specifically from the UHL Executive/Clinical management team on the assumptions being made about the schemes for 2016/17. The impact of the trajectory for emergency admissions for the BCF related activities is that 1,500 admissions are to be avoided by the BCF schemes in 2016/17 which represents a 2.49% reduction.
- Evaluation and lessons learned from implementing the initial four emergency admissions avoidance schemes in 2015 have been shared proactively with NHS providers including ambulance, acute and community trusts, and discussed thoroughly as part of the refresh process undertaken at our Integration Operational Group and Integration Executive.
- Risks to delivery of the BCF including the risks to delivery of the emergency admissions trajectory within the urgent care system have been reflected in the Integration Risk Register.
- Impact on other providers (community services, social care, housing) have also been quantified in terms of investment levels, specification and delivery requirements including refreshing KPIs and trajectories where applicable. The governance at project level and via the Integration Operational Group is designed to ensure the lead commissioner in each case has enacted the contractual requirements.
- In terms of the impact of DFG allocations the BCF plan confirms the commitment to passport a £1.7m DFG allocation to Districts Councils for 2016/17, same as the arrangement in 2015/16. The additional £1.3m DFG allocation which replaced the social care capital grant is being retained within the BCF pooled budget. This is because it is already committed on a range of essential services that benefit all partners and the communities they serve, including elements of housing related support (e.g. for example assistive technology and the housing discharge support schemes at the Bradgate Unit and LRI). The position will be reviewed following consideration of the Lightbulb Business Case with District Councils later in 2016.

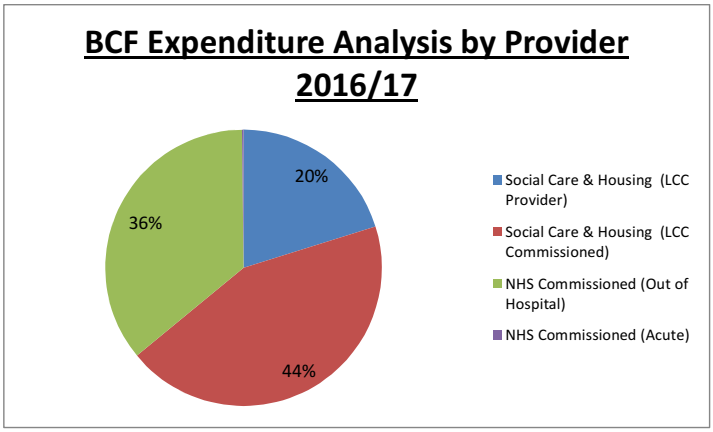
5.6 Agreement to Invest in NHS Commissioned Out of Hospital Services

The detailed spending plan submitted in the NHSE Submission template at Appendix 6 demonstrates the breadth of the Leicestershire BCF plan in investing in NHS commissioned services out of hospital. This includes not only NHS community services and social care services but a range of prevention services such as first contact, housing support and local area coordination.

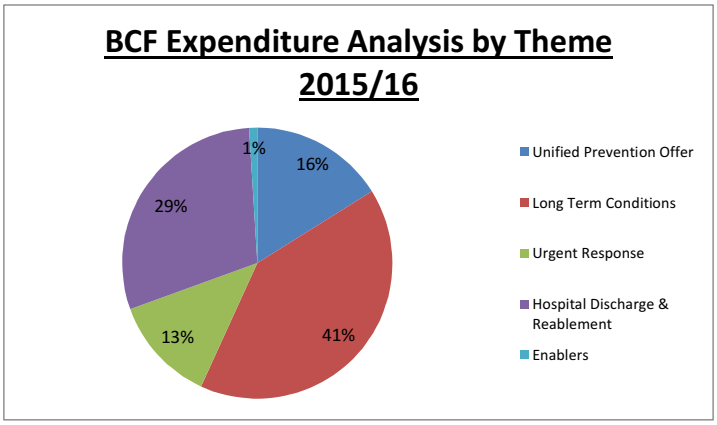
The proportion of the plan invested in these services is illustrated in the following pie chart with a comparison chart provided for 2015/16:

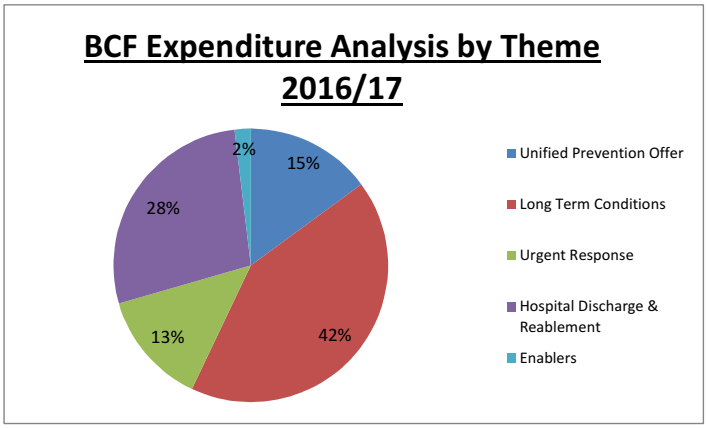
Analysis of Expenditure by Provider	2015/16 £'000	2016/17 £'000
Social Care & Housing (LCC Provider)	8,438	7,942
Social Care & Housing (LCC Commissioned)	16,790	17,298
NHS Commissioned (Out of Hospital)	13,638	14,102
NHS Commissioned (Acute)	0	78
	38,866	**39,419**





Analysis of Expenditure By Theme	2015/16 £'000	2016/17 £'000
Unified Prevention Offer	6,266	5,881
Long Term Conditions	15,824	16,617
Urgent Response	4,930	5,298
Hospital Discharge & Reablement	11,479	10,887
Enablers	367	737
	38,866	**39,419**





The charts demonstrate the Leicestershire BCF plan 2016/17 has again achieved a good balance between adult social care protected spend and NHS Commissioned out of hospital services.

The emergency admissions avoidance schemes implemented in 2015, all of which are community based alternative pathways commissioned by the NHS, have been evaluated through a combination of clinical audit, site visits and an independent evaluation by Loughborough University.

Each of the emergency admissions avoidance schemes has a trajectory and is performance managed against this trajectory intensively. Findings from the evaluation, including scheme level performance data and Urgent Care Board analysis from 2015/16, have been used to inform the refresh of the trajectories for the existing schemes that are continuing into 2016/17.

All new emergency admissions avoidance schemes for 2016/17 either have trajectories in place or have trajectories in development via Business Case submissions at the time of this BCF submission.

Trajectory data has been used to assess our confidence in delivery in 2016/17 which has in turn informed our decisions about risk pool.

As performance on emergency admissions remains extremely challenging in LLR and we achieved only 70% of the admissions to be avoided by the four schemes in 2015, we have agreed a local risk pool will still be needed for 2016/17.

The ongoing requirement for a risk pool has placed additional pressure on the BCF financial plan for 2016/17.

In line with our local agreement in 2015/16, this risk pool will be available to compensate CCGs for any underperformance against the scheme delivery within the BCF related to emergency admissions avoidance, and which therefore has an impact on acute over performance.

Through the Integration Performance and Finance governance group which oversees the BCF section 75, decisions will be taken on a quarterly basis about the release or retention of the risk pool depending on performance/forecast out turn. This can include monies being released back into the BCF for other priorities to be funded, based on a prioritisation process already completed as part of the BCF refresh.

The risk pool for 2016/17 has been set at £1m, based on 70% performance across the schemes for 2016/17.

There have been no immediate disinvestments within the out of hospital commissioned services affecting the 2016/17 BCF plan, however two of the existing four emergency admissions schemes are subject to further redesign and VFM assessments which may result in significant variations in year.

A range of ongoing commissioning actions and activities, including further evaluations were identified across the BCF plan as part of our detailed refresh. These actions have been incorporated into our programme plan which is at Section 7.5 and will inform future commissioning decisions.

An analysis of our performance against the emergency admissions pay for performance metric in 2015, with scheme level breakdown can be found at Appendix 11.

5.7 Agreement on Local Action plan to reduce Delayed Transfers of Care (DTOC)

In January 2015 the Leicestershire Health and Wellbeing Board received a comprehensive report about DTOC performance in the context of the poor performance of the urgent care system at that time. This report showed that

- As at the end of November 2014 the average number of patients delayed accredited to adult social care and combined adult social care and NHS per 100,000 population was 4.22, which represented an uplift of 2.19 (or 107.9%) above the level reported for November 2013 of 2.03.
- As at the end of November 2014 the average number of delayed days per month per 100,000 population (per the BCF metric definition) was 403.17, which represented an uplift of 46.62 (or 13.1%) above the 2014/15 Q3 target of 356.55.
- In terms of benchmarking with peer authorities as at November 2014, performance for Leicestershire was at 2.26 and for Leicester City was at 1.57. Leicestershire's performance was 0.84 (or 27.1%) below the peer group benchmark of 3.10 and Leicester City's performance was 1.53 (or 49.4%) below the benchmark.
- There was also a significant "await care list" for packages of care in the county.

The report analysed the reasons for the poor performance and provided an overview of the system wide action plan being implemented and governed by the LLR Urgent Care Board.

The LLR Urgent Care Action Plan had activities organised into three themes; inflow, flow and outflow. The outflow section of the plan focused on discharge routes out of hospital and incorporated a number of the key interventions which were already been prioritised and invested in by partners through the implementation of the 2015/16 Leicestershire BCF plan. These included:

- Alignment of BCF interventions into the new, five (rationalised) discharge pathways for LLR.
- Introduction of safe minimum transfer data set.
- Improvements to social care seven day working on acute sites.
- Implementation of housing advisers within hospital discharge teams on acute sites.
- Systematic review of all care packages two weeks post discharge by expert review team.
- Pilot sites for residential reablement pathways.
- Introduction of a new non weight-bearing pathway.
- Improvements to CHC pathways (discharge to assess).
- Re commissioning of Leicestershire's domiciliary care services (joint commissioning NHS and LA partners – new service called "help to live at home".

Assurance on the delivery of the discharge improvements during 2015/16 has been achieved and governed as follows:

Local Footprint:

1) Participation of adult social care in daily discharge planning MDT activities with partners
2) Oversight within adult social care in terms of routine performance reporting/performance management within the department and corporate management structures of Leicestershire County Council.
3) Assurance on the delivery of the suite of Leicestershire BCF DTOC activities, investments and metrics, including tracking achievement of quarterly targets - through the multiagency Integration Operational Group and Integration Executive.

LLR Footprint

1) Assurance through the Urgent Care Board dashboard, tracking delivery and performance of KPIs including DTOC performance at the LLR level.

Regional and National Reporting

1) Regional/National DTOC reporting on ASCOF metrics by adult social care.
2) Monthly DTOC SITREP NHSE reporting.
3) National quarterly BCF returns via NHSE ref BCF DTOC metric performance.

The impact of the improvements resulted in Leicestershire achieving the BCF DTOC metric by May 2015 and sustaining this performance throughout the remainder of 2015/16.

The Leicestershire BCF plan during 2015/16 has also had a relentless focus on admissions avoidance, with four new admission avoidance schemes implemented and performance managed intensively throughout the year.

These schemes have had demonstrable impact, albeit the overall rise in emergency admissions across LLR has remained extremely challenging.

The four BCF schemes were formally evaluated as part of the BCF refresh. Two new admissions avoidance schemes are also being incorporated within the 2016/17 plan. Driving down the number of admissions and readmissions continues to be an important feature of our DTOC approach.

During the BCF refresh for 2016/17 the following activities have been undertaken to consider our DTOC plans for 2016/17:

- A multiagency team from LLR attended the regional East Midlands DTOC Guidance Event where we shared the learning from our area as well as taking on board the practice from other areas.
- The new definitions, guidance and high impact changes for DTOC were presented to our Integration Executive and Health and Wellbeing Board in December and January 2016 respectively and assurance given on the local application of the guidance.
- A self-assessment is currently in progress against the high impact changes framework which will be reported via the Integration Executive in April, then into the Leicestershire Health and Wellbeing Board's May meeting.
- We have reviewed current performance in depth and analysed the areas where further improvements could be made, especially in relation to performance on non-acute sites and out of county acute sites.
- We have undertaken an evaluation, with extremely positive evaluation findings, for the housing discharge enabler, resulting in recurrent commitment from commissioners.
- We have examined benchmarking information as at December 2015 and considered the level of stretch to apply locally given the progress already made.
- We have already confirmed a range of commissioning intentions for 2016/17 on the basis of the impactful changes made in 2015/16. These are in the process of being recurrently commissioned through the BCF refresh and CCG operating plans in order to sustain performance for 2016/17.
- We are engaging with health and care voluntary sector partners in March about the BCF plan for 2016/17, including the DTOC components.
- On 4th February we issued an OJEU notice for our new domiciliary care service. This was the culmination of a year's work to develop a new specification jointly between LA and NHS commissioners - to create a new outcomes based model of care focused on reablement. This has involved significant engagement with the independent sector through a series of targeted provider engagement events.

- We have recently completed an organisational development programme for integrated health and social care teams operating in localities, where case management for planned and unscheduled care is now delivered to joint operating models.
- The early benefits of the new community equipment service (and the operational improvements and demand management processes associated with it) have been reviewed by the Integration Executive.

5.7.1 Discharge Developments for 2016/17

- The LLR integrated points of access review will result in a business case by April 2016. It is anticipated this will provide further opportunities to integrate the response of the local workforce to urgent care and planned care including discharge support. The technological aspects of this integration are intended to provide new tools for scheduling and capacity management across the community based workforce.

- The introduction of the MIG (viewing technology for sharing the summary care record) will bring additional benefits for discharge planning, care coordination and admissions/readmissions avoidance.

- During the autumn of 2016 there will be a planned transition into the new domiciliary care services. ("Help to Live at Home"). Good practice in reviewing care packages at two weeks has been incorporated into the new model of care and the new providers will be receiving induction into localities so they integrate effectively with other parts of the local health and care system including community based preventative support.

- During 2016/7 further joint commissioning activities are planned between LA and NHS partners, specifically in relation to care and nursing homes placements and falls prevention.

- During 2016/17 our Lightbulb housing offer, which is currently being piloted is likely to roll out across Leicestershire, bringing a new on stop-shop for housing related support such as aids and adaptations, home maintenance, home safety, affordable warmth. The lightbulb housing offer will also adopt the successful hospital discharge enabler staff into the new service.

- An LLR workforce strategy and supporting workforce analysis is currently being developed by Better Care Together, and this is a key dependency for the Leicestershire BCF plan as detailed in our risk register.

- The introduction of Care and Healthtrak in 2015 has resulted in a new set of dashboards which allow greater interrogation of patient journeys across the whole health and care system including social care components. The impact of DTOC interventions can be evaluated through this tool with effect from January 2016.

5.7.2 DTOC Target for 2016/17 and Risk Pool Decisions

Using all the analysis outlined above we have concluded that the performance improvements achieved in 2015 have been driven by focussed delivery of interventions in the acute sector, and analysis is being concluded at the time of this submission on the proportion of our delays that are generated from non-acute sites.

Our approach to target setting for 2016/17 is therefore to set a target to maintain the good performance in the acute sector and apply a 0.5% improvement across non-acute delays. This has also been reflected in CCG operating plans.

Partners have agreed not to have a risk pool in relation to DTOC performance given the progress made in 2015/16. As indicated in section 6 of this document a risk pool is being applied in the case of the emergency admissions avoidance target.

5.7.3 Assurance on delivery in 2016/17

Assurance and governance routes will apply as per 2015/16, as listed in section 5.7 above, e.g. the Integration Executive will provide County level assurance associated with BCF delivery and the Urgent Care Board will continue to provide oversight of delivery at system level across LLR.

The Urgent Care Board is in the process of refreshing its governance arrangements for 2016/17, in line with the Vanguard developments.

Sustaining LLR wide DTOC performance operationally and strategically will continue to be a high priority across all partners, with high levels of commitment to improve performance further in 2016/17, in particular in relation to LOS and DTOC across community hospitals, mental health sites and out of county acute sites.

Appendices below includes supporting information as follows:

- Appendix 12 - The emerging self-assessment analysis against the DTOC high impact changes (work in progress for the May Health and Wellbeing Board)
- Appendix 13 - The LLR discharge action plan from the Discharge Sub Group of the Urgent Care Board.
- Appendix 14 - LLR RAP from the Urgent care Board – high level system resilience document.
- Appendix 15 - Delayed Transfer of Care Monthly Reporting April 2015 to January 2016

5.8 Better Care Fund Metrics – Our Targets for 2016/17

The following table explains the definition of each metric, and the rate of improvement we are aiming for in each case. Please refer to the NHSE BCF Planning Template, Appendix 6 for the more detailed metrics analysis.

National Metric (1)	Definition	Trajectory of improvement
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	This is a nationally defined metric measuring delivery of the outcome to reduce inappropriate admissions of older people to residential care.	The target for 2016/17 has been set at 630.1 per 100,000 based on the 2015/16 target of 670.4 per 100,000 and a 90% confidence level that the trajectory is decreasing. Current performance is on track to achieve the target for 2015/16. As part of the development of a four year adult social care strategy, detailed analysis of this metric has taken place and the target set accordingly. In 2014/15 there were 710.5 permanent admissions per 100,000 people. In 2015/16 this is likely to reduce to 669.6 per 100,000 people.

National Metric (2)	Definition	Trajectory of improvement
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	This is a nationally defined metric measuring delivery of the outcome to increase the effectiveness of reablement and rehabilitation services whilst ensuring that the number of service users offered the service does not decrease. The aim is therefore to increase the percentage of service users still at home 91 days after discharge.	The target for 2016/17 has been set at 84.2%, based on the expected level of 82.6% being achieved in 2015/16 and a 75% confidence interval that the trajectory is increasing. The lower confidence interval has been chosen to ensure that the target is realistic and achievable. Performance is currently on track to meet the 2015/16 target of 82.0% As part of the development of a four year adult social care strategy, detailed analysis of this metric has taken place and the target set accordingly. In 2014/15 83.8% of reablement service users were still at home after 91 days. In 2015/16

		this is likely to reduce to 82.6%. Due to the introduction of a Help to Live at Home scheme planned for November 2016, a conservative target has been set.

National Metric (3)	Definition	Trajectory of improvement
Delayed transfers of care from hospital per 100,000 population (average per month)	This is a nationally defined metric measuring delivery of the outcome of effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults. The aim is therefore to reduce the rate of delayed bed days per 100,000 population.	Recent reductions in delays have focussed on interventions in the acute sector. We have therefore set a target based on reducing the number of days delayed in non-acute settings by 0.5%, while maintaining the rate of days delayed in acute settings at its current low level. The targets are quarterly and are 238.0, 233.3, 215.9, 220.7 for quarters 1 to 4 of 2016/17 respectively. As part of the development of a four year adult social care strategy, detailed analysis of this metric has taken place and the target set accordingly. Substantial improvement in the rate of days delayed has been achieved – the annual rate has dropped from 4,753 per 100,000 in 2014/15 to a probable 2,730 per 100,000 in 2015/16.

National Metric (4)	Definition	Trajectory of improvement
 **Non-Elective Admissions (General & Acute)**	This is a nationally defined metric measuring the reduction in non-elective admissions which can be influenced by effective collaboration across the health and care system. Total non-elective admissions (general and acute) underpin the payment for performance element of the Better Care Fund.	In 2014/15 there were 58,479 non-elective admissions for Leicestershire residents, In 2015/16 it is likely that there will be 59,957. The proposed target for 2016/17 is 726.38 per 100,000 per month, based on a 2.49% reduction on the probable number of non-elective admissions for patients registered with GP practices in Leicestershire for 2015/16 (allowing for population growth). This equates to no more than 58,836 admissions in 2016/17. This assumption has been aligned with final CCG operational plan targets. All existing admission avoidance schemes have been subject to evaluation in 2015/16, and the results reflected in the development of a trajectory of 1,500 avoided admissions from these schemes in 2016/17.

National Metric (5)	Definition	Trajectory of improvement
 **Improved Patient Experience**	Selected metric for BCF Plan from national menu: - taken from GP Patient Survey: “In the last 6 months, have you had enough support from local services or organisations to help manage long-term health condition(s)? Please think about all organisations and services, not just health.” The metric measures the number of patients giving a response of "Yes, definitely" or "Yes, to some extent" to the above question in the GP Patient Survey in comparison	It is proposed to set this target at 63.5% for 2016/17 (data will be released February 2017). This is based on the 2015/16 target (data due for release July 2016) and a 2% increase in the number of positive replies. Current performance of 61.6% (January 2016) is below the England average of 63%.

	to the total number of responses to the question.	

Local Metric (6)	Definition	Trajectory of Improvement
 **Injuries due to falls in people aged 65 and over**	This is a locally defined metric measuring delivery of the outcome to reduce emergency admissions for injuries due to falls in people aged 65 and over.	It is proposed that this target is set at 1742.9, based on holding the number of admissions for injuries due to falls steady for the 65-79 age group (a reduction in the rate per 100,000 from 678.9 to 664.0) while lowering the rate per 100,000 for the 80+ age group from 7,919.1 to 7,523.1 (this equates to 25 fewer admissions in the year despite the increase in population) The latest published data (2014/15) shows Leicestershire as having a directly standardised rate significantly better than the England average for the whole age 65+ cohort and for the separate 65-79 age group and the 80+ age group.

5.9 Scheme Level Overview with Mapping

The BCF Plan for 2016/17 will involve delivery of the following elements:

I. Continuation of the business as usual components of the BCF plan. This includes all our designated “protected services” across adult social care and NHS provision.

II. Implementation and further evaluation of the following components of the BCF plan per the table below.

The following summary provides a high level scheme overview with mapping to BCF national conditions and metrics, Leicestershire BCF Themes, and LLR’s Better Care Together Programme Workstreams.

Further scheme level detail is provided in the NHSE Planning template at Appendix 6.

Leicestershire BCF Components being implemented/evaluated in 2016/17	Scoping Stage	Delivery Stage	BCF Plan Theme	Map to BCT/STP	Map to BCF National Condition(s)	Map to BCF Metric(s)
Information, Advice and Guidance	Y		Unified Prevention Offer	Prevention (STP)	Care Act	
Communities Offer	Y		Unified Prevention Offer	Prevention (STP)		
Local Area Coordination		Y	Unified Prevention Offer	Prevention (STP)		
Lightbulb Housing Offer		Y	Unified Prevention Offer	Prevention (STP)	DFG/Housing Support	
Supporting Leicestershire Families			Unified Prevention Offer	Children, Young People & Families (BCT)	Accountable professional	
Falls Prevention Programme	Y		Unified Prevention Offer	Prevention (STP) Frail & Older People		
Falls non-conveyance pathway		Y	Integrated Urgent Care	Urgent Care Frail & Older People	7 day services	
Management of Falls in Care Homes	Y		Integrated Urgent Care	Prevention (STP) Urgent Care (BCT) Frail & Older People (BCT)	Out of Hospital Care	
Integrated Crisis Response 24/7		Y	Integrated Urgent Care	Urgent Care (BCT) Frail & Older People (BCT)	7 day services Out of Hospital Care	
Older Person's Assessment Unit		Y	Integrated Urgent Care	Urgent Care (BCT) Frail & Older People (BCT)	Accountable professional Out of Hospital Care	
7 day services in primary care, including the Acute Visiting Service		Y	Integrated Urgent Care	Urgent Care (BCT)	7 day services Accountable professional Out of Hospital Care	
Ambulatory Care on CDU Pathway (Glenfield)		Y	Integrated Urgent Care	Urgent Care (BCT) Long Term Conditions (BCT)	7 day services Out of Hospital Care	
LLR Integrated Points of Access	Y		Integrated Urgent Care (Enabler)	Urgent Care (BCT)	7 day services Out of Hospital Care	

Leicestershire BCF Components being implemented/evaluated in 2016/17	Scoping Stage	Delivery Stage	BCF Plan Theme	Map to BCT/STP	Map to BCF National Condition(s)	Map to BCF Metric(s)
Care and Health Trak Phase 2		Y	IT Enabler	IM&T	Data sharing Data integration	
Integration of health and care records for case management	Y		IT Enabler	IM&T	Data sharing Data integration IT Interoperability	
Implementation of Help to Live at Home (new domiciliary care service)		Y	Hospital Discharge and Reablement	Urgent Care (BCT) Frail Older People (BCT)	7 day services DTOC action plan	
Integrated Commissioning Outcomes Framework and work plan for 2016/17	Y		Commissioning Enabler	N/A		
Improved Oversight of other Section 75s	Y		Commissioning Enabler	N/A		
Integration Programme Evaluation	Y (phase 2)	Y (phase 1)	Evaluation Enabler		Will include evaluation of 7 day services	
Liaison Psy	Y		IUR	Urgent Care (BCT)	7DS	
LTC QIPP	Y		IUR/LTC	Urgent Care (BCT) LTC (BCT)		
Neuro rehab	Y		IUR/HDR	Urgent Care (BCT) LTC (BCT)		

Existing Leicestershire BCF Components	HTM Legacy	BCF Plan Theme	Map to BCT	Map to BCF National Condition(s)	Map to BCF Metric(s)
First Contact Plus	Yes	Unified Prevention Offer	Prevention (STP)		
Carers Services	Yes	Unified Prevention Offer	Prevention (STP)	Care Act	
Assistive Technology	Yes	Unified Prevention Offer	Frail & Older People (BCT) Long Term Conditions (BCT)	DTOC	
LD Short Breaks (NHS)		Unified Prevention Offer	Learning Disabilities (BCT)		
Residential Reablement Respite Services		Unified Prevention Offer	Frail & Older People (BCT)	Social Care Protection DTOC	
Integrated Proactive Care	Yes	Long Term Conditions	Frail & Older People (BCT) Long Term Conditions (BCT)	Accountable professional	
Improving Quality in Care Homes	Yes	Commissioning Enabler	Frail & Older People (BCT)		
Nursing Care Packages Home Care Service		Long Term Conditions	Frail & Older People (BCT)	Social Care Protection DTOC	
Health and Social Care Protocol Training		Commissioning Enabler		DTOC 7 day services	
Residential Reablement	Yes	Hospital Discharge and Reablement	Frail & Older People (BCT)	DTOC	
Hospital to Home	Yes	Hospital Discharge and Reablement	Frail & Older People (BCT)	DTOC	
Intermediate Care	Yes	Hospital Discharge and Reablement	Frail & Older People (BCT)	DTOC	
Reablement (NHS)		Hospital Discharge and Reablement		DTOC	
Intensive Community Service		Hospital Discharge and Reablement		DTOC	
Improving Mental Health Discharge	Yes	Hospital Discharge and Reablement	Mental Health (BCT)	DTOC	

Existing Leicestershire BCF Components	HTM Legacy	BCF Plan Theme	Map to BCT	Map to BCF National Condition(s)	Map to BCF Metric(s)
Non-weight bearing pathway		Hospital Discharge and Reablement	Frail & Older People (BCT)	DTOC	
Step Down (NHS)		Hospital Discharge and Reablement		DTOC	
Assertive In Reach (NHS)		Hospital Discharge and Reablement		DTOC	
Assessment and Review		Hospital Discharge and Reablement		Social Care Protection DTOC	
Care Act Enablers		Enabler		Care Act	
Programme Leads and Support		Enabler			

5.10 <u>What will our health and care system look like as a result of the changes planned in 2016/17?</u>

Long Term Conditions, Frailty and Dementia

- Central to the development of the local multi-speciality community provider model, integrated health and care teams will be available in each locality, combining the expertise of adult social care services from Leicestershire County Council and the community nursing and therapy teams of Leicestershire Partnership Trust (LPT), working hand in hand with GP practices.

- Via primary care, people with long term conditions will have their risks assessed and their care plans coordinated by the integrated health and social care team in their locality. They will benefit from

    - electronic care plans
    - a designated accountable professional for their care
    - a new prevention offer which will target social prescribing interventions such as housing support, carer support, assistive technology and local area coordinators to support vulnerable people and help them remain as independent as possible in the community for as long as possible..

- People with Heart Failure and Atrial Fibrillation will benefit from improvements to case management to reduce premature mortality and the risk of stroke.

- People with long term respiratory and cardiology conditions will be supported to remain in the community rather than being admitted to hospital through the development of a new ambulatory pathway in conjunction with Glenfield Hospital and primary care.

- Seven day services will be available in primary care, coordinated by GPs across Leicestershire localities. This will be targeted in particular to frail and vulnerable people, those with complex and multiple long term conditions and those at the end of life.

- Through LLR's digital road map, further interoperability between IT systems will be achieved to enable shared care records and care plans, using the NHS Number as the consistent identifier to plan and deliver person centred care more effectively across organisational boundaries.

Integrated Urgent Care

- LLR's urgent care system will be redesigned in line with the models of care proposed by the Vanguard project , with the BCF focused particularly on

    - improving and streamlining points of access into the health and care system on a 24/7 basis
    - delivering a number of the alternative pathways to avoid hospital admission

- 1,500 emergency admissions will be avoided in 2016/17 through improved urgent care pathways funded by the Leicestershire BCF, which include integrating pathways

between the ambulance service, NHS Trusts, locality teams and GP practice across on a 24/7 basis.

Hospital Discharge and Reablement

- We will continue to limit delayed bed days despite a 0.69% population growth. This will be achieved by reducing the number of delayed bed days in non-acute settings by 0.5% and maintaining our good performance on acute sites. Without this focus we would see 102 additional delayed bed days per year.

- 3,500 people will benefit from the new domiciliary care service for Leicestershire "Help to Live at Home" which will focus on reablement outcomes, and maintaining independence.

- We will continue to reduce the numbers of people aged 65 and over needing hospital care after a fall, despite a 2.48% increased in this population. Instead more people will receive care at home and there will be a new LLR wide approach to falls prevention. We aim to achieve no increase in the number of emergency admissions for injuries due to falls in the 65-79 age group, despite an increased population. For the 80+ age group we plan to lower the number of similar admissions by 25, despite growth in the population.

- Fewer people will be permanently admitted to residential or nursing care, due to improvements to the care and support they can receive at home.

Unified Prevention and Social Prescribing

- Our unified prevention offer will describe a clear, consistent menu of services that are on offer in each community, with First Contact Plus as the coordinating "front door" for accessing a range of social prescribing solutions.

- 2,900 carers will benefit from enhanced information and health and wellbeing support, including via assessments provided under the Care Act

- 240 vulnerable people per year will be supported by Local Area Coordinators operating in Leicestershire's communities, to help them make the most of what's on offer on their doorstep.

- A new integrated housing service "Lightbulb", operating across District Councils will offer a one stop shops and housing "MOT" where practical expertise and support for people needing aids, equipment, adaptations, handy person services and advice on energy efficiency/affordable warmth can be delivered.

Other Benefits

- Leicestershire people will experience significant changes in how care is planned and delivered, feel confident in community based services, and report improvements in their overall experience of integrated care and support.

- By reconfiguring services and investing in community alternatives, improving delayed discharges, reducing emergency admissions, and creating enhanced locality based

services, we can confidently reduce the overall number of inpatient beds in Leicestershire, at key intervals in line with the 5 year plan.

- A new outcomes framework for integrated commissioning will support partners to take a joint approach to value for money, quality assurance and service user outcomes. This will deliver improvements during 2016/17 in areas such as nursing and care home placements, as well as inform our joint commissioning priorities for 2017/18.

- The benefits of the Care and Healthtrak data sharing tool will be embedded as business as usual, and will inform impact analysis for the STP, BCT workstreams, including the LLR Vanguard and BCF delivery.

SECTION 6: BCF PLAN FUNDING SOURCES, SPENDING PLAN AND OUR APPROACH TO RISK SHARING

The BCF refresh for 2016/17 has involved a comprehensive review of the proposed spending plan for 2016/17. The BCF Operational Group and the Integration Performance and Finance group have led the detailed work to evaluate the performance of the BCF plan in 2015/16 including assessing financial performance and risks and the outputs of this work have been reported via the Integration Executive and assured via the Health and Wellbeing Board in line with local governance arrangements.

Partners have considered the overall pressures within the BCF spending plan, the level of investment needed to meet the BCF metrics and national conditions, including the ongoing requirement for a risk pool for emergency admissions and the impact of the unexpected DFG allocation increase.

These discussions have taken place in the context of wider financial pressures affecting all partners in the health and care system, plus the need to balance priorities within a complex planning environment and a health and care economy which continues to face significant sustainability risks linked the over use of acute care.

This BCF refresh process has identified a number of new areas of investment for 2016/17. This has been achieved by maximising the use of the reserve from 2015/16 and the main categories of additional investment are as follows:

- Investment in further emergency admissions avoidance interventions and seven day services improvements.
- Increasing the level of adult social care protection to sustain DTOC performance and mitigate (in part) demographic/demand pressures.
- Securing ongoing investment for DTOC related schemes (e.g. the housing discharge pilots have been funded recurrently from the BCF).

The process to refresh the BCF spending plan has confirmed the following:

- That partners will continue to pool the required minimum BCF level of funding in 2016/17 which is £39.1m.
- Additional contributions above the required minimum BCF level of funding total £0.2m.
- That a risk pool of £1m (for emergency admissions performance risk) will be applied to the fund in 2016/17.
- That a contingency reserve of £1m will be applied to the fund in 2016/17.
- That the investment in adult social care protection within the fund will be increased from £16m to £17m.
- That £1.7m of the 2016/17 DFG allocation will be passported directly to Districts for DFG delivery.

- That £1.3m of the 2016/7 DFG allocation will be utilised within the financial envelope of the BCF pooled budget to drive medium term housing solutions redesign by agreement with District Councils.

Confirmation of the Source of Funds for the Refreshed BCF Plan

Better Care Fund Funding Comparison 2015/16 to 2016/17

Funding Source	2015/16 £	2016/17 £	Movement £	Movement %
Minimum Contributions	-	-	-	-
East Leicestershire & Rutland CCG*	15,187,000	15,559,591	372,591	2.5%
West Leicestershire CCG*	20,073,000	20,476,926	403,926	2.0%
Social Care Capital Grants	1,344,000	0	-1,344,000	-100.0%
Disabled Facilities Grants	1,739,000	3,067,448	1,328,448	76.4%
	38,343,000	39,103,965	760,965	2.0%
Additional Contributions				
Additional Contribution (Reserve funding)	504,800	0	-504,800	
Additional LA Contribution - Integrating Points of Access	0	137,000	137,000	
Additional LA Contribution - 50% CD Post	0	50,000	50,000	
	504,800	187,000	-317,800	
Total BCF Funding	**38,847,800**	**39,290,965**	**443,165**	
* Inclusive of Care Act Funding (including non-recurrent element in 2015/16)	1,893,000	1,388,000	-505,000	-26.7%
Health and Social Care Integration Reserve at start of the financial year (forecast)	5,758,000	4,520,000	-1,238,000	-21.5%

6.4 Our Approach to Risk Sharing

Per the existing BCF Section 75 agreement and supporting schedule three, partners already have in place an agreed risk sharing agreement for the BCF.

This functioned well in 2015/16 and was applied to the treatment of the 2015/16 risk pool for emergency admissions performance.

Partners have agreed that a risk pool will apply to the emergency admissions metric in 2016/17 and this has been calculated on the basis of the following assumptions:

In order to deliver a 3% reduction in emergency admissions in 2016/17, the BCF plan is required to deliver 1,723 avoided admissions.

Using the BCF standard cost of an emergency admission of £1,490 the cost of 1,500 admissions equates to £2,235,000.

There is clarity and agreement between partners that this figure represents the BCF's contribution to the overall reduction in emergency admissions reflected in the CCG operating plans and capacity plans. The BCF emergency admissions reduction target has also been reflected in the contractual process with acute providers.

Based on our performance in 2015/16 and the refreshed trajectories we have developed for admissions avoidance in 2016/17 we have placed £1m in the risk pool for 2016/17.

The £1m pool will be released into the fund or retained by CCGs based on quarterly performance and forecast outturn against the emergency admissions trajectory associated with the BCF emergency admissions schemes.

Recommendations on the treatment of the risk pool are assessed quarterly by the Integration Finance and Performance Group (see governance diagram in section 7.1), with ultimate approval and assurance via the Integration Executive and the Health and Wellbeing Board.

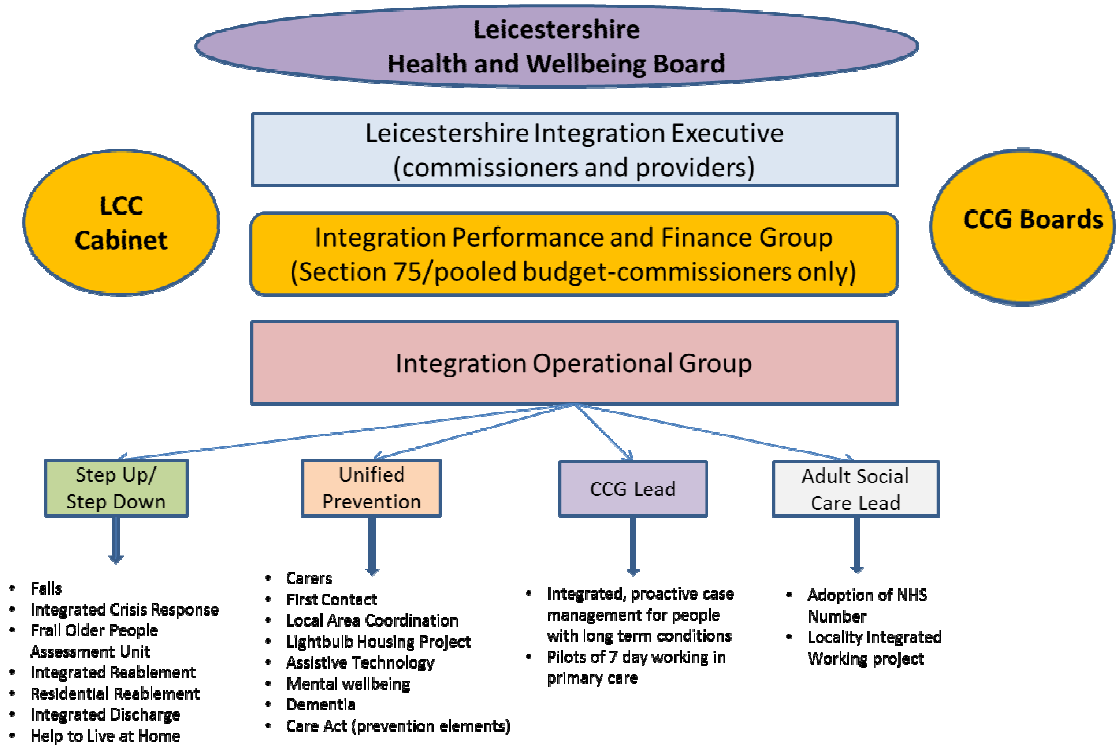
During the prioritisation process for the 2016/17 BCF plan a number of new schemes have been agreed as the next joint priorities for investment from the BCF, subject to business case assessment/approval. If monies are released from the risk pool into the BCF plan in year these items will be ready for immediate consideration.

SECTION 7: GOVERNANCE OF THE LEICESTERSHIRE BCF PLAN

7.1 Summary of Governance Arrangements

The Leicestershire BCF has a well-established and effective programme governance structure. The structure is designed to ensure that there is co-production, transparency and pace in delivering our vision for integration. The structure ensures that providers and commissioners co-produce solutions and take joint accountability for decisions and delivery. The structure also ensures that statutory decision making is respected and the appropriate bodies are involved in decision making per the scheme of delegation.

The diagram below shows the governance structure for Leicestershire's Integration Programme. The Programme structure incorporates the BCF in its entirety plus some other related elements our integration programme such as the recommissioning of domiciliary care.



The Health and Wellbeing Board meets six times per year. The Board is ultimately responsible for approving and delivering the BCF plan and sets the overall strategic direction.

Since February 2014, the Health and Wellbeing Board has delegated the day to day delivery and oversight of the integration programme to the Leicestershire Integration Executive, which meets monthly.

This is an officer group at Director level comprising representatives from local NHS partners, the LA, Districts Councils and Healthwatch.

The Integration Executive supports and advises the Health and Wellbeing Board with respect to the vision, aims, and pace of the programme per national and local policy and strategic context, provides the infrastructure to support assurance of the section 75 agreement, ensures stakeholder engagement and joint leadership and accountability at senior level, and makes recommendations to the Health and Wellbeing Board concerning prioritisation and resourcing the integration programme including the detailed spending plan for the BCF.

The Integration Operational Group meets monthly and comprises senior operational managers from the same partner organisations. This group coordinates the day to day delivery of the individual projects and services within the BCF within the approved spending plan, produces the Integration Executive's finance and performance analysis reporting on a monthly basis, ensures delivery of the individual milestones within projects and the programme as a whole, assesses and addresses policy developments at an operational level, ensures matrix working and resourcing across organisational boundaries within individual projects, and directs the engagement plan between the integration programme and the structure and governance arrangements of all partner organisations as well as the communications and engagement plan with wider stakeholders, including the public.

The functions, duties, and delegation in terms of decision making are reflected in the terms of reference for the groups operating at the respective tiers of the programme governance structure diagram, with terms of reference updated and refreshed at least annually.

7.2 Assurance for the 2016/17 BCF Plan via the Health and Wellbeing Board

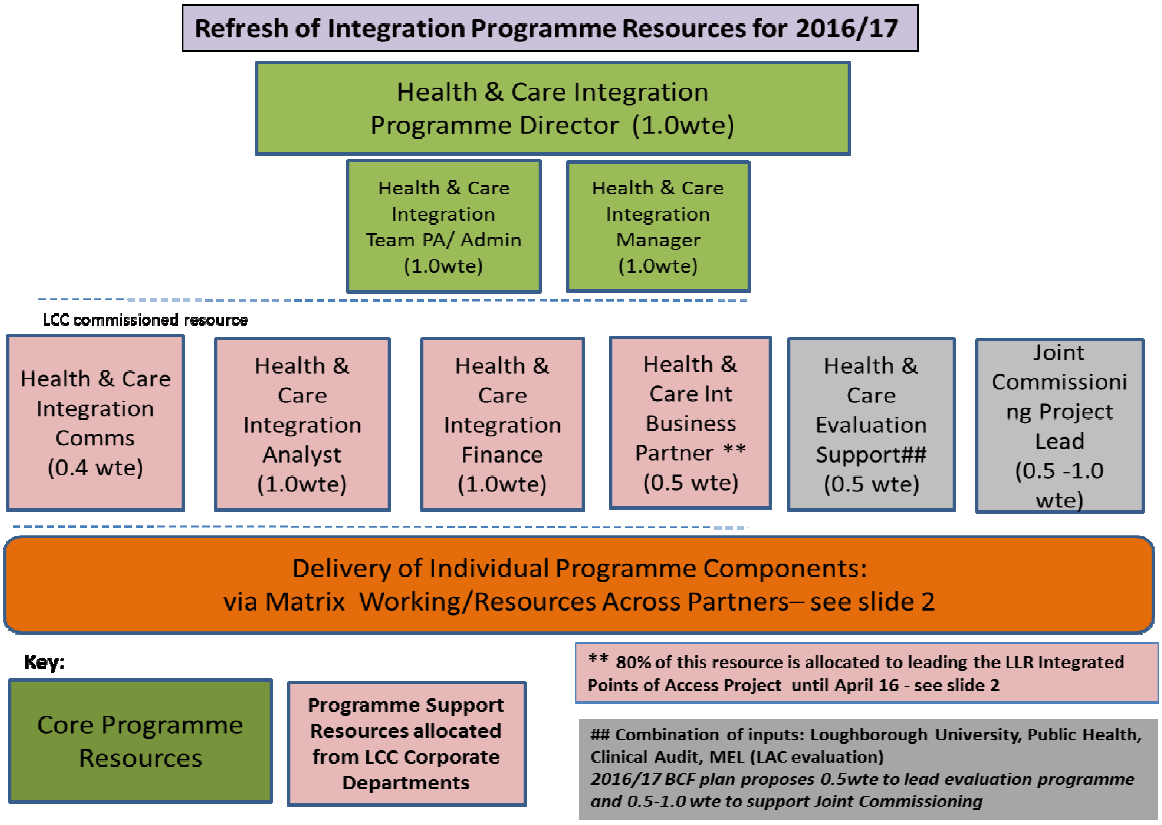
The Health and Wellbeing Board received a presentation and an interim report on the BCF refresh at its meeting on January 7, 2016 (http://politics.leics.gov.uk/ieListDocuments.aspx?MId=4630 item 251.

At their meeting 10th March 2016 Board meeting, the Board received further assurance on the progress of the BCF plans and associated submissions. The Board approved that remaining work required be completed by the Integration Executive http://politics.leics.gov.uk/ieListDocuments.aspx?MId=4631 (item 5).

7.3 Integration Programme Resources and Programme Management

The diagrams below show the core integration team resources and the matrix working that is in place across partner organisations to ensure delivery across the Integration Programme.

7.3.1 Core Programme Team



7.3.2 Matrix Management for Programme Delivery across the Partnership

Unified Prevention Delivery

LAC Project Manager 1.0 wte *(check end date)*

Falls Project Manager 1.0 wte - to Oct 2016

Unified Prevention Design & Performance Specialist 1.0 wte

Lightbulb:

- Programme Manager (1.0 wte to Mar 2017)
- Service Manager (1.0 wte to Mar 2017)
- Performance Specialist – (0.8wte to March 2017)

Integrated Urgent Care Delivery

4 x BCF emergency admissions schemes delivery: 0.5 wte (interim) to March 2016, 1.0 wte (WLCCG) from March 2016.*Confirmation needed for 2016/17 on*

- *CCG resource allocation for 7 day working in primary care*
- *Dedicated UHL delivery resources for Glenfield Scheme*

0.8 wte project lead for LLR Integrated Points of Access

Matrix working with BCT Urgent Care Vanguard (Workstream 1) delivery resources

Hospital Discharge & Reablement Delivery

Matrix working with Help to Live at Home Programme

- *Help to live at home transition resources – (estimate April - October)*
- *Help to live at home back office resources (November 2016 onwards)*

Matrix working with

- BCT Discharge Lead Tracey Yole
- LCC Discharge Lead Jackie Wright

Given new national condition in BCF 2016/17 ref DTOC should we identify some p/t dedicated resource?

Long Term Conditions Delivery

Matrix working with BCT LTC Lead

Matrix working with LTC delivery resources in each CCG

Matrix working with Integrated locality teams

Leicestershire BCF plan for 2016/17 proposes an expansion of our LTC linked to BCT LTC workstream priorities - likely to require additional implementation resource at county level. (? Wte)

Enablers and Emerging Priorities

Data Integration - Care and Health Trak (0.2 wte interim to March 2016) *Resources for 2016/17 to be confirmed in Feb (via Chief Officers)*

Health and social care protocol –may require review/ resource in 2016

Personal budgets –1.0 wte leading (EL&RCCG)

Integrated Care Records – BCF plan for 2016/17 indicates further work/resource needed - linked to LLR IM&T strategy

Joint commissioning framework

Joint commissioning for nursing and residential homes – scoping in progress

Matrix Implementation Resources Key: Green = LCC, Brown = District Council, Purple= BCT, Blue = NHS, Grey = Other. ***Text in italics indicates further information/discussion required***

7.4 Measuring the Impact of the Leicestershire Better Care Fund Plan

The impact of the plan is measured in the following ways:

a) Quarterly, nationally using a national template into NHS England. This measures the delivery of each local plan in relation to the *BCF national conditions* and *BCF national metrics* as detailed by definitions provided in Annex A and B of the BCF policy framework 2016/17.

(https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/490559/BCF_Policy_Framework_2016-17.pdf) – see also summary metrics table below.

b) Quarterly, locally via our Integration Finance and Performance Group – (oversight of the BCF section 75/pooled budget).

c) Quarterly, locally to Leicestershire's Health and Wellbeing Board.

d) Monthly, locally via the Leicestershire Integration Executive Programme performance dashboard providing performance summary across the whole programme/metrics (example at Appendix 16).

e) Monthly, locally via individual project/theme level governance boards, with monthly operational oversight by the BCF operational group. This tier providing much more in-depth discussion on specific milestones, trajectories and KPIs at project level.

f) Via specific evaluation activity– for example clinical audits, independent evaluations, academic studies. During 2015/16, we conducted an evaluation and research study in conjunction with Loughborough University and Leicestershire Healthwatch. This evaluated our four BCF emergency admissions schemes. Findings are being disseminated regionally and nationally during 2016/17. A second phase of our evaluation has also been planned, using funds allocated from national and regional BCF support monies.

7.5 Programme Milestones for 2016/17

Our Programme Plan has been refreshed in light of the work undertaken to review the BCF plan for 2016/17. A high level summary is given below:

	Q1	Q2	Q3	Q4
Programme Management				
Sign-off section 75 agreement	■			
Agree communications and engagement plan for 2016/17	■			
Develop the commissioning outcomes framework	■			
BCF Schemes				
Unified Prevention Offer				
Review workplan of Unified Prevention Board to ensure clarity of priorities & milestones	■			
Strengthen the Unified Prevention Board dashboard of KPIs & outcomes	■			
Local Area Coordination Evaluation Findings Reported		■		
Co-produce specific health and wellbeing outcomes for social prescribing developments within Leicestershire		■		
Co-produce specific health and wellbeing outcomes for Supporting Leicestershire Families	■			
Lightbulb business case approvals		■		
Review the hospital & community based dementia services (currently commissioned by the Alzheimer's Society) and recommendations for future commissioning		■		
Target prevention offer to specific cohorts of patients per BCF/BCT	■			
Integrated Urgent Response				
Review the cost effectiveness of the ICRS Night Nursing Service	■			
Establish the future commissioning intentions for ICRS Night Nursing Service		■		
Review the service model & cost effectiveness of the Older Persons Unit	■			
Implement model of care changes following Older Persons Unit review		■		
Assess Liaison Psychiatry business case (develop KPIs & avoided admissions targets)	■			
Assess LTC QIPP business case (develop KPIs & avoided admissions targets)	■			
Assess Stroke/Neuro Rehab business case (develop KPIs & avoided admissions targets)	■			
Further evaluation reports for avoided admission schemes	■	■		
Integration with Vanguard governance arrangements	■			
Hospital Discharge and Reablement	■	■		
Review of the HART service & refresh service specification	■	■		
Transition to Help to Live at Home new service		■		
Commence Help to Live at Home service			■	
Enablers/Dependencies				
Development of LLR STP plan	■			
Deliver final business case for LLR Integrated Point of Access & implementation plan	■			
Jointly review existing range of commissioned support into care & nursing homes	■	■	■	■
Review of Health & Social Care Protocol		■		
Phase 2 implementation of Care & Healthtrak	■			
BI strategy for Care & Healthtrak	■			
Commissioning intentions for Care & Healthtrak for 2017/18			■	
Scoping a Summary Care Record solution for care planning		■		
BCF Evaluation				
Phase 2 evaluation study scoping	■			
Phase 2 delivery		■	■	
National dissemination of phase 1 evaluation study	■	■		

The programme plan refresh has included incorporating a number of commissioning actions and activities that have been identified during the refresh where some of the BCF schemes and pilots will be subject to further evaluation including ongoing VFM assessment in 2016/17.

The Integration Programme Plan has interdependencies with BCT workstreams including the LLR Vanguard as shown in the BCF scheme table summary in Appendix 3.

7.6 Programme Risk Register

The risk register for the Leicestershire Integration Programme which reflects the risks associated with the delivery of the BCF plan can be found at Appendix 17.

The programme level risk register is reviewed operationally and strategically at regular intervals as part of the routine work of the Integration Executive and Integration Operational Group.

The high level risks are reflected in the corporate risk registers of Leicestershire County Council and the two County CCGs, updated on a quarterly basis.

The Programme Director's highlight report at the Integration Executive also summarises key risks on a monthly basis.

The main risk affecting delivery of the BCF plan in 2016/17 is as follows:

- A risk that we are unable to deliver against the national metrics for the BCF – specifically due to failure to reduce the rate of total emergency admissions
- This may result in the need to release monies from the BCF risk pool and escalation of our performance via NHS England quarterly BCF assurance returns

7.7. Equality and Human Rights Impact Assessment

In January we completed an impact assessment for the BCF which has been approved through Leicestershire County Council's governance processes – a copy of the documentation can be found at this weblink.
http://www.leics.gov.uk/better_care_fund_overview_ehria.pdf

SECTION 8: SUMMARY OF ENGAGEMENT UNDERTAKEN

8.1 Refresh Engagement Activities

There has been extensive engagement undertaken within the BCF programme throughout 2015/16. The table below focuses on the detail of activities between December 2015 and April 2016 evidencing how the BCF refresh has been undertaken, with the engagement of all stakeholders.

Date	Purpose	Audience
4th Dec 15	Briefing on BCF progress, and progress with developing the Lightbulb Housing Offer	Members Briefing to Oadby & Wigston Borough Councillors
4th Dec 15	Briefing on BCF progress, and progress with developing the Lightbulb Housing Offer	Members Briefing to Coalville District Councillors
7th Dec 15	To review and shape joint commissioning intentions across partner agencies	HWB Board Annual Development Session on Commissioning Intentions
8th Dec 15	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17	WLCCG Corporate Management Team
8th Dec 15	Engagement to jointly review the performance of the BCF emergency admissions avoidance schemes January – December 2015	University Hospitals of Leicester Executive Management/Clinical Director Team
10th Dec 15	Evaluation of BCF delivery in 2015/16 including using the national BCF assessment tool.	Integration Operational Group Meeting
10th Dec 15	Briefing on BCF progress, and progress with developing the Lightbulb Housing Offer	District Council's Joint Chief Executive's Meeting
14th Dec 15	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17	ELRCCG Corporate Management Team
15th Dec 15	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17	Integration Executive meeting
17th Dec 15	Briefing on BCF progress and progress with developing the Lightbulb Housing Offer	Members Briefing to Hinckley & Bosworth Borough Councillors
17th Dec 15	Briefing on BCF progress and progress with developing the Lightbulb Housing Offer	Members Briefing to Blaby District Councillors
4th Jan 16	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17	WLCCG Corporate Management Team
7th Jan 16	Presentation on planning guidance and approach to BCF refresh/emerging priorities to seek feedback from the H&WB Board	Health & Well Being Board
11th Jan 16	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17	ELRCCG Corporate Management Team
12th Jan 16	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17	WLCCG Corporate Management Team
14th Jan 16	Further evaluation of BCF delivery in 2015/16 to inform the refresh including using the national BCF assessment tool.	Integration Operational Group Meeting
14th Jan 16	Multiagency session to set scale of ambition for national BCF metrics for 2016/17	Review of Emergency Admissions and DTOC targets and scheme trajectories
20th Jan 16	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17	A&C Departmental Transformation Delivery Board
22nd Jan 16	Briefing on BCF progress, emphasis on developments for Local Area Coordination and the Lightbulb Housing Offer	Hinckley & Bosworth Borough Council Health & Well Being Board
26th Jan 16	Assurance on BCF delivery 2015/6 and	Integration Executive Meeting

	BCF refresh progress for 2016/17	
28th Jan 16	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17	Leicestershire County Council's Transformation Delivery Board
1st February	Review progress with Care and Health Trak implementation and agree commissioning intentions for 2016/17	LLR (NHS and LA) Chief Officers' Meeting
2nd Feb 16	Sharing good practice from Leicestershire BCF and capturing good practice from other parts of the West Midlands	West Midlands Regional BCF Network meeting
8th Feb 16	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17	ELRCCG Corporate Management Team
8th Feb 16	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17	WLCCG Corporate Management Team
9th Feb 16	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17	UHL Executive Team Meeting
10th Feb 16	Board Development Session - System Leadership for planning and delivery of health and care integration/health and wellbeing outcomes	Health and Wellbeing Board
11th Feb 16	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17	Integration Operational Group Meeting
11th Feb 16	Sharing good practice from Leicestershire BCF and capturing good practice from other parts of the East Midlands	East Midlands Regional BCF Network meeting
23rd Feb 16	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17 Assurance for BCF national submission on March 2nd	Integration Executive
26th Feb 16	Detailed review of BCF spending plan for 2016/17 and further prioritisation Decision on Risk Pool levels for 2016/17	Integration Finance & Performance Group
28th Feb 16	LLR Better Care Together prevention workshop – to scope the strategic approach to prevention across the programme including the contribution of the prevention components delivered within the BCF	BCT Stakeholders from across LLR
8th Mar 16	Briefing on BCF progress in 2015/16 and refresh plans for 2016/17	Voluntary Action Leicestershire Health & Social Care Forum
14th Mar 16	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17	ELRCCG Corporate Management Team
14th Mar 16	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17	WLCCG Corporate Management Team
17th Mar 16	Review of BCF submissions materials including draft narrative	Integration Operational Meeting
21st Mar 16	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17	LPT Executive Team Meeting
29th Mar 16	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17 Assurance for BCF national submission on March 21st	WLCCG Extraordinary Board Meeting
29th Mar 16	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17 Assurance for BCF national submission on March 21st	Integration Executive
30th Mar 16	Scrutiny of performance in 2015/16 and refreshed plan for 2016/17	Health & Overview Scrutiny Meeting

31st Mar 16	Assurance on plan completion and submissions	LCC Transformation Delivery Board
4th Apr 16	Engagement on BCF and briefing on devolution/combined authorities	NHS England Executive Team Meeting
11th Apr 16	Assurance on final BCF submission for April 25th	ELRCCG Corporate Management Team
11th Apr 16	Assurance on final BCF submission for April 25th	WLCCG Corporate Management Team
12th Apr 16	Engagement on BCF delivery 2015/6 and BCF refresh progress for 2016/17	Leicestershire Partnership Trust Community Health Service Divisional Management Team meeting
13th Apr 16	Engagement on BCF delivery 2015/6 and BCF refresh progress for 2016/17	EMAS Senior Management Team
13th Apr 16	Assurance on final BCF submission for April 25th	A&C Departmental Transformation Delivery Board
14th Apr 16	Assurance on final BCF submission for April 25th	Integration Operational Meeting
14th Apr 16	Engagement on BCF delivery 2015/6 and BCF refresh progress for 2016/17 with particular emphasis on prevention theme of BCF	Leicestershire Fire Service Executive Board
19th Apr 16	Assurance on final BCF submission for April 25th Approval of final submission as delegated from Integration Executive	Integration Executive
20th Apr 16	Routine (Quarterly) all Member Briefing – will include engagement on BCF delivery and other LLR wide health and care activities (e.g. STP/Better Care Together)	Leicestershire County Council's All Member Briefing – Health & Care Integration

The following is a summary of the engagement undertaken with domiciliary care providers and service users during the development of the specification and commissioning approach for our new model of domiciliary care "Help to Live at Home" (HTLAH).

8.2 HTLAH Provider Workshops

Date	Purpose
2nd/6th Feb 2015	Two market engagement events were undertaken, providing an opportunity to explore with both existing and prospective Service Providers the benefits and challenges of the range of strategic options considered in the development of this business case. 112 participants attended the events from 61 organisations. The February 2015 engagement events were supplemented by an online questionnaire that was made available to all delegates (including those unable to attend facilitated events) with the aim of: • Helping the programme in understanding if there are different views on the options from small and large providers • Contributing to informing feasibility of implementation of the options • Helping to develop the approach to support market readiness for the new way of working, including gauging provider interest in the proposed options.
13th/19th May 2015	Two further events were held May 2015 to explore the delivery of Reablement through the independent sector, commissioning for outcomes and developing the role of

	providers in coordinating support for individuals from community resources and assistive technology. These events provided an opportunity to appraise the Market of the delivery model under development, compared and contrasted to the current model, and supported the development of the new model utilising the knowledge and expertise of the Market. Topics discussed were: • Reablement in practice; Assistive Technology; Social Capital and developing community resources. • Outcomes commissioning: the current market experience; delivering to outcomes, putting the service user/patient at the heart of support planning
30th July/5th Aug 2015	Two market engagement events were undertaken in July and August 2015, providing an opportunity to explore with both existing and prospective Service Providers the benefits and challenges of the chosen strategic options considered in the development of this business case. These engagement events included live voting to ascertain the market view of chosen strategic options. This was supplemented by an anonymised survey of indicative bidding intentions against the 18 draft lots across 7 localities. This was made available to all delegates with the aim of: • Helping the programme in understanding if lots are commercially viable and likely to attract bids in the procurement phase • Contributing to informing the development of the provider delivery model as part of the Full Business Case • Helping to develop the approach to support market readiness in respect of Lead Provider, Sub-contracting and Consortia arrangements
22nd/24th Sep 2015	Two market engagement events were undertaken in September 2015 facilitate informal provider networking and information sharing opportunities.
10th/11th Dec 2015	Two events held to give providers an update on HTLAH Procurement process and progress; Continuing Healthcare (CHC) requirements; Introduction to the Abridged Joint Service Specification and Service elements and rates. The sessions were facilitated with: • Table top discussions • 'Ask the Audience' Voting
11th Feb 2015	A bidders day event was held to launch the PQQ

8.3 Evaluation Study Engagement Workshops

The following illustrates the multiagency stakeholder workshops and service user engagement workshops held to evaluate our four emergency admissions schemes within the Leicestershire BCF plan 2015/16. These were part of our research and evaluation study completed in conjunction with Loughborough University and Leicestershire Healthwatch

Date	Aim	Scheme
11th Sept 15	Stakeholder workshops – to review the computer simulation of the patient pathway for each intervention; test scenario's about future improvements to the scheme; and make recommendations of future actions to the Integration Programme.	Integrated Crisis Response Service – Night Nursing Service
11th Sept 15		Older Persons Unit
29th Oct 15		7 Day Services in Primary Care
29th Oct 15		Rapid Response Falls Service
10th Nov 15	User workshops – to review a computer simulation model of the service; to engage patients with the process of avoiding emergency admissions; and to explore ways of measuring patient satisfaction.	Integrated Crisis Response Service – Night Nursing Service
10th Nov 15		Older Persons Unit
2nd Feb 15		Rapid Response Falls Service

In addition to the above engagement activities we publish regular editions of our stakeholder bulletins – 2015 editions can be found at this
www.leics.gov.uk/healthwellbeingboardnews#hcibulletins

8.4 Microsite Development

Due to the upgrading of Leicestershire County Council's website, new arrangements are being made to create a health and care integration microsite. This will become the new location for our integration programme communications and engagement product which have previously been located on historical pages of the Leicestershire Health and Wellbeing Board. This microsite will also hold all BCF related materials from 2014 onwards.

APPENDICES

Appendix 1 Raising our Ambitions for Integration

Appendix 2 Public Health Summary Needs Analysis

Appendix 3 Vanguard Value Proposition and Work Plan

Appendix 4 Population Level Risk Stratification

Appendix 5 Operations Group RAG rating results

Appendix 6 BCF Spending Plan shown in the NHSE BCF Submission Template

Appendix 7 IM&T Programme Plan

Appendix 8 BCT Clinical Workstream IM&T Requirements

Appendix 9 EL&RCCG Accountable Professional supporting information

Appendix 10 WLCCG Accountable Professional supporting information

Appendix 11 Emergency Admissions P4P Metric 2015 Scheme Level Breakdown

Appendix 12 Emerging Self-Assessment Analysis against DTOC High Impact Changes

Appendix 13 LLR Discharge Action Plan from Urgent Care Board, Discharge sub group

Appendix 14 LLP RAP from Urgent Care Board

Appendix 15 DTOC Monthly Reporting April 2015 – January 2016

Appendix 16 Integration Executive Programme Performance Dashboard

Appendix 17 Risk Register

This page is intentionally left blank

Better Care Fund Spending Plan 2016/17

Ref No.	Resubmission BCF Scheme Heading	2016/17 PROVISIONAL West Leics CCG £'000	East Leics & Rutland CCG £'000	Leics County Council £'000	Integration Reserve	Total £'000
UNIFIED PREVENTION OFFER						
UPO1	First Contact Plus	92,707	70,509	0	0	163,216
UPO2	Carers Services:					
	Care Act Support Pathway	257,872	196,128	0	0	454,000
	Carers Health and Wellbeing Service	93,720	71,280	0	0	165,000
	Specialist Support to People with Dementia & Carers (Memory Support Service)	181,006	137,667	0	0	318,673
		532,598	405,075	0	0	937,673
UP03	Local Area Co-ordination	14,802	11,257	263,941	0	290,000
UPO5	Assistive Technology:	0	0	950,200	0	950,200
UPO6	Integrated Housing Solutions:					
	Disabled Facilities Grants	0	0	1,739,307	0	1,739,307
	Hospital Discharge - Housing Enablers	0	0	114,000	0	114,000
		0	0	1,853,307	0	1,853,307
UPO7	Protected Prevention Services:					
	NHS - LD Short Breaks	588,000	256,000	0	0	844,000
	Social Care - Residential Respite Services	421,797	320,803	0	0	742,600
		1,009,797	576,803	0	0	1,586,600
UPO9	Supporting Leicestershire Families (April 16 to September 16)	57,000	43,000	0	0	100,000
UNIFIED PREVENTION OFFER TOTAL		**1,706,903**	**1,106,645**	**3,067,448**	**0**	**5,880,996**
LONG TERM CONDITIONS						
LTC1	Integrated, Proactive Care (Risk Stratification & Care Management):					
	Proactive Care Model (WLCCG)	540,000	0	0	0	540,000
	Integrated Care Team (ELRCCG)	0	430,000	0	0	430,000
		540,000	430,000	0	0	970,000
LTC3	Improving Quality in Care Homes:					
	Quality Improvement Team	176,818	134,482	0	0	311,300
	Safeguarding Team	108,999	82,901	0	0	191,900
		285,818	217,382	0	0	503,200
LTC4	Protected LTC Services					
	Social Care - Nursing care packages	1,908,821	1,451,779	0	0	3,360,600
	Social Care - Home Care Services	6,102,592	4,641,408	0	0	10,744,000
	Social Care - Growth in Community Based Services	170,400	129,600	0	0	300,000
	Social Care - Growth in Nursing Care Home Services	135,575	103,113	0	0	238,688
		8,317,388	6,325,900	0	0	14,643,288
LTC5	Health and Social Care Protocol Training	58,115	44,201	0	0	102,316
LTC6	LTC QIPP Investments	229,000	168,700	0	0	397,700
TOTAL LONG TERM CONDITIONS		**9,430,321**	**7,186,183**	**0**	**0**	**16,616,504**
URGENT RESPONSE						
IUR1	Integrated Health & Care Crisis Response (ICRS):					
	Night Nursing Element	601,020	486,500	0	0	1,087,520
	Social Care Element	320,920	244,080	0	0	565,000
		921,940	730,580	0	0	1,652,520
IUR2	Rapid Assessment for Older People:					
	Loughborough Frail Older People's Unit	500,000	0	0	0	500,000
	Loughbourough Urgent Care Centre	390,000	0	0	0	390,000
	Integrated Community Health	0	563,000	0	0	563,000
	Care Home Support (Pressure Sores)	0	54,000	0	0	54,000
	ANPs Physical Health Assessment (MHSOP Patients)	0	77,000	0	0	77,000
	Care Home and Community Inreach Support (MH)	0	82,000	0	0	82,000
		890,000	776,000	0	0	1,666,000
IUR4	Weekend Working Service (WLCCG)	427,500	0	0	0	427,500
	Acute Visiting Service (WLCCG)	851,000	0	0	0	851,000
IUR 6	Integrated 7 Day Community Care (with additional AVS capacity) - ELRCCG	0	622,500	0	0	622,500
IUR5	Ambulatory Care on CDU - Glenfield Hospital	44,304	33,696	0	0	78,000
TOTAL URGENT RESPONSE		**3,134,744**	**2,162,776**	**0**	**0**	**5,297,520**
HOSPITAL DISCHARGE AND REABLEMENT						
HDR1	Residential Reablement	92,584	70,416	0	0	163,000

		2016/17 PROVISIONAL				
Ref No.	Resubmission BCF Scheme Heading	West Leics CCG £'000	East Leics & Rutland CCG £'000	Leics County Council £'000	Integration Reserve	Total £'000
	Hospital to Home	40,896	31,104	0	0	72,000
	Intermediate Care	313,000	267,000	0	0	580,000
HDR2	Protected Reablement Services:					
	NHS - Reablement	2,419,000	1,713,000	0	0	4,132,000
	NHS - Intensive Community Service	951,000	870,000	0	0	1,821,000
		3,370,000	2,583,000	0	0	5,953,000
HDR3	Improving Mental Health Discharge:	154,263	117,326	0	0	271,589
HDR5	Protected Hospital Discharge Services					
	NHS - Step Down	300,000	229,000	0	0	529,000
	NHS - Assertive InReach	208,000	184,000	0	0	392,000
	Expansion of Assertive Inreach	0	0	0	0	0
	Social Care - Assessment and Review	803,272	708,368	0	128,248	1,639,888
		1,311,272	1,121,368	0	128,248	2,560,888
HDR6	Help to Live at Home:					
	Hospital Discharge Care Packages Review Team (to Oct 16)	136,774	104,026	0	0	240,800
	Community Based Review Team (from Nov 16)	97,696	74,304	0	0	172,000
	HTLAH Transitional Costs (TBC)	0	0	0	0	0
	HTLAH - Pathway 2 Case Management	0	211,500	0	0	211,500
	Back Office Support	23,667	18,000	0	0	41,667
	CCG Reablement	185,000	141,000	0	0	326,000
		443,137	548,830	0	0	991,967
HDR7	Non Weight Bearing Pathway (Pathway 3)	48,507	36,893	0	0	85,400
HDR9	Social Care DST Workers	118,712	90,288	0	0	209,000
TOTAL HOSPITAL DISCHARGE AND REABLEMENT		**5,892,371**	**4,866,225**	**0**	**128,248**	**10,886,844**
ENABLERS						
EN01	Programme Leads and Support:					
	Programme Lead - Falls Strategy	17,229	13,104	0	0	30,333
		17,229	13,104	0	0	30,333
	Programme Support (Main)	107,361	81,674	50,000	0	239,035
	Programme Support (Finance)	31,537	23,986	0	0	55,523
	Programme Support (Transformation BP)	20,710	15,751	0	0	36,461
	Programme Support (Lead Analyst - H&SC Integration)	28,456	21,643	0	0	50,099
	Programme Support (Communications)	8,605	6,545	0	0	15,150
EN01	Programme Leads and Support	196,669	149,599	50,000	0	396,268
EN02	Care Act Enablers:					
	Independent Mental Health Advocacy	45,638	34,710	0	0	80,348
	Veterans GIP	9,883	7,517	0	0	17,400
		55,521	42,227	0	0	97,748
EN03	IT Enablers - PI Caretrak	39,760	30,240	0	0	70,000
	IT Enablers - MicroWebsite	3,408	2,592	0	0	6,000
		43,168	32,832	0	0	76,000
EN04	Service Enablers: Integrated Points of Access	0	0	0	137,000	137,000
TOTAL ENABLERS		**312,587**	**237,762**	**50,000**	**137,000**	**737,349**
	Total Expenditure	**20,476,926**	**15,559,591**	**3,117,448**	**265,248**	**39,419,213**

Agenda Item 9

Leicestershire County Council

HEALTH AND WELLBEING BOARD: 5th MAY 2016

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

LEICESTERSHIRE'S EMERGING APPROACH TO SOCIAL PRESCRIBING

Purpose of report

1. The purpose of this report is to inform the Health and Wellbeing Board of the work being undertaken to develop a consistent approach to social prescribing across Leicestershire and to seek endorsement of the emerging approach.

Links to the local Health and Care System

2. A consistent approach to social prescribing has been identified as one of the priorities for the Unified Prevention Board, one of the pillars of the Better Care Fund. Social prescribing is also a key element within the prevention strand of the Sustainability and Transformation Plan.

Recommendation

3. The Health and Wellbeing Board is asked to:-

   (a) note the work to coordination approaches to social prescribing;
   (b) endorse the emerging model for social prescribing in Leicestershire.

Background

4. Social prescribing is defined as "a means of enabling primary care services to refer patients with social, emotional or practical needs to a range of local, non-clinical services, often provided by the voluntary and community sector."

5. In practice this means that GPs, nurses or other healthcare practitioners work with patients to identify non-medical opportunities or interventions that will help them adopt healthier lifestyles or improve wider social aspects of their lives. The resulting services that patients can choose could include everything from debt counselling, support groups and walking clubs, to community cooking classes and one-to-one coaching.

6. Social prescriptions can be seen as a natural extension to 'information prescriptions' – which are tailored information given to patients to help them make informed choices about their care and access a wider range of services, such as social care, housing and leisure services.

7. Within Leicestershire a number of concerns and 'must-dos' have been expressed by partners in relation to social prescribing. These include:

- GP concerns about duplication of initiatives and services across partner
- Better Care Fund obligations
- Unclear links and methodologies
- The need for better patient / citizen targeting

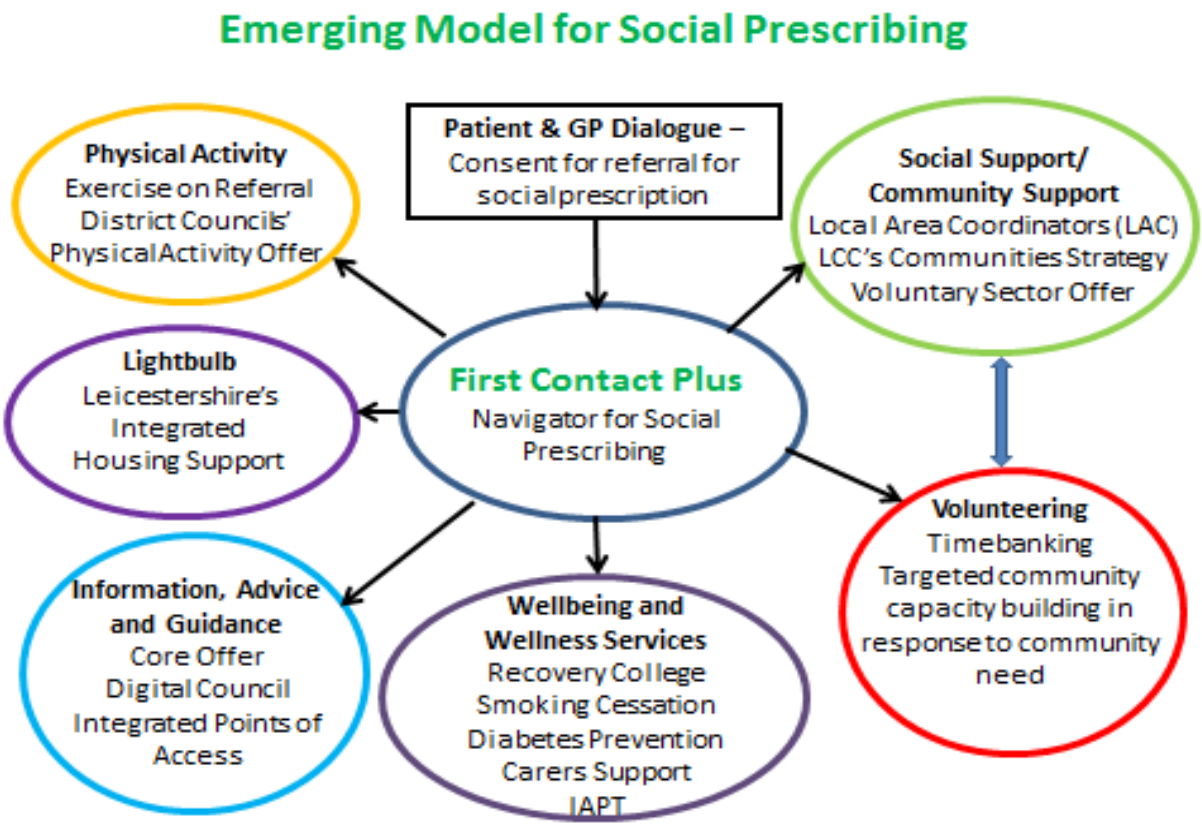
8. Under the Unified Prevention Board we have sought to address these by agreeing a shared model and vision for social prescribing.

Draft Shared Vision

9. Our vision for social prescribing is that: 'We will work together to create a coherent social prescribing offer across Leicestershire that will benefit citizens by allowing them greater access to our menu of services and community resources, to enhance their health and wellbeing'.

10. Our unified prevention offer will describe a clear, consistent menu of services that are on offer in each community, with First Contact Plus as the coordinating "front door" for accessing a range of social prescribing solutions. Figure 1.

Figure 1



Next steps

11. A Social Prescribing action plan will be developed for the Unified Prevention Board (UPB). This will cover:

    - Regular reporting and feedback timetable on progress
    - Initial thoughts about targets and milestones
    - Creating a flow diagram to show collective working:
        - Using First Contact Plus as a front door
        - Exit strategies and handovers
        - Referral processes
        - Show how we target certain populations

12. A review of related social prescribing developments within Leicestershire to establish where further integration and efficiencies can be achieved will be completed by August 2016.

Resource Implications

13. Services within the social prescribing framework are funded through core budgets or BCF (Lightbulb and Local Area Co-ordination). No other additional resource requirements have been identified.

Officer to Contact

Mike Sandys
Director of Public Health
Telephone: 0116 395 4239
Email: mike.sandys@leics.gov.uk

Relevant Impact Assessments

Equality and Human Rights Implications

14. Developments within the BCF Plan, such as social prescribing, are subject to equality impact assessment and the evidence base supporting the BCF Plan has been tested with respect to Leicestershire Joint Strategic Needs Assessment.

Partnership Working and associated issues

15. The delivery of the BCF Plan, including the emerging model for social prescribing, is dependent on close collaborative working form Health and Wellbeing Board partners.

16. The delivery of the Leicestershire BCF ensures that a number of key integrated services are in place and contributing to the system wide changes being implemented through the 5 year plan to transform health and care in Leicestershire, known as Better Care Together.

This page is intentionally left blank

HEALTH AND WELLBEING BOARD: 5th MAY 2016

REPORT OF LLR Urgent Care

Update on Discharge Planning / Processes

Purpose of report

1. The purpose of this report is to provide the Health and Wellbeing Board with an update on the progress of completion of the '**High Impact Change Model – Managing Transfers of Care',** and how this will inform the Whole System Discharge Summit, to be held on 5th May 2016.

Link to the local Health and Care System

2. **Context:**
In April 2015, NHS England wrote to Clinical Commissioning Group (CCG) leaders, to set out their plans for 2015/16 operational resilience funding. This letter included eight 'high impact interventions', for which it was expected that all CCGs would allocate sufficient funding to meet. Two of these interventions related directly to delayed transfers of care:

- *Consultant-led morning ward rounds should take place seven days a week so that discharges at the weekend are at least 80% of the weekday rate and at least 35% of discharges are achieved by midday throughout the week. This will support patient flow throughout the week and prevent A&E performance deteriorating on Monday as a result of insufficient discharges over the weekend.*
- *Many hospital beds are occupied by patients who could be safely cared for in other settings or could be discharged. SRGs will need to ensure that sufficient discharge management and alternative capacity such as discharge-to-assess models are in place to reduce the delayed transfer of care (DTOC) rate to 2.5%. This will form a stretch target beyond the 3.5% standard set in the planning guidance.*

Recommendation

3. The Board are asked to note the work which has taken place on improving discharge processes across LLR, previously taken forward by the Discharge Steering Group which has been instrumental in achieving the 2.5% DTOC target for UHL, and particularly the progress on completion of the High Impact Change Model – Managing Transfers of Care' framework (given as Appendix 1 to this paper).

Policy Framework and Previous Decisions

4. The Health and Wellbeing Board have been previously sighted on this piece of work and had asked for an update on progress.

Background

Local Performance:

5. The current performance reports published in the Urgent Care Dashboard, and regularly received by the Operational Resilience Group suggest that the DTOC rate for University Hospitals Leicester (UHL) is currently at 2.8% (at a target of 2.5%) - and has been lower than this over recent months, as low as 1.5%. For the Leicestershire Partnership Trust this is currently at 11.8%,(against a target for Community Trusts of 6%. Patients awaiting discharge from LPT are often more complex in terms of their requirements, hence the higher rate of DTOCs.

6. Despite the low DTOC rate for UHL it is clear that while we have made many improvements in our discharge pathways for more complex patients with ongoing requirements for CHC or ASC packages of care, the other 80% of non-complex patients continue to pose some logistical problems in terms of supporting flow through the system, with many patients often discharged very late in the day and relatively few at the weekend.

7. The Discharge Steering Group, which meets monthly, have discussed these issues during recent meetings and have been using the '**High Impact Change Model – Managing Transfers of Care',** framework to guide and influence change in this area.

8. The model, which was published in late 2015, describes 8 changes which have been developed through last year's Helping People Home Team's work (a joint DH, DCLG, NHS England, ADASS and LGA programme). This tool was been developed at pace with some co-design to help local systems over the winter period. Its aim was to encourage areas to consider new interventions during the winter, but also to assess how effective current systems are working.

9. The Discharge Steering Group has made some progress in terms of completing this toolkit, and a summary of the outputs is given as **Appendix 1** to this paper. However, this is as yet incomplete, specifically with more work required to complete the 'Gaps', 'Next Steps' and 'Timelines', as this requires further, whole system work in order to unpick the issues which have been identified, and the partially completed tool will now be used to influence and inform some of the work being taken forward at a whole system Discharge Summit to be held on Thursday 5th May.

Proposals/Options

10. The Discharge Summit on 5th May will have external facilitation, and be attended by senior clinicians and managers from across the whole system. We have deliberately kept the agenda high level in order to provoke discussion amongst partners around the issues we face in the discharge process. The nature of the workshop will be:

    - Short presentation on the new discharge pathways which will be implemented in late 2016;
    - What is working well?
    - What is not working?
    - What do we need to do in order to fix the problems we have identified?

11. Whilst working through these questions, we will be aiming to identify what are the key issues with simple flow across the system – which accounts for approx. 80% of patients, and how we can improve both weekend discharges and discharges earlier in the day. Differences in ward processes across UHL will be explored, and the previous Ian Sturgess report will be revisited to explore what of this has been implemented successfully. The new Vanguard pathway around discharge will be held as the point to which we are working towards later this year, and to ensure we do not reinvent anything which is currently working well in the system. The overall aim will be to identify short - medium term solutions for processes, which will help the discharge steering group be more focussed on complex issues. The summit will of course also tackle issues faced by the community Trust, mental health, end of life and social care pathways.

Consultation/Patient and Public Involvement

12. Healthwatch and patient / public representatives have been invited to the Discharge Summit on 5th May.

Resource Implications

13. No evident resource implications at the current time.

Timetable for Decisions

14. Outputs from the Discharge Summit will be formulated into high-impact actions which will be built into the whole system Recovery Action Plan (RAP). The outputs will also be used to complete the High Impact change model. A summary of this RAP and the completed change model will be presented to the Health and Wellbeing Board at the June meeting.

Officer to Contact

Samantha Merridale – Head of Operational Resilience, LLR
Telephone: 07947 453492
Email: Samantha.merridale@nhs.net

List of Appendices

Appendix 1: LLR 'High Impact Change Model – Managing Transfers of Care'

Relevant Impact Assessments

Equality and Human Rights Implications

15. The Urgent Care Improvement plan and Vanguard work pay due regard to equalities including the impact on protected characteristics and vulnerable groups within the population. We have not conducted an equalities impact assessment on the whole vanguard programme to date but will keep this under review and undertake an assessment as and when the workstream proposals are sufficiently well developed.

Crime and Disorder Implications

16. *Not relevant.*

Environmental Implications

17. *Not relevant.*

Partnership Working and associated issues

18. The completion of the High Impact change model has been carried out in full partnership with our system partners from acute, community and primary care, social care, mental health, ambulance and non-acute transport services, end of life services, with patient/public representation, Healthwatch and from commissioners at all three CCGs. We have also had input on the group from NHS England. This same representative group of stakeholders will also be present at the Discharge Summit. As such, our work is cohesive and fully represents the views and perspectives of all our strategic partners.

Risk Assessment

19. The Urgent Care Programme Board / Operational Resilience Group has a risk register covering its work and this is reviewed at each meeting.

Appendix 1

High Impact Change Model – Managing Transfer of Care – Current LLR Position – April 2016

Impact Change	Status	Current Activity	Gaps	Next Steps	Timelines	Success Criteria
Change 1: Early Discharge Planning. *In elective care, planning should begin before admission. In emergency/unscheduled care, robust systems need to be in place to develop plans for management and discharge, and to allow an expected dates of discharge to be set within 48 hours.*						
• Elective Care	Plans In Place	Early Discharge in place for both community hospital beds and elective admissions. There are Pre assessments for some surgical elements				
• Discharge planning does not start in A&E	Exemplary	Understanding discharge dates set are achieved				
• CCG and ASC commissioners are discussing how community and primary care coordinate early discharge planning.	Established	Primary care is currently not in place and system is to be developed, however joint management of preadmissions is widely undertaken			.	
• Plans are in place to develop discharge planning in A+E for emergency admissions	Plans in place	LLR have a system wide discharge group that meets monthly Perform complex case management via out DTOC lists Daily Conference Calls are undertaken with actions put in place				
• Joint pre admission discharge planning is in place in primary care .	Plans in place	Primary Care Coordinators are in place				
• Emergency admissions have a provisional discharge date set in within 48hrs	established	Emergency call have discharge date set within 48 hours				
• GPs and DNs lead the discussions about early discharge planning for elective admissions	Not yet Established	GP Elective does not occur				
• Emergency admissions have discharge dates set which whole hospital are committed to delivering	Plans In place	The aim is for all patients to have a discharge date which is set in the ED, with a commitment to deliver.		we are looking what percentage EDD are met and reason why this slips		
• Early discharge planning occurs for all planned admissions by an integrated community health and social care team.	Exemplary	This is undertaken				
• Evidence shows X% patients go home on date agreed on admission	Plans in place	Routinely do not have planning integrated team for emergency planned admissions. Not routinely completed.				
Change 2 : Systems to Monitor Patient Flow. *Robust Patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example, if capacity is not available to meet demand), and to plan services around the individual.*						
• No relationship between demand	Plans in place	Policy in place through new				

Impact Change	Status	Current Activity	Gaps	Next Steps	Timelines	Success Criteria
and capacity in care pathways		discharge pathway (Pathway 3)				
• Capacity available not related to current demand	Not yet established	Analysis to determine new discharge pathway with further work to be undertaken which includes what this will mean in terms on capacity, demand and flow into A&E				
• Bottlenecks occur regularly in the Trust (UHL) and in the community	Plans in place	Bottlenecks have been analysed in relation to complex discharges. A discharge summit to improve performance, recognise core work around less complex cases has been arranged for 5th May 2016.				
• There is no ability to increase capacity when admissions increase – tipping point reached quickly	Plans in place	We have an escalation process which is utilised on a regular basis				
• Staff do not understand the relationship between poor patient flow and senior clinical decision making and support	Established	Staff and providers understand the requirement to increase clinical support however this is not consistently applied in time				
Change 3 : Multi-Disciplinary/Multi-Agency Discharge Teams, including the voluntary and community sector. *Co-ordinated discharge planning based on joint assessment processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients*						
• Separate discharge planning processes in place	Mature/established?	Joint discharge working is in place – i.e. Programme in place with a single assessment process. Developing plans through Minimum Data Set				
• No daily MDT meeting in place	Mature / exemplary	MDT meeting are in place within community wards and adult and social care; however this doesn't have voluntary sector involvement		The system has initiated a pilot integrated process to support the MDT		
• CHC assessments carried out in hospital and taking "too" long	Established / mature	The system has discharge process in place with CHC complex extra care in acute services. Link to pathway 3.		Looking to extend within the community an improved service to deliver a bed based plan i.e. pathway 3.		
• Discussion ongoing to create Integrated health and ASC discharge teams	Mature			Developing new discharge pathway which encompasses a fully integrated discharge service.	Winter 2016	
Change 4 : Home First/Discharge to Access. *Providing short-term care and reablement in people's homes or using 'step-down' beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn, this reduces delayed discharges and improves patient flow.*						
• People are still assessed for care on an acute hospital ward	Mature	currently there are some patients who return home with reablement support from an integrated team		Integrated team is in place with further role out to be undertaken	Winter 16	
• People enter residential /nursing	Mature	Most have assessment for the		Need to prioritise final decisions being		

Impact Change	Status	Current Activity	Gaps	Next Steps	Timelines	Success Criteria
care too early in their care career		longer term home care.		made for out of hospital transfers before permanent decision are made for suitable placements		
• People wait in hospital to be assessed by care home staff	Plans in place	There are currently still to many patients waiting for transfers to care homes with UHL.		Further work is being carried out to identify care homes and work with relative to resolve issues		
Change 5 : Seven-Day Service. *Successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs.*						
• Discharge and social care teams assess and organise care during office hours 5 days a week	Plans In place	Within some areas we have 7 day working patterns Access to 7 day services is arranged in some areas with established access to a range of services. Not all discharge service are offered on a 7 days basis		Other areas require further work		
• OOHs emergency teams provide non office hours and weekend support	Plans in place	CNCS cover for patients at weekends/bank holidays. CCGs have their respective Weekend services such as Weekend Access Service and CRT, Hubs?		Further work to be undertaken such as Dietetics		
• Care services only assess and start new care Monday – Friday						
• Diagnostics ,pharmacy • and patient transport only available Mon-Fri		Diagnostic for pharmacies and transport is in place				
Change 6: Trusted Assessors. *Using trusted assessors to carry out a holistic assessment of need avoids duplication and speeds up response times so that people can be discharged in a safe and timely way.*						
• Assessments done separately by health and social care	Established	Jointly we do assess on each other's behalf in some areas such as OT.				
• Multiple assessments requested from different professionals	Established	Single assessment is performed with a mechanism of professional boundaries sharing information at the best interest of the patient.				
• Care providers insist on assessing for the service or home	Not yet established	Care home assessments are performed in early stages on complex packages of care for CHC.		Care homes dialogue has started this is to ensure assessment is performed at an early stage.		
Change 7 : Focus on Choice. *Early engagement with patients, families and carers is vital. A robust protocol, underpinned by a fair and transparent escalation process, is essential so that people can consider their options, the voluntary sector can be a real help to patients in considering their choices and reaching decisions about their future care.*						
• No advice or information available at admission	Plans in place	At present individual advice and information available includes community and acute sectors.		We acknowledge the need to review and determine what information, advice and guidance is available for patient and families and are currently in the process of revising this as this needs to be robust		
• No choice protocol in place	Plans in place	Ensuring we are being proactive				

Impact Change	Status	Current Activity	Gaps	Next Steps	Timelines	Success Criteria
• No voluntary sector provision in place to support self-funders	Not yet established					
Change 8 : Enhancing Health in Care Homes. *Offering people joined-up, co-ordinated health and care services, for example by aligning community nurse teams and GP practices with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.*						
• Care homes unsupported by local community and primary care	Established	This is subject to intensive support in hiring homes. There is case management across acute and primary care teams using a "one home on practice model"				
• High numbers of referrals to A+E from care homes especially in evenings and at weekends	Plans in place	There are a number of schemes that are designed to support improving health and wellbeing of resident of care homes and reduce unnecessary admission to acute hospitals; this include good case management, acute visiting service, dedicated pharmacy and dietician services in some areas. include good case management, acute visiting services, dedicated pharmacy and dietician service in some		Further work to be carried out with small a number of care homes to understand processes and establish relationships to promote integration, data analysis for admission, quality improvements and compliance issues		
• Evidence of poor health indicators in CQC inspections	Established	Robust process in place for when CCGs are informed of CQC outcome for providers. Plans to address issues Appropriately and in a timely manner.				

Agenda Item 11

Leicestershire County Council

HEALTH AND WELLBEING BOARD: 5 MAY 2016

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

LEICESTER, LEICESTERSHIRE AND RUTLAND (LLR) SUICIDE PREVENTION STRATEGY and ACTION PLAN

Purpose of the Report

1. This report provides an update on the work of the LLR Suicide Audit and Prevention Group and the progress on development of the next LLR Suicide Prevention Strategy and Action Plan (2016-19).

Link to the local Health and Care System

2. The work of the LLR Suicide Audit and Prevention Group feeds directly into the LLR Better Care Together work stream and the LLR Crisis Concordat.

3. Promoting positive mental health is a cross cutting priority of the current Leicestershire Health and Wellbeing Strategy.

Recommendation

4. It is recommended that

   (a) The impact of death from suicide in Leicestershire is noted;

   (b) The purpose and work of the LLR Suicide Audit and Prevention Group is noted;

   (c) The current and emerging priorities of the LLR Suicide Audit and Prevention Group particularly in relation to development of the next LLR Suicide Prevention Strategy and Action Plan (2016-19) are supported.

Policy Framework and Previous Decisions

5. In 2013 the Leicestershire Health and Wellbeing Board agreed to support the approach outlined in his LLR Suicide Prevention Strategy and Plan (2013-2015) and to endorse and oversee the work of the Leicestershire, Leicester and Rutland (LLR) Suicide Audit and Prevention Group.

Background

6. The Parliamentary All-Party Group on Suicide has called for each upper tier council to develop and implement a suicide prevention strategy and for Health and Well Being Boards (HWBBs) to:

   - Develop and support a local suicide prevention group.

   - Ensure that suicide and self-harm are addressed in the Joint Strategic Needs Assessment beyond being a measure.

   - Ensure that the local suicide prevention plan is written into the local Health and Wellbeing Strategy (HWBS) and includes specific measures to provide support for people bereaved by suicide, and addresses self-harm prevention.

   - Investigate opportunities for developing links with neighbouring local authorities to coordinate work through a regional group that could pool resources and expertise.

7. Death from suicide is a major public health concern. Whilst such deaths are a small proportion of overall mortality, they account for a disproportionate amount of years of life lost to premature death. This is mainly because suicide rates are higher in people aged between 35 and 54 years. It is also one of the most important contributors to inequality in premature mortality in LLR as it disproportionally affects the more disadvantaged members of our local communities.

8. Suicides are not inevitable. They are often the end point of a complex history of risk factors and distressing events. The prevention of suicide has to address this complexity through concerted action and collaboration amongst services, communities, individuals and across society as a whole. This means there is a clear need to co-ordinate local plans and actions.

9. Depression is one of the most important risk factors for suicide. Timely identification and treatment of depression has a major role to play in suicide prevention across the whole population.

10. Tackling social factors linked to mental ill-health is critical in reducing suicide. These factors may include unemployment, debt, social isolation, family breakdown and bereavement. Reducing alcohol and drug dependence are also critical to reducing suicide.

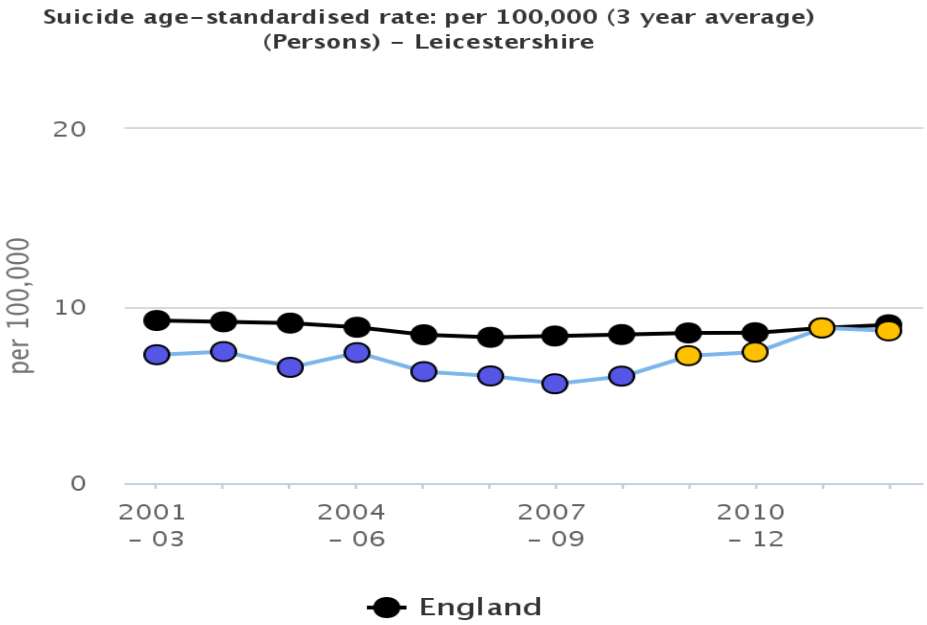
11. There are several other specific groups at increased risk of suicide including children and young people who are vulnerable such as looked after children, care leavers and children and young people in the youth justice system; survivors of abuse or violence, including sexual abuse; veterans; people living with long-term physical health conditions; lesbian, gay, bisexual and transgender people; and people from black and minority ethnic groups and asylum seekers.

12. The LLR Suicide Audit and Prevention Group was established to bring together key partners across the health and care systems with the purpose of tackling the causes and the impact of suicide locally (see Appendix 1 for terms of reference of the group). The group meets quarterly and develops and updates local suicide prevention strategies and

action plans in line with the national strategy. The group is in the process of updating its local strategy and action plan for 2016-19 and would welcome input from members of the Health and Wellbeing Board in relation to this.

13. A core principle of the LLR Suicide Audit and Prevention Group is that deaths through suicide are preventable. Modifiable social and economic factors, individual factors and access to health and other services can directly impact on people's vulnerability, or conversely, increase their resilience to adverse life events which may be linked to suicide.

14. The graph below shows that since 2001 the trend in the age standardised rate of suicide per 100,000 in Leicestershire initially reduced before increasing again following the recession.[1] The rates are measured on a 3 year rolling average. For 2001-3 the rate was 7.3 per 100,000 (95% CI 6.0, 8.6). The rate for 2010-12 was 8.6 per 100,000 (95% CI 7.3, 10.0). In 2012 the regional rate was 8.8 and the national rate 8.9. **This equates to roughly 60 people per year across Leicestershire**.



15. In all respects the pattern of deaths from suicide in Leicestershire is not significantly different to the national and regional picture. For instance rates are higher in males than females. However, at 33.4 per 10,000, the years of life lost to suicide in Leicestershire were slightly higher than the regional value (31.3 per 10,000) and the England value (31.9 per 10,000). Although this figure was not significantly different, it indicates that on average cases of suicide in Leicestershire were younger than those for the region and England.

16. Prevention of suicides requires concerted action at many levels, so the LLR Suicide Audit and Prevention Group in line its 2013-15 Strategy and Action Plan currently targets the following key outcomes:

- To develop and inform the local strategic direction for suicide prevention across LLR;
- To influence commissioning responsibilities and structures across the wider partnerships in LLR to ensure that opportunities to prevent suicide are optimised;

- To promote collaborative arrangements across LLR and where appropriate to establish task and finish groups to complete reviews and develop commissioning plans for specific service areas;
- To encourage responsible reporting of suicide in the media;
- To promote mental well-being in the wider population;
- To engage with commissioning organisations, such as Clinical Commissioning Groups, Local Authorities and others.

17. The LLR Suicide Audit and Prevention Group Strategy and Plan (2013-15) are geared to working collaboratively with partners and stakeholders, to map current practice and address service provision with any gaps. Progress in 2014/15 includes**:**

- Good engagement amongst key partners;
- Regular suicide audits carried out and analyzed;
- Progress on suicide reporting/real time surveillance and working with local coroner's office to enable suicide data to be accessed faster. The group is working with Leicestershire Police on a pilot project to support real time surveillance of suspected suicide cases. The aim of the pilot is to have information about potential cases available as early as possible. This will enable commissioners and providers to plan appropriate and timely responses to emerging trends and to manage potential suicide clusters;
- Suicide awareness training is offered across LLR including bespoke training and support for school staff in identifying and managing pupils who self-harm;
- Mental Health First Aid training now offered to key partners;
- Suicide awareness raising exercises carried out e.g. 'Finding Hope' https://www.youtube.com/user/findinghopeleicester and events linked to International Suicide Prevention Day;
- Wider mental health/illness awareness raising and anti-stigma work e.g. 'Time to Talk' October, 2015;
- Initial discussions re 'zero suicide approach' linked to preliminary development of personal safety plans;
- Advocacy: Input into Parliamentary All-Party Group on Suicide leading to key recommendations on the overall governance of plans and strategies to reduce the impact of suicide: http://uk-sobs.org.uk/wp-content/uploads/2014/02/Future-of-local-strategies.pdf
- Establishment of formal links with Survivors of Bereavement by Suicide (SOBS) organization.

Proposals/Options

18. The future direction of the LLR Suicide Audit and Prevention Group and development of LLR Suicide Prevention Strategy and Action plan (2016-19) will be closely aligned with *Preventing suicide in England: Two years on Second annual report on the cross-government outcomes strategy to save lives* (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/405407/Annual_Report_acc.pdf)

19. Additional areas of local focus will include:

- Further development of suicide reporting/real time surveillance plus working with local coroner's office;

- Creation of a unified approach to city and county audits with enhanced data through linkages with primary and secondary care health services and an enhanced report to Health and Wellbeing Boards 6 monthly outlining progress of actions;
- Build on mental health awareness, suicide awareness and anti-stigma campaigns;
- Renew interest and effort in suicide awareness training
- Communication strategy involving voluntary sector and other relevant stakeholders on the need for training, awareness and use of personal safety plan;
- Identification of resources from partner organisations to help facilitate the work of the group make the above happen?
- Consideration of how to embed appropriate elements of 'zero suicide' approach locally including introduction of personal safety plans;

Consultation/Patient and Public Involvement

20. The voluntary and community sector is represented through the Samaritans, and the Rural Community Council (RCC). Other attendees have included regional suicide prevention representation, primary care professionals, researchers into hate crime, representatives of lesbian, gay, bisexual and transgender people, local universities and elected members

Resource Implications

21. The main resource implications relate to the time and input of representatives into the Suicide Audit and Prevention Group. Individual partners may also need to ensure that tackling suicide is prioritised within commissioning plans according to local need.

Officer to Contact

Dr Mike McHugh, Consultant in Public Health, Leicestershire County Council
0116 3054236
Mike.McHugh@leics.gov.uk

This page is intentionally left blank

Agenda Item 12

Leicestershire County Council

HEALTH AND WELLBEING BOARD: 5 MAY 2016

REPORT OF THE DIRECTOR OF HEALTH AND CARE INTEGRATION

OUTPUTS FROM THE HEALTH AND WELLBEING BOARD DEVELOPMENT SESSION – 10 FEBRUARY 2016

Purpose of report

1. The purpose of this report is to provide members of the Health and Wellbeing Board with assurance that the actions arising from the Board Development Session held on 10 February 2016 are being acted upon.

Link to the Local Health and Care System.

2. This report is concerned with the overall connectivity between the Health and Wellbeing Board and the Leicester, Leicestershire and Rutland (LLR) wide BCT programme.

Recommendations

3. The Health and Wellbeing Board is asked to:-

   (a) Consider whether members wish to receive the Integration Programme Director's Highlight Report on a monthly basis;

   (b) Comment on the proposed items relating to health and care integration for consideration at future meetings of the Board set out in paragraph 8 of the report;

   (c) Approve the proposed change to the reporting arrangements for the Unified Prevention Board;

   (d) Comment on the proposed items relating to the wider determinants of health for consideration at the meeting of the Board in July set out in paragraph 15 of the report;

   (e) Approve the revised Terms of Reference for the Health and Wellbeing Board.

Policy Framework and Previous Decisions.

4. The Board considered a report outlining progress with outputs from the Health and Wellbeing Board Development Session at its meeting on 10 March. That report focused on improvements in the following three areas:-
   - System leadership;
   - Joint Health and Wellbeing Strategy, including key priorities for 2016 onwards;

- Making the Health and Wellbeing Board more effective.

5. System Leadership issues are addressed further in the report on the Sustainability and Transformation Plan which appears elsewhere on the agenda for this meeting. The refresh of the Joint Health and Wellbeing Strategy will be the subject of a development session on 21 June 2016 and a report to the July meeting of the Health and Wellbeing Board. This report focuses on actions that have been taken to make the Health and Wellbeing Board more effective.

Improving the Effectiveness of the Health and Wellbeing Board.

Relationship between the Board and the Integration Executive

6. Board Members agreed at the Development Session that the Integration Executive was having a good impact. However, some concern was expressed that the Integration Executive did not have a clear mandate from the Board and was not sufficiently held to account. It could sometimes feel that the Board was being sidelined and acting as a figurehead rather than leader in this area.

7. Consideration has now been given to ways in which the relationship between the two bodies can be improved, in order to give more visibility to the work of the Integration Executive and to improve its accountability. Attached as Appendix 1 to this report is the Programme Director's Highlight Report from the Integration Executive meeting on 19 April. This report is produced on a monthly basis to keep the Integration Executive informed of progress across the integration programme. It is proposed that this report is circulated by email to members of the Health and Wellbeing Board on a monthly basis.

8. Attached as Appendix 2 to this report is the high level programme plan for the integration programme during 2016/17. This was included with the Better Care Fund Plan Submission. It is suggested that the following items which form a significant part of the integration programme should be approved by the Board rather than the Integration Executive:-

   - Lightbulb Business Case;
   - Health and Wellbeing Outcomes for Social Prescribing;
   - Summary Care Record Solution for Care Planning;
   - Joint Commissioning Work Plan.

9. The Health and Wellbeing Board is asked to consider whether these items are appropriate for consideration at the Board and whether there are other items on the programme plan which the Board would wish to discuss.

Board Substructure

10. Linked to the concerns raised about the relationship between the Health and Wellbeing Board and the Integration Executive, other parts of the Board's substructure have also been reviewed. It is proposed that the Unified Prevention Board reports directly to the Health and Wellbeing Board recognising that specific elements of work associated with Better Care Fund deliverables/metrics will also be subject to monthly assurance via the Integration Executive.

11. If agreed, the Terms of Reference for the Unified Prevention Board will be revised accordingly and submitted to the next meeting of the Health and Wellbeing Board for approval.

Virtual Sign-off Process

12. In order to keep the agendas for meetings focused on key items of business, it was suggested that a virtual sign-off process be developed for those items which required Board approval but did not form part of its core business. It has been agreed with the Chairman of the Board that this would not be feasible, due to the number of partners and statutory members of the Board that would need to be involved. There is also the risk that a virtual sign-off process could be perceived as reducing the democratic accountability of the Board.

13. The Board is also reminded that, where appropriate, it can delegate specific matters to County Council Chief Officers, following consultation with either partners or the appropriate Cabinet Lead Member. This procedure has already been used by the Board for signing off the Transformational Plan for the Emotional Health and Wellbeing of Children.

Addressing the Wider Determinants of Health

14. The development session discussed the importance of having a clear vision and ambition that embraced 'wellbeing' as well as health and looked more widely across the whole agenda, including the wider determinants of health. These issues are expected to be picked up in the refresh of the Joint Health and Wellbeing Strategy and will therefore be incorporated into the revised performance framework.

15. Discussions from the development session also informed the subsequent BCT partnership board development session and the approach to the Sustainability and Transformation Plan. The proposition arising from these discussions is that the three Health and Wellbeing Boards in Leicester, Leicestershire and Rutland become the vehicle for developing the strategic approach to health and wellbeing in its broadest sense, harnessing the wider determinants of health and wellbeing including for example housing, transport and economic development. Health and Wellbeing Boards therefore have the clear mandate and system leadership role to drive the development of new, integrated models of prevention. All partners will look to the three Health and Wellbeing Boards to develop outcome frameworks and delivery models for prevention which support:
    - A core wrap around prevention offer which integrates with other community based health and care services, taking a place based approach;
    - Key priorities and service changes within the Sustainability and Transformation Plan such as scaling up prevention in the medium term;
    - Key pathway changes within Better Care Together such as ensuring prevention is embedded as a cross cutting theme in each workstream.

16. In order to start this piece of work the Board will receive a report address the health and wellbeing outcomes for the following wider determinants of health at its meeting in July:-
    - Housing/the Lightbulb Project;
    - Community Safety;
    - Employment.

17. The Board is asked to consider whether there are any other areas where it would like to consider the contribution made by health and wellbeing.

Template for Reports

18. The report template has been reviewed and reports to this meeting of the Health and Wellbeing Board have been written using the new template. It includes a section on links to the local health and social care system. It should also point to clearer decision making as recommendations now appear on the first page of the report.

Terms of Reference

19. The Board's Terms of Reference have been revised to address the following:-
    - To give the wellbeing, prevention and wider determinants components more prominence, co-ordination and drive;
    - To recognise that the Board will lead communication and engagement on a specific and limited number of focused matters but will continue to work with other partners in the system on more routine general communications and engagement.

20. The revised terms of reference are attached for approval as Appendix 3 to this report.

Resource Implications

21. The resources available to support the Board, both financial and non-financial, will be reviewed in the light of the actions arising from the Development Session, as they will change the focus of the Board which may affect the level of support that it requires.

Background papers

Report to the Health and Wellbeing Board on 10 March 2016 – Outputs from the Health and Wellbeing Board Development Session – 10 February 2016
http://politics.leics.gov.uk/Published/C00001038/M00004631/AI00047100/$OutputsfromtheDevelopmentSession.docA.ps.pdf

Circulation under the Local Issues Alert Procedure

N/A

List of Appendices

Appendix 1 – Integration Programme Director's Highlight Report, 19 April 2016
Appendix 2 – High Level Integration Programme Plan for 2016/17
Appendix 3 – Revised Terms of Reference.

Officers to Contact

Cheryl Davenport, Director of Health and Care Integration
Telephone: 0116 305 4212
Email: Cheryl.davenport@leics.gov.uk

Rosemary Palmer, Democratic Services Manager
Telephone: 0116 305 6098
Email: rosemary.palmer@leics.gov.uk

Relevant Impact Assessments

Equality and Human Rights Implications

22. The role of the Health and Wellbeing Board is to collectively tackle health inequalities and to make sure that all people can access health and care when they need to. Individual proposals coming before the Health and Wellbeing Board will be subject to an equalities and human rights implications assessment.

This page is intentionally left blank

APPENDIX 1

INTEGRATION EXECUTIVE: 26 APRIL 2016

PROGRAMME DIRECTOR'S HIGHLIGHT REPORT

1. This report provides an update on a range of matters for the attention of the Integration Executive and should be read in conjunction with the Performance and Finance Reports.

Help to Live at Home (HTLAH) Update

2. The PQQ stage has been completed with bidders notified of the outcome on 15th April. ESPO's internal governance and quality assurance panel signed off the PQQ process and outcomes on 14th April.

3. The ITT will commence from the 25th April and applicants will have a period of six weeks to return responses. Final evaluations and award of contracts is scheduled for July 2016, with the new service scheduled to commence in November 2016.

4. The steering group is receiving analysis of the impact of provider bids that did not pass the PQQ and will oversee mitigation plans for any risks arising from this in terms of current provision.

5. Letters have been mailed out to all service users in receipt of a managed domiciliary care service (both local authority and CCG funded) explaining HTLAH and how it may impact upon their service package. A Leicestershire County Council telephone helpline went live on 21st March with 60 calls received in the first week. Two informal service user and family information events have been arranged for 26th and 27th April to explain how the transition arrangements will be managed and to help people to start considering the options available. A media release was issued week commencing 11th April.

6. Good progress is being made across all workstreams preparing for the transition to the new service.

7. A revised timeline has been agreed for the final governance approvals of the HTLAH s75 agreement during May. A draft of the agreement with associated schedules was circulated on the 8th April and has been forwarded to the CCGs' legal advisers for review.

8. A workshop with UHL and LPT has been arranged for 11th April as part of the Operational Dependencies workstream to devise new operational processes across all teams.

Integrated Data: Care and Health Trak Update

9. Representatives from Leicestershire showcased the implementation of Care and Health Trak at the ADASS spring seminar in April.

10. Following approval of CCG MDs to a further 12 months of investment in Care and Health Trak the following activities are underway:

APPENDIX 1

a) Recommissioning the tool with effect from 26th April 2016 for a further 12 months

b) Adoption of additional data sets – out of county acute, NHS 111.

c) Progressing potential inclusion of WLCCG primary care data (pilot)

d) Developing a workplan for the tool in 2016/17 in conjunction with BCT workstreams and the Care and Health Trak Business Intelligence users group.

e) Ensuring a piece of BCT workforce analysis can be undertaken using a data extract from Care and Health Trak.

Integrating LLR Points of Access

11. A presentation was provided at the March Integration Executive which provided an overview of the development of the options and roadmap for the business case.

12. The roadmap outlines the proposed stages including a programme of business readiness for each organisation, co-location opportunities to be exploited with a view to achieving the longer term integration of our adult social care and health call centre offering.

13. The operational readiness will include system and process improvement across all in scope areas, to ensure we have a consistent method of operating, in line with the agreed design principles, to create a baseline from which to co-locate and integrate. It will include:

    a) The operation of all in-scope services under a uniform governance structure for each site.

    b) A revised, clearly communicated service offer.

    c) The implementation of a Performance and Change function.

    d) The start of the standardisation of activities that will drive efficiency in all in-scope areas.

14. The proceeding phases of the project will implement co-location and integration activities, ensuring system resilience and continuous improvement across the complete operation.

15. The draft business case will be presented to the Project Board on 3rd May and be finalised by the end of May.

16. There is a schedule of governance meetings that will then take place, including being presented to each partner's respective board for approval prior to implementation.

17. Implementation resources are being scoped.

APPENDIX 1

Integrated Community Equipment Service

18. The Demand Management approach, which was brought to the Integration Executive at scoping stage in January, is reaching a conclusion and the outputs will be reported in the next few weeks.

19. Operational delivery within the service has been impacted in recent weeks by two issues - building work and new rotas/terms and conditions affecting staff. These matters are being addressed with the provider.

Health and Social Care Protocol

20. A piece of work has been commissioned to consider the health and social care protocol in the context of changes to the wider domiciliary care contract, with a view to providing an initial report to the Health and Social Care Oversight Board on 2nd August 2016.

Transforming Care Update

21. The Transforming Care Partnership was formally agreed as a function of the BCT LD workstream in December 2015 and will be responsible for the development and delivery of the Transforming Care Plan.

22. Since the update report to the Integration Executive on the 27th February, a second draft of the LLR Transforming Care plan was submitted to the NHS England on the 4th March. Following regional and national moderation the plan has now been assessed as "green" which means that it meets national expectations. A final submission with minor alterations based on feedback was submitted on the 11th April.

Unified Prevention Board (UPB) Update

23. At their April meeting the UPB discussed refreshing their workplan in line with the BCF plan for 2016/17. The UPB discussed the overall vision for integration, the person-centred model of integrated care in localities and how a wrap-around prevention offer is a critical component of this vision.

24. The work of the group will include defining the model for social prescribing across Leicestershire working with First Contact Plus, District Councils, Local Area Co-ordinators, the Voluntary Sector, and CCG's.

25. The vision is that by 2018 we will have a comprehensive offer for community based prevention for the citizens of Leicestershire, funded by bringing together all the resources available to Local Councils and NHS partners. This will include:

    a) A core menu of preventative services which will wrap around individuals and communities, as an essential component of the model of integrated care.

    b) Prevention will be targeted proactively to specific cohorts of people through social prescribing.

c) Every opportunity will be taken to improve health and wellbeing, support vulnerable people, maintain people's independence, manage demand, and address the wider determinants of health and wellbeing.

d) First Contact Plus will provide the "front door" and navigator for maximising social prescribing.

26. A workshop had also been held in March with relevant scheme leads for social prescribing to start work on the menu of services that will make up the offer. This included initial discussions around using First Contact Plus as a front door.

27. The refreshed workplan for the UPB will be supported by an improved performance framework that will track metrics and outcomes including the impact of social prescribing.

28. There will be some additional workstreams that will work in partnership to provide countywide offers, for example, integrated housing solutions via the Lightbulb Service and a core information, advice and guidance offer.

29. Terms of reference for the UPB will be updated to reflect the above including restructured representation where necessary.

Housing Discharge Enabler Scheme

30. Following a successful recruitment campaign for the Housing Enabler posts working at LRI, Glenfield, General and the Bradgate Unit Hospitals, the following people have been appointed to post:

a) Team Leader Post – Taranjeet Bhaur

b) Housing Enabler – Jackie Hands, Andrew Byron and Amardeep Matharu

c) Housing Related Support – Kyle Richardson and Justin Moulder

31. These roles will become part of the overall Lightbulb Team.

Emergency Admissions Avoidance – Actions to improve performance

32. The combined trajectories for 2016/17 from the six BCF funded avoided admissions schemes total 1,500 avoided admissions, against a target of 1,600.

33. Some in year changes are anticipated due to reviews currently in progress on the design of OPU and Night Nursing services. Also, additional activity is anticipated from two to three additional schemes from CCG QIPP Business Cases which are currently being assessed.

34. The action plan for delivery of avoided admissions in 2016/17 is being finalised. This takes into consideration governance routes for particular schemes, for example the ambulatory (admissions avoidance) pathway for CDU at Glenfield will be governed by the BCT long term conditions workstream.

APPENDIX 1

Older Persons' Unit (OPU)

35. As part of the BCF refresh, it was agreed in January to extend the OPU for a further six months to 30th September 2016 to allow time to test new models through the Frail Older People BCT workstream. Therefore it was timely to consider next steps and generate ideas to optimise utilisation of the service. During January to March a review of patient transport, the ongoing offer and management of follow-ups and workforce, in particular the OPU geriatrician time and therapy input, were reviewed.

36. Outputs of the review have now been implemented and progress will continue to be monitored through the Step Up/Step Down Programme Board.

Integrated Crisis Response Service (ICRS)

37. Within the Better Care Together programme, a wider review of all end of life provision across LLR is being carried out, led by Caroline Trevithick, and will report back in April 2016. A decision was made at the Integration Operational Group in January to continue the night nursing service as-is until the end of life review findings are released, which can then be incorporated into future service model planning.

38. A meeting is planned on 20th April to discuss the night nursing element with LPT. This will include a discussion on current referrals into the service and to identify the cohort of patients that may benefit from the original brief in preparation for the end of life commissioning intentions.

39. A task and finish group has been set up between Adult Social Care and LPT to consider the feasibility and options for integrating the social care crisis response service and the urgent care services within CCHS. A workshop will be taking place mid/end of April to look at the different cases that are coming through the social care crisis response service, Rapid Response in CCHS and EDT and consider how these could be responded to by an integrated service.

40. An update on progress will be provided to the Step Up/Step Down Programme Board in May.

Falls Service

41. A new Falls Project Manager has been appointed and started 7th April.

42. The work encompassing "Falls Prevention" and the "Falls Services" will be ran as a single programme of work to ensure consistency, and that results cover the full pathway of care.

43. The draft workplan has been reviewed and was presented to Integration Operational Group on 14th April for feedback.

44. Due to the change in Project Manager, the task and finish groups were not scheduled as previously expected. As part of current stakeholder meetings the requirements of these workshops is being assessed, with a view to holding them late spring. Current intentions

are that they will discuss and report on the following areas, with results to feed into the revised strategy:

a) a robust referral and triage process for fallers/those at risk of falling;

b) directory of services, and

c) the community falls prevention offer.

45. Funding has now been identified for the new FRAT tool e-learning platform which will be rolled out November 2016. An evaluation of the training previously offered to existing staff, along with the current paper based system will be undertaken.

46. The management of the falls in care homes pilot is currently on the reserve list for BCF funding, and will continue to be evaluated further along with other potential schemes based availability of funding and agreed priorities.

7 Days Services in Primary Care

47. **WLCCG** – The service has been operational since the beginning of 2016. Trajectories have been agreed. Avoided admissions are now being reported directly from the HCPs and represent clinical judgement.

48. **ELRCCG** – The initial pilot is for six months and will cover four GP practices. The Croft Medical Centre went live on 6th Feb 2016, the Glenfield Surgery went live on 27th Feb and the Latham House went live on 12th March. Meetings are taking place to look into the logistics for the fourth practice. And the information governance and IT requirements that will need to be fulfilled. Avoided admissions for February have exceeded the target and work continues to evaluate effectiveness and determine future targets.

Ambulatory Pathways on CDU (Glenfield Scheme)

49. A presentation was provided to the Step Up/Step Down Programme Board on 14th April on the CDU Glenfield Rapid Assessment Clinic Test Cycle Week which took place from 14th to 18th March.

50. During the test cycle week the rapid assessment clinic was available between 10am and 8pm with the last patient triaged to clinic at 6pm. Two GPs and a dedicated cardiac specialist nurse where involved.

51. Phase two proposals include:

a) An eight week extended pilot from mid-May to early June.

b) May include weekends so has been costed as a seven day service by eight hours per day.

c) Increased GP presence in triage to identify more patients suitable for same day discharges.

d) Greater integration with GP teams and Intensive Care Support to reduce length of stay in CDU and facilitated discharges.

e) Detailed analysis of outcomes, sustainability and cost effectiveness.

f) Estimated cost is £60k (total across both county and city) to include GP costs, non-recurrent IT start up and project management.

52. Further work on trajectories for avoided admissions and other issues raised in the meeting are to be reviewed between meetings. Governance for the delivery of the scheme will be via the BCT long term conditions workstream.

Charnwood Integrated Urgent Care Testbed

53. Within WLCCG a task and finish group is being set up to lead on the design, testing and delivery of an integrated urgent community and primary care model in the Charnwood locality. This is part of a wider piece of work across each individual CCG across LLR, where each federation will be testing a particular area.

54. The scope of the programme will focus on testing an integrated community urgent care service. This will pick up a number of urgent care schemes that are funded through the BCF plan.

Communications and Engagement

55. Work is progressing on the new Leicestershire Health and Care Integration website. The name has now been confirmed – www.healthandcareleicestershire.co.uk. Content for the web pages is being created and with the initial content on the site ready for 25th April.

56. We have updated the Better Care Fund plan on a page for the refresh submission.

57. The letter and leaflet for the next phase of Help to Live at Home communications has now been distributed to Leicestershire County Council and CCG service users. A press release was issued week beginning 11th April. Two service user information events have also been arranged for 26th and 27th April.

58. The @LeicsHWB twitter now has 286 followers.

59. Content has been drafted for the next edition of the stakeholder health and care integration bulletin including a focus on how prevention services can help GP practices and their patients:

a) First Contact Plus – progress in 2015 and case studies on how the service is being used by GP practices.

b) Lightbulb – a GP view of the housing pilot in Hinckley.

c) Improvements in hospital discharge – what progress has been made and what are the next areas to tackle.

APPENDIX 1

d) The vision for integrated health and care in Leicestershire localities.

60. We are currently working on communications to showcase the SIMTEGR8 evaluation work at national conferences and through academic channels etc.

61. An article has been developed for the Barwell and Hollycroft GP surgery newsletter to promote the Lightbulb programme.

62. We have also developed a leaflet to give out in GP practices where we are running Lightbulb pilots to promote the drop-in session.

63. A refresh 2016/17 BCF communications plan is currently being drafted.

Key Risks

BCF Programme Level Risks

64. The schemes contributing to the achievement of the reduction in emergency admissions are not currently achieving the required trajectory – this has been refreshed for the 2016/17 delivery plan in line with the national guidance.

65. The action plan to address the utilisation of schemes continues and is being monitored by the Step Up/Step Down Programme Board in order to continually assess the confidence level in schemes meeting the required target and will feature as part of review of the trajectories for each scheme and the decisions required for the 2016/17 refresh.

66. Financial pressures affecting all partners means delivery of the BCF plan will be even more challenging than in 2015/16.

67. If our BCF refreshed plan or national quarterly submission templates highlight that we are not satisfactorily meeting any of the national conditions or metrics for the BCF, our plan could be escalated via NHS England depending on the identified risk.

68. The escalation process ultimately leads to the ability for NHS England to use its powers of intervention provided by the Care Act legislation in consultation with DH and DCLG.

Recommendations

69. The Integration Executive is asked to:

- Note the contents of the report.
- Provide any feedback and challenge to the programme team concerning the matters raised.

Officer to Contact:
Cheryl Davenport
cheryl.davenport@leics.gov.uk
Director of Health and Care Integration (joint appointment)
0116 305 4212/ 07770 281610

INTEGRATION PROGRAMME PLAN

Key
- In progress / Not started
- Completed
- Behind schedule
- Ongoing process/no critical milestones

	2016/17												2016/17		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Programme Management															
Better Care Fund Plan and Reporting															
BCF Plan Submission															
Final sign-off of BCF Plan	26														
BCF Plan Submission to NHS England		3													
Assurance on BCF plan from NHS England															
BCF Quarterly Reporting (timetable from NHS England pending)															
Communications Plan for Integration Programme															
Develop and launch integration programme website															
Integration programme Stakeholder Bulletins															
Social isolation public campaign															
All Member Briefings	20														
Section 75 Agreement															
Revise schedules of existing section 75 agreement & approval process															
Confirm with NHS England section 75 document signed off (via quarterly report)															
Unified Prevention Offer															
Design Unified Prevention Offer and Commissioning Intentions for 2017/18															
Design and refresh performance designed dashboard for 2017/18 offer															
Co-produce specific health & wellbeing outcomes for social prescribing developments within Leicestershire															
Target prevention offer to specific cohorts of patients per BCF/BCT															
First Contact Plus															
Development of integral web based/website/inbound & outbound referral plus case management system															
Develop quality assurance monitoring of First Contact Plus Service															
Comms and Engagement Plan															
Development/design of literature															
Media launch of First Contact Plus															
Ongoing engagement programme across partners															
Information Sharing Agreement															
Carers Service															
Develop a new LLR joint (health & care) Carers Strategy for 2017/20															
Develop carers strategy															
Review/sign-off of the draft carers strategy prior to consultation															
Consultation of draft strategy (Stakeholders and Carers)															
Write up the consultation findings and finalise strategy															
Governance process to sign-off strategy															
Launch of strategy															
Review of Carer Support Pathway															
Plan to be completed															
Review the current carers services															
GP Health and Wellbeing Board Service															
Support for Carers															
Carers Respite Framework															
Local Area Coordination															
Deliver the Local Area Coordination Pilot															
Level 1 delivery - information, advice & guidance to clients															
Level 2 delivery - each LAC to be working with 50-65 individuals at one time															
Ongoing delivery of level 2 support to 50-65 individuals per LAC															
Local Area Coordination Business Case & Intentions for 2017/18															
Develop draft business case															
Review & share costing models approach with partner organisations															
Identify partner benefits															
Governance process to approve draft Business Case															
Decision on funding of Local Area Coordination required															
Implement agreed decisions for future service															
Evaluation															
Second interim report															
Third interim report															
Final evaluation report															
Implement the lessons learnt from reports into phase 2															
Using asset based community development to support cultural change															
Assistive Technology (details in progress)															
Develop OT & AT strategy 2017-20															
Develop strategy															
Review/sign-off of draft strategy prior to consultation															
Consultation of draft strategy															
Write up the consultation findings and finalise strategy															
Governance process to sign-off strategy															
Launch of strategy															
Assistive Technology Contract															
Decision of procurement option															
Integration with Telehealth															
TO BE COMFIRMED															
Assessment/Monitoring Tool															
Support 100% healthcare with AT															
Review options for implementation of trying to support 100% healthcare with AT (for standalone equipment)															
Engage with CHC - how they can order AT, recharge back and who signs off															
Link to Help to Live at Home programme															
Monitor/review capacity for increased activity															
Marketing/comms activity with domiciliary providers															
Lightbulb Pathway															
Pre-Business Case development															
Full Business Case, including service model redesign signed off by Programme Board															
Roll-out of assessment & triage redesign implemented															
Expansion of Housing Support Coordinator role into triage & referral routes															
Locality model roll-out															
Development of preventative elements with health colleagues to expand locality model															
Full implementation															
Falls Pathway															
Falls Pathway Dashboard															
Develop falls dashboard															
Build in pathway 3 data															
Build in eFRAT tool reporting															
Understand data on pathway of NHS111 calls															
Falls Clinic Commissioning															
Review of commissioning activity for falls clinic															
Understand delivery requirements															
Recommendations for new delivery pathway															
Clinical Audit of Falls Service															
Design & undertake audit															
Feed recommendations of audit into falls pathway															
Falls Prevention IAG Pathway to overall prevention offer															
Understand what information each service currently has & current pathways															
Ensure signposting reflects new pathway design															
Launch of falls prevention IAG pathway to prevention offer															
Falls Prevention Strategy															
Refresh existing strategy															
Stakeholder consultation															

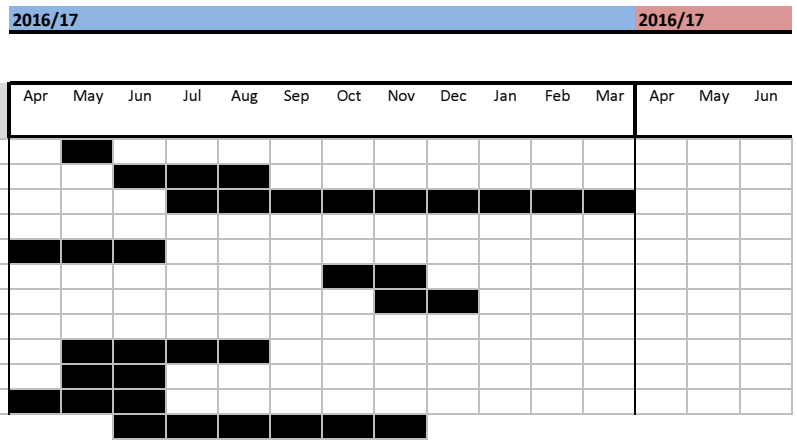
INTEGRATION PROGRAMME PLAN

Key
- In progress / Not started
- Completed
- Behind schedule
- Ongoing process/no critical milestones

	2016/17												2016/17		
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Finalise strategy							■								
Launch of strategy								■							
Review of use of Assistive Technology in the falls pathway															
Joint strategy of use of AT across the partnership				■	■	■									
Single agreed approach to falls prevention in care homes				■	■	■									
Early prevention for self-funders and those at risk of falling				■	■	■									
Use Care and Healthtrak to track known fallers															
Review current data captured of known fallers	■	■													
Review actions taken by professionals (GPs, Pharmacists) if know patient at risk of falling	■	■													
Design information routes & access to services for falls			■	■	■										
Build outcomes into falls prevention pathway						■									
FRAT Tool															
Understand the use and issues of current paper FRAT tool			■												
Design electronic version & referral point				■	■										
Test eFRAT tool for accuracy & ease of use						■	■								
Create & deliver staff training on eFRAT tool							■	■							
Launch eFRAT tool								■							
Supporting Leicestershire Families															
Future commissioning intentions for the Supporting Leicestershire Families Service						■									
Protected Prevention Services															
LD Short Breaks (NHS) - (funded by BCF)															
Residential Respite (SC)															
Commissioning intentions for Alzheimer's Society dementia services (dates TBC)															
Integrated, Proactive Care in People with Long Term Conditions (LTCs)															
Integrated, Proactive Care (Risk Stratification and Care Management)															
Proactive Care (West Leicestershire)															
Long Term Conditions (East Leicestershire)															
Improving Quality in Care Homes															
Protected LTC Services															
Nursing Care Packages (SC)															
Home care services (SC)															
Long Term Conditions QIPP															
TBC															
Integrated Urgent Response															
Integrated Crisis Response Service (ICRS)															
Review current effectiveness of service	■	■													
Alignment with the BCT end of life review output		■													
Review options/opportunities for the integration of health and care services for further integration	■	■	■	■											
Establish and agree future commissioning intentions for the service			■												
Draft service specification				■	■										
Rapid Assessment for Older Persons' Unit (OPU)															
Implement service provision adjustments agreed by Step Up/Step Down Programme Board	■														
Develop metrics/KPIs	■														
Conclude OPU evaluations (SIMTRG8 & clinical audit)	■														
Link to wider prevention offer	■	■	■	■	■	■									
Review the service model of the OPU to establish future service design		■	■	■	■										
Implement model of care changes follow OPU review						■									
ELRCCG - Integrated 7 day community urgent care (with additional AVS capacity)															
Run six month pilot (start Feb 16)	■	■	■	■											
Evaluation of six month pilot					■										
Development of KPIs/Trajectories	■														
Recruit/identify resource to undertake scoping exercise		■													
Additional triage ECPs & GPs recruited & in post to cover ELR population 7 days per week			■												
Healthier Communities Programme Board to lead implementation of recommendations from scoping exercise				■											
WLCCG - Weekend Working Service															
Ongoing service delivery															
Agree KPIs/trajectories	■														
Review of service (see below - Charnwood Urgent Care Testbed)															
WLCCG - AVS Service															
Ongoing service delivery															
Agree KPIs/trajectories	■														
Review of service (see below - Charnwood Urgent Care Testbed)															
WLCCG - Charnwood Urgent Care Testbed (Vanguard)															
Produce terms of reference for oversight group	■														
Further details to follow															
Testbed will pick up the enhanced clinical care at Loughborough Urgent Care Centre															
Ambulatory Pathways at Clinical Decisions Unit (Glenfield Scheme)															
Present findings of rapid assessment clinic test cycle week (14-18 March)	■														
Agree phase 2 proposal	■														
8 week extended pilot		■	■	■											
Detailed analysis of outcomes, sustainability and cost effectiveness				■	■										
Hospital Discharge and Reablement															
Residential Reablement															
Hospital to Home															
Review current Hospital to Home service & report findings	■	■													
Intermediate Care															
Protected Reablement Services															
Reablement (NHS)															
Intensive Community Service (NHS)															
Improving Mental Health Discharges															
Protected Hospital Discharge Services															
Step Down (NHS)															
Assertive In Reach (NHS)															
Maintaining the Social Care Assessment Pathway (SC)															
Help to Live at Home (HTLAH)															
Review of HART service & refresh service specification	■	■	■	■	■	■									
Transition to new HTLAH (domiciliary care) service				■	■	■									
Commence HTLAH service								■							
Non-weight bearing pathway															
Social Care DST Workers															
Better Care Fund Enablers															
BCF Evaluation															
Appoint lead to coordinate evaluation programme															
Simtegr8 Evaluation Project															
Dissemination of phase 1 evaluation study findings in conjunction with Loughborough University	■	■	■												
Phase 2 evaluation study scoping	■	■	■												
Phase 2 evaluation delivery				■	■	■	■	■							
Phase 2 report									■	■	■	■	■	■	
Clinical Audits															
2016/17 programme being scoped															
Joint Commissioning Workplan for 2016/17															
Scope 3 elements of the workplan		■	■												
Joint Commission 1 - Care and Nursing Homes															
Joint Commission 2 - High cost placements for learning disabilities															
Joint Commission 3 - CHC/personal budgets															
LLR Integrated Point of Access (PoA)															

INTEGRATION PROGRAMME PLAN

Key
- In progress / Not started
- Completed
- Behind schedule
- Ongoing process/no critical milestones



- Delivery final business case for LLR PoA and implementation plan
- Review through governance process across LLR organisations (governance plan available)
- Implementation plan for phase 1 of PoA

Care and Healthtrak

- Phase 2 implementation of Care & Healthtrak
- BI workplan for 2016/17
- Commissioning intentions for Care & Healthtrak in 2017/18

Health and Social Care Protocol

- Priority actions for the health & social care protocol for 2016/17

Scoping a Summary Care Record solution for care planning (via LLR IM&T Group)

Development of LLR Sustainability Transformation Plan (STP) (Dependency)

Preparation of the medium term integration plan 2017-20 (link to STP) - *National guidance pending*

This page is intentionally left blank

APPENDIX 3

Leicestershire Health and Wellbeing Board
May 2016

Terms of Reference

Introduction

The Health and Wellbeing Board has been appointed by the County Council as a subcommittee of the Executive to:-

(a) Discharge directly the functions conferred on the County Council by Section 194 of the Health and Social Care Act 2012 or such other legislation as may be in force for the time being;

(b) Carry out such other functions as the County Council's Executive may permit.

[Note: The County Council's executive function of approving the Better Care Fund and Plans arising from its use has been delegated to the Health and Wellbeing Board.]

Terms of Reference

The Health and Wellbeing Board shall have the following general role and function:-

To lead and direct work to improve the health and wellbeing of the population of Leicestershire through the development of improved and integrated health and social care services by:-

1. Identifying needs and priorities across Leicestershire, and publishing and refreshing the Leicestershire Joint Strategic Needs Assessment (JSNA) so that future commissioning/policy decisions and priorities are based on evidence.

2. Preparing and publishing a Joint Health and Wellbeing Strategy and Plan on behalf of the County Council and its partner clinical commissioning groups so that work is done to meet the needs identified in the JSNA in a co-ordinated, planned and measurable way.

3. In conjunction with all partners, communicating and engaging with local people in how they can achieve the best possible quality of life and be supported to exercise choice and control over their personal health and wellbeing.

4. Approving the Better Care Fund Plan including a pooled budget used to transform local services so people are provided with better integrated care and support together with proposals for its implementation.

5. Having oversight of the use of relevant public sector resources to identify opportunities for the further integration of health and social care services.

The Work of the Board in Practice

Identifying Needs and Priorities

The Health and Wellbeing Board will take a key role in identifying future needs and priorities in Leicestershire to ensure that future work is based on evidence of needs. The Board will:-

- Ensure that the JSNA is refreshed, using a variety of tools, evidence and data, including user experience, to support this process.

- Ensure that the Pharmaceutical Needs Assessment is refreshed, using a variety of tools, evidence and data, including user experience, to support this process.

- Reach a shared understanding of the health needs, inequalities and risk factors in local populations, based on the JSNA and other evidence, and demonstrate how this evidence has been applied to our decisions and strategic priorities.

- Reach a shared understanding of how improvements in outcomes will be monitored and measured, including the benefits of improving integration.

- Ensure that all partners that commission services demonstrate how the JSNA and other appropriate evidence has been used to support integrated outcome based commissioning.

- Provide high-level guidance on the achievement of Leicestershire's strategic health and wellbeing outcomes.

Strategy

The Health and Wellbeing Board will develop, publish and refine a Joint Health and Wellbeing Strategy which is supported by all stakeholders and sets out objectives, a rate of improvement for health and wellbeing outcomes, including reduction in health inequalities, and how stakeholders will be jointly held to account for delivery. In addition, the Board will:-

- Take account of the JSNA and the recommendations of the Director of Public Health's Annual Report.

- Focus collective efforts and resources on the agreed set of strategic priorities for health and wellbeing, recognising the contributions of the wider determinants of health.

- Ensure the work of the Board develops in tandem with other local and national policy developments, dependencies and legislation.

- Retain a strategic overview of the work of commissioners to further the Board's strategic objectives.

- Ensure that all partners that commission services demonstrate how the Joint Health and Wellbeing Strategy has been used to set and measure

achievement against a framework for integrated outcome based commissioning across the partnership.

- Quality assure and sign off joint delivery plans to achieve the Board's agreed strategic outcomes.

- Receive reports from other strategic groups and partners responsible for delivery, including specialist commissioning groups.

- Challenge performance of delivery plans which support the strategic priorities of the Health and Wellbeing Board, taking action as necessary, including by agreeing recovery and improvement plans.

- Be accountable for applicable outcomes and targets, as agreed by partners, via specific performance frameworks applicable to the NHS, public health and local authorities.

Integrated Working

The Health and Wellbeing Board will approve and implement plans which will set out how health and social care services will be transformed to provide the people of Leicestershire with better integrated care and support, the expected outcomes and how stakeholders will be jointly held to account for delivery. In addition the Board will:-

- Ensure that appropriate partnership agreements, financial protocols, monitoring and risk management arrangements are in place to facilitate the use of the Better Care Fund and other areas of integrated commissioning.

- Have an overview of the management of resources committed to the Better Care Fund and other integrated commissioning arrangements to enable the effective management of service pressure and ensure the long term sustainability of services.

- Provide system level oversight to the totality of commissioning expenditure in Leicestershire which is relevant to achieving the Board's strategic priorities and the plans for changing the health and social care system across Leicester, Leicestershire and Rutland.

- Identify service areas where additional improvements in integrated commissioning are required to and recommend the extension of pooled budgets to support this in line with national and local priorities.

- Where there are realisable efficiencies in relevant public sector services, encourage partners to share or integrate services.

- Make recommendations on the priority of projects and allocation of resources to service providers and/or localities as appropriate, in order to achieve jointly agreed objectives.

- Have an overview of major service reconfiguration by providers of relevant public sector services and make recommendations to those providers to enable improved and integrated delivery of services.

- Ensure that an integrated approach is taken to addressing the promotion of wellbeing, including through the wider determinants of health and preventative services.

Communication and Engagement

The Health and Wellbeing Board will, in conjunction with partners, communicate and engage with local people in how they can achieve the best possible quality of life and be supported to exercise choice and control over their personal health and wellbeing. In support of this, the Board will:-

- Develop and implement a Communications and Engagement strategy for the work of the Board, including how the work of the Board will be influenced by stakeholders and the public, including seldom heard groups, and how the Board will support the specific duties with respect to consultation and engagement on service changes, for example within the Better Care Together Programme.

- In line with the Joint Health and Wellbeing Strategy and its key priorities, lead communications and engagement activities based on an annual work plan.

- In line with the Leicestershire Communities Strategy and the Unified Prevention Offer, look for opportunities to build community capacity in order to manage the level of demand on health and social care services, including through preventative services.

Standing Orders

The Access to Information Procedure Rules and Meeting Procedure Rules (Standing Orders) laid down by the County Council will apply with any necessary modifications including the following:-

The Chairman will be an elected member of Leicestershire County Council's Cabinet.

The quorum for a meeting shall be a quarter of the membership including at least one elected member from the County Council and one representative of the Clinical Commissioning Groups.

Membership

The Board will keep its membership under review and make such changes as it feels necessary in accordance with Regulations.

County Council Lead Member for Health
County Council Lead Member for Adult Social Care
County Council Lead Member for Children & Young People
County Council Director of Public Health
County Council Director of Adults & Communities
County Council Director of Children & Family Services

Two representatives from each of the two Clinical Commissioning Groups in the Leicestershire County Council area
Two representatives of the Local Healthwatch
Two representatives of the District Councils
One representative from the Leicestershire and Lincolnshire Local Area Team of NHS England
One representative of the Leicestershire Constabulary
One representative of the Leicestershire Partnership NHS Trust
One representative of the University Hospitals of Leicester NHS Trust

This page is intentionally left blank