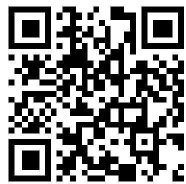


Meeting: **Cabinet**

Date/Time: **Tuesday, 1 April 2014 at 2.00 pm**

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

Contact: **Mr. B. Smith (Tel. 0116 305 6036)**

Email: **ben.smith@leics.gov.uk**

Membership

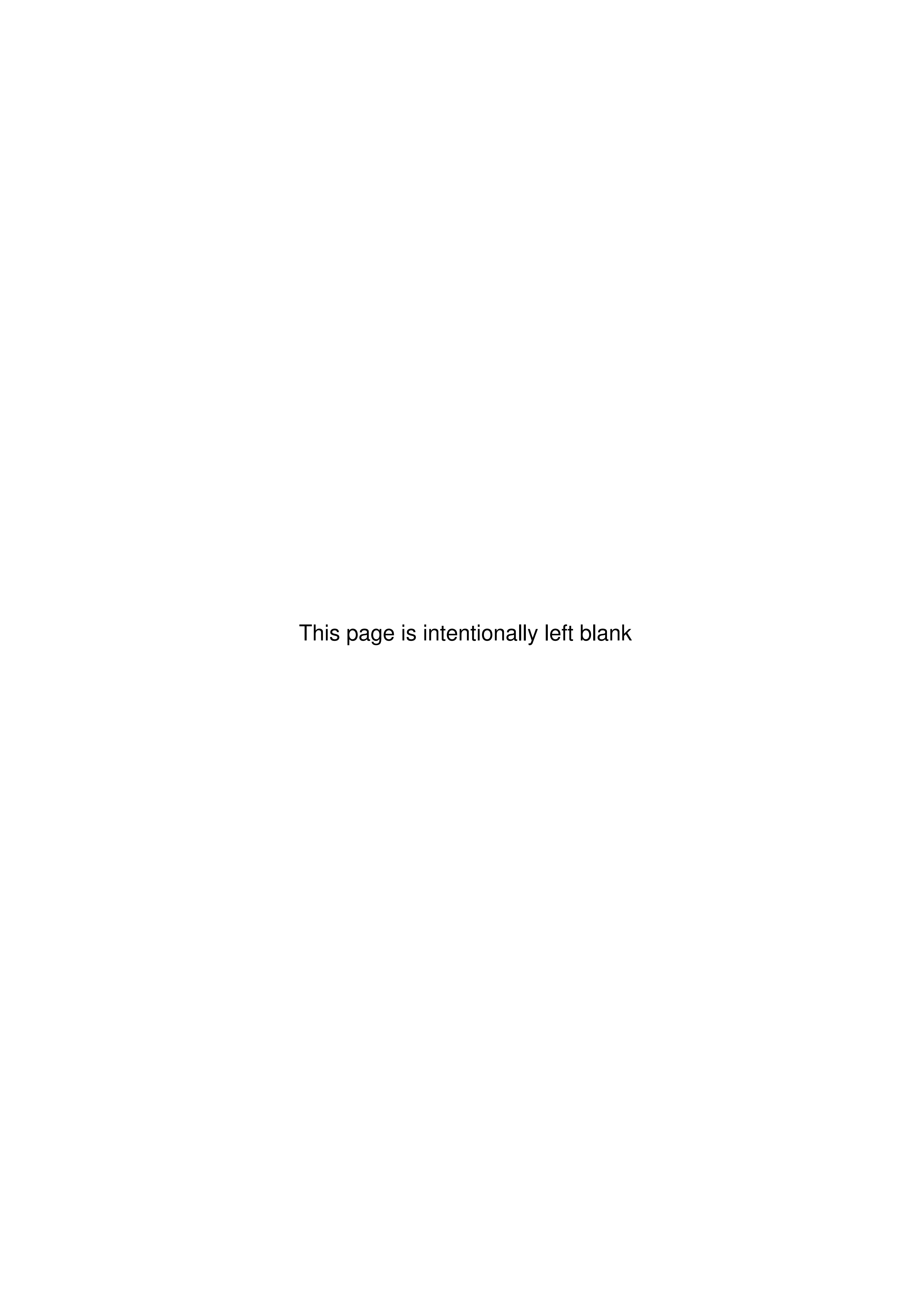
Mr. N. J. Rushton CC (Chairman)

Mr. R. Blunt CC	Mr. B. L. Pain CC
Mr. Dave Houseman MBE, CC	Mrs. P. Posnett CC
Mr. J. T. Orson JP CC	Mr. J. B. Rhodes CC
Mr. P. C. Osborne CC	Mr. E. F. White CC
Mr. I. D. Ould CC	

A G E N D A SUPPLEMENT

The following supplementary reports have now been published, agenda items 4 and 6 of the main agenda refers.

Item		Report by	
4	Leicester and Leicestershire City Deal.	Chief Executive	(Pages 3 - 8)
6	Better Care Fund Update.	Chief Executive	(Pages 9 - 152)



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Agenda Item 4

CABINET – 1 APRIL 2014

SUPPLEMENTARY REPORT OF THE CHIEF EXECUTIVE AND DIRECTOR OF CORPORATE RESOURCES

LEICESTER AND LEICESTERSHIRE CITY DEAL: LOUGHBOROUGH UNIVERSITY SCIENCE AND ENTERPRISE PARKS

Purpose of Report

1. To provide the Cabinet with an update on the signing of the Leicester and Leicestershire City Deal on 24 March 2014 and to seek approval for a contribution of £450,000 towards a package of funding of £7.4m to secure the development of an Advanced Innovation Technology Centre (ATIC) and associated infrastructure at Loughborough University Science and Enterprise Parks (LUSEP).

2. Reporting on this issue through a supplementary report, to that of the substantive item 4 on the agenda, has been necessary as the final contents of the City Deal were embargoed until 24 March after the publication of the papers for this meeting.

Recommendations

3. That the signing of the City Deal, and its final contents, be noted;

4. That £450,000 be provided from funds allocated within the County Council's Capital Programme as the Council's financial contribution towards a package that includes the provision of an Advanced Technology Innovation Centre and associated infrastructure at Loughborough University Science and Enterprise Parks; and

5. That delegated authority be given to the Chief Executive, following consultation with the Leader, to finalise and agree the terms under which the funding is provided.

Reasons for Recommendations

6. To ensure the Cabinet is aware of the latest position regarding the signing of the City Deal;

7. To enable the financing of the development of an ATIC and associated infrastructure at LUSEP; and

8. To ensure that the Council receives appropriate outcomes in return for its financial contribution.

Policy Framework and Previous Decisions

9. See paragraphs 5 to 12 of the main City Deal report on the agenda.

Resource Implications

10. The City Deal includes £2m of Government funding towards the expansion of Loughborough University Science and Enterprise Parks (LUSEP), as part of a wider funding package including a proposed contribution of £450,000 from the County Council. Provision has previously been made in the MTFS Capital Programme, approved by the County Council on 19 February 2014, for £1.5m to be utilised to support expansion of LUSEP.

11. The Director of Corporate Resources has been consulted on the contents of this report.

Circulation under Local Issues Alert Procedure

A copy of this report has been sent to all Members of the Council via the Members' News in Brief.

Officers to Contact

Tom Purnell, Acting Assistant Chief Executive
0116 305 7019 tom.purnell@leics.gov.uk

Elisabeth Carter, Strategic Property Manager
0116 305 6926 Elisabeth.Carter@leics.gov.uk

PART B

The Leicester and Leicestershire City Deal

12. The City Deal was formally signed between Government and local partners (including the Leader of the County Council) on 24 March 2014. The full City Deal document can be viewed at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/295280/Leicester_and_Leicestershire_City_Deal_Document.pdf

13. The City Deal includes proposals for a Leicester and Leicestershire 'to work' programme which will:
    - establish a case work support service that will provide personalised help for young people to give them the help they need to improve their education, seek training, secure an apprenticeship or get a job;
    - set up an Employment and Apprenticeship Hub that will drive up demand in local businesses for apprenticeships, traineeships and other national employment schemes;
    - create an innovative new employment and training scheme that will help 200 young offenders into work; and
    - establish local youth employment schemes that complement national programmes.

14. In addition it:
    - provides funding to support the expansion of LUSEP;
    - provides for a range of tailored business support programmes that will help grow small and medium enterprises; and
    - establishes a new pan-Midlands supply chain initiative that will support the growth of manufacturing and engineering small and medium enterprises.

15. The Government funding for LUSEP is £2m towards the provision of infrastructure to unlock 8 hectares of employment land alongside the development of an Advanced Technology Innovation Centre (ATIC). This forms part of a wider funding package including a proposed contribution from the County Council of £450,000. The following sections provide more detail on the proposal.

Loughborough University Science and Enterprise Parks

16. Loughborough University Science and Enterprise Parks (LUSEP) provides an exceptional opportunity for the Leicestershire (and UK) economy to develop an internationally significant centre for knowledge based employment. The Park is already one of the largest developments of its kind, with 63,000 sq m of high quality space. Additional University land holdings provide the opportunity to increase this space by 200%, creating as many as 4,000 additional jobs on site and investment (mostly private) of up to £200m. Planning permission is already

in place for 8 hectares of this land and a further 27 hectares is allocated in the emerging Charnwood Local Plan, where LUSEP is included as Policy CS 23.

17. The LUSEP vision is of a substantial and growing high quality facility, with clusters of knowledge based businesses in a range of sectors highly relevant to the UK, Midlands and Leicestershire economies, acting as powerful driver of growth and prosperity.

18. The expansion of LUSEP will support a range of national and local strategies and policy priorities. At national level, the need to build a knowledge-intensive and Research and Development led renewal of UK industry is well recognised. Whilst LUSEP will not in itself be a significant manufacturing base, recent developments highlight that future manufacturing locations may be clustered around knowledge centres. The attraction of locations of the very highest quality, like LUSEP, is recognised in relation to highly mobile research-led activities.

19. LUSEP will be attractive to activities that are either spun-out from the University or "spin-in" attracted by a location adjacent to the research and skills/workforce resources it provides. Intelligent Energy is a good example of a successful spin out, with approaching 300 staff and extensive lab facilities on LUSEP, and the Energy Technologies Institute's choice of Loughborough for its HQ illustrates the type of high quality activity attracted to such a site.

20. At sub-regional level, the development of LUSEP will make a major contribution to the realisation of the LLEP's Strategic Economic Plan (within which LUSEP is identified as a transformational priority) and the County Council's Economic Growth Priorities. The Park also features in the emerging Charnwood Local Plan as a key site for future economic growth.

21. The current University Strategy, Towards 2016, includes a clear statement of intent to develop LUSEP and to realise its full potential. It is anticipated that LUSEP will be one of the main priorities of the new University Strategy which will be launched on 7th April 2014.

22. The development of the Park can be seen in three phases:-

    Phase One: The initial development in 1992 was a stand-alone commercial development for British Gas with no University ownership or management. The University purchased the site in 2002 and began a process to develop a multi-occupancy Science and Enterprise Park, including both commercial and University uses.

    Phase Two: This relates to an additional 12 hectares of land secured in 2006 and 2007, including one existing development (4,000 sq m). A subsequent development of 6,000 sq m was opened in 2010. This development focussed on the business of sport, housing many national governing bodies, and more than 500 people are now employed at this site. Outline planning permission is in place for a further 8 hectares of development, and it is this land which will be unlocked and developed by the funding package associated with the City Deal and proposed County Council funding.

Phase Three: A further 27 hectares of University owned land is provisionally allocated for Science and Enterprise Park and university uses in the emerging Local Plan. This opens up opportunities for major inward investment. Additional land not in University ownership is also allocated for science and enterprise activities in the emerging Charnwood Local Plan, which will provide still greater opportunities for growth and further phases of development.

23. The development has reached a critical point and to achieve further development the next phase of the Park needs to be opened up. This presents significant cost challenges in terms of:(a) the advance provision of essential infrastructure, where up-front public investment is urgently needed to release the potential of the site; (b) developing a purpose-built innovation centre for new and high growth advanced technology businesses; and (c) being able to continue investment in the medium term as the need for “grow-on” space develops and opportunities for pre-let and inward investment developments arise.

24. The proposal is for a strategic investment that will both secure and accelerate the further development of the Park. The County Council’s contribution will form an essential component within a funding package that will provide infrastructure to open up 8 hectares of employment land, creating a number of “development ready sites”. This will have a transformational impact on the speed of development at LUSEP, and is a critical step towards creating up to 750 new jobs by 2020.

25. The overall package of funding will enable the construction of the Advanced Technology Innovation Centre (ATIC) with ERDF support which will bring forward opportunities for business growth and private sector employment that leverage the research and skills base of one of the UK’s leading Universities, and other higher education institutions, harnessing the UK knowledge base to increase competitiveness. This will lead to the creation of 3,000 sq m of employment space for more than 225 people, including 150 new jobs. Building the Advanced Technology Innovation Centre will also be a critical step in creating the pipeline of growing businesses that will populate LUSEP in future years.

26. The investment will also catalyse substantial future investment in further infrastructure developments and in the investment needed for grow on space. These are major investments (more than £50m by 2020, and in excess of £100m by 2025) that will lead to significant longer term outputs including more than 2,000 jobs by 2025. This illustrates that the package of funding is intended to act as a catalyst for further developments, with very significant economic and innovation benefits in the next five years and beyond.

27. The financial package for the project is:

Costs	
Innovation Centre	£4,916,000
Infrastructure developments	£2,600,000
Total Cost	**£7,516,000**

Funding	
University	£2,950,000
ERDF	£1,966,000
Leicestershire CC	£450,000
Charnwood BC	£150,000
City Deal	£2,000,000
Total Funding	**£7,516,000**

28. This package of expenditure will result in significant short, medium and long term benefits focussed around the growth of an outstanding centre for the development of R&D intensive businesses. In just five years the package of funding is forecast to have generated additional GVA of more than £58m (based on a recent independent report on the economic impact of the University and LUSEP), a multiplier of more than 3 on all investment and more than 7 on the additional cost of accelerating the programme.

29. Should Cabinet approve this proposal a funding agreement will be drawn up, setting out the terms and conditions upon which the funding from the Council would be provided. As part of that process the Council would ensure that compliance with state aid regulations and any other regulatory requirements are dealt with appropriately.

Equal Opportunities Implications

30. The City Deal seeks to strengthen the local economy to improve the economic and social wellbeing of residents. It will particularly seek to improve the employment prospects of those currently out of work and this is likely to benefit groups who are disproportionately affected by unemployment and worklessness.

Partnership Working and Associated Issues

31. Successful delivery of programmes and projects to support economic growth is dependent on collaborative partnership working across the functional economic area of Leicester and Leicestershire. This work is co-ordinated through the LLEP, within which the County Council is an active partner. LUSEP is a particular example of effective partnership working involving central and local government and higher education.

Agenda Item 6

CABINET - 1 APRIL 2014

SUPPLEMENTARY REPORT OF THE CHIEF EXECUTIVE

FINAL DRAFT OF THE LEICESTERSHIRE BETTER CARE FUND

Purpose

1. The purpose of this report is to present the final draft of the Better Care Fund Plan for Leicestershire and supporting papers as outlined in paragraph 5 of the main report to Cabinet.

Appendices

2. Appendix A is the Better Care Fund Planning Template – Part 1with supporting appendices 1, 3, 4 and 5. Supporting Appendix 2, the Plan on the Page, will be tabled at the meeting. This will be submitted to NHS England on 4th April.

3. Appendix B is the Better Care Fund Planning Template – Part 2, which will also be submitted to NHS England on 4th April

4. Appendix C is a supplementary briefing paper for the Health and Wellbeing Board on the Better Care Fund metrics and trajectories. It was agreed by the Integration Executive that this paper be submitted to the Board.

5. Appendix D is the Better Care Fund Spending Plan.

Recommendation

6. The Cabinet is recommended to:

   a) Support the Better Care Fund Plan attached to this supplementary report;

   b) Consider any comments it wishes to submit to the Health and Wellbeing Board, noting that it will be considering the Plan, for approval, subject to any final amendments to be made by the Chief Executive prior to its submission to NHS England on 4th April 2014.

Officer to Contact

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Director of Health and Care Integration (Joint Appointment)
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0116 305 4212
07770 281610

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APPENDIX A

Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission. Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net. To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	Leicestershire County Council
Clinical Commissioning Groups	East Leicestershire and Rutland CCG
	West Leicestershire 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 Council
Dates agreed at Health and Well-Being Board:	**13/02/2014 and 01/04/14**
Date submitted:	**14/02/2014 and 04/04/14**
Minimum required value of ITF pooled budget: 2014/15	**£2.012m**
2015/16	**£38.343m**
Total agreed value of pooled budget: 2014/15	**£18.251m**
2015/16	**£38.481m**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Dr Dave Briggs
Position	Managing Director, East Leicestershire and Rutland CCG
Date	02/04/14
Signed on behalf of the Clinical Commissioning Group	
By	Toby Sanders
Position	Managing Director, West Leicestershire CCG
Date	02/04/14

Signed on behalf of the Council	
By	John Sinnott
Position	Chief Executive, Leicestershire County Council
Date	02/04/14

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Cllr Ernie White, Chair, Leicestershire Health and Wellbeing Board
Date	02/04/14

c) Service provider engagement
Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

The leaders of the Leicester, Leicestershire and Rutland (LLR) health and care economy have recently developed an overarching vision setting out the changes needed in the local health and care system over the next five years.

This work involves all partners including providers and will culminate in publishing a five year strategy by June 2014.

The five year strategy will set out how partners will:

- Address rising demand
- Reduce pressure on acute care
- Provide more integrated and coordinated support in community settings
- Prevent unnecessary hospital admissions
- Offer more effective hospital discharge
- Reconfigure services to support the improved pathways of care

The programme of work to deliver the vision is already underway with all local providers, commissioners and many other stakeholders actively involved.

Leicestershire's Better Care Fund Plan (BCF) forms an important component of the LLR five year strategy.

The development of the Leicestershire BCF has been led by Leicestershire's Health and Wellbeing Board in the context of the LLR-wide strategy and the Joint Health and Wellbeing Strategy for Leicestershire.

In terms of provider engagement the Leicestershire BCF has been developed in conjunction with University Hospitals of Leicester (UHL), District Councils including housing providers, the social care providers at Leicestershire County Council, and Leicestershire Partnership Trust (LPT), all of whom are represented at the Health and Wellbeing Board.

The Leicestershire BCF plan demonstrates that partners have jointly agreed:

- A number of immediate priorities to transform the health and care system in the Leicestershire's communities over the next two years
- How the funds available will be used to support these changes
- The rate of improvement we aim to achieve against the six metrics within the BCF plan
- The impact on the activity and financial assumptions for providers as a result of these changes. This has been demonstrated by factoring these assumptions into the QIPP plans of CCGs and providers, and into the contract negotiations with providers.

The two year Leicestershire BCF plan comprises a combination of existing and new developments all of which will be progressed jointly between commissioners and providers across the whole system of health and care locally.

The Plan will:

- Consolidate, integrate and extend community based care for local people, to avoid unnecessary admissions to hospital and improve integrated care across all care settings
- Deliver some important new developments, such as the introduction of 24/7 integrated community services with a two hour response time, a new approach to prevention in Leicestershire's communities, and new care pathways for the care of frail older people

Multi Agency Workshops Involving Providers

Since the draft BCF submission on 14th February two significant elements of additional work have been completed, with the full involvement of providers. These are as follows:

- **Multi Agency Risk Workshop** – this session involved reviewing the draft BCF risk analysis, developing principles for the pooled budget and discussing the issues and workplan for the development of a section 75 agreement.

- **Multi Agency Impact Analysis workshop** – this session involved reviewing the proposals within the BCF in terms of their evidence base and benefits analysis, confirming and challenging the assumptions, understanding the metrics in more depth, the individual and collective contribution of schemes to one or more of the metrics, the trajectory of improvement anticipated.

Recommendations arising from both workshops have been used in finalising the BCF submission documents for 4th April.

Individual meetings and briefings with providers have also taken place during the period to develop the draft BCF Plan submission so that the overall BCF plan and its impact across the system is widely understood and the products are co-produced.

Governance Arrangements and Provider Involvement

The Terms of Reference for Leicestershire's Health and Wellbeing Board have been refreshed so that representatives from UHL and LPT became members of the Board with effect from February 2014.

UHL and LPT were therefore directly involved in the Health and Wellbeing Board's discussions and decision to approve the draft and final submissions of the BCF at the HWB meeting on 13th February and 1st April, as full members of the Board.

Introduction of the Multi-agency Integration Executive

From March 2014 a new Integration Executive has been created to oversee the programme of work to integrate health and care services in Leicestershire including providing strategic oversight and assurance to delivery of the BCF plan.

The representatives on the Integration Executive include providers such as UHL, LPT and the East Midlands Ambulance Service (EMAS).

The Integration Executive will meet monthly and report to the Health and Wellbeing Board.

From April 2014 an operational level group to oversee the day to day delivery of the components of the BCF will also be in place. This will be Chaired by the Director of Health and Care Integration, and will also have provider representation.

d) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

In December 2013 at a Leicestershire Health and Wellbeing board development session, all partners agreed to adopt the National Voices principles and definitions for integration, reflecting the engagement with, and feedback from the public, that was achieved nationally during their development.

Patient, service user and public engagement in the development of the BCF Plan has involved a number of channels and there has been close, ongoing involvement of Local Healthwatch (LHW) in shaping and influencing the BCF Plan for Leicestershire throughout.

Summary of engagement to date:

- NHS Call to Action events
- The Council's consultation with the public about its future budgetary plans
- LHW public consultation to shape priorities for their 2014/15 workplan. The respondents to this consultation cited improving integration across health and care services as their top priority (66% of respondents).
- A launch event for the LLR five year strategy was held in January 2014.
- In order to engage further on the specific BCF plan proposals we also held a stakeholder event with the support of Local Healthwatch on 24th February. The purpose was to seek feedback on the progress to date with the Joint Health and Wellbeing Strategy and the emerging proposals in our BCF plan. **Appendix 1** to this template summarises the feedback from this event which has informed the final submission.

Future engagement plans

- The development of the LLR five year strategy for health and care transformation will involve a coordinated engagement plan with the public over coming months.
- The Leicestershire Health and Wellbeing Board in conjunction with LHW will develop a range of channels and mechanisms for engaging on the specific changes affecting health and care services in the county of Leicestershire.
- The Leicestershire Health and Wellbeing Board complies with the Public Sector Equality Duty and will ensure it gives 'due regard' in its decision making to the outcomes from public consultations and associated Equalities and Human Rights Impact Assessment.
- An early output to support our emerging communication and engagement plan is the development of the "BCF plan on a page" shown at **Appendix 2** to this submission – this is an easy read visual aid to the components of the BCF plan.

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Joint Strategic Needs Assessment	http://website/healthwellbeingboard.htm
Joint Health and Wellbeing Strategy	http://website/healthwellbeingboard.htm
ELRCCG Operating Plan	Links will be shown here when documents are finalised
WLCCG Operating Plan	
LLR Five Year Strategy Vision and Goals	
LCC MTFS	

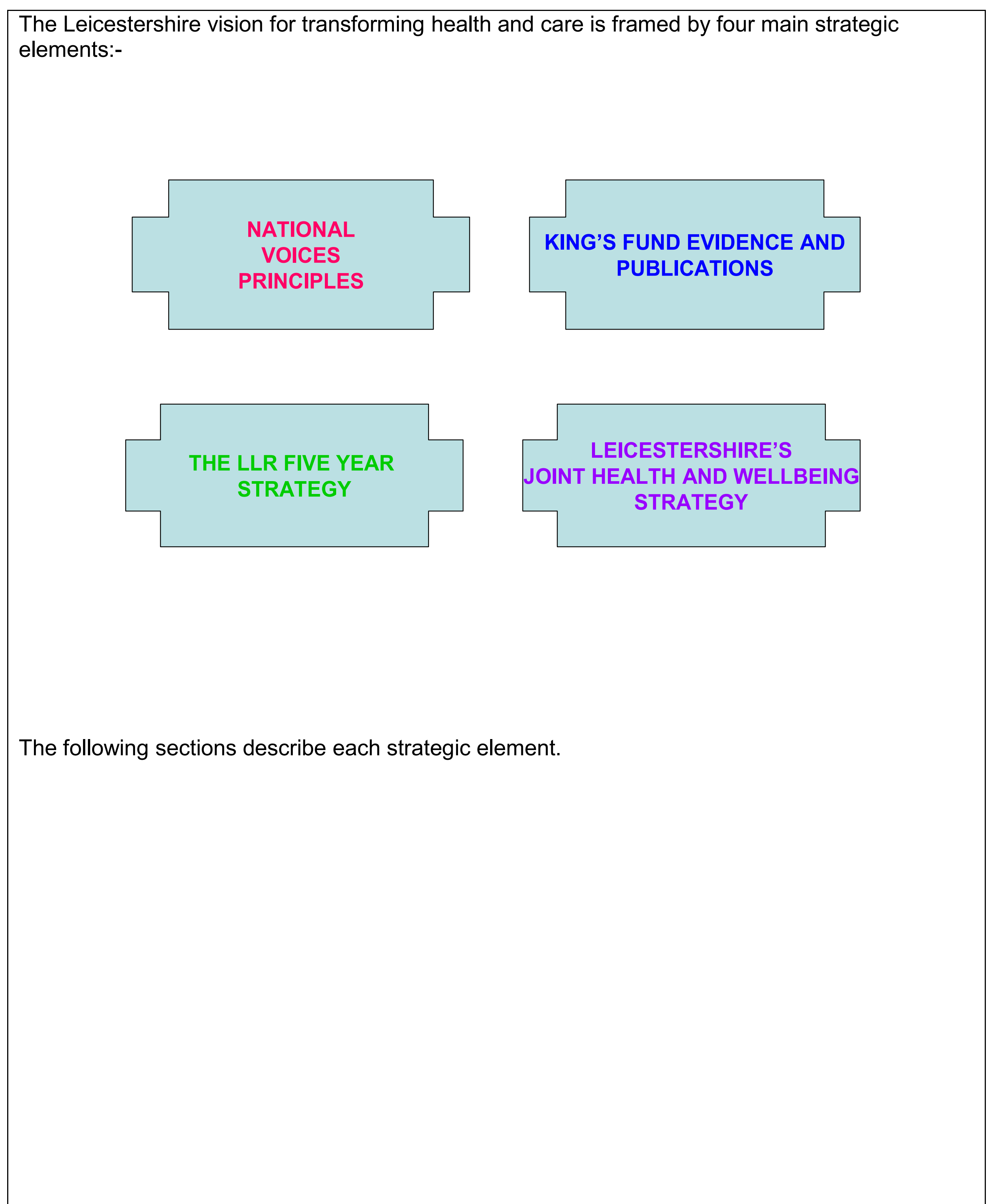
2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

The Leicestershire vision for transforming health and care is framed by four main strategic elements:-



The following sections describe each strategic element.

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

In December 2013 the Leicestershire Health and Wellbeing (HWB) Board held a development session to consider collective commissioning intentions for 2014/15 in the context of the national policy developments for integration and the BCF plans.

At this session partners considered the principles and narrative for integrated care developed by National Voices who were seeking wide support for the principles from commissioners and other stakeholders. As a result, Leicestershire HWB Board agreed to:

- Adopt the principles – see box below
- Ensure the principles underpin our approach to integration including the development of the BCF Plan

- I tell my story once
- I am always kept informed of what the next steps will be
- I always know who is coordinating my care
- I have one first point of contact
- I can see my health and care records at any time
- I know how much money is available to me for care and support and can determine how this is used.

The King's Fund	KING'S FUND EVIDENCE AND PUBLICATIONS

The work of The King's Fund has informed our vision for integration and the development of the BCF Plan in two key ways:

1. The core elements of integrated care
2. The evidence base for integrated care interventions

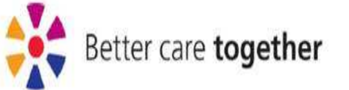
The Core Elements of Integrated Care

In line with The King's Fund recent report "***Making our health and care systems fit for an ageing population"***, http://www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population partners in Leicestershire have a clear view of the core elements of integrated care that should be in place to provide the optimum system of health and care - as illustrated in this diagram, taken from The King's Fund Report

Leicestershire partners agree that if care and support is designed and structured more effectively to meet the needs of the ageing population, it will also be planned and delivered more effectively for many other parts of the population, such as those under 65 who need support following surgery or illness, those who have a long term condition, or are at risk of developing a long term condition in later life.

Understanding and Applying the Evidence for Integrated Care

The BCF evidence summary provided by The King's Fund
http://www.kingsfund.org.uk/publications/making-best-use-better-care-fund
has been used to consider the anticipated impact of the interventions and care pathway changes proposed in the Leicestershire BCF and to test our ability to improve our performance against the six metrics in the BCF plan. An initial impact assessment was completed in March 2014 and further work on this has been factored into the programme plan for the Integration Executive in Q1 of 2014/15.



THE LLR FIVE YEAR STRATEGY

The LLR vision is:

To maximise value for the citizens of Leicester, Leicestershire and Rutland (LLR) by improving health and wellbeing outcomes that matter to them, their families and carers in a way that enhances the quality of care at the same time as reducing cost across the public sector to within allocated resources by restructuring the provision of safe, high quality services into the most efficient and effective settings.

The LLR Five Year Strategy sets out:

- The overall direction for the models of health, care and support services that will need to apply in five years time across the whole health and care system operating in LLR
- The steps needed to realise that vision; and
- A roadmap to better outcomes for our citizens.

Delivering the LLR Strategy

The LLR strategy must be delivered in an integrated way, so that we together:

- Enhance the quality of care, at the same time as reducing cost across the public sector, to within allocated resources
- Manage demand and restructure the provision of safe, high quality, services into the most efficient and effective settings

Therefore:

- Each of the Joint Health and Wellbeing Strategies of the three Health and Wellbeing Boards in LLR will be informed by the LLR strategy and roadmap, tailored to the needs of their specific populations.

- Each of the operating plans of the respective NHS organisations and Local Authorities will reflect the roadmap for improving health and care in LLR, so that locally everyone will deliver on the important changes for which they are individually and jointly responsible.

The emerging LLR five year strategy is readily aligned to Leicestershire's current Joint Health and Wellbeing Strategy and BCF plan, due to the emphasis across the system on reducing avoidable admission to hospital, with the redesign of alternative pathways and prevention outside of hospital settings.

In Leicestershire we now have the benefit of much stronger connections and strategic alignment into this larger unit of planning, and it is becoming clearer how our local Joint Health and Wellbeing Strategy and BCF plan will contribute to the overall shift of activity from acute to community settings which is planned at scale across LLR, over the five year period.

LEICESTERSHIRE'S JOINT HEALTH AND WELLBEING STRATEGY	

Overall Goal:	To Be Achieved By:
"Add quality and years to life" http://www.leics.gov.uk/leicestershire_health_well being_strategy.doc	• **Improving health throughout people's lives,** • **Reducing health inequalities** • **Focusing on the needs of the local population.**

To deliver Leicestershire's Joint Health and Wellbeing Strategy the following four priorities have been identified,

Getting it right from childhood

Managing the shift to early intervention and prevention

Supporting the ageing population

Improving mental health and wellbeing

The strategy also has cross-cutting theme as follows:

- Tackling the wider determinants of health by influencing other Boards

Overall, the successful delivery of our Joint Health and Wellbeing Strategy, and the LLR five year strategy are dependent upon the ability of partners in Leicestershire to focus on shifting activity from acute to community settings and achieve greater integration of care for local citizens.

The key to success in Leicestershire is the local translation of the LLR strategy and road map into the most effective practical changes that will transform the way care is delivered, and that the leaders of the health and care economy drive change on the ground towards shared outcomes. The BCF is therefore a real opportunity to demonstrate how we can target local resources to achieve greater integration, transform services and make measurable impact on the outcomes that matter most for local people.

Leicestershire's Vision for Integrated Health and care 	**We will create a strong, sustainable, person-centred and integrated health and care system which:** • **Meets future demands** • **Supports the LLR five year strategy** • **Improves outcomes for the local population**

What changes will we deliver through the BCF Plan and what will local services and support look and feel like in the future as a result

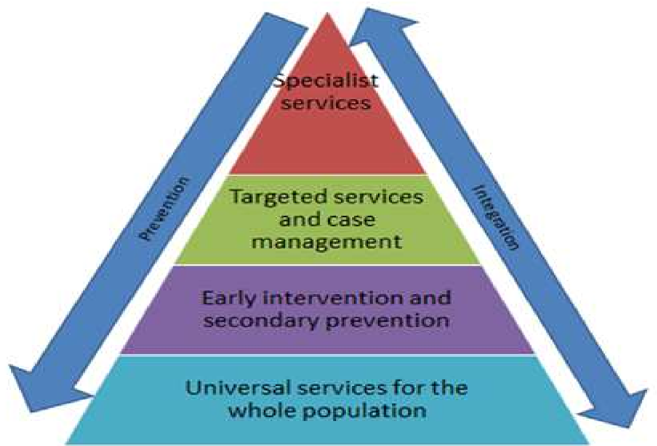
People rarely need support from a single service as they age, or if they are vulnerable through ill health, disability, injury or social exclusion/isolation. They have told us that they find it difficult to navigate between services and feel that there are many barriers in the way as they move between health, social care and other statutory services.

These barriers are simply not understandable or acceptable to the population we serve. A key feature of this plan is to address this, and support people and communities much more effectively so that when people are in need of information, support or services to maintain or improve their health and wellbeing, local partners will:

- Deliver this support in a co-ordinated way across agencies
- Provide this support as early as possible, anticipating future needs, as well as dealing with immediate needs in the most appropriate setting.

Ultimately our BCF plan aims to provide a very clear articulation of the menu of services, information and support available to the public, and make this menu more understandable and accessible, particularly in community settings.

The Leicestershire BCF plan is based on improving how citizens access information, support and services and how these are designed across the stepped pyramid of care illustrated in this diagram.



There will be clear integrated service offers at each layer of the pyramid, operating across organisational boundaries, with a view to coordinating care for individuals, carers and families. We will design service offers that maintain people at the lowest possible level of the pyramid according to their needs, so that progression up the pyramid is avoided/delayed wherever possible and admission to specialist services is only undertaken when absolutely necessary.

Over the next two years we will work towards achieving an integrated health and care system through:

- Providing focused leadership to integration across organisational boundaries.
- Building on existing priorities and current work, where we can see measurable impact.
- Aligning our plans across the system of health and care.
- Streamlining and focusing our efforts on tackling a smaller number of areas.
- Identifying those citizens at greatest risk and supporting them to maintain or regain their independence which will reduce their reliance on more costly interventions.
- Adopting a whole system approach to pathway re-design (patient journey) ensuring integration of planning, commissioning and delivery is considered where appropriate.
- Improving the customer experience through driving up quality and performance.
- Delivering efficiencies through developing more effective and streamlined practices and processes.
- Integrating care records and using more integrated technology to support joint care plans.

b) Aims and objectives
Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

The implementation of the Better Care Fund marks an important milestone in the relationship between local partners.

It presents a huge opportunity to make lasting and fundamental changes to the way we work together, for the benefit of local people and the public purse.

The aim of the BCF plan is to deliver important improvements to the way we collectively offer care and support to local citizens. To do this, we are making stepped changes to both the composition and capacity of local, integrated, community based services so that avoidable pressure on hospital care is reduced. Our BCF Plan contains four themes as shown below:

Unified Prevention Offer for Leicestershire's Communities	**Integrated, Proactive Care for those with Long Term Conditions**
Bring together prevention services in Leicestershire's communities into one consistent offer, including housing expertise and support to carers Provide better coordination in communities of this offer so that local people have easy access to information, help and advice.	Scale up the support already offered by primary and community care services for patients with long term conditions/the frail order – including through: • The introduction of case management for the over 75s • Changes to how records and data are shared between agencies and with patients so that ongoing care is planned more effectively and changes in needs/care plans can be anticipated and addressed earlier.

Integrated Urgent Response	**Hospital Discharge and Reablement**
Introduce an integrated two hour community services response, to avoid unnecessary hospital admissions for those who need urgent assistance Introduce seven day working in GP practice which integrates effectively with community based health and care services, both in and out of hours Implement an integrated service for frail older people	Make significant improvements in the timeliness and effectiveness of discharge pathways from hospital, especially for frail older people. Consolidate, integrate and extend a number of Leicestershire's existing community based services into one 24/7 service operating across health and social care, with a single point of access - to focus on maintaining independence in the community for as long as possible

Measuring the impact of the BCF Plan

Since the original BCF submission on 14th February 2014 a detailed impact analysis has been undertaken of the components of the BCF plan per the (five) national and (one) local metrics, against which delivery of the BCF plan will be assessed.

The impact assessment was the subject of a multiagency workshop to confirm and challenge the plan, held on 12th March 2014.

As a result of implementing our BCF plan we expect to see:

	A reduction in hospital bed days due to discharge being delayed
	A reduction in avoidable hospital admissions
	To Be Confirmed
	More support in the community including preventing falls
	More people receiving help to recover at home
	Less people going into nursing and residential care

The following sections explain the definition of each metric, and the rate of improvement we are aiming for in each case, over the two year period.

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 proposed trajectory is for a reduction from 762.73 permanent admissions per 100,000 population per year to 718.74 (or 5.77%) by 31st March 2015

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 proposed trajectory is for an increase from 78.22% of service users still at home 91 days after discharge to 82.19% (or 5.08%) by 31st March 2015.

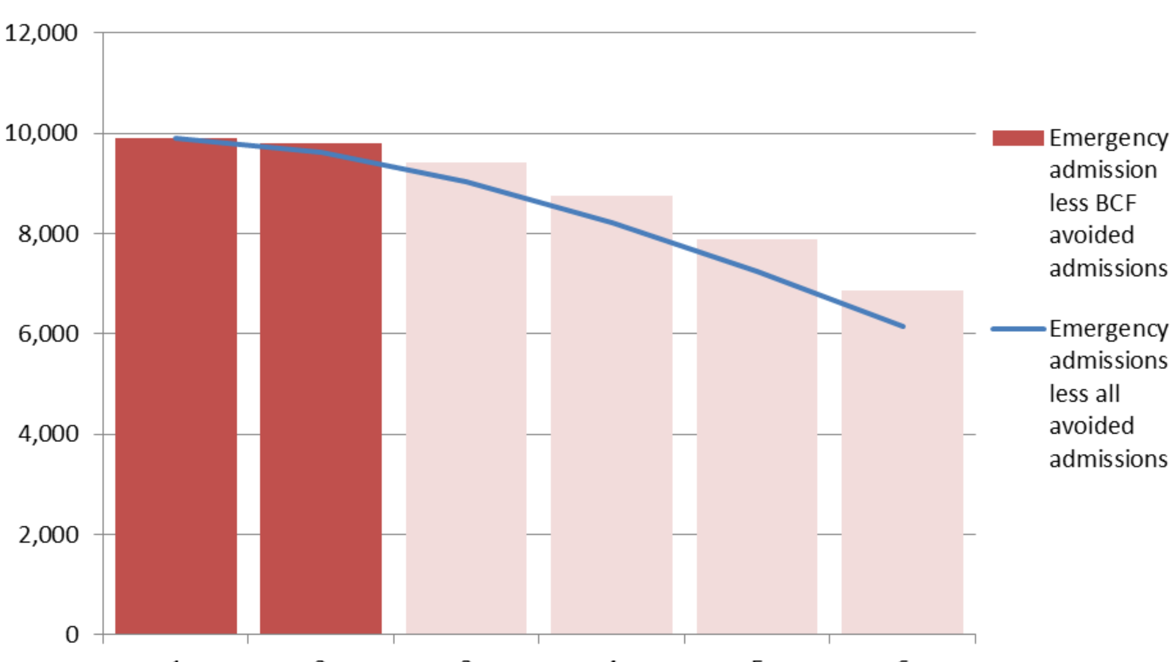
National Metric (3)	Definition	Trajectory of improvement
Delayed transfers of care from hospital per 100,000 population (average per month)	This is a nationally defined metric measuring delivery of the outcome of effective joint working of hospital services (acute, mental health and non-acute) and community-based 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.	The proposed trajectory is for a decrease from a baseline of 292.71 delayed bed days per 100,000 per month to 288.18 (1.55%) by 31st December 2014 followed by a further reduction to 287.67 (0.18%) by 30th June 2015.

National Metric (4)	Definition	Trajectory of improvement
Avoidable emergency admissions	This is a nationally defined metric measuring delivery of the outcome to reduce avoidable emergency admissions which can be influenced by effective collaboration across the health and care system. This is a composite measure of: Unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages) Unplanned hospitalisation for asthma, diabetes and epilepsy in children Emergency admissions for acute conditions that should not usually require hospital admission (all ages) Emergency admissions for children with lower respiratory tract infections	The proposed trajectory is for a decrease from a baseline of 124.12 emergency admissions per 100,000 per month to 121.69 (1.96%) by 30th September 2014 and then remaining the same at 121.69 until 31st March 2015.

Avoidable Emergency Admissions – supplementary information

The two CCGs in Leicestershire have set out a combined trajectory to reduce avoidable emergency admissions by 15% by 2018/19. Only a proportion of this trajectory is to be achieved by the schemes in the BCF, with a selection of other parts of CCG commissioning plans impacting on the remainder of the trajectory.

The overall trajectory to reduce avoidable emergency admissions over the five year period is illustrated in the graph below in (one colour) with the BCF contributing elements shown in (another colour)



In 2014/15 a 3% combined reduction in emergency admissions is based on the impact that can be achieved via a full year effect through the following interventions:

- Implementation of Intensive Community Support (Virtual Beds)
  - 48 beds for ELRCCG and 48 beds for WLCCG.
  - WLCCG beds in place from April 2013
  - Phased implementation of ELRCCG beds commenced in October 2013, with all 48 virtual beds fully operational from December 2013.
- Implementation of CRS (Social Care Crisis Response Service) – phased implementation from September 2013
- Proactive Care WLCCG – Risk Stratification and case management approach to LTC patients within a primary care setting
- Integrated Care Model ELRCCG – Risk Stratification and case management approach of patients identified at medium risk using the risk stratification model - the model was fully rolled out across from January 2014
- Children's community nursing pilot – commenced late 2013.
- COPD Scheme
- CVD Scheme
- Single Front Door (A&E)

Through the BCF plan we have set out how we plan to expand on the existing platform of integrated community services in Leicestershire e.g. by the introduction of the integrated two hour urgent response, and developing a business case to improve the integrated care of frail older people.

The impact of these further interventions, will allow for increasing levels of ambition with a stretch applied to the trajectory from 2015/16 onwards.

National Metric (5)	Definition	Trajectory of Improvement
Patient / service user experience	TBC This will be a nationally defined metric however, at the time of writing this paper the guidance confirming the definition of the metric has not be released. The outcome will be to demonstrate local population/health data, patient/service user and carer feedback has been collated and used to improve patient experience. To provide assurance that there is a co-design approach to service design, delivery and monitoring, putting patients in control and ensuring parity of esteem.	**TBC**

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 due to falls in people aged 65 and over	The proposed trajectory is for a decrease from a baseline of 168.20 emergency admissions per 100,000 per month to 162.17 (3.58%) by 31st March 2015 followed by a slight increase to 162.21 (0.02%) by 30th September 2015. *This metric is being reviewed following the proposal to introduce an additional falls prevention scheme within the BCF in association with East Midlands Ambulance Service. The evidence from other areas suggests the trajectory can be significantly improved with the introduction of this service and this trajectory will be re-modelled in Q1 2014/15 accordingly.*

In addition to the six metrics above, the BCF Plan will also drive the following improvements in terms of length of stay:

- A reduction in the number of people whose length of stay is 15 days or greater.
- A reduction in the time between a patient being assessed as medically fit for discharge and the time that they are discharged.

Further work will be completed in relation to the overall impact on length of stay in the BCF as part of the work to develop a business case for an integrated service for frail older people.

The work completed on impact analysis for the BCF to date has also indicated that further work is needed to validate/develop performance indicators for each component of the BCF so that the contribution of individual interventions in the BCF against the six top line metrics can be evidenced more effectively. This work has been factored into the BCF programme plan.

Appendix 3 shows a more detailed breakdown against each of the metrics in support of this submission. This includes a table which illustrates which BCF component schemes we consider will have the greatest impact on each of the six metrics.

What measures of health gain will you apply to your population?
The measures of health gain will be those linked directly to the outcomes within our LLR-wide strategy and the Joint Health and Wellbeing Strategy for Leicestershire which map across as shown in the table below. These are associated primarily with delivering improved outcomes for those with specific LTCs and frail older people, the impact on their associated mortality rates, and measures of quality of life such as maintaining independence, and the impact on health inequalities. Results will be achieved by significant improvements in prevention, proactive care, and care coordination for the local population, by developing a fully integrated health and care system by 2018.

LLR Wide Strategy Priorities *(Provisional)*	**Leicestershire's Joint Health and Wellbeing Strategy Priorities**	**BCF Themes**
Respiratory Disease	Supporting the ageing population Managing the shift to prevention and early intervention Getting it right from childhood	Unified prevention offer LTCs Integrated urgent response Hospital discharge and reablement
CVD	Supporting the ageing population Managing the shift to prevention and early intervention Getting it right from childhood	Unified prevention offer LTCs Integrated urgent response Hospital discharge and reablement
Cancer	Supporting the ageing population Managing the shift to prevention and early intervention Getting it right from childhood	Unified prevention offer LTCs Integrated urgent response Hospital discharge and reablement
Mental Health & Substance Misuse	Improving mental health and wellbeing Managing the shift to prevention and early intervention Getting it right from childhood	Unified prevention offer Hospital discharge and reablement
Dementia	Supporting the ageing population Improving mental health and wellbeing Managing the shift to prevention and early intervention	Unified prevention offer LTCs Integrated urgent response Hospital discharge and reablement

The delivery of the outcomes in our Joint Health and Wellbeing Strategy, and the LLR-wide strategy, are also supported by the significant investment in primary prevention through services commissioned by Public Health (e.g. smoking cessation, obesity and physical activity programme).

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery (see below)
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care *(see pages 3, 34-36 and pages 43-44).*

A Unified Prevention Offer for Leicestershire's Communities

Intervening early can have a major impact on the health of individuals and prevent or reduce the need for more costly care later on.

In Leicestershire, prevention is a key strand of our Health and Wellbeing strategy, and our delivery model per the care pyramid. It is also an area where we believe collaboration is key to achieving successful outcomes and a greater quality of life for the citizens in Leicestershire.

We have considered evidence from other communities (e.g. Derby), where prevention is more targeted, consolidated and cost effective, through for example, Local Area Coordination, and we can see opportunities to achieve these benefits in Leicestershire.

By investing in the bottom tier of the care pyramid as a priority we are also providing the necessary infrastructure for other elements of the BCF plan to function effectively.

What do we want to achieve?

We want people and communities to:

- Be able to access a range of support early, through social and community networks
- Be empowered to take control of their health and wellbeing
- Live healthier and independent lives
- Maintain their independence within their community for longer.

By 2018 we aim to 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 the NHS.

By investing in prevention we expect to see a reduction in the number of people accessing services in crisis or inappropriately and when people have a need for a health or care intervention that they can quickly return to their optimum independence within a supportive community.

We already have local examples of where this has proved successful including support to Carers, Supporting Leicestershire Families, First Contact and Housing related support for older people.

However in order to feel confident that we are reaching more vulnerable people in time to make a difference - both to them as individuals and their impact on the health and care system - we need to consolidate our efforts and raise our ambition.

We are already investing part of the current social care allocation in a menu of prevention services. It is important that we continue to fund some of these services whilst we plan for a new model. These include the existing services to carers, extra care housing for older people and timebanking.

Last year we worked with the Chartered Institute for Housing and our District Councils Housing colleagues to look at what housing has to offer around promoting and supporting positive health and wellbeing.

This has led to a number of opportunities for further work around Disabled Facilities Grant (DFG), aids and equipment, and home improvement, which have been incorporated into the overall BCF prevention plan.

How will the Unified Prevention component of the BCF Plan deliver improvements and what are the initial milestones
(Please refer also to the high level programme plan at **Appendix 4**)

The initial part of the BCF prevention plan will involve:

1. **Extending the existing carers health and wellbeing support programme** across all GP practices in the county

2. **Scoping the new unified prevention offer (leading to an outline business case)** including:
    - Understand all the prevention services and resources currently available from all partners
    - Examine the evidence in terms of proven interventions elsewhere, such as Local Area Coordination
    - Examine how we can achieve greater integration of the prevention offer for those who present at the emergency department, or in crisis, so that where applicable citizens can be diverted to appropriate community based support, linking with the other priorities and care pathways in the BCF plan.
    - Examine how greater integration of housing support can be achieved in our prevention offer (see 4.1.3 below)
    - Agreeing how the model needs to change and become a unified offer

Our programme plan shows we intend to have completed the outline scope and outline business case by Q1 2014/15

3. **Implementation plan will follow** - to include:

- Testing the concept and model of Local Area Coordination in Leicestershire. This will introduce a new model of support for vulnerable people which focuses on identifying and supporting those who need help before they hit crisis, and working towards building an inclusive resilient community around them.

- We aim to test the model to support vulnerable people, those with Long Term Conditions, and to meet the differing needs of those in rural and urban areas.

- Assessing the contributions that stakeholders will make to the BCF budget for 2015/16

- Launching the new prevention offer/model

- If proved effective, implementation will include rolling out Local Area Coordination to the remaining areas. This will be a phased implementation which will allow the model to be evaluated, and lessons learned to be incorporated in the roll out.

Unified Prevention Offer: Integrating Housing

Housing professionals and our Health and Wellbeing Board recognise the potential that housing services have to deliver better health and social care outcomes. Everyone is fully engaged in shaping and delivering different ways of working in Leicestershire to achieve this, including a range of housing providers who have been actively engaged in our work to date.

In 2013, we worked with the Chartered Institute of Housing to identify the “Housing Offer to Health.” As a result, Leicestershire’s approach to prevention will include implementing an integrated offer of housing support targeted to improve health and wellbeing in our communities.

Using our current First Contact scheme and the proposed Local Area Coordination approach described above, we can reduce demand on other services such as GPs and hospital care by effectively signposting to practical housing advice and interventions across multiple agencies, using one referral form. This will pick up important interventions such as Keeping Warm and Well at Home, and providing a range of practical support to older and vulnerable people.

Our aim is to reduce emergency admissions and prevent delayed hospital discharge through primary prevention focused on housing support. Our BCF plan for Integrating Housing as a key part of prevention therefore focuses on two main areas as illustrated in the table below:

A consistent housing improvement offer across Leicestershire	This will provide practical support for both self funders and those eligible for statutory support so that aids, equipment, adaptations, handy person maintenance services and energy efficiency interventions are readily and rapidly available across all tenures, including via statutory assessments by occupational therapists and for those accessing DFGs. This will reduce the time taken to provide practical help to individual service users, reduce process costs for services paid for through the public purse and support vulnerable people to access the low level practical support that helps them remain independently at home. Existing funding streams which could be redirected to deliver this service, including the DFG funding, will be scoped in 2014/15, and the service developed through negotiations and business case proposals.
Housing as an Integral part of care planning - e.g. all planning and decisions around an individual’s hospital discharge will include early consideration and action regarding appropriate and supportive housing options.	Housing will become much more clearly linked to all aspects of the BCF and its priority care pathways. Partners will work collaboratively to identify and deliver housing solutions to prevent delayed hospital discharge, support reablement, offer an urgent response to avoid admission, including via the emergency department, and to maintain the independence of those with Long Term Conditions for as long as possible. We will build health, social care and housing considerations into assessments of a customer’s needs right from the start, in a way that recognises the potential of appropriate housing and housing based support in delivering independence and reducing whole system costs. The specific needs of those with mental health problems are also being considered with a number of local solutions being discussed across LLR. This is also a critical part of the housing offer, given the increased emphasis nationally on parity of mental health with physical health, and locally due to the trends in occupancy and delayed transfers of care experienced over the last two years for mental health patients.

Unified Prevention Summary Table

Leicestershire Better Care Fund Plan	***New or Existing***	***Investment 2014/15 £000's***	***Investment 2015/16 £000's***	***Metrics***	***Metric Symbols***
First Contact	Existing	159	162	4,5	
Carers Services	Existing	370	450	1,5	
Time Banking	Existing	72		5	
Advice and Information	Existing	4		5	
Carers Assessments (Care Bill Implications)	New		275	1,5	
Specialist support to people with Dementia & Carers	Existing	294	320	5	
Strengthening Autism Pathway	Existing	163	95		
Assistive Technology	Existing	984	995	1,5,6	
Assistive Technology – replacement equipment	Existing	1,444			
Local Area Co-ordination	New	240	600	4,5,6	
Housing Offer – Disabled Facilities Grants	New		1,739	1,5,6	
		3,730	**4,636**		
Protection of Services					
NHS – LD Short Breaks	Existing		844	5	
		3,730	**5,480**		

Key to metrics

1. Permanent admissions of older people (aged 65 and over) to residential and nursing homes, per 100,000 population.
2. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.
3. Delayed transfer of care from hospital per 100,000 population (average per month).
4. Avoidable emergency admissions (composite measure).
5. Patient/service user experience
6. Injuries due to falls in people aged 65 and over

Integrated, Proactive Care for those with Long Term Conditions

Both local Clinical Commissioning Groups have developed effective models of care to support people with long term conditions to maintain the maximum level of independence and self care that they can.

This involves risk stratification and care planning, with primary and community based support planned around the patient, carer and family.

Care plans “step up” care when needed to support through period of crisis or increased need and “step down” care when the person stabilises or needs decrease.

Further integration of pathways, data, records, technology and, where appropriate, services, are the key to improving our local service offer to patients with Long Term Conditions

In order to transform primary care services and respond to the challenge of case management of patients over 75s, the CCGs are further developing their plans to enable primary care to proactively manage patients with multiple morbidities and those that are at the end of their lives. This includes the local plans for extending primary care services across the seven day period.

Releasing time for primary care to undertake a co-ordinated multidisciplinary approach to patient care is a key enabler to improved system management of patients that are complex and have multiple health and social care issues.

Leicestershire CCGs are also working with local authorities and other health partners to establish effective systems to deliver personal health budgets to individuals eligible through the NHS Continuing Health Care (CHC) process, with a view to the extension of this approach to those with LTCs in line with national policy implementation timescales.

An LLR steering group has been established to plan and develop policies and procedures for implementation for on-going management of personal health budgets. Membership includes health and social care representatives.

National timeline:

- April 2014 - those in receipt of CHC have the right to ask for a personal health budget
- October 2014 - those in receipt of CHC have the right to have a personal health budget
- October 2015 - those with long term conditions will be able to have a personal health budget (further guidance pending).

By putting in place:

- A more accessible, unified prevention offer
- Enhanced, multidisciplinary integrated care on a 24/7 basis
- Integrated crisis response within two hours
- Case management for those over 75 by GPs
- Greater integration of data and care records, centred on the NHS number
- Greater use of telecare and telehealth
- An implementation plan for personal health budgets

We can continue to enhance the whole system of care for patients with Long Term Conditions in Leicestershire to maximise independence and choice, and avoid unnecessary acute care episodes on a 24/7 basis.

Summary Table: Long Term Conditions

Better Care Fund Schemes	***New or Existing***	***2014/15 £000's***	***2015/16 £000's***	***Metrics***	***Metric Symbols***
Proactive Care (West Leicestershire)	Existing	540	540	4,5,6	
Integrated Model for Long Term Conditions (East Leicestershire)	Existing	460	460	4,5,6	
Pathway to Housing	Existing	72		5	
Memory Plus Service	Existing	10		1	
Improving Quality in Care Homes	Existing	487	501	4,5,	
IT Enablers – data sharing, care plans, telehealth & telecare	New		650	5	
		1,569	**2,151**		
Protection of Services					
Social Care – Nursing care packages	Existing	2,995	3,361	4	
Social Care – Sustainable community services	Existing	1,466	1,876	1,4	
Social Care – Increasing demographic pressures	Existing & New	1,741	4,584	4	
Social Care – protection of community care packages	Existing		3,852	1,4	
		7,771	**15,824**		

Key to metrics

1. Permanent admissions of older people (aged 65 and over) to residential and nursing homes, per 100,000 population.
2. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.
3. Delayed transfer of care from hospital per 100,000 population (average per month).
4. Avoidable emergency admissions (composite measure).
5. Patient/service user experience
6. Injuries due to falls in people aged 65 and over

Integrated Urgent Response

Our Ambitions for Improving Integrated Community Care

A key priority of the Integrated Commissioning Board and its partners has been to prevent unnecessary time spent in acute settings. Using the existing social care allocations and working with local community providers to change models of care, Leicestershire County Council, East Leicestershire and Rutland CCG and West Leicestershire CCG have made some good initial progress to integrate local community based services across the health and care system, with the emphasis on:

- Admission avoidance
- Effective reablement, e.g. following illness or injury
- Proactive and integrated management of patients with long term conditions

Initial progress has consisted of strengthening the range of interventions that are jointly offered to support the urgent care system by preventing unnecessary admission, and agreeing a shared approach to discharge which ensures that the individual gets the right support to facilitate their recovery.

Developments in 2013/14 have included:-

- Community based teams across Leicestershire and Rutland being configured around clusters of GP practices,
- More options for care in the community, including the introduction of intensive community nursing support in the home
- The addition of night care to the intensive community support service
- The addition of therapy and Community Psychiatric Nurse support to discharge pathways
- A social care crisis response service, with a two hour response time.

There is now greater clarity and ambition about how further integration could be achieved and a pressing need to redesign services on an LLR wide basis so we can sustain the health and care system in line with the LLR strategy.

The Leicestershire BCF plan initially will focus on two main components of work:

1. Harmonise a number of still separate, historical services operating across health and the local authority into an integrated package for the future

and;

2. Address some important remaining gaps in service which are negatively affecting the urgent care system, in particular the ability of health and care partners in the community to respond as one, rapidly, on a 24/7 basis.

We recognise there are still gaps in delivering the optimum pathways of care locally and we urgently need to consider additional opportunities to stretch our ambitions to impact on the metrics at pace and scale and improve outcomes further.

Evidence shows that for older people, if a length of stay in an acute trust can be achieved which is less than 16 days, mortality reduces and the ongoing costs of managing their care reduces, since their chances of regaining their previous functional baseline improves.

However, when older patients become unwell they often need investigations and medical supervision as well as intensive nursing support for a short period of time. They are not acutely ill in the traditional sense of what hospitals are designed for, but often end up there because there are very limited options currently that can offer diagnostics, medical supervision and intensive nursing support other than urgent care in an acute hospital.

At times the length of stay can be affected by the need for additional diagnostics and treatment which could be achieved outside of hospital, hence the term "Discharge to Assess" rather than be kept unnecessarily as an inpatient.

Within the LLR-wide strategy all partners are keen to develop better options for those discharged from acute settings and those who need investigation and treatment but for whom admission could be avoided.

In response to this, in 2014/15 we will undertake further scoping work, in particular to consider

- How the rapid diagnosis and treatment of frail older people can be improved in community settings
- What the options could be for this
- The relative impact and affordability of these options

This work will be in the context of acute sector activity assumptions/expenditure over the next five years per the LLR-wide strategy, and the stepped changes needed to reduce the costs of acute care.

One of the options we would wish to test is whether further consolidation of services into a rapid assessment and treatment service for frail/complex older people would be feasible and cost effective. If so, this potentially could offer outpatient and short stay options (e.g. up to 72 hours) which are not readily available in our current models of care.

In the meantime we will press ahead with two important developments which put in place firmer foundations and prepare the way for our future ambitions.

Partners agree there are a number of important benefits that can be achieved by creating an integrated service which can respond in a crisis which include:

- Provide a more responsive, needs led service, managed through a single co-ordination point, operating on a 24/7 basis
- Create a team of sufficient size and scale to respond to urgent need within two hours

The BCF plan therefore incorporates the investment needed to move to a two hour response time across both health and social care components of the service.

This will be achieved in the context of designing this service offer within a consolidated group of other community based services - all of which are to be delivered on a 24/7 basis in the future, as detailed above.

This will entail the development of a (joint) single point of access across health and care services and will need to be underpinned by the enabling work related to data integration and information technology to support care planning across the system.

This work will also be supported by the extension of primary care services across seven day working and the further integration of community and primary care services in support of patients with LTCs and frail older people.

Summary Table Integrated Urgent Response

Better Care Fund Schemes	***New or Existing***	***2014/15 £000's***	***2015/16 £000's***	***Metrics***	***Metric Symbols***
Integrated Crisis Response Service (Health & Social Care)	Expanding	1,039	2,000	4,3,1,5,2	
Health & Social Care Older Frail Service	New	1,000	2,000	4,5	
Ambulance Falls Prevention	New	50	100	6,4,5	
Expanded Role of Primary Medical Care	New	300	750	4	
		2,389	**4,850**		

Key to metrics

1. Permanent admissions of older people (aged 65 and over) to residential and nursing homes, per 100,000 population.
2. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.
3. Delayed transfer of care from hospital per 100,000 population (average per month).
4. Avoidable emergency admissions (composite measure).
5. Patient/service user experience
6. Injuries due to falls in people aged 65 and over

Hospital Discharge and Reablement

Length of stay and Hospital Discharge

Over the last year there has been significant investment in a number of joint initiatives across the County such as strengthening hospital discharge through in reach, which has proved to be very effective.

The BCF plan builds on this progress, focusing the system as a whole on avoiding admissions and tackling an upward trend in lengths of stay, in particular those above 11 days where we have experienced a 19% increase in the last financial year across Leicester, Leicestershire and Rutland.

A number of existing initiatives are taking place within the acute setting to streamline discharge arrangements and these will carry on, along with continued investment through the BCF (per the existing social care allocations) for hospital to home and the new bridging service, along with assertive in reach, and the work LLR-wide on improving the range of discharge solutions and support available for mental health patients.

Implementing the Minimum Safe Data Set - (for patient transfer between health & social care)

During 2013/14 clinical, therapeutic and social care partners worked together to agree a minimum data set to enable the safe transfer of patients between care settings. Across LLR agreement has been reached to implement the tool currently being used electronically by South Warwickshire Foundation Trust. This has delivered a three day reduction in processing time for discharging older adults, and has smoothed transitions generally across health and social care boundaries.

During 2014/15 we will deploy this tool in UHL and consider its use in other settings to ensure that people get the best opportunity to have their risks of transfer assessed with the greatest equality across the system.

An additional benefit of the tool is that it contains a risk algorithm that allows clinicians to select another service option if there is insufficient capacity in the identified service, or if they feel that the particular circumstances of the patient warrant a different service offer. This will provide additional intelligence for commissioners when considering future service models.

Consolidation of 24/7 Community Based Health and Care Services

The intent to integrate community services further, forms an essential part of the plan to avoid admission and support effective discharge and reablement.

The existing services that would be subject to consolidation are:

- Intermediate care
- Single point of access
- Intensive community support (including night cover)
- Reablement (Health)
- Reablement (Social Care).

As a result of these changes the two hour rapid response will be created and a number of other benefits will also be realised as follows:

- There will be improvements for patients, carers and families in their experience of care, including care planning and coordination.
- There will be process efficiencies in referral times and choices – by providing the acute trust with a single discharge service.
- There will be process efficiencies in referral times and choices – by providing GP's, social care and community health services with a single service to avoid unnecessary acute admissions.
- We will be able to release savings as part of the overall LLR cost efficiencies.
- There will be savings in duplications between teams and inter-team referrals.
- There will be workforce improvements and broader skills training within the integrated team.
- There will be improvements to the coordination of care and the ability to provide more flexible care to suit the changing risks and needs of individuals.
- There will be improvements to records and data sharing for the integrated team.

An initial outline of this work is shown below
(See also the high level programme plan at **Appendix 4**)

- April 2014 - deploy night cover for the intensive community support service
- April - June 2014 create a single specification for all services that have traditionally comprised "step up and step down care" with work force development requirements and a trajectory for implementing the new specification
- Focus on cost effectiveness - some of the individual component parts of the service offer have a high unit cost. Through 2014/15 we will be working with public health to evaluate the benefits of the model both qualitatively and quantitatively to ensure that we are able to consider the interventions that add the most value and produce the most benefits for people through the specification period.
- July 2014 onwards agree the workforce development plan, implementation timescales and approach to contract variations with providers
- September 2014 evaluate the benefits of the night care component, and the existing crisis response service from social care
- 2015/16 – Integrate the new specification into core community services

Underlying these activities will be a full programme of work around workforce engagement/development, to ensure that people are clear about their roles and relative contributions to the delivery of the new service specification, with a skills profiling activity and training programme to maximise the early benefits of deployment.

Summary Table: Discharge and Reablement

Better Care Fund Schemes	*New or Existing*	*2014/15 £000's*	*2015/16 £000's*	*Metrics*	*Metrics Symbols*
HART Reablement	Existing	432	432	2,3,5	
Intermediate Care Team	Existing	580	580	2,3,4,5	
Integrated Residential Reablement	Existing	556	556	2,3,5	
Hospital to Home	Existing	72	72	2,3,5	
HART Scheduling System	Existing	95	130		
Patient Transfer Minimum Data Set	New	90		5	
Bridging Service	New	500	750	1,2,3,5	
Strengthening Mental Health Discharge Provision	Existing	255	261	3,5	
		2,580	**2,781**		
Protection of Services					
NHS – Step Down	Existing		529	3,5	
NHS – Intensive Community Service	Existing		1,821	3,4,5	
NHS – Assertive In Reach	Existing	569	569	3,5	
NHS – Reablement	Existing		4,132	3,5	
Social Care – Residential Care Respite	Existing	743	743	4	
Social Care – Cost pressures linked to new models of working	Existing & new	220	1,640		
		4,112	**12,215**		

c) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Section needs cross checking/aligning to final outcome of UHL contract negotiations

The implications for the acute sector in 2014/15 involve £4.648m of non elective activity being removed from the acute sector contract on the basis that this activity will be avoided by delivering the schemes in the draft BCF, with impact on the metrics detailed on page 14-19.

This equates to £2.217m of activity for East Leicestershire and Rutland CCG and £2.431m of activity for West Leicestershire CCGs.

These assumptions have been reflected in the QIPP plan currently being agreed between CCGs and the local acute Trust as part of the 2014/15 contract negotiations, and are therefore subject to change for the final submission on 4th April.

It should be noted that the QIPP non-elective assumptions for CCGs and the acute trust comprise a number of activities only some of which are directly linked to schemes in the BCF.

As part of the approach to risk sharing and risk management of the pooled budget through which the BCF Plan will be delivered and governed, a figure of £1.3m has been identified to mitigate the risk of schemes failing to deliver and any consequence on acute sector activity.

The individual elements of the BCF, their impact on acute activity, the QIPP plans between CCGs and the acute trust and the impact of the plan on the metrics have been subject to an impact assessment through a multi-agency workshop, the outputs of which have been shared with the Integration Executive on 25th March and the Health and Wellbeing Board on the 1st April.

d) Governance
Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

LLR-Wide Strategic Programme

The LLR strategic programme is governed by local health and care system leaders through a Programme Board which has the following terms of reference:

- To ensure the production of a five year LLR Health & Social Care Strategy in line with NHSE/LGA guidance
- To ensure that the strategy is co-produced and owned and fit for purpose for execution by LAs, CCGs and HWBBs
- To ensure that the strategy has been subject to patient engagement and involvement
- To ensure that the BCF Plans and five year LLR strategy are properly integrated
- To agree the future governance structure as a vehicle for implementation of the Strategy from June 2014 onwards

The composition of the programme board is as follows:
- CHAIR: Independent
- 3 x LLR HWBB Chairs
- 3 x CCG Accountable Officers
- 3 x CCG Chairs
- UHL Chief Executive
- UHL Medical Director
- LPT Chief Executive
- LPT Medical Director
- 3 x Directors of Adult Social Care
- NHS England
- Healthwatch

The programme was launched on 29th January 2014, following work to refresh and refine the vision, workstreams and governance of the Better Care Together (BCT) programme operating in LLR.

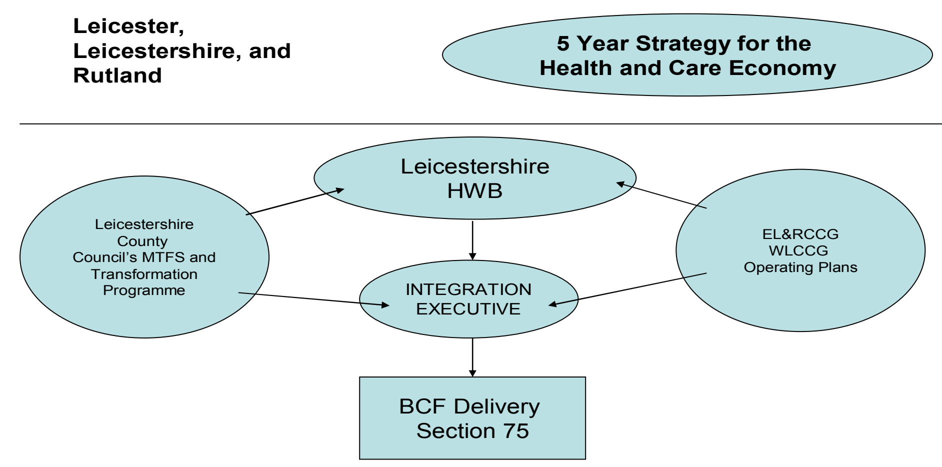
The BCT Programme has a joint shared vision for all partners. 'To maximise value for the citizens of LLR by improving health and wellbeing outcomes that matter to them, their families and carers in a way that enhances the quality of care at the same time as reducing cost across the public sector to within allocated resources by restructuring the provision of safe, high quality services into the most efficient and effective settings'

All partners have acknowledged that the BCT Programme is the preferred vehicle in delivering the changes needed to address the long term needs in both health and social care of the citizens of LLR.

Three key features of the refreshed BCT Programme are:

- To ensure much stronger alignment and integration between the LLR wide programme and the respective strategies of local Health and Wellbeing Boards
- The adoption of Health and Wellbeing Board Chairs into the membership and leadership of the programme
- Embedding of the BCF plans in the workstream arrangements as key enablers to integrated working across the five year strategy by transforming how care is delivered, in particular outside of hospital settings.

The following diagrams illustrate the relationship between the LLR-wide tier of the strategy and the local governance arrangements for the Leicestershire Health and Wellbeing Board including the role of the Integration Executive in overseeing the delivery of the BCF and the section 75 agreement for the pooled budget.



Refreshing the JHWBS and the Health and Wellbeing Board Terms of Reference

On 24 February 2014 the Leicestershire Health and Wellbeing Board's stakeholder event will reflect on progress to date in delivering our Joint Health and Wellbeing Strategy (JHWBS).

Although we anticipate maintaining our current JHWBS priorities, based on the JSNA evidence, we will be building on the "how" of delivery with respect to the work now in progress across the LLR wide programme and the development of the BCF plan.

We anticipate Leicestershire's JHWBS, workplan and governance arrangements will be updated during 2014/15 to take account of the LLR wide strategy and the introduction of BCF plan.

At their meeting on 13th February 2014 (http://politics.leics.gov.uk/ieListDocuments.aspx?CId=1038&MId=4072&Ver=4) the Leicestershire Health and Wellbeing Board refreshed their terms of reference including the following key areas of change:

- Providers joining the Board
- Taking into account the Board's new responsibilities with respect to the BCF
- Reflecting the relationship with the LLR wide five year strategy and associated governance arrangements

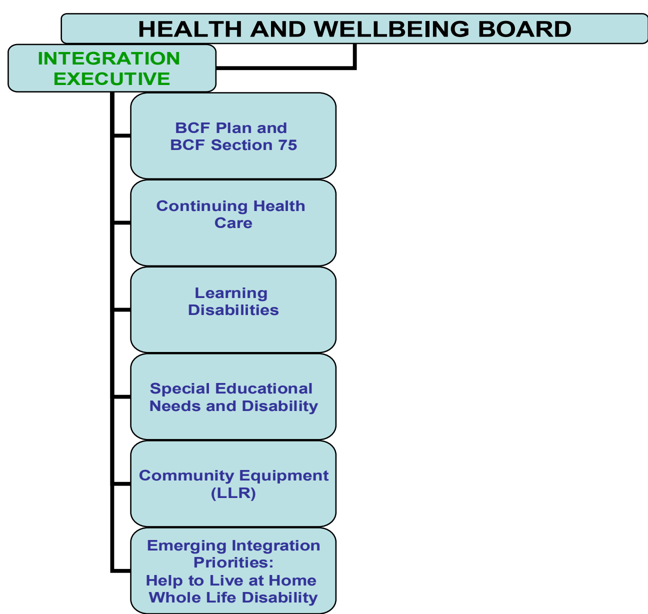
At the 13th March meeting of the Leicestershire Health and Wellbeing Board (http://politics.leics.gov.uk/ieListDocuments.aspx?CId=1038&MId=3981&Ver=4), the Board approved the creation of a new sub group, the Integration Executive, to support the Health and Wellbeing Board in:

- Steering the delivery of the BCF
- Governing the pooled budget
- Extending our ambitions for local integration/transformation beyond the current scope of the BCF
- Further crystallise the local alignment of the BCF to the priorities within the JHWBS and the LLR wide programme.

The terms of reference can be found at (http://website/leics_health_wellbeing_board_tor-2.pdf)

Proposed structure of work to be overseen by the Integration Executive (provisional)

The Integration Executive will meet monthly with membership to include CCGs, LA, District Councils, Local Health Watch and the two large local NHS providers.



Integration Programme Plan - 2014/15

There is now an established programme for the LLR five year strategy.

Integration forms one of the main strands of Leicestershire County Council's transformation programme and has a high priority corporately.

In Leicestershire NHS partners, the council and a range of other partners have already developed an integration work plan over the past two financial years led by a sub group of the HWB Board, called the Integrated Commissioning Board, using the existing social care allocations.

Leicestershire's BCF plan demonstrates how we have taken the learning from our progress to date, refined our vision and set out an incremental plan to create a joined up health and care system by 2018.

There are several areas of the plan which require further proof of concept by undertaking further preparatory work, business case development and evaluation in 2014/15, before wider implementation, either within Leicestershire itself, or as part of the LLR-wide strategy

The BCF plan shows how our approach can be scaled up over the next two years on a countywide basis, using the extended pool of resources which will become available through the BCF and the further work ahead to achieve this.

A high level programme plan has been developed which brings together all the main elements of joint work across the health and care system has been developed, which will be governed by the Integration Executive. This is attached at **Appendix 4.**

The information gathered during the impact analysis in February and March 2014 has involved taking a baseline position for each element of the integration programme including the BCF related elements. We have looked at the status of current progress, governance evidence of delivery, and assessed key milestones for 2014/15, and the current project resources allocated to each element of the programme from all parts of the system of health and care.

In addition there are some centralised resources to support delivery of the Integration Programme which include

- a Director of Health and Care Integration (0.8wte) - a shared leadership role operating across the NHS and local government in Leicestershire
- a full time business analyst allocated from Leicestershire County Council's Change Unit
- a full time programme administrator from adult social care
- 0.5 wte finance support from within Leicestershire County Council.

The Integration programme plan consists of the four different themes that are in the BCF plan along with five additional areas of ongoing joint work. The BCF themes are :

- Unified prevention offer for communities in Leicestershire
- Integrated, Proactive Care for those with long term conditions
- Integrated urgent response
- Hospital discharge and reablement

The other five elements proposed to be included into the overall integration programme:

- Special Educational Needs and Disabilities (SEN&D)
- Help to Live at Home
- Whole Life Disabilities
- Continuing Health Care (CHC)
- Integrated Community Equipment

An Operational Group, which includes membership from all the different areas within the integration programme, has been set up to oversee coordination and delivery. This will meet fortnightly and will report directly to the Integration Executive.

Key Milestones of the Integration Programme Plan

The key milestones for quarter one (2014/15) for the plan are detailed below.

Theme	Task	Delivery Date	Implementation
Unified prevention offer	Develop the local area coordination business case	June 2014	Q3 – 2014/15
Urgent response	Develop the older frailty service business case	June 2014	Q3 – 2014/15
CHC	Commissioning support model analysis	June 2014	Q3 – 2014/15
CHC	CCGs to confirm approach to GEM contract and commissioning support models	June 2014	Q2 – 2014/15
Help to live at home	Complete the design stage of the model	June 2014	Early implementation Q2 – 2015/16
Community equipment	Consolidate the community equipment team/service (hosted in the City)		April 2015

Programme Mgt - with linkage to LLR 5 Year Strategy	Develop a communications plan for the programme	June 2014	Implement early activities from May 2014 onwards
Programme Mgt - with linkage to LLR 5 Year Strategy	Develop a joint implementation plan for data sharing and adopting the NHS number	June 2014	By 2016/17 Phasing to be confirmed
Programme Mgt with linkage to LLR 5 Year	Develop a seven day working implementation plan (BCF dependent elements)	June 2014	Implementation phasing to be confirmed
Programme Mgt	Assess Care Bill Analysis and care bill implementation plan ref BCF dependencies	June 2014	Milestones per LA implementation plan
Programme Mgt	Develop and approve the section 75 pooled budget agreement	By February 2015	April 2015

Programme Plan Next Steps

Further work will be undertaken with the operational group to develop the detail beneath the high level programme plan including the findings from the impact analysis which shows the current project (people) resources allocated to the schemes in the BCF and wider integration programme.

Governance Arrangements for the BCF Pooled Budget

The new Integration Executive will govern the delivery of the BCF and the pooled budget reporting to the Health and Wellbeing Board. Ahead of the Integration Executive's first meeting in March, a multi-agency risk management workshop was held on 18th February to:

a) Review the draft risk assessment that submitted with the draft BCF on 14th February

b) Develop principles and scenarios for the risk sharing agreement for the BCF section 75 and pooled budget

c) Discuss the CIPFA guidance on section 75 development and consider the factors affecting the preparation of a section 75 agreement for the BCF in Leicestershire

Attendees included CCGs, providers and LA representatives including finance leads.

A summary of the outputs is given in the table below with a status report where relevant.

Risk Workshop Outputs

Action/Comment	Status
A number of amendments/updates and additional risks will be added to the BCF risk analysis using feedback from this meeting	Edits have been made and reflected in the risk assessment in the final submission
There will be some additional briefing/stakeholder sessions with LPT and UHL teams, to extend the stakeholder engagement to date	Additional briefings arranged
The Section 75 agreement will need to include explanatory narrative about the definition of protection	Noted
Interim Memorandum/Agreement to be drafted for the 2014/15 period pending full section 75 agreement for 2015/16.	Draft agreement to be prepared for approval at the April Integration Executive Meeting
Impact analysis work prior to final submission with provider input	Completed with provider input.
There is a need to develop and articulate collective benefits across the pathways of care/interventions within the BCF and gain greater understanding of impact and risks across partners	Will be picked up as part of the further work (identified in the programme plan) on impact analysis in Q1 2014/15
Risk assessment and risk sharing protocol needs setting in the context of the deficit position of UHL, which is likely to be the situation over the full two year BCF period	Noted
Contingency discussion at the March meeting of the integration executive - need to include information about levels of contingency in other parts of financial planning for LA and NHS partners for comparison purposes, need also to look beyond 2015/16	Actioned via Integration Executive
Principles for the Pooled budget – draft to be produced using the initial list considered at the meeting with cross referencing to other examples such as the LD pooled budget, the alliance contract for planned care and local shared services arrangements.	Draft produced and approved by Integration Executive in March
A dedicated accountant role to be established for financial management of the BCF, funded from the pool, flexible on who hosts this role for employment purposes.	This requirement has been factored into the resource plan for the integration programme from 1st April onwards.

It was noted that the lead time for developing a section 75 agreement is usually 6months+ and will require the appropriate legal advice.	The programme plan identifies a strand of work specifically for the development of the section 75 and supporting risk sharing agreement.
A number of scenarios were discussed which will be developed for the risk sharing agreement.	The scenarios are reflected later in this section
A number of financial matters were highlighted (such as treatment of VAT/inflation etc) which will be discussed/developed by finance leads in the work to draft the section 75 agreement.	Factored into programme plan
The CIPFA guide	Digest/share with other colleagues as appropriate.

Risk Sharing Agreement, Scenarios, and Section 75 Next Steps

Following approval of the risk sharing principles in March, a memorandum of understanding will be drafted for the April meeting of the Integration Executive. This will set out the risk sharing approach and confirm the level of contingency for the plan (£1.3.m), show the main milestones, the operational team across agencies who will prepare the draft, and an estimate of legal costs.

The participants at the risk workshop agreed the initial MOU/risk sharing agreement should specifically cover the following scenarios:

a. Actions to be taken in the event that the trajectory of improvement for avoidable emergency admissions is not achieved
b. Situations that are exempt (outside of the BCF plan control) – e.g. impact of a major incident
c. BCF plan components prove measurably effective, but the rate of acute demand outstrips the impact of the BCF, which still leads to over performance on the acute contract
d. BCF components prove more effective than anticipated in driving care into the community, leading to higher than planned levels of demand on reablement or home care packages
e. Timetable for assurance on the outputs of the financial modelling work associated with the impact of the Care Bill

In assessing the level of contingency within the pooled budget required the Integration Executive initially considered the potential impact of scenarios a) and c) and modelled the potential financial consequences.

The details of these two scenarios are shown at **Appendix 5** to this plan.

Summary of Governance Milestones/Other Activities to Approve the BCF Plan Submission

A timetable for local approval of the draft and final BCF submissions was developed to include various actions needed to ensure NHS and LA partners are fully briefed and can approve the submission of the plan, culminating in joint sign off at a public meeting of the Health and Wellbeing Board in February for the draft submission, and in April for the final submission.

Summary leading to the approval of the draft submission

29th January	LLR-wide (better care together) Strategy launch	To bring over 140 leaders together from across the health and care economy to shape the vision and objectives for the next five years and the transformation needed for a sustainable system in the future.
23rd January and 3rd February	BCF Multiagency Project Meetings	To seek assurance from partners to the direction of travel, refine the content of the submission, agree financial assumptions including social care protection, troubleshoot remaining issues.
4th February	Cabinet	Report to set out the background to the BCF, a brief outline of discussions to date with partners and timetable for decisions. Delegation to Health and Wellbeing Board (pending revision of HWBB terms of reference)
4th February	Briefing with UHL Strategy Board	Review scope of plan, impact of acute sector activity and financial assumptions, metrics – seek feedback
5th February	Submission of papers for CCG Boards and HWB Board	Covering Sheet Part 1 Template Part 2 Template BCF Plan Narrative Document
10th February	Members Briefing	Briefing for key members Cabinet Lead Members and Chairmen and Spokesmen of: • Children and Families • Adult Social Care • Health
11th February	WLCCG Board Meeting ELRCCG Board Meeting	Approval of draft submission
13th February	H&WB Board Meeting	Approval of draft BCF submission Refresh of HWB TORs**
24th February	HWB Board Stakeholder meeting	Seek feedback from a wide range of stakeholders including the public about the refresh the Joint Health and Wellbeing Strategy in the context of the BCF
24th February	BCF briefing meeting on with LPT Executive Team	Review scope of draft plan, activity, financial assumptions, metrics, the developments affecting community services 2014/15–2015/16 – seek further feedback
18th February	Risk Workshop	Risk assessment, and principles and scenarios for the pooled budget

Programme of Work undertaken to Finalise the BCF Submission March –April 2014

- Impact assessment across all elements of the BCF plan
    - Including on 12th March AM a multi agency impact assessment workshop
- Review of metrics per regional assurance feedback and impact assessment
- Apply other feedback from regional assurance
- Apply updated BCF guidance issued on 12th March
- Develop BCF “plan on a page”
- Update BCF plan templates for final submission
- Develop programme plan and milestones for the BCF plan over a two year period
- Finalise principles and a memorandum of understanding for the 2014/15 pooled budget
- Meetings with LLR five year strategy programme director – strategic alignment
- Cross check for strategic alignment where applicable (e.g. LLR context and provider impact) with BCF leads for Leicester City and Rutland
- Update Risk Assessment

Governance Milestones March – April 2014

11th March
- East Midlands Health and Wellbeing Programme Leadership Group meeting in Kegworth - will receive outputs of the BCF regional assurance process
- CCG Board Meetings –update paper on BCF - assurance on work in progress to finalise the BCF plan

12th March
- AM – Multi agency impact assessment workshop
- PM – Health Overview and Scrutiny Committee Leicestershire County Council - BCF Update

13th March
- 2pm (Regular) HWB Board Meeting: Agenda includes set up of the Integration Executive, update on progress with the finalisation of the BCF plan, report on outputs of the JHWBS/BCF stakeholder engagement event held on 24th February, and feedback from the East Midlands BCF assurance review.

19th March
- Position Statement at Leicestershire County Council’s Council Meeting (Mr. White CC)

24th March
- BCF covering report to be issued for HWB Board meeting on 1st April

25th March
- 5pm Inaugural meeting of the Integration Executive

26th March
- BCF final draft documents to be issued for HWB Board on 1st April

1 April
- 2pm Leicestershire County Council Cabinet Meeting – Report on the BCF submission, ahead of HWB Board meeting
- 5pm-6pm Extraordinary Meeting of the Leicestershire HWB Board to discuss and approve the BCF submission, subject to any final amendments needed.

4th April
- Submit BCF final plan to NHS England.

8th April
- CCG Board Meetings: opportunity for further BCF update which could include:
    - Formal receipt of final BCF submission
    - Feedback from Integration Executive/HWB Board
    - Discussion ref BCF programme plan/governance arrangements for 2014/15.

11th April
- 11am – All Member Briefing at Leicestershire County Council – BCF Update

***Updated HWBB terms of reference will also be addressed as part of the next review of the County Council’s Constitution during the summer of 2014.*

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services. Please explain how local social care services will be protected within your plans.

We have agreed a number of investments from the BCF (mapped to each BCF theme) where specific types of packages of care/services are being protected to support hospital discharge and admission avoidance.

The prioritisation and type of resource to be protected has been 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 pressures still to be addressed.

While the protection identified within the BCF plan does not resolve all aspects of this pressure, 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 the frail older 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 GP practices.

The key points and table below show the analysis undertaken in the context of the MTFS, and the packages/activity type and investment levels that have been agreed in order to protect Adult Social Care in support of the BCF plan.

Leicestershire County Council is required to make a total of £110m budget savings between 2014-18 representing 30% of its total budget. The Council recognises the need to protect the most vulnerable citizens 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 2014/15 Medium Term Financial Strategy shows a proposed increased budget totalling £21.3m for Adult Social Care with £9.2m towards meeting increased demographic pressures by 2015/16.

The balance of projected unfunded additional demographic pressures is proposed to be funded from the BCF with £1.7m in 2014/15 and £4.6m from 2015/16.

The additional funding proposed from the BCF will meet increasing levels of demographic growth and continue to protect essential social care services as outlined below.

The impact of the social care protected interventions as detailed in the table below is subject to further analysis in February and March.

Service Protected	Health and ASC Benefit	BCF Contribution 2014-15	BCF Contribution 2015-16	BCF Theme
Nursing Care Home Packages	Ongoing provision of c300 nursing care placements enabling these high dependency service users to stay out of the acute sector.	2,995	3,361	Integrated proactive care for LTC
Sustaining community based services with increased pricing and increased average size of packages of homecare	Existing price and increased dependency in domiciliary care and other community based services enabling more people to stay or return to their homes.	1,466	1,876	Integrated proactive care for LTC
Residential reablement respite	Ongoing provision of Residential reablement respite care for c20 service users per week	743	743	Improving Hospital Discharge and Reablement
Increasing demographic pressures	Provision of care packages to meet above budgeted increasing demographic pressures for 18-64 years mental, physical and learning disabilities plus increasing people with dementia and more complex needs. Additional to the £21m being funded by the LA over four years.	1,741	4,584	Integrated proactive care for LTC
Maintaining Social Care pathway	Maintain capacity in social care pathway (i.e. social workers) to support new integrated model of working.	220	1,640	Improving Hospital Discharge and Reablement
Maintain care packages	Maintain support levels for existing service users. This will avoid a 20% average reduction in all long term support packages		3,852	Integrated proactive care for LTC
Total Value of Protected Services		**7,165**	**16,056**	

Implications of the Care Bill

The Care Bill will be implemented in stages between 2014 and 2016.

Amongst the key changes are national eligibility criteria, new responsibilities for Information and Advice, increased rights and access to services for carers, and Adult Social Care funding reforms.

It is likely that these changes will have a significant impact on publicly funded Adult Social Care, and therefore, increase the financial pressure on the Council.

At this stage it is too early to make a full assessment about the scale of this impact.

Since the draft BCF was submitted, Local Authorities have received confirmation of their specific allocation from a national investment of £135m for the implementation of the Care Bill. This forms one of the elements of the overall BCF financial envelope for each Authority and its partners. The Leicestershire allocation is circa £1.3m.

There will be further allocations of resources directly to Local Authorities in 2015/16 to pay for implementation of the non-financial reform elements of the Bill and in 2016/17 to fund the financial reforms. There is a risk that these allocations will not fully fund the actual costs.

Further analysis is needed to assess specific implications against the requirements of the Bill and to assist with this national modelling tool has been developed. This tool is being piloted in a number of Local Authority's and over time will be used to assess the potential impact of the Care Bill with respect to their population.

The development and application of the tool is iterative, and at the time of this submission further refinements to the modelling tool are anticipated. There is also a national consultation in progress about eligibility criteria.

The BCF submission has already identified an indicative £300k for additional carer assessments based on current estimates but this could be subject to change and represents only one aspect of the Bill's requirements.

Risks in relation to the introduction of the Care Bill have been reflected in the risk register, and all assumptions and risks will be updated as further analysis becomes available, with regular updates to the Integration Executive

b) 7 day services to support discharge
Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

Following the publication of NHS England's clinical standards for seven day working, all Acute Trusts in the East Midlands are undertaking a baseline assessment by June 2014 against the ten elements of the clinical standards.

This will include an overview of how other elements of the health and care system that intersect with acute providers on a seven day basis are being configured to support seven day working, for example for Leicestershire the intensive crisis response service which will offer a combined health and social care response to avoid admissions where urgent held is needed in the community.

In terms of primary care developments in support of seven day working, the Leicestershire Health and Wellbeing Board received a report in March 2014 from NHS England covering the emerging strategy of NHS England/Operating plan.

This report and the Board's discussions included how primary care strategy is developing nationally and how this will be translated into Leicestershire and Lincolnshire, with respect to our Area Team.

The Health and Wellbeing Board discussed the parameters of the core contract for GPs and the additional services currently being commissioned by both NHS England and CCGs in order to extend the primary care service offer to local patients beyond the core contract. The minutes capturing the Health and Wellbeing Board's discussions on this topic and the action agreed can be found here (http://politics.leics.gov.uk/ieListDocuments.aspx?CId=1038&MId=3981&Ver=4)

In the meantime, £1m has been identified within the BCF plan to extend the role of primary care further in relation to seven day working and case management of the over 75s. This is a starting point which will be reviewed as the local primary care strategy becomes further developed.

Further discussions are planned between NHS England and local CCGs to consider the application of these funds in the context of the current levels/pattern of commissioning between the two commissioning organisations and to co-produce future milestones for extending primary which will also need to interface with out of hours GP provision, social care services and the acute sector developments noted above..

Several components of the BCF relate specifically to making a significant shift in delivering 24/7 integrated community based support for Leicestershire's communities. The draft BCF plan shows how we will develop from our foundations and then rapidly create further integration across acute, community and GP settings of care, starting with these developments:

- The introduction of an integrated single point of access across health and care services 24/7
- The introduction of a two hour integrated response service for urgent health and care support in the community
- The introduction of case management of the over 75s
- The introduction of a new Bridging Service to make further improvements to hospital discharge, including at weekends.
- The extension of primary care services across seven day working and the further integration of community and primary care services in support of patients with LTCs and frail older people.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

The NHS locally already uses the NHS number as a primary identifier.

Adult social care are not currently in a position to do this, although the systems we utilise have provision for holding the NHS number and this is populated where a number is known. – see next steps below.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

As part of our plans for integration and use of minimum patient transfer dataset over 2014/15 & 2015/16, our ambition is to fully implement the use of the NHS number as the primary identifier by 2016/17.

A high level interagency agreement has been produced setting out the principles for data sharing. This work will be progressed further in the context of the LLR five year strategy.

All three BCF plans within the LLR strategy will be coordinating their “ask” of the data/IT LLR workstream to ensure the milestones and dependencies across the system are captured and the pace of this work is accelerated in support of BCF delivery.

This is particularly important in terms of overall effectiveness of, and dependencies related to, the BCF plans that relate to an integrated single point of access 24/7, the two hour urgent response in the community, discharge planning, case management for the over 75s, seven day working and LTC joint care plans.

In the meantime, operationally, both Leicester City Council and Leicestershire County Council are in the process of implementing a new Adult Social Care information system called IAS. This has built in functionality to record the NHS number as an identifier.

Local and national discussions are in progress, including via the Department of Health to consider how IAS functionality should be developed and exploited in support of the integration agenda.

IAS also has provider portal which allows, for example domiciliary care providers, to access the IAS system to upload core data on the activity they have performed.

The programme plan for the Integration Executive includes a milestone to develop an multiagency implementation plan by June 2014 to set out the steps needed to achieve data sharing and adoption of the NHS number in Leicestershire.

This work will include:

- How data and care records can be shared more effectively between IAS and the systems of other commissioners and providers in Leicestershire’s health and care system and the respective milestones across operating systems in order to achieve this.
- The information governance requirements.
- The cultural and organisational differences affecting the progression of this work.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK)

We are committed to adopting systems that are based upon Open APIs and Open Standards (i.e. secure email standards, interoperability standards (ITK).

Both the new Adult Social Care and home care rostering products being introduced by Leicestershire County Council have a range of open API's and XML schemas to utilise web services and re-use of interfacing code.

NHS systems used locally such as HISS (PAS); ICE, EMIS, Maracis/RiO are supportive of Open APIs and Open Standards. The main exception is the nationally contracted TPP SystmOne product.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

We are committed to ensuring that the appropriate Information Governance (IG) Controls will be 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.

In addition to the above elements Leicestershire County Council will be hosting a national centre for excellence in data sharing which will bring a number of additional benefits to the BCF programme and the Council's overall transformation programme. In particular it will facilitate the opportunities to learn from national best practice in information sharing, and provide capacity to support the local programme.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Both CCGs have implemented risk stratification tools with case management for at risk populations as part of their programme of support for:

- Older frail patients
- Those with LTCs
- Those at risk of developing LTCs/frailty.

West Leicestershire CCG

In WLCCG 49 of the 50 practices have implemented risk stratification which collates and analyses a combination of acute and primary care data through clinical systems The exception is the Loughborough University practice, who has a student based population. In WLCCG there are ten clinical coordinators who are the case managers for those categorised at risk using the risk stratification tool. Since April 2013, 409 patients have been reviewed and admitted to virtual wards where case management is delivered accessing social care resource. These patients receive joint assessment, interventions and care plans per their assessed needs. Through the introduction of the BCF plan there will be a much greater integration of social care risk factors and interventions into case management, including housing support, which has proved to be an increasingly important element, hence the development of the housing offer to health. The BCF plan seeks to align the existing and improving inputs of primary care teams, community nursing teams and social care into fully integrated teams clustered around GP practices, with case management also being introduced as standard for the over 75s. Over the course of the BCF plan period the intention is to develop a new model of care for frail older people from the existing/ extending components.

Supporting information WLCCG Risk Stratification

In terms of the categorisation of at risk patients:

Patients who are frail will have one or more of 12 diagnoses, such as falls, dementia, urinary or faecal incontinence or malnutrition.

The Likelihood of Admission refers to a patient's chance of being electively or non-electively admitted in the next 12 months.

A score of five represents a 50% or greater chance of being admitted. A score of four represents a 40-49% chance of being admitted. Three equals 30-39% and so on.

Relative to the whole population, patients in groups four and five have a high likelihood of being hospitalised.

Resource Utilisation Band (RUB) These bandings (1-5) show groups of patients with increasing likelihood of being in the top 5% costliest group next year.

The risk factors are currently comprised of the following elements:

- The likelihood of any patient being in the top five per cent highest cost group of patients next year.
- Patients most likely to be admitted in the next 12 months.

- Prescription given associated with the named condition.
- Read Diagnosis Code / Primary Code / Secondary Care code present.
- Both RX and ICD are present.
- Treatment - the patient has a prescription associated with that condition and has attended OPD or ED for that condition, but no diagnostic code was found in the primary care record for that condition.

East Leicestershire and Rutland CCG
East Leicestershire and Rutland CCG utilises the Adjusted Clinical Groups (ACG) risk stratification tool to identify patients at risk of future avoidable hospital admissions. The CCG and Local Authorities Integrated Care service, uses this risk stratification tool within a joint process to assess patients at risk, coordinate identified interventions to reduce/manage this risk and allocate a lead professional where appropriate.

There are ten integrated health and social care coordinators who are the care coordinators for those patients identified at risk using the risk stratification tool and whom have opted into the service. These patients receive joint assessment, interventions and care plans per their assessed needs. Through the introduction of the BCF plan there will be a much greater integration of social care risk factors and interventions into case management, including housing support, which has proved to be an increasingly important element, hence the development of the housing offer to health.

4) RISKS
Please provide details of the most important risks and your plans to mitigate them.

This should include risks associated with the impact on NHS service providers.

We provided an initial risk analysis for the draft submission. This was refined following:-

- The risk workshop at the end of February
- Further testing and modelling in relation to the activity and financial assumptions, and the impact on the metrics during February and March.

Risks to Plan Preparation and approval

Description	Likelihood	Risk rating before Mitigation	Potential Impact	Mitigation	Risk Rating following mitigation
Lack of agreement to one or more components of the plan	M	H	• Draft and final plans are not secure between partners,	• Iterations of draft plan with CCG MDs and LA, regular project team meetings to refine content/assumptions. • Build in sufficient confirm and challenge time. • Multiagency workshop on risk assessment and pooled budget 18/02/14 • Multiagency workshop on impact assessment 12/03/14 • Review by Integration Executive prior to final submission. • Seek early agreement to adult social care protection levels – see below	L
Lack of agreement to the levels of social care protection in the plan	M	M	• Draft and final plans are not secure between partners, • Regional/national assurance sign off is compromised due to not meeting a key national condition	• Ensure elements for adult social care protection map clearly to the themes and metrics in the BCF. • Determine level of granularity needed and discuss with CCGs • Prepare breakdown of social care protection allocation to meet BCF guidance and stakeholder requirements • Prepare briefing materials for CCG Board discussions in January/February. • Check feedback from regional/national assurance for any concerns about the submitted levels, if applicable.	L

Description	Likelihood	Risk rating before Mitigation	Potential Impact	Mitigation	Risk Rating following mitigation
Lack of agreement to the metrics and trajectories for the plan	H	H	• Draft and final plans are not secure between partners. • Regional/national assurance sign off is compromised, • Providers and other stakeholders have low confidence in plans	• Initial cut of data for metrics and trajectories prepared by CCGs/CSU/LA. • Quality assurance review of metrics undertaken using NHSE feedback. • Detailed review per metric at the impact assessment workshop in March with provider representation • Review of recommendations arising from the workshop by Integration Executive and HWB Board prior to submission of final BCF.	L Except for avoidable emergency admissions (M)
Lack of agreement to scale of ambition within the plan	M	H	• Draft and final plans are not secure between partners. • Lack of confidence that the health and care system can transform. • Impact on CCG/provider contract negotiations.	• Iterations of draft plan with CCG MDs and LA, regular project team meetings to refine content/assumptions. • Build in sufficient confirm and challenge time including provider input • Multi agency Workshop on impact assessment 12/03/14 • Clear rationale for trajectory for reducing avoidable emergency admissions over a five year period. • Review by Integration Executive prior to final submission. • Alignment to final outcome of contract negotiations by 31/03/14	M

Description	Likelihood	Risk rating before Mitigation	Potential Impact	Mitigation	Risk Rating following mitigation
Plan not assured regionally/nationally by NHSE/Local Govt	L	M	• Additional regional intervention is needed. • Reputation of BCF plan and HWB Board partnership are compromised • Lack of confidence in local delivery.	• Apply national guidance including all updates when published • Apply the technical guidance for metrics • Stress test the metrics before final submission • Provide clear rationale for any local variations from metrics technical guidance • Local awareness of self assessment parameters for regional assurance • Review other examples of BCF draft plans for good practice. • Establish contact with national BCF lead • Assimilate feedback from regional assurance before final submission	L
BCF impact assessment challenges one or more element of the plan	M	H	• Plan components need further prioritisation • Alternative proposals may need to be introduced • Financial assumptions may need adjustment	• Impact assessment workshop to review impact of proposals to metrics, and consider KPIs beneath the main metrics to seek further assurance on delivery/impact. • Recommendations on any deletions/additions for BCF schemes (and/or the balance of investment between schemes) to be received by the Integration Executive and HWB Board prior to final submission. • Regular milestone reviews of the BCF by the Integration Executive	M

Description	Likelihood	Risk rating before Mitigation	Potential Impact	Mitigation	Risk Rating following mitigation
Risk Sharing arrangements for pooled budget not agreed	H	M	• Partners are not clear on their level of risk in undertaking the plan, • Individual board/committees of organisations unable to approve plan • Impact on CCG/provider contract negotiations	• Workshop held in February to develop the principles and scenarios for the pooled budget. • Outputs received by the Integration Executive in March • Assurance via the HWB board meeting on 1st April.	M
Insufficient alignment with LLR five year Strategy	M	M	• Mismatch between strategic objectives, • Duplication of effort, • Unclear impact for providers, • Regional/national assurance sign off is compromised	• LLR Strategy launch on 29th January to confirm direction of travel, workstreams and governance. • LLR strategy workstreams and governance refreshed February/March • Meetings held with LLR programme director in early March to ensure alignment of BCF to emerging strategic objectives of the LLR programme. • TORs for integration executive (new - March) and TORs for HWB Board (updated - February) have both ensured alignment of governance arrangements	L
Insufficient alignment with BCF plans in Leicester City and Rutland (where applicable)	M	M	• Unclear impact for providers, • Inconsistency of submissions in LLR context. • Regional/national assurance sign off is compromised	• Review/cross check across key elements of City and Rutland Plans as part of local assurance before final submission – in particular for LLR context and aggregated provider impact.	L

Description	Likelihood	Risk rating before Mitigation	Potential Impact	Mitigation	Risk Rating following mitigation
Lack of visibility/engagement across wider stakeholders including the public and VCS	H	M	• Stakeholders disengaged, • Lack of public understanding and support for the plans • VCS unclear as to how they can contribute to and support the plan.	• Close involvement of LHW in plan preparation. • Wider stakeholder engagement meeting held 24th February. • Forward engagement plan under discussion in context of comms/engagement plan for the LLR-wide programme. • BCF "plan on a page" being developed to support external comms • Easy read symbols and diagrams applied to final BCF submission • More targeted VCS engagement planned for Q1 of 2014/15	M
Wider stakeholders including the public and VCS challenge proposed changes	H	H	• Formal challenge through judicial review process delays implementation of change • Reputational impact • Financial costs of legal action and delays	• Ensure stakeholder engagement and consultation follows recent Council guidance approved in January 2014 on Consultation Principles, Equalities and Human Rights Assessments and Legal Implications of Service Change. • Ensure 'due regard' given in decision making by Health and Wellbeing Board	M
Providers not able to support initial draft	H	H	• Draft and final plans are not secure between partners • Reputation of BCF plan and HWB Board partnership are compromised • Lack of confidence in local delivery • Impact on CCG/provider contract negotiations • Regional/national assurance sign off is compromised.	• Individual briefings with providers • Engagement of providers in preparation of proposals/project team meetings and workshops • Providers as members of the HWB Board and Integration Executive • Additional briefings/engagement/ comms cascade into wider teams within UHL and LPT	M

Risks to Plan Delivery

Description	Likelihood	Risk before mitigation	Potential Impact	Mitigation	Risk after mitigation
Lack of clarity/pace on LLR five year strategy affects pace of BCF delivery	M	H	• Mismatch between strategic objectives, • Duplication of effort, • Unclear impact for providers across LLR • Dependencies are not clearly articulated • Risks between programmes are not transparent or well mitigated • Mismatch in accountability between programmes • BCF delivery stalls due to an unforeseen delay due to LLR dependencies	• Health and Wellbeing Board & BCF directly linked to LLR Programme Board • Close working between BCF lead and LLR programme lead • Risk analysis for BCF to be shared proactively with the LLR programme director • LLR programme structure incorporates clear BCF workstreams for each council • LLR dependencies affecting sequencing and pace to be assessed and factored into the programme plan • Refresh risk analysis with programme plan detail in Q1 2014/15	M
Lack of LLR integrated workforce plans	H	H	• Unable to plan effectively for local workforce requirements including the necessary workforce development and training in the medium term. • Workforce planning between LA and NHS partners remains disjointed and workforce related investment and benefits realisation not aligned. • LLR's "ask" of academic and other training partners is piecemeal/confused.	• To be progressed via the LLR Programme Board with mitigating actions translated into BCF programme plan • Seek clarity on the TORs and workplan of the LLR workforce subgroup. • Seek assurance that the LLR workforce subgroup has taken into account the specific workforce requirements within the BCF plan, with reporting into the Integration Executive.	H

Description	Likelihood	Risk before mitigation	Potential Impact	Mitigation	Risk after mitigation
Insufficient capacity or expertise to deliver the BCF (programme resource)	M	M	• Unable to execute plan to milestones • Compromise delivery of metrics • Lack of confidence that programme will deliver	• Programme plan and impact assessment has identified resource and expertise required with associated risks/mitigation	M
Delays/slippage on delivery of components of the plan	H	H	• Unable to execute plan to milestones • Compromise delivery of metrics • Lack of confidence that programme will deliver	• High level and detailed programme plans to be developed • Expenditure realistically profiled to plan • Contingency agreement per the pooled budget • Governance via Integration Executive	M
Poor evidence base/analysis for proof of concept/business case development	H		• Poor decision making affecting commissioning decisions • Poor selection of schemes to metrics • Lack of assurance on plan delivery	• Secure analyst resource. • Clinical/subject matter experts engaged in evidence base analysis (including public health) • Multiagency impact assessment workshop and product details evidence base. • Confirm and challenge via Integration Executive • Data quality review on scheme related KPIs supporting metrics in Q1 2014/15 • Scope development of intelligence hub as enabler within BCF plan.	M

Description	Likelihood	Risk before mitigation	Potential Impact	Mitigation	Risk after mitigation
Plan does not deliver against metrics e.g. The BCF plan does not deliver sufficiently to allow CCGs to release the planned level of funding across the two financial years. The impact of the BCF plan does not result in providers being able to extract the required levels of capacity from the system	H	H	• Unable to execute plan to milestones • Compromise delivery of metrics • Pressure on the acute system • Additional system costs • Reputational damage to HWB partners • Lack of public confidence in using alternatives to hospital. • Over performance on CCG acute contracts. • QIPP plans cannot be delivered in the acute sector. • Fixed costs and overheads cannot be reduced in line with planned activity reductions in the acute sector. • Impact on future contract negotiations and sustainability across the health and care economy.	• Further analysis on the impact of BCF schemes prior to final submission. • Metrics and trajectories subject to quality assurance in February/March • Evidence base to be linked more clearly to trajectory assumptions • Impact assessment workshop to stress test the metrics with provider involvement • Realistic stretch projections over the five year period on key metrics such as avoidable emergency admissions • Clear line of sight from BCF plan to acute contract activity and financial assumptions • Aggregated BCF plan impact clear across LLR • Detailed programme plan • Expenditure realistically profiled to plan. • Reporting on BCF delivery through Integration Executive • Scenario specifically addressed in risk sharing agreement • Contingency fund in pooled budget	H (until further evidenced at end of Yr 1)
Commissioning decisions/arrangements do not support integration	M	M	• Plan is not enacted in support of integrated care priorities	• Health and Wellbeing Board through Integration Executive to govern how integrated commissioning plans are enacted	L

Description	Likelihood	Risk before mitigation	Potential Impact	Mitigation	Risk after mitigation
Lack of contingency/effective alternative schemes if plan is failing	H	M	• Unable to reach trajectory of performance • Loss of confidence in local health and care system • Reputational damage	• Programme plan to include scoping effective alternatives/extensions of BCF schemes beyond 2015/16, including feasibility of mobilisation • Integration Executive to promote culture of innovation	M
Lack of effective communication about the BCF and how this supports/ fits with other plans	H	H	• Confusion about local plans, stakeholders disengaged, lack of support for plans	• Communications support to programme plan, joint messages to be agreed/enacted in conjunction with LLR-wide comms and engagement plan.	M
Dispute on risk sharing agreement	H	M	• Inability to maintain BCF funding plans beyond 2014/15 • Partnership unable to be sustained.	• Risk sharing agreement progressed February/March including via multi agency workshop • Pooled budget principles developed • Risk sharing arrangements for the pooled budget to cover dispute scenarios and methods of resolution • Contingency fund to be confirmed and challenged by Integration Executive following impact assessment workshop	M

Description	Likelihood	Risk before mitigation	Potential Impact	Mitigation	Risk after mitigation
Challenged Health Economy - External advisers External Advisers (for LLR 5 year plan) challenge/redirect local strategy including BCF assumptions leading to reprioritisation of BCF	M/H?	H	• Changes to BCF plan before impact of current schemes can be realised. • Potential impact on metrics delivery. • Lack of confidence in BCF plan. • Increased national/regional scrutiny and upward reporting. • Resources diverted to steering new course, rather than delivery. • Potential for escalating tensions between commissioners/providers/ other stakeholders. • Potential for change of personnel/leading to instability within the health and care system. • Impact of remedial work detracts from BCF delivery	• LLR Pre work on five year strategy • BCF refresh in Autumn 2014/15 to sense check position post publication of five year strategy. • Contingency plan if BCF is stalled/ reconfigured from 2016/17 onwards with comms plan to support this scenario. • Integration Executive contingency plan on resource allocation (people) if further work needed.	M
Challenged Health Economy –deficit (acute provider)	H	H	• System is in deficit for whole BCF period. • BCF funding is compromised. • System leadership could be subject to further change/ instability • Impact of remedial work detracts from BCF delivery	• Ensure BCF delivery to planned milestones • Seek stretch on metrics from 2015/16 onwards where possible • Consider additional/replacement schemes if can go further faster within available resources.	H

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Description	Likelihood	Risk before mitigation	Potential Impact	Mitigation	Risk after mitigation
BCF delivery costs greater than estimated	H	M	• Affordability of plan is jeopardised • Unable to deliver milestones/trajectory • Loss of confidence in the plan • Lack of financial control	• Further scoping and business case analysis in support of programme elements. • Phasing assumptions tested via programme plan. • Expenditure to plan kept under close review by integration executive with mitigation plan for re-prioritisation. • Dedicated finance lead for pooled budget	M
Costs of implementing the care bill not yet quantifiable and may not be fully funded	H	H	• MTFS of council placed under additional pressure • Additional savings needed in ASC • Potential impact on acute NHS	• Work plan within council to scope and implement Care Bill to inform BCF plan • Address the implications of national guidance and allocations letters about Care Bill funding as these are published. • Active involvement in the national modelling tool design and outputs. • Phased approach to financial planning with respect to Care Bill implementation • Briefings via the Integration Executive as implementation progresses, to include outcome of national and local work on eligibility. • Risk analysis to be regularly reviewed	M
Demand outstrips social care protection assumptions	M	M	• MTFS of council placed under additional pressure • Additional savings needed in ASC • Potential impact on acute NHS • Recurrent BCF plan in dispute	• Data tracking via ASC to inform BCF plan performance. • Risk sharing agreement to specifically cover this scenario • Regular BCF programme milestone reviews/risk reviews	L

Description	Likelihood	Risk before mitigation	Potential Impact	Mitigation	Risk after mitigation
Lack of opportunity to bring in additional schemes/innovate/flex the plan within the two year period.	H	M	• Missed opportunities for improving integrated care as additional evidence becomes available. • Culture of the programme is not conducive to mature debate. • Lack of openness to ideas from other settings/locations	• Regular BCF programme milestone reviews • Provider innovation to be encouraged via Integration Executive.	L
Environmental/Policy Change (e.g. election/ fundamental change to BCF/integration policy affecting NHS and/or LA partners)	M	M	• BCF approach is scrapped or expanded nationally. • Metrics/performance regime changes • Organisational integration becomes more of a policy imperative than service/care pathway integration (organisational integration not currently part of our BCF proposals) • Pace of delivery compromised due to change of direction	• Integration Executive and HWB Board to provide strategic local leadership to ensure improving integrate care remains central to five year objectives with linkage to LLR-wide strategy. • Integration Executive and HWB Board to consider an MOU to cover future proofing medium term commitments within the boundaries of the existing mechanisms for joint working across health and local govt.	L

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APPENDIX 1

HEALTH AND WELLBEING BOARD: 13 MARCH 2014

REPORT OF THE DIRECTOR OF PUBLIC HEALTH

**JOINT HEALTH AND WELLBEING STRATEGY 2013-16
EVENT – 24 FEBRUARY 2014**

Purpose of report

1. This report is a summary of an event hosted by the JHWS/ JSNA Steering Board to review progress towards the Joint Health and Wellbeing Strategy (JHWS). The event was held on the 24 February 2014 and is part of the ongoing commitment of the steering board to consult with stakeholders on the progress that is being made against the JHWS so that the delivery and development of the strategy can be revised in light of the feedback that we receive.

2. Due to the short period of time between the event and this meeting the information is not complete. A more detailed analysis will be made available in the Health and Wellbeing Board Annual Report, due for publication in May.

3. The event had two principle objectives:
   - To review the progress that has been made in delivering the Joint Health and Wellbeing Strategy since it was published in January 2013
   - To assess the Better Care Fund (BCF) proposals against the strategy and identify any changes needed to the strategy to support the delivery of the BCF.

   The event was hosted jointly by
   - Leicestershire County Council
   - East Leicestershire and Rutland Clinical Commissioning Group (CCG)
   - West Leicestershire CCG
   - Healthwatch Leicestershire

   The event was split into two sessions, one focussed on the JHWS and one focussed on the BCF.

Participants

4. The event attracted over 100 delegates from a range of different backgrounds. A full break down of the organisations that attended will be made available in the complete report.

The Joint Health and Wellbeing Strategy

5. Delegates were asked to consider the progress that has been made in delivering the strategy against a number of themes. There were 10 groups in total considering five different topics.

6. The feedback from the workshop sessions are detailed in Appendix 1.

7. The feedback has been summarised into the diagram below and the themes have been summarised.

7.1. There is support for the incorporation of learning disabilities as a priority and the group that reviewed this topic have provided an initial steer on the issues that will need to be incorporated into this work programme going forwards.

7.2. The users accepted that a lot of progress had been made to put things in place across the whole wellbeing system to address the needs of the population that were identified in the JSNA and the JHWS. However, these have not yet translated into improvements that are experienced by the actual users of services and this needs to be evaluated and developed going forwards.

7.3. The needs of carers was identified as a key issues across a number of themes as a priority. It is essential that there is greater understanding of the needs of carers going forwards and more is done through the strategy and the action plans to address their needs.

7.4. There is need for better information and signposting for patients.

7.5. There needs to be better join up across the whole system, starting with the leaders of the various partners with a cultural shift to ensure join up throughout the whole system.

7.6. The needs of the most disadvantaged populations / people with protected characteristics are not being adequately met though the strategy and more needs to be done to understand and meet their needs.

The Better Care Fund

8. Delegates were asked to consider the main benefits for the BCF schemes that were presented and how these could be further improved. They were also asked to consider how the JHWS and action plans should change or be further developed to promote integration.

9. The notes from the workshop are summarised in the diagram below:

10. The feedback from the event was focussed more on the benefits of the BCF themes rather than the developments that need to be made to the strategy. The feedback has been summarised in Appendix 2, and the key themes are presented below.

10.1. The JHWS action plans need to be developed to incorporate the BCF work programme.

10.2. The needs of carers need to be considered in more detail.

10.3. There is a need for a programme of community development to support communities and patients to manage better for themselves

10.4. There is a need for better integration across health and social care with care-coordinators crossing the whole spectrum of care

10.5. The action plans need to make better use of new technology to support patients and carers with both access to professionals and to enable people to manage in their own homes for longer.

10.6. There needs to be better information sharing across agencies for both provision of care and planning of care.

10.7. The needs of the most disadvantaged populations / people with protected characteristics need to be addressed through BCF.

10.8. There were significant concerns identified in the workshop reviewing integrated urgent response – the mechanisms to make this happen well need to be more fully developed in the action plans going forwards.

10.9. Integration needs to happen at all areas of strategy and delivery from organisational leadership through to service delivery.

Evaluation

11. The evaluation of the event is not yet complete. However, feedback on the day indicates that the number of attendees at the event has grown to such an extent that it is no longer possible to manage this as a single event. It was also felt that the mixing of professional stakeholders with members of the public did not work at this event, although this model has worked effectively in other events. The engagement team at Leicestershire County Council will be asked to support the JHWS/ JSNA Steering Board in developing an engagement plan to ensure future engagement activities are adapted to reflect the feedback that is collated.

Recommendations

It is recommended that the Health and Wellbeing Board:

12. Note the findings of the engagement event for the JHWS

13. Support a refresh of the JHWS in 2014/15 to incorporate:

13.1. The development of the better care fund workstreams

13.2. The inclusion of learning disabilities as an additional priority in the JHWS

14. Consider the feedback from the stakeholder event and the key themes identified and task the sub-boards of the HWB with developing these through the strategy refresh and action plans.

15. Support the strengthening of the JHWS actions plans around the needs of carers and the needs of people with protected characteristics

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Appendix 1: Review of progress against the Health and Wellbeing Strategy

	RESULTS	**REVIEW and REFLECT**	**REFOCUS**	**RELATIONSHIPS**
Giving children the best start in life	Sharing information Targeting vulnerable groups Supporting Leicestershire Families: a worker who works across a whole family – can facilitate access to a whole range of other services	Low level 'mental health' support – school nurse capacity is a concern. Whole family approach – needs more work with some groups e.g. carers. Children's oral health – gap in PH. Transition from child to adult services Services during school holidays	Themes for children and young people are right and each has notable successes over last 12 months But we need HWB to have simple, strong & direct governance and to set outcomes & targets that all relevant organisations sign up to and are accountable for. Need mental health and integrated provision to be a top priority	Issues with links between services e.g. Maternity Services- UHL/HV-LPT – need to join up.
Early Intervention and prevention	Success of 111 contract Improved links between HV and midwives in sure starts Increase in access to physiotherapy services	Ideas are there but needs more progress to embed across the whole county Need a single point of contact for patients and carers	Increased visibility of services Better linkages and co-ordination between services Objectives need to be targeted and "SMART"	Desire for partnership Better and earlier public consultation Better leadership Better communication with the public

	RESULTS	REVIEW and REFLECT	REFOCUS	RELATIONSHIPS
	Four ways to warmth	Are we maximising the opportunities through community pharmacy	Understanding low cost and zero cost options Strengthen strategy and delivery for hard to reach groups	Better matrix working across organisations – break down silos
Supporting the ageing population	Some good developments – shared lives, extra care Providing the right information for people in an appropriate format, particularly around hospital discharge Carers hospital services is a good model for involving carers in decisions about care Assistive technology is good and successful but new to some people	Single point of access Delay in adaptations is a problem Hospital discharge – people need a 'check up' call to see if they are ok after first 24 hours at home Services need to take more account of peoples needs around access – reasonable adjustments	Need a workforce training & development plan for carers Need more low level support based in communities for older people Increased support for people to stay in their own homes	Healthwatch should keep the website questions page open as it's a good way to get feedback from people

	RESULTS	REVIEW and REFLECT	REFOCUS	RELATIONSHIPS
Mental health	Better training / feedback systems to account for feedback from service users. Better joint services of adult / children / acute service. Better referral systems from e.g. GP / different pathways for referrals. Better guidance for pathways to mental health services. Linking different organisations better to promote better care. One Joint Care Plan to allow for integrated care (to incorporate physical and mental health issues).	No real improvement felt from service users or practitioners / mental health services appear to get worse - not enough capacity for acute mental health services / health professionals leads to 'Gate Keeper' system. Crisis Intervention Team (Resolution): great idea, but after initial contact, they pass you on to other services who can't or won't help and pass you back to the Crisis Team A greater focus on meeting childrens mental health needs Reduction in psycho-oncology services is negative	No real improvements though changes in health and social care system felt. Clear outline of strategy and what has been achieved One point of contact for mental health services. Better understanding of what is 'mental health'. Need to consider mental health needs of people with protected characteristics, including children More support for children and young people Resources must follow referral. Don't refer	Mental Health: a cross cutting issue for all elements of the strategy and this is helpful, as physical activity for example, has positive impact on mental health, so good to see emphasis on prevention that has a by-product of improved wellbeing . Request for a county wide health promotion group to drive the agenda forwards Districts having local health partnerships is a good development – has been difficult to get mental health strategic leadership. Impact of £ pressure. Act together to tackle diminishing resources. Create/explore new ways of doing things. Taking some calculated risks together Supporting schools to address mental health issues in children

	RESULTS	REVIEW and REFLECT	REFOCUS	RELATIONSHIPS
		Need to evaluate initiatives Carers support	into services that can't accommodate volume Mental health promotion strategy	Role of community safety partnerships
Learning disabilities	Changing eligibility criteria. Developing information about who we have. Health Checks / Health Action Plans. Pooled budgets. Gap in transition from traditional services to personal budget. Review of short breaks. Inclusion as a priority in JHWS	Very tough for long term carers. Different ways to engage: users /carers can find it difficult to attend meetings Personal budgets: better support for families, infrastructure for pooling individual budgets. Better (and more accessible) information about services that are available Look at evidence of what's working well. Transition from childrens to adults services needs to improve	What do we need to do in light of Winterbourne? Learning disability CANNOT be mixed up in Mental Health. Ageing caring population. Dual caring – caring for person with LD and family member. Short breaks. Social interaction. Early intervention for those out of eligibility. Protected characteristics	Named care co-ordinator with families and people who use services. Information at point of access/discharge. Signposting. Recognise we are carers for life

Appendix 2: The Better Care Fund

	From your perspective, what are the main benefits you would expect to see from the proposals under this BCF theme…. and how could these be improved further…. For	In what ways should our JHWS and action plans change/develop to promote integration?
The unified prevention offer	Local area support needs to be wider than social care Good neighbour scheme Early identification and support is needed Extend the principles of first contact Difficulties of financial pressures means that focus is on acute priorities rather than prevention Issues for gypsies and travellers need to be considered Issues BCF should focus on: • Transport help to appointments • Helping with children • Help with using internet • Can we expand care online • First contact person to be able to signpost effective – use standard questions. • Vulnerable elderly – short term illness – 72 hours support at home including for carers. • 'mini plans' for what to do in a crisis	Carers assessment in care bill - need to identify issues for older male carers. Carers should be seen as an at risk group Broaden the JHWS to incorporate the BCF elements Need to include employers / faith communities / neighbourhoods / parishes / voluntary sector. Sharing agendas to deliver information. Organisational behaviour change. Challenge of what we won't do any more to enable these areas to develop; What can we do to help communities to develop: Targeting – greatest need and hard to reach
Long term conditions	A number of issues were raised about the need to have better integration across health and social care and some of the barriers to this. Including: • A need to move a way from the idea of a medical or a social model to a holistic model • Better case management • A single number for people with LTC	Integration is key to supporting people with LTC and the development of seamless services Links between the LTC workstream and the unified prevention offer Changing the way services are delivered and

	From your perspective, what are the main benefits you would expect to see from the proposals under this BCF theme…. and how could these be improved further…. For	In what ways should our JHWS and action plans change/develop to promote integration?
	• Better support for patients to manage their own condition/s • Role of community pharmacy • Making every contact count • Managing cultural barriers for medical and social care professionals • Peer support Issues raised about cuts impacting on prevention Better use of technology, including: • Home adaptations • Telephone and web based consultations • Access to good quality information Sharing information across agencies: • Essential for case management • Essential for robust planning across the pathways • Concerns about personal data being shared Issues raised about reaching the whole population • LTC all ages not just elderly • LTC and people with learning disabilities • Carers • People from disadvantaged groups / people with protected characteristics	making better use of technology Improved information sharing Ensuring that the strategy reaches the whole population Targeting – greatest need and hard to reach
Integrated urgent response	This theme raised a number of concerns identified below: • Will GPs work seven days a week • Discharges must be planned	The action plans in the JHWS need to be updated to incorporated integrated urgent response and the mechanisms for developing this and

	From your perspective, what are the main benefits you would expect to see from the proposals under this BCF theme…. and how could these be improved further…. For	**In what ways should our JHWS and action plans change/develop to promote integration?**
	• A need for a co-ordinator to support people through the discharge • People leaving hospital need better information about the support that is available • Linking in the voluntary sector services that are available • Issues with providers understanding the different support needs for people with protected characteristics Some specific issues were raised for people with mental ill-health, particularly lack of discharge support for people that have attempted suicide and the need for discharge planning to ensure that people are not returning to an unsafe environment.	delivering this well need to reflect the concerns identified here.
Hospital discharge and reablement	The benefits were identified as: • Rapid assessment of individual needs • Full assessment (including health needs / housing needs / technology and adjustments) before hospital discharge. • 7 day working, 24/7; • Continuity of care • Less pressure on working • Must be a range of services – possibly GP led • Easier to cost • Identify patterns of care. • Opportunity for welfare review across health and social care. • Better support for carers	Action plans need to focus on staff training to ensure that the integration is managed as effectively as possible, providing the right support and information for patients and their carers. Action plans need to be holistic across health and social care and the integration needs to happen throughout all levels of care. Strategic join up of the strategy across health and social care so that there is a join up on the issues that are being addressed, including using language that works across all organisations

	From your perspective, what are the main benefits you would expect to see from the proposals under this BCF theme…. and how could these be improved further…. For	In what ways should our JHWS and action plans change/develop to promote integration?
	The concerns were identified as: • 2 hour response team – who will be on the team; • Triaged • Challenges of having 'strangers' in a person's home who is already distressed • Cultural challenges • Holistic approach to review of services – NOT SILOS. • Relationship between CCGs – working co-operatively on issues, not slightly different themes. • How will future strategies developed a shared language across health, social care and independent sector. • Aligning of management structures and operational processes	

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APPENDIX 3

BETTER CARE FUND IMPACT ANALYSIS

1. INTRODUCTION

The Leicestershire Better Care Fund (BCF) Plan for 2014/15 and 2015/16 will be submitted on 4 April 2014. This will compromise an updated BCF plan with a supporting financial and performance outcome template submission. The aim of this paper is to present the findings of an impact analysis of the thirty-seven components of the BCF plan against the plans of the six outcome metrics. NHS England provided technical guidance for the preparation of baselines and trajectories for each metric, including an indication of what would constitute a statistically significant improvement based on the population size.

2. FINDINGS FROM METRIC REVIEWS

Since the original BCF submission on 14 February 2014 a detailed impact analysis has been undertaken of the (five) national and (one) local metrics against which delivery of the BCF plan will be assessed. This initial impact assessment was presented for discussion at a multiagency workshop held on 12 March 2014. The findings are presented below.

2.1. METRIC 1: 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. Chart 1 shows a bar chart illustrating the proposed trajectory detailed in Table 1 below. The line chart shows that validation of this metric using BCF base data and the statistical significance calculator (see Appendix B) has ratified the proposed trajectory.

Chart 1.1 Chart 1.2

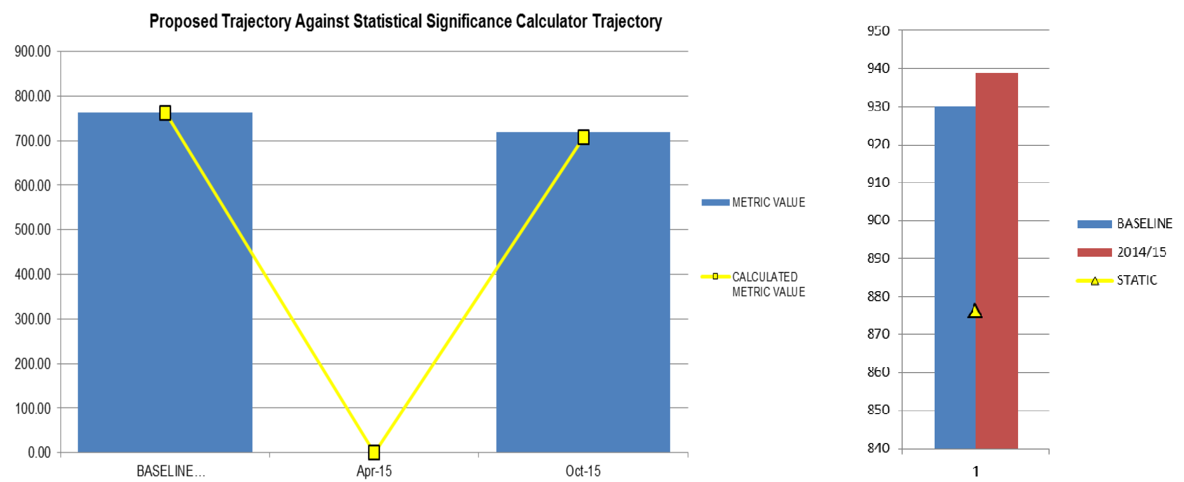


Table 1

	BASELINE (Apr-12 – Mar-13)	Apr-15 PAYMENT	Oct-15 PAYMENT (Apr-14 – Mar-15)
NUMERATOR	930		939
DENOMINTOR	121,930		130,645
METRIC VALUE	762.73		718.74

The proposed trajectory is for a reduction from 762.73 permanent admissions per 100,000 population per year to 718.74 (or 5.77%) by 31 March 2015 (this is against a national benchmark of a reduction of 13%). It is noted that the numerator for the October 2015 payment is 939 which is an increase of 9 (0.97%) against the baseline of 930. Chart 1.2 illustrates this increase in the numerator. This chart also shows the effect of discounting population growth which would result in 54 fewer permanent admissions to residential or nursing care.

2.2. METRIC 2: 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. Chart 2 shows a bar chart illustrating the proposed trajectory detailed in Table 2 below. The line chart shows that validation of this metric using BCF base data and the statistical significance calculator (see Appendix B) has ratified the proposed trajectory.

Chart 2.1 Chart 2.2

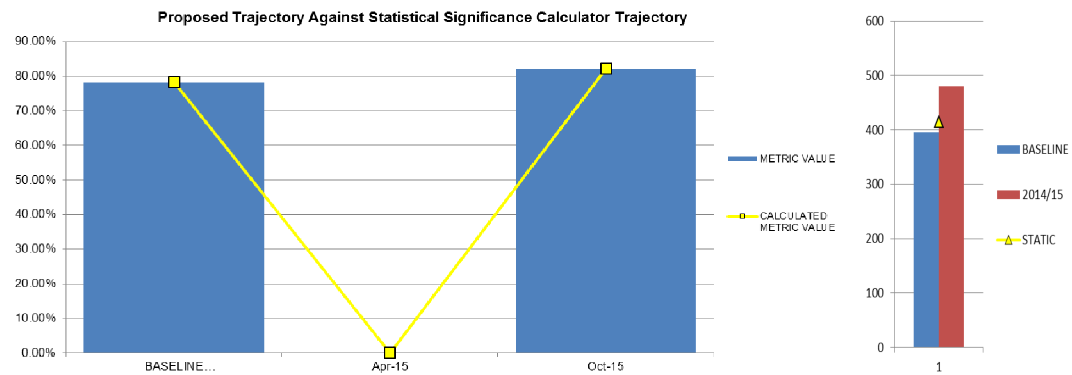


Table 2

	BASELINE (Apr-12 – Mar-13)	Apr-15 PAYMENT	Oct-15 PAYMENT (Apr-14 – Mar-15)
NUMERATOR	395		480
DENOMINTOR	505		584
METRIC VALUE	78.22%		82.19%

The proposed trajectory is for an increase from 78.22% of service users still at home 91 days after discharge to 82.19% (or 5.08%) by 31 March 2015 (this is against a national benchmark of an increase of 6%). It is noted that an action plan is being developed to improve the data quality to more accurately measure the 91-day period from discharge. Chart 2.2 shows the effect of discounting population growth on the number of older people who were still at home 91 days after discharge. It is noted however, that the percentage delivery against this indicator remains the same.

2.3. METRIC 3: 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. Chart 3.1 shows the cumulative monthly rate of delayed bed days per 100,000 population for the baseline period, 2014/15 and Q1 2015/16. Chart 3.2 shows the reduction in cumulative bed days comparing the end of the baseline period with 2014/15.

Chart 3.1

Chart 3.2

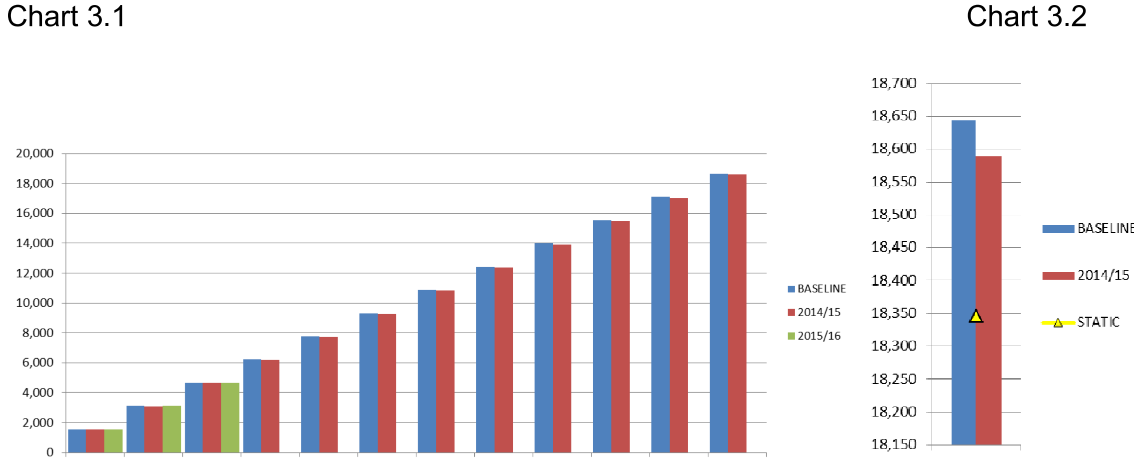


Table 3

	BASELINE (Apr-12 – Mar-13)	Apr-15 PAYMENT (Apr-14 – Dec-14)	Oct-15 PAYMENT (Jan-15 – Jun-15)
NUMERATOR	12,429	13,915	9,348
DENOMINTOR	530,769	536,515	541,600
METRIC VALUE	292.71	288,18	287.67

Table 3 shows the proposed trajectory to be submitted for this indicator. The proposed trajectory is for a decrease from a baseline of 292.71 delayed bed days per 100,000 per month to 288.18 (1.55%) by 31 December 2014 followed by a further reduction to 287.67 (0.18%) by 30 June 2015. This is against a national benchmark of a reduction of 4%. Chart 3.2 also shows the effect of discounting population growth which would result in a further reduction of 242 delayed bed days at the end of 2014/15.

2.4. METRIC 4: Avoidable emergency admissions (composite measure)

This is a nationally defined metric measuring delivery of the outcome to reduce avoidable emergency admissions which can be influenced by effective collaboration across the health and care system. This is a composite measure of:

- Unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages)
- Unplanned hospitalisation for asthma, diabetes and epilepsy in children
- Emergency admissions for acute conditions that should not usually require hospital admission (all ages)
- Emergency admissions for children with lower respiratory tract infections

Chart 4.1 Chart 4.2

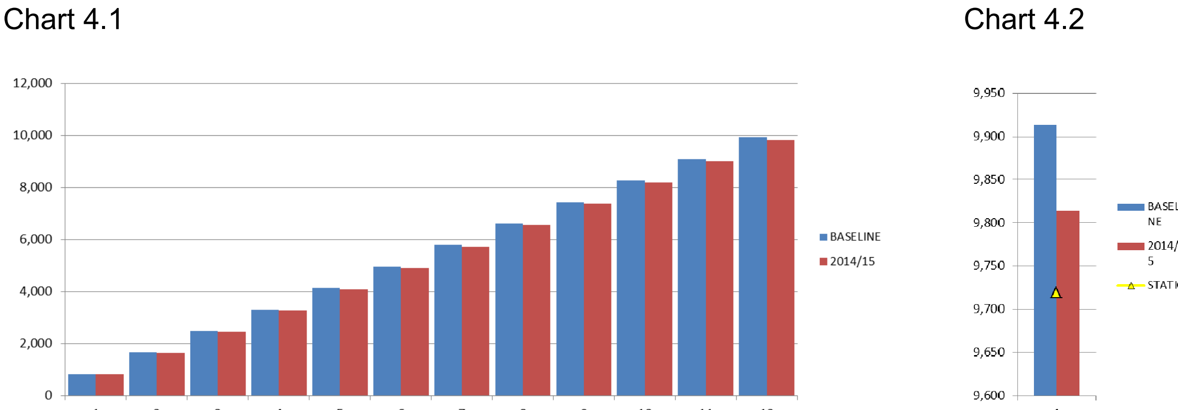


Chart 4.1 shows the cumulative monthly rate of emergency admissions per 100,000 population for the baseline period, 2014/15 and Q1 2015/16. Chart 4.2 shows the reduction in cumulative bed days comparing the end of the baseline period with 2014/15.

Table 4

	BASELINE (Apr-12 – Mar-13)	Apr-15 PAYMENT (Apr-14 – Sep-14)	Oct-15 PAYMENT (Oct-14 – Mar-15)
NUMERATOR	9,913	4,907	4,907
DENOMINTOR	665,557	672,049	672,049
METRIC VALUE	124.12	121.69	121.69

Table 4 shows the proposed trajectory to be submitted for this indicator. The proposed trajectory is for a decrease from a baseline of 124.12 emergency admissions per 100,000 per month to 121.69 (1.96%) by 30 September 2014 and then remaining the same at 121.69 until 31 March 2015. Chart 4.2 also shows the effect of discounting population growth which

would result in a further reduction of 99 avoidable emergency admissions at the end of 2014/15

2.5. METRIC 5: Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]

This will be a nationally defined metric however, at the time of writing this paper the guidance confirming the definition of the metric has not be released. The outcome will be to demonstrate local population/health data, patient/service user and carer feedback has been collated and used to improve patient experience. To provide assurance that there is a co-design approach to service design, delivery and monitoring, putting patients in control and ensuring parity of esteem.

In the absence of this clarity this metric was reviewed as part of the BCF workshop held on 12 March 2014.

2.6. METRIC 6: 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 due to falls in people aged 65 and over. Chart 5.1 shows the cumulative monthly rate of emergency admissions per 100,000 population for the baseline period, 2014/15 the period October 2014 to September 2015. Chart 5.2 shows the increase in cumulative emergency admissions comparing the end of the baseline period with 2014/15 and the period October 2014 to September 2015.

Chart 5.1

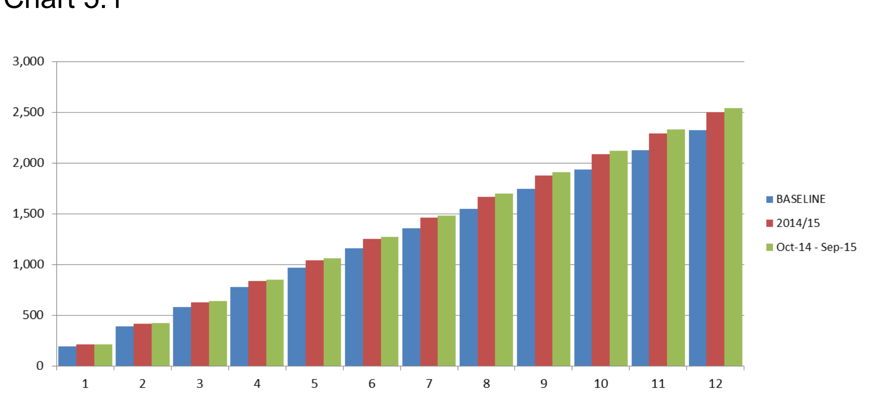


Chart 5.2

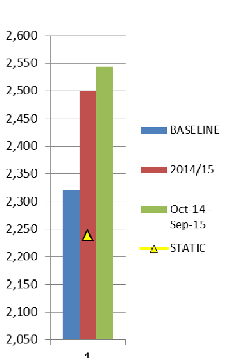


Table 5

	BASELINE (Apr-10 – Mar-11)	Apr-15 PAYMENT (Apr-14 – Mar-15)	Oct-15 PAYMENT (Oct-14 – Sep-15)
NUMERATOR	2,322	2,500	2,543
DENOMINTOR	115,044	128,466	130,645
METRIC VALUE	168.20	162.17	162.21

Table 5 shows the proposed trajectory to be submitted for this indicator. The proposed trajectory is for a decrease from a baseline of 168.20 emergency admissions per 100,000 per month to 162.17 (3.58%) by 31 March 2015 followed by a slight increase to 162.21 (0.02%) by 30 September 2015. Chart 5.2 also shows the effect of discounting population growth which would result in a further reduction of 83 emergency admissions due to falls at the end of 2014/15 in comparison to the baseline.

3. OUTCOME OF WORKSHOP/RECOMMENDATIONS

A multi-agency BCF Impact Assessment Workshop was held on 12 March 2014. The aim of the workshop was to jointly assess the achievability of the six BCF metrics and the impact on the health and care system. In light of the assessment, the workshop would propose any material changes to the BCF submission on 4 April 2014 and associated recommendations.

The proposed trajectories for each of the six metrics in section 2 reflect the output of analysis and validation undertaken up to and following the workshop. During the course of the workshop, the team made an assessment of which of the BCF schemes would make the most directly measurable contribution to the delivery of each metric. The workshop also assessed the overall risks to deliver each metric and created a product showing the top three risks in each case for immediate prioritisation, along with suggested mitigation.

Products from this work are:

- An updated BCF Scheme Impact Analysis (included as Appendix A)
- An updated BCF Metric Impact Analysis (included as Appendix B)

- Appendix C shows updated tables which illustrate how each of the 37 schemes contribute to the delivery of the six metrics
- A prioritised list of risks and associated mitigations to deliver each of the six metrics (included as Appendix D)

3.1. RESIDUAL RISKS REQUIRING MITIGATION PRIOR TO 4 APRIL SUBMISSION

With reference to Appendix D the following table highlights a list of risks and associated mitigations which will be addressed as part of the work to finalise the submission for 4 April.

METRIC	RISK	MITIGATION	STATUS
3	Need to categorise the BCF schemes to identify measureable, core schemes directly contributing to the delivery of the DToC metric and those schemes which make a minimal contribution	Schemes currently identified against the DToC metric in the BCF Impact Assessment were reviewed by both Risk Working Groups and a list of schemes was agreed **ACTION**: SR to reflect the rationalised list of core schemes in an updated version of the BCF Impact Assessment and corresponding pivot table	COMPLETE (Appendix C)
	The current DToC metric needs to be amended prior to resubmission so that it has a negative gradient in line with the national benchmark	**ACTION**: It was agreed that GEM would send SR revised numerators for the DToC metric by close of play Friday 14 March. This revision would be aligned to the CCGs' 5-year Strategy. GEM will also confirm that the baseline includes DToC for both UHL and LPT	COMPLETE
	Need to identify schemes outside of the BCF that directly impact on the DToC metric for Adult	The revised version of the BCF submission to include an appendix of non-BCF schemes which make a measurable contribution to the delivery of	IN PROGRESS

METRIC	RISK	MITIGATION	STATUS
	Mental Health DToC	the DToC metric. These will be included toward evidencing delivery of the DToC metric	
4	Need to categorise the BCF schemes to identify measureable, core schemes directly contributing to the delivery of the metric and those schemes which make a minimal contribution	Schemes currently identified against the metric in the BCF Impact Assessment were reviewed by both Risk Working Groups and a list of schemes was agreed **ACTION**: SR to reflect the rationalised list of core schemes in an updated version of the BCF Impact Assessment and corresponding pivot table	COMPLETE (Appendix C)
	The current metric needs to be reviewed and amended prior to resubmission so that it is inline with CCG plans and 2014/15 contracts	**ACTION**: It was agreed that GEM would review the metric and if necessary send SR revised numerators for the metric by close of play Friday 14 March.	IN PROGRES
	Are all providers (i.e. UHL, LPT and out-of-county) included in the current submission?	**ACTION**: It was agreed that GEM would review and send confirmation to SR by close of play Friday 14 March.	COMPLETE
	Need to identify childrens schemes outside of the BCF that directly impact on the metric	The revised version of the BCF submission to include an appendix of non-BCF schemes which make a measurable contribution to the delivery metric. These will be included toward evidencing delivery of the DToC metric	IN PROGRESS
6	EMAS service – a proven scheme which is likely to deliver	Propose the addition of the EMAS non conveyance/falls service and cost into the BCF,	IN PROGRESS

METRIC	RISK	MITIGATION	STATUS
	against the metric quickly is not within the BCF plan (or therefore linked to this metric)	adjust other schemes as needed to find the resource required. Ensure this is a joint scheme between EMAS/LA and NHS so that operational protocols and local pathways are aligned to support non conveyance	

3.2. RESIDUAL RISKS TO BE CAPTURED IN BCF PROJECT PLAN FOR 2014/15

METRIC	RISK	MITIGATION
1	Capacity in Dom Care market – workforce risks	Better care together (LLR wide strategy) will include a workforce strategy Help to Live at Home project group is also tackling this issue in Leicestershire However we need to understand the pace and milestones for these improvements to ensure we meet the metric
	Limited staff pool to develop new areas of service	Action plan to include plans to develop generic workers. How contract terms for Dom care workers can be addressed
	Mobilisation, resource and capacity are concerns	Clear agreement of model asap Data baseline required asap
2	Normally bottom quartile for this metric	Immediate feasibility work to change the approach to data capture and cost the implications of these changes – need to capture where people actually end up after reablement – across all settings of care.
6	Number of the schemes are about future delivery (prevention) and will not see	Longer term prevention schemes still need to be prioritised and developed but clarity is needed in presentation of these schemes

METRIC	RISK	MITIGATION
	results/impact on metrics immediately in year 1	against this metric that they will deliver later and need measurables

4. CONCLUSIONS AND RECOMMENDATIONS

I. Gaps remain in the impact analysis, including where evidence is missing or incomplete, where governance or project resources are unclear, or where there is insufficient detail in the measurement of the interventions/data capture. It is recommended that the impact analysis is subject to further work in Q1 2014/15, with a progress update at the April meeting of the Integration Executive.

II. That KPIs be further validated (where they exist) or developed as necessary for each of the BCF component schemes, so that their contribution to the 6 headline metrics is clear and the impact can be tracked by scheme.

III. The risk analysis and mitigation plan by metric should be incorporated into the project plan and risk register of the relevant component of the integration programme.

IV. The Integration Executive is recommended to approve the submission of the metrics per the analysis in this paper with the following caveats:

   a. Further work is required to improve data quality for metric 2 (reablement 91 days)

   b. That the DTOC metric may be subject to further national development in 2014/15

   c. That the avoidable emergency admissions trajectory should be expressed over a 5 year period with supporting narrative indicating the improved pace of delivery (stretch to be applied) from 2015/16 onwards in line with CCG operating plan/5 year plan intentions.

   d. In the absence of a national metric for capturing patient experience the Integration Executive should ask quality leads to consider the feasibility of using a local proxy metric or metrics which can be applied to the 4 themes of the BCF.

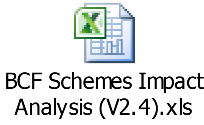
   e. That the numerator for the falls metric currently increases over the course of the proposed trajectory. Due to this further analysis is needed on the impact of the schemes to deliver against this metric – see V below

V. The Integration Executive should include a new scheme in the BCF to address the falls metric, as the findings of the workshop the schemes currently in the plan will not deliver in the first 18 months but are valid for prevention in the longer

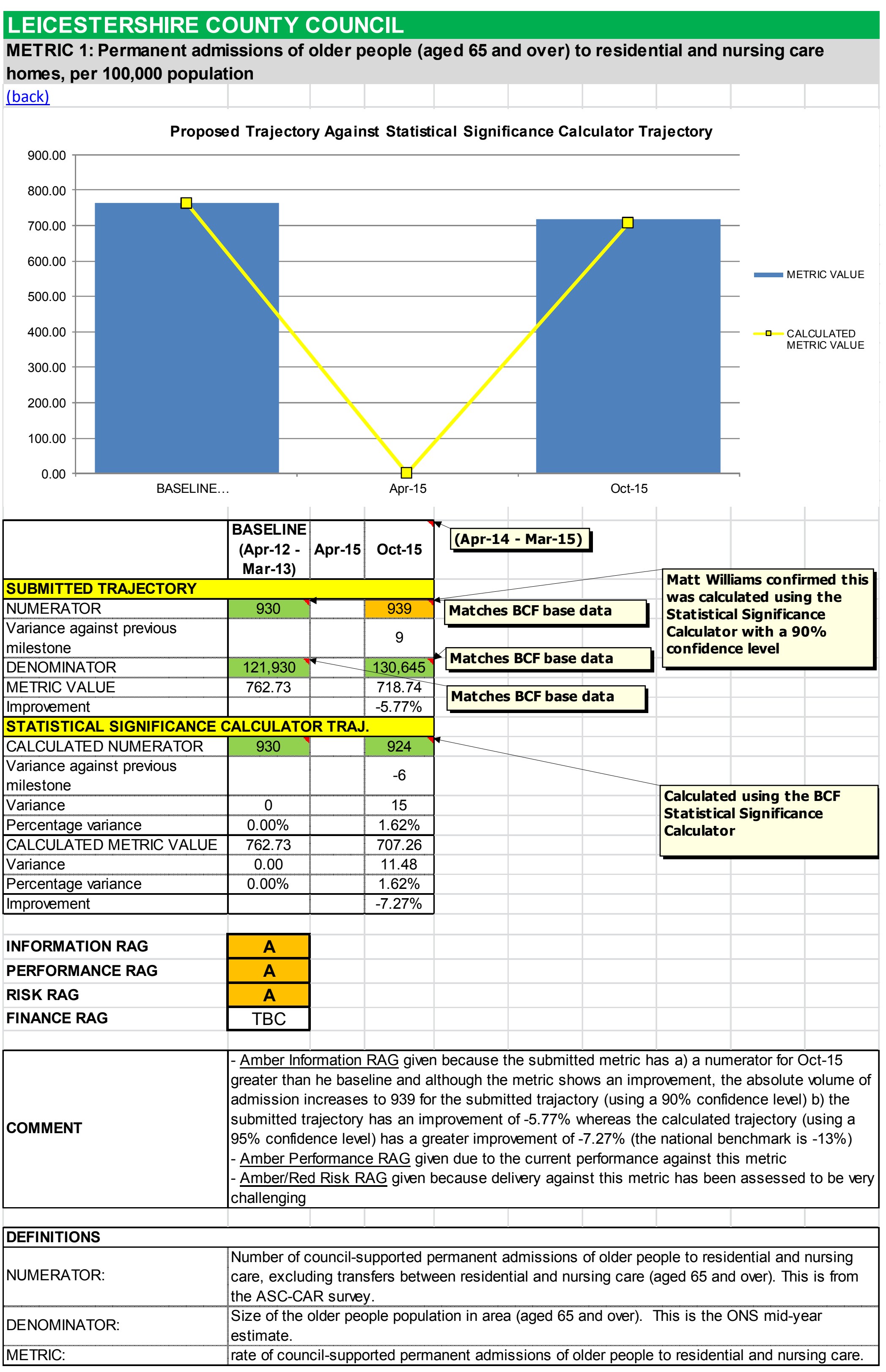
term. The addition of the EMAS falls prevention scheme is recommended as this has good evidence from elsewhere in the East Midlands and analysis is currently underway to assess the financial requirements for this scheme in 2014/15.

VI. The papers for the Health and Wellbeing Board on April 1st should include a short cover paper outlining the decisions of the integration executive with supporting Appendix B, so that assurance can be given on the validation undertaken of the metrics prior to BCF approval.

5. APPENDIX A: BCF Scheme Impact Analysis



6. APPENDIX B: BCF Metric Impact Analysis



LEICESTERSHIRE COUNTY COUNCIL

METRIC 1: Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population

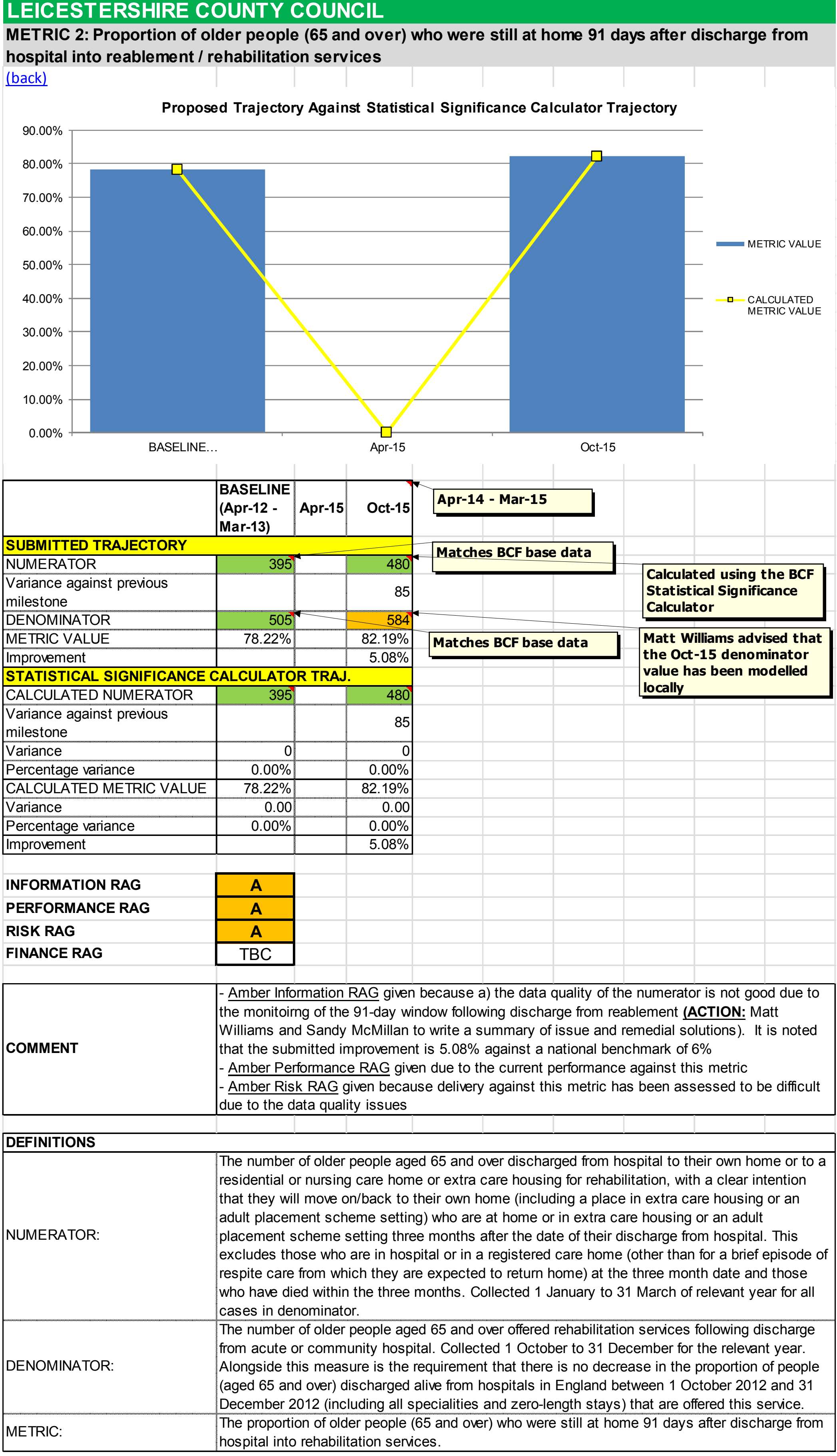
(back)

	BASELINE (Apr-12 - Mar-13)	Apr-15	Oct-15
SUBMITTED TRAJECTORY			
NUMERATOR	930		939
Variance against previous milestone			9
DENOMINATOR	121,930		130,645
METRIC VALUE	762.73		718.74
Improvement			-5.77%
STATISTICAL SIGNIFICANCE CALCULATOR TRAJ.			
CALCULATED NUMERATOR	930		924
Variance against previous milestone			-6
Variance	0		15
Percentage variance	0.00%		1.62%
CALCULATED METRIC VALUE	762.73		707.26
Variance	0.00		11.48
Percentage variance	0.00%		1.62%
Improvement			-7.27%

INFORMATION RAG	A
PERFORMANCE RAG	A
RISK RAG	A
FINANCE RAG	TBC

COMMENT	- Amber Information RAG given because the submitted metric has a) a numerator for Oct-15 greater than he baseline and although the metric shows an improvement, the absolute volume of admission increases to 939 for the submitted trajactory (using a 90% confidence level) b) the submitted trajectory has an improvement of -5.77% whereas the calculated trajectory (using a 95% confidence level) has a greater improvement of -7.27% (the national benchmark is -13%) - Amber Performance RAG given due to the current performance against this metric - Amber/Red Risk RAG given because delivery against this metric has been assessed to be very challenging

DEFINITIONS	
NUMERATOR:	Number of council-supported permanent admissions of older people to residential and nursing care, excluding transfers between residential and nursing care (aged 65 and over). This is from the ASC-CAR survey.
DENOMINATOR:	Size of the older people population in area (aged 65 and over). This is the ONS mid-year estimate.
METRIC:	rate of council-supported permanent admissions of older people to residential and nursing care.



LEICESTERSHIRE COUNTY COUNCIL

METRIC 2: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

(back)

	BASELINE (Apr-12 - Mar-13)	Apr-15	Oct-15
SUBMITTED TRAJECTORY			
NUMERATOR	395		480
Variance against previous milestone			85
DENOMINATOR	505		584
METRIC VALUE	78.22%		82.19%
Improvement			5.08%
STATISTICAL SIGNIFICANCE CALCULATOR TRAJ.			
CALCULATED NUMERATOR	395		480
Variance against previous milestone			85
Variance	0		0
Percentage variance	0.00%		0.00%
CALCULATED METRIC VALUE	78.22%		82.19%
Variance	0.00		0.00
Percentage variance	0.00%		0.00%
Improvement			5.08%

Apr-14 - Mar-15

Matches BCF base data

Calculated using the BCF Statistical Significance Calculator

Matches BCF base data

Matt Williams advised that the Oct-15 denominator value has been modelled locally

INFORMATION RAG	A
PERFORMANCE RAG	A
RISK RAG	A
FINANCE RAG	TBC

COMMENT	- Amber Information RAG given because a) the data quality of the numerator is not good due to the monitoirng of the 91-day window following discharge from reablement **(ACTION:** Matt Williams and Sandy McMillan to write a summary of issue and remedial solutions). It is noted that the submitted improvement is 5.08% against a national benchmark of 6% - Amber Performance RAG given due to the current performance against this metric - Amber Risk RAG given because delivery against this metric has been assessed to be difficult due to the data quality issues

DEFINITIONS	
NUMERATOR:	The number of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting) who are at home or in extra care housing or an adult placement scheme setting three months after the date of their discharge from hospital. This excludes those who are in hospital or in a registered care home (other than for a brief episode of respite care from which they are expected to return home) at the three month date and those who have died within the three months. Collected 1 January to 31 March of relevant year for all cases in denominator.
DENOMINATOR:	The number of older people aged 65 and over offered rehabilitation services following discharge from acute or community hospital. Collected 1 October to 31 December for the relevant year. Alongside this measure is the requirement that there is no decrease in the proportion of people (aged 65 and over) discharged alive from hospitals in England between 1 October 2012 and 31 December 2012 (including all specialities and zero-length stays) that are offered this service.
METRIC:	The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation services.

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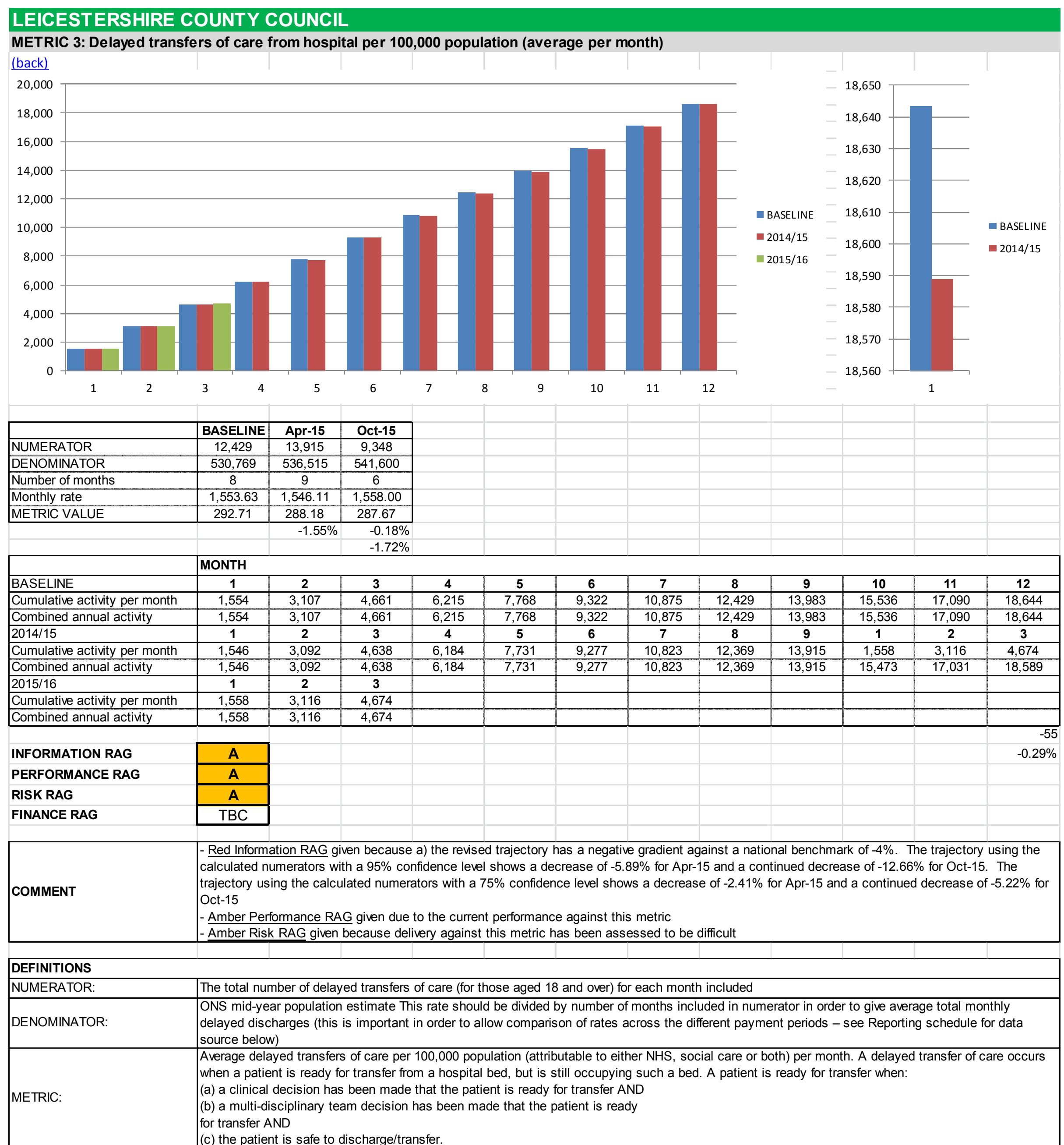
METRIC 3: Delayed transfers of care from hospital per 100,000 population (average per month)

(back)



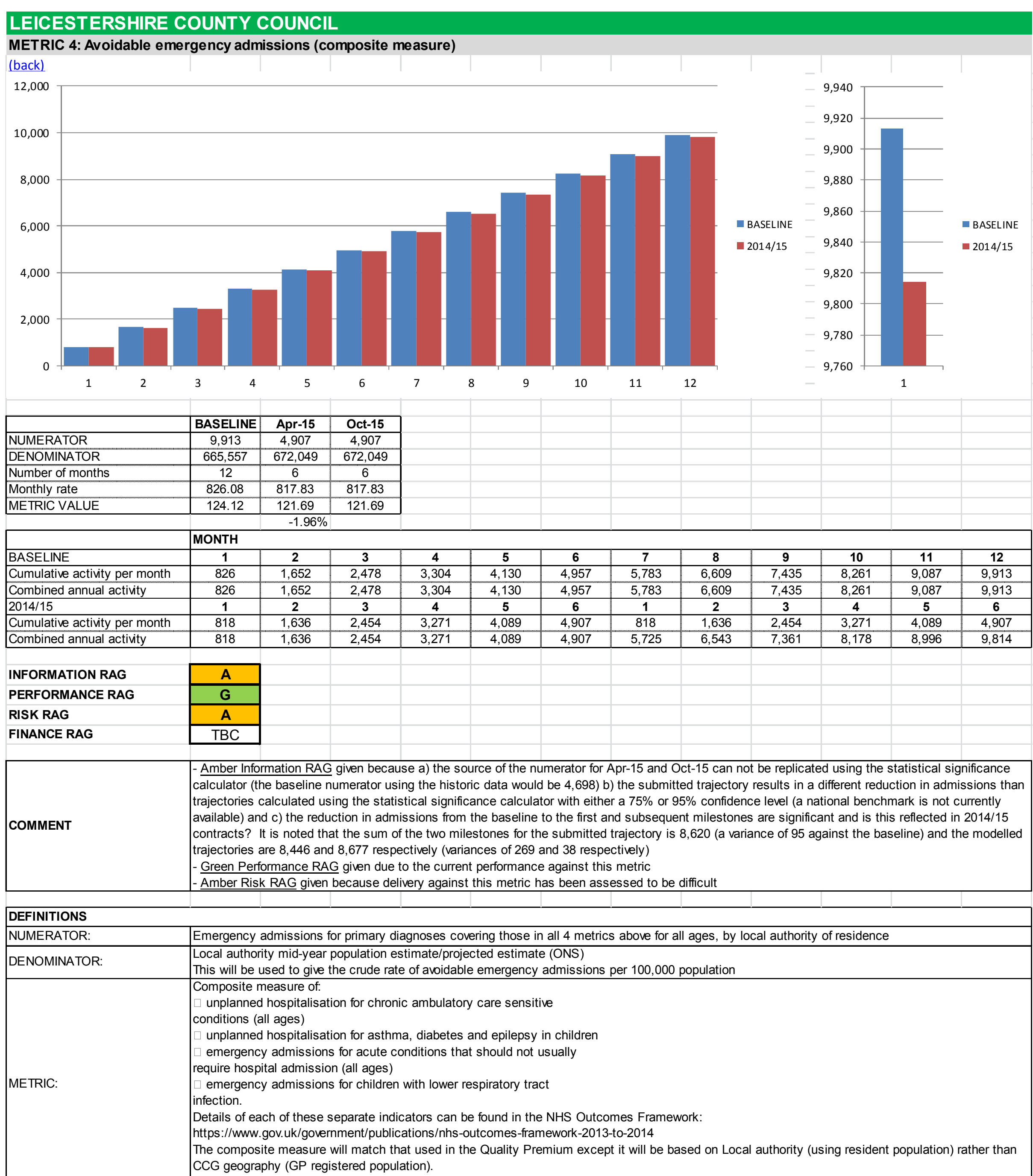
	BASELINE	Apr-15	Oct-15
NUMERATOR	12,429	13,915	9,348
DENOMINATOR	530,769	536,515	541,600
Number of months	8	9	6
Monthly rate	1,553.63	1,546.11	1,558.00
METRIC VALUE	292.71	288.18	287.67
		-1.55%	-0.18%
			-1.72%

	MONTH											
BASELINE	1	2	3	4	5	6	7	8	9	10	11	12
Cumulative activity per month	1,554	3,107	4,661	6,215	7,768	9,322	10,875	12,429	13,983	15,536	17,090	18,644
Combined annual activity	1,554	3,107	4,661	6,215	7,768	9,322	10,875	12,429	13,983	15,536	17,090	18,644
2014/15	1	2	3	4	5	6	7	8	9	1	2	3
Cumulative activity per month	1,546	3,092	4,638	6,184	7,731	9,277	10,823	12,369	13,915	1,558	3,116	4,674
Combined annual activity	1,546	3,092	4,638	6,184	7,731	9,277	10,823	12,369	13,915	15,473	17,031	18,589
2015/16	1	2	3									
Cumulative activity per month	1,558	3,116	4,674									
Combined annual activity	1,558	3,116	4,674									
												-55
												-0.29%

INFORMATION RAG	A
PERFORMANCE RAG	A
RISK RAG	A
FINANCE RAG	TBC

COMMENT	- Red Information RAG given because a) the revised trajectory has a negative gradient against a national benchmark of -4%. The trajectory using the calculated numerators with a 95% confidence level shows a decrease of -5.89% for Apr-15 and a continued decrease of -12.66% for Oct-15. The trajectory using the calculated numerators with a 75% confidence level shows a decrease of -2.41% for Apr-15 and a continued decrease of -5.22% for Oct-15 - Amber Performance RAG given due to the current performance against this metric - Amber Risk RAG given because delivery against this metric has been assessed to be difficult

DEFINITIONS	
NUMERATOR:	The total number of delayed transfers of care (for those aged 18 and over) for each month included
DENOMINATOR:	ONS mid-year population estimate This rate should be divided by number of months included in numerator in order to give average total monthly delayed discharges (this is important in order to allow comparison of rates across the different payment periods – see Reporting schedule for data source below)
METRIC:	Average delayed transfers of care per 100,000 population (attributable to either NHS, social care or both) per month. A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when: (a) a clinical decision has been made that the patient is ready for transfer AND (b) a multi-disciplinary team decision has been made that the patient is ready for transfer AND (c) the patient is safe to discharge/transfer.



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METRIC 4: Avoidable emergency admissions (composite measure)

(back)

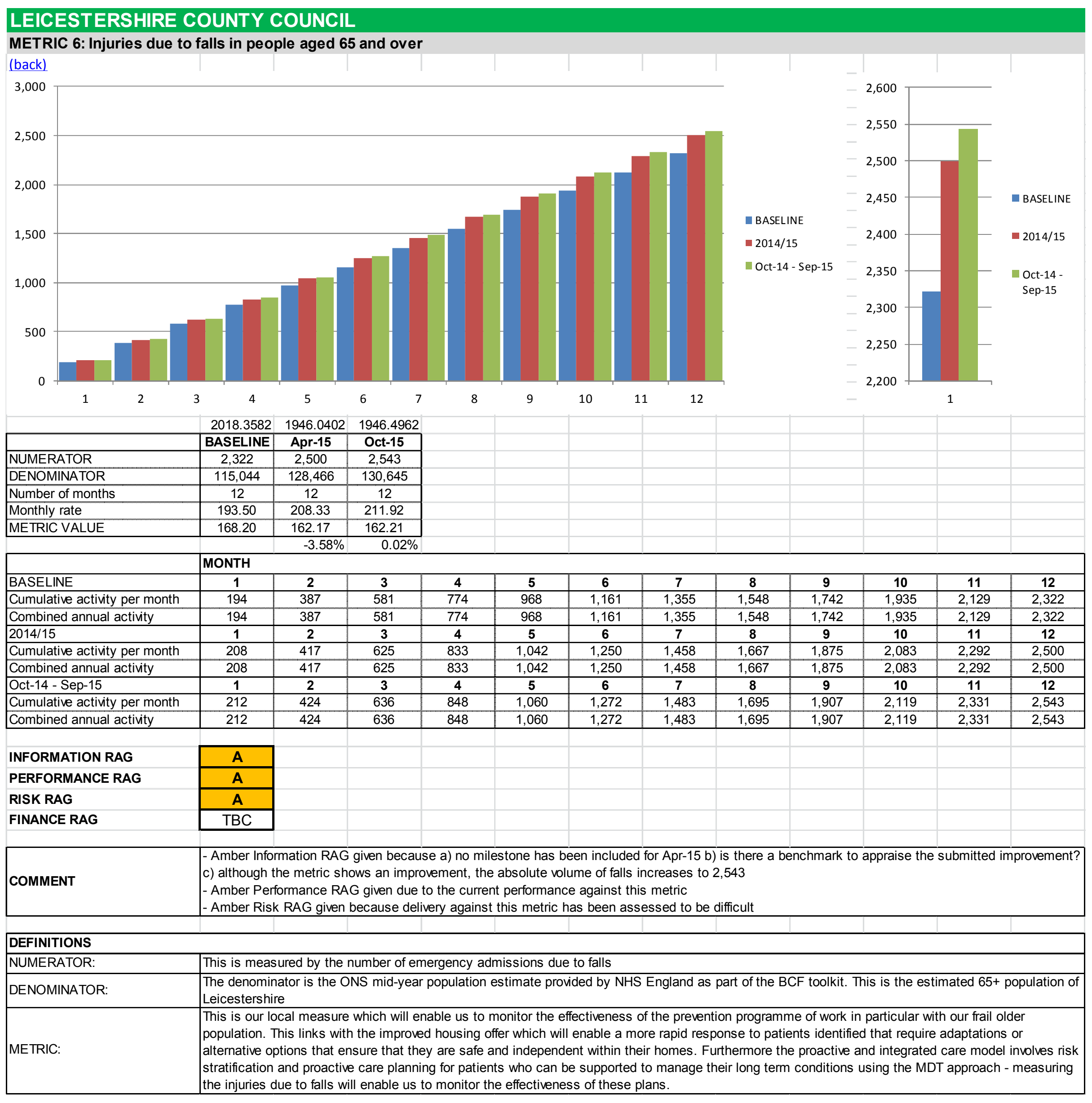
	BASELINE	Apr-15	Oct-15
NUMERATOR	9,913	4,907	4,907
DENOMINATOR	665,557	672,049	672,049
Number of months	12	6	6
Monthly rate	826.08	817.83	817.83
METRIC VALUE	124.12	121.69	121.69
		-1.96%	

	MONTH											
BASELINE	1	2	3	4	5	6	7	8	9	10	11	12
Cumulative activity per month	826	1,652	2,478	3,304	4,130	4,957	5,783	6,609	7,435	8,261	9,087	9,913
Combined annual activity	826	1,652	2,478	3,304	4,130	4,957	5,783	6,609	7,435	8,261	9,087	9,913
2014/15	1	2	3	4	5	6	1	2	3	4	5	6
Cumulative activity per month	818	1,636	2,454	3,271	4,089	4,907	818	1,636	2,454	3,271	4,089	4,907
Combined annual activity	818	1,636	2,454	3,271	4,089	4,907	5,725	6,543	7,361	8,178	8,996	9,814

INFORMATION RAG	A
PERFORMANCE RAG	G
RISK RAG	A
FINANCE RAG	TBC

COMMENT	- Amber Information RAG given because a) the source of the numerator for Apr-15 and Oct-15 can not be replicated using the statistical significance calculator (the baseline numerator using the historic data would be 4,698) b) the submitted trajectory results in a different reduction in admissions than trajectories calculated using the statistical significance calculator with either a 75% or 95% confidence level (a national benchmark is not currently available) and c) the reduction in admissions from the baseline to the first and subsequent milestones are significant and is this reflected in 2014/15 contracts? It is noted that the sum of the two milestones for the submitted trajectory is 8,620 (a variance of 95 against the baseline) and the modelled trajectories are 8,446 and 8,677 respectively (variances of 269 and 38 respectively) - Green Performance RAG given due to the current performance against this metric - Amber Risk RAG given because delivery against this metric has been assessed to be difficult

DEFINITIONS	
NUMERATOR:	Emergency admissions for primary diagnoses covering those in all 4 metrics above for all ages, by local authority of residence
DENOMINATOR:	Local authority mid-year population estimate/projected estimate (ONS) This will be used to give the crude rate of avoidable emergency admissions per 100,000 population
METRIC:	Composite measure of: □ unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages) □ unplanned hospitalisation for asthma, diabetes and epilepsy in children □ emergency admissions for acute conditions that should not usually require hospital admission (all ages) □ emergency admissions for children with lower respiratory tract infection. Details of each of these separate indicators can be found in the NHS Outcomes Framework: https://www.gov.uk/government/publications/nhs-outcomes-framework-2013-to-2014 The composite measure will match that used in the Quality Premium except it will be based on Local authority (using resident population) rather than CCG geography (GP registered population). http://www.england.nhs.uk/wp-content/uploads/2013/05/qual-premium.pdf



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METRIC 6: Injuries due to falls in people aged 65 and over

(back)

	2018.3582	1946.0402	1946.4962
	BASELINE	**Apr-15**	**Oct-15**
NUMERATOR	2,322	2,500	2,543
DENOMINATOR	115,044	128,466	130,645
Number of months	12	12	12
Monthly rate	193.50	208.33	211.92
METRIC VALUE	168.20	162.17	162.21
		-3.58%	0.02%

	MONTH											
BASELINE	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Cumulative activity per month	194	387	581	774	968	1,161	1,355	1,548	1,742	1,935	2,129	2,322
Combined annual activity	194	387	581	774	968	1,161	1,355	1,548	1,742	1,935	2,129	2,322
2014/15	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Cumulative activity per month	208	417	625	833	1,042	1,250	1,458	1,667	1,875	2,083	2,292	2,500
Combined annual activity	208	417	625	833	1,042	1,250	1,458	1,667	1,875	2,083	2,292	2,500
Oct-14 - Sep-15	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
Cumulative activity per month	212	424	636	848	1,060	1,272	1,483	1,695	1,907	2,119	2,331	2,543
Combined annual activity	212	424	636	848	1,060	1,272	1,483	1,695	1,907	2,119	2,331	2,543

INFORMATION RAG	A
PERFORMANCE RAG	A
RISK RAG	A
FINANCE RAG	TBC

COMMENT	- Amber Information RAG given because a) no milestone has been included for Apr-15 b) is there a benchmark to appraise the submitted improvement? c) although the metric shows an improvement, the absolute volume of falls increases to 2,543 - Amber Performance RAG given due to the current performance against this metric - Amber Risk RAG given because delivery against this metric has been assessed to be difficult

DEFINITIONS	
NUMERATOR:	This is measured by the number of emergency admissions due to falls
DENOMINATOR:	The denominator is the ONS mid-year population estimate provided by NHS England as part of the BCF toolkit. This is the estimated 65+ population of Leicestershire
METRIC:	This is our local measure which will enable us to monitor the effectiveness of the prevention programme of work in particular with our frail older population. This links with the improved housing offer which will enable a more rapid response to patients identified that require adaptations or alternative options that ensure that they are safe and independent within their homes. Furthermore the proactive and integrated care model involves risk stratification and proactive care planning for patients who can be supported to manage their long term conditions using the MDT approach - measuring the injuries due to falls will enable us to monitor the effectiveness of these plans.

7. APPENDIX C: BCF Scheme Impact Analysis Pivot Table

METRIC 1: Residential & Nursing Care Admissions	
THEME	**SCHEME**
Discharge Reablement	Bridging Service
LTCs	SC - protection of community care packages
	SC - Sustainable community services
Prevention	Assistive Technology
	Carers Assessment
	Carers Service
	Disabled Facilities Grants
Urgent Response	Integrated Crisis Response Service

METRIC 2: Rehabilitation / Reablement	
THEME	**SCHEME**
Discharge Reablement	Bridging Service
	HART Reablement
	Hospital to Home
	Integrated Residential Reablement
	Intermediate Care
Urgent Response	Integrated Crisis Response Service

METRIC 3: Delayed Bed Days	
THEME	**SCHEME**
Discharge Reablement	Bridging Service
	HART Reablement
	Hospital to Home
	Integrated Residential Reablement
	Intermediate Care
	NHS - Assertive In Reach
	NHS - Intensive Community Service
	NHS - Reablement
	NHS - Step Down
	Strengthening Mental Health Discharge Provision
Urgent Response	Integrated Crisis Response Service

METRIC 4: Avoidable Emergency Admissions	
THEME	**SCHEME**
Discharge Reablement	Intermediate Care
	NHS - Intensive Community Service
	SC - Residential Care Respite
LTCs	Improving Quality in Care Homes
	Integration Model for LTCs (ELRCCG)
	Proactive Care (WLCCG)
	SC - Increasing demographic pressures

	SC - Nursing care package
	SC - protection of community care packages
	SC - Sustainable community services
Prevention	First Contact
	Local Area Coordination
Urgent Response	Elderly Frail Service
	Expanded role of Primary Medical Care
	Integrated Crisis Response Service

METRIC 5: Patient / Service User Experience	
THEME	**SCHEME**
Discharge Reablement	Bridging Service
	HART Reablement
	Hospital to Home
	Integrated Residential Reablement
	Intermediate Care
	NHS - Assertive In Reach
	NHS - Intensive Community Service
	NHS - Reablement
	NHS - Step Down
	Patient Transfer Minimum Data Set
	Strengthening Mental Health Discharge Provision

LTCs	Improving Quality in Care Homes
	Integration Model for LTCs (ELRCCG)
	IT Enablers - data sharing, care plans , t/health & t/care
	Pathway to Housing
	Proactive Care (WLCCG)
Prevention	Assistive Technology
	Carers Assessment
	Carers Service
	Disabled Facilities Grants
	First Contact
	Local Area Coordination
	NHS - LD Short Breaks
	Specialist Support to People with Dementia & Carers
	Time Banking (Non-recurrent funding)
Urgent Response	Elderly Frail Service
	Expanded role of Primary Medical Care
	Integrated Crisis Response Service

METRIC 5: Falls	
THEME	**SCHEME**
LTCs	Integration Model for LTCs (ELRCCG)
	Proactive Care (WLCCG)
Prevention	Assistive Technology
	Disabled Facilities Grants
	Local Area Coordination

It is noted that the schemes below may be enabling overall rather than relate in a measurable way to a specific metric

THEME	SCHEME
Discharge_Reablement	HART Scheduling System
	SC - cost pressures linked to new models of working
Prevention	Assistive Technology (replacement equipment) (Non-recurrent funding)
	Strengthening Autism Pathway

8. APPENDIX C: prioritised list of risks and associated mitigations to deliver each of the six metrics

Metric Name: One – Residential/Nursing Care

Leicestershire County Council

Risk / Issue	Theme / Projects Affected	Mitigation Steps	Prioritisation Score (In the boxes mark top 3 with 1 being highest, then 2, then 3) Group 1	Group 2	Group 3
GP communications on available services	ALL	Communications plan/support tools for GPs so they have the most up to date information on care pathways and have details of when new elements of service come on stream via the BCF plan.			
First Contact in GP surgeries may not be well developed	First Contact	As above but to include ensuring the GPs role in First Contact is communicated.			
Cultural risk on Assistive Technology adoption – staff and citizens seem not to favour it in LLR, and so this presents a risk in the BCF plan, where we are aiming to get greater uptake of AT to avoid use of other services	Assistive Technology	Educating GPs / nursing staff / public about the benefits of AT, evaluate knowledge and confidence of AT before and after awareness campaign			
Mobilisation, resource and capacity are concerns	Bridging Service	Clear agreement of model asap Data baseline required asap	3		
Capacity in Dom Care market – workforce risks		Better care together (LLR wide strategy) will include a workforce strategy Help to Live at Home project group is also tackling this issue in leicestershire	1		

Metric Name: One – Residential/Nursing Care

Risk / Issue	Theme / Projects Affected	Mitigation Steps	Prioritisation Score (in the boxes mark top 3 with 1 being highest, then 2, then 3) Group 1	Group 2	Group 3
Limited staff pool to develop new areas of service		Action plan to include Plans to develop generic workers. How contract terms for Dom care workers can be addressed	2		
Financial risks in changing profile of workforce		For discussion with the LLR-wide strategy group – how can the workforce strategy influence T&Cs to support BCF priority workforce changes/groups			
Housing offer to Health – 'light bulb'	Unified Prevention	Project plan needed to deliver consolidated service as soon as possible. Procurement timeline needs factoring in District buy in and agreement to Pooling of DFGs is a key factor –need to factor in time required to reach agreement			
Lack of prioritisation and coordination of schemes across the metric	All metrics	Too many priorities and lack of clarity about which scheme best serves which metric(s) will lead to a confused and ineffective programme of work			
Risks to change in carer assessments as a result of the Care Bill		Modelling the costs of these changes, and comparing to the figures currently in the BCF			
Schemes that are about improving hospital discharge are not featuring in this metric and are potentially applicable.	Discharge	Consider the impact on the trajectory for this metric that can be achieved via improved discharge – confirm and challenge with CCGs and UHL			

Metric Name: One – Residential/Nursing Care

Risk / Issue	Theme / Projects Affected	Mitigation Steps	Prioritisation Score (in the boxes mark top 3 with 1 being highest, then 2, then 3) Group 1 Group 2 Group 3
Carers service - difficult to measure the contribution	Carers	More work needed on how we will measure effectiveness of carers service – may need to link to patient experience metric	
We may not be capturing data that tracks the impact of reablement on mitigating admissions to residential and nursing care	Reablement/ IC	Look at the feasibility of capturing this data and calculate the trends in activity /outcomes from reablement service in avoiding residential/nursing care. Will help with future pathway development and BCF costings	
Continence management/care not featuring in the BCF but is a key risk factor for admissions to nursing and residential homes		Triggers for admission to residential care needs considering, emphasis in the BCF plan may need revisiting	

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Metric Name: Two – 91 Days

Risk / Issue	Theme / Projects Affected	Mitigation Steps	Prioritisation Score (in the boxes mark top 3 with 1 being highest, then 2, then 3) Group 1	Group 2	Group 3
Current problems exist with the baseline data which could be exacerbated with the move to the new ASC data system	All reablement	Action plan to improve data capture/quality and mitigate the impact of the IT changes			
The Metric as defined nationally is a blunt instrument and does not look at all aspects of the patient experience pathway and how this can be improved via the BCF plan	All reablement	Measure readmission via use of NHS number Agree definition of what we mean by readmission With agreement on evidence base and capturing the timing of readmission			
Residential reablement discharge to assess pathway needs improving	All reablement	Plan in place to re-commission the model			
Normally bottom quartile for this metric	All reablement	Immediate feasibility work to change the approach to data capture and cost the implications of these changes – need to capture where people actually end up after reablement – across all settings of care.	1		
Risk that when the reablement pathway ends we are not signposting to other services effectively such as low level support in communities	All reablement	Identify the hand off points between reablement and other services and have a product suitable for professionals and public per locality.(link to LAC)			
Need to make the link between speed of hospital discharge and effectiveness of reablement		Correlate data between speed of hospital discharge and end point of reablement (e.g. measure to span length of stay through to outcome of reablement)			

Metric Name: Three – Delayed Transfers of Care (DToC)

Risk / Issue	Theme / Projects Affected	Mitigation Steps	Prioritisation Score (in the boxes mark top 3 with 1 being highest, then 2, then 3) Group 1 Group 2 Group 3
Need to categorise the BCF schemes to identify measureable, core schemes directly contributing to the delivery of the DToC metric and those schemes which make a minimal contribution		Schemes currently identified against the DToC metric in the BCF Impact Assessment were reviewed by both Risk Working Groups and a list of schemes was agreed **ACTION**: SR to reflect the rationalised list of core schemes in an updated version of the BCF Impact Assessment and corresponding pivot table	1
Need to identify schemes outside of the BCF that directly impact on the DToC metric for Adult Mental Health DToC		The revised version of the BCF submission to include an appendix of non-BCF schemes which make a measurable contribution to the delivery of the DToC metric. These will be included toward evidencing delivery of the DToC metric	3
To identify schemes outside of the BCF Programme which make a contribution to the delivery of the DToC metric		The revised version of the BCF submission to include a caveat noting that other, non-BCF schemes contribute to the delivery of the DToC metric. However, due to complexity and pragmatism these scheme will be noted and not discretely included in monitoring delivery of the DToC metric (e.g. EMAS workstream)	
The current DToC metric needs to be amended prior to resubmission so that it has a negative gradient in line with the national benchmark		**ACTION**: It was agreed that GBM would send SR revised numerators for the DToC metric by close of play Friday 14 March. This revision would be aligned to the CCGs' 5-year Strategy. GBM will also confirm that the baseline includes DToC for both UHL and LPT	2
Need to develop local metrics for: • DToC across all Providers (i.e. UHL, LPT and out-of-county) • Delayed days (rather than delays) (*note, since the workshop on 12/3/2014, revised BCF guidance has changed the metric from delays to delayed days*) • To split out health and mental health delays (*note, since the workshop on*		**ACTION**: It was agreed that GBM would work with SR and CCG colleagues to develop these metrics	

Metric Name: Four – Avoidable Emergency Admissions

Risk / Issue	Theme / Projects Affected	Mitigation Steps	Prioritisation Score (in the boxes mark top 3 with 1 being highest, then 2, then 3)		
			Group 1	Group 2	Group 3
The current metric needs to be reviewed and amended prior to resubmission so that it is inline with CCG plans and 2014/15 contracts		ACTION: It was agreed that GBM would review the metric and if necessary send SR revised numerators for the metric by close of play Friday 14 March.	2		
Are all providers (i.e. UHL, LPT and out-of-county) included in the current submission?		ACTION: It was agreed that GBM would review and send confirmation to SR by close of play Friday 14 March.	2		
Need to categorise the BCF schemes to identify measureable, core schemes directly contributing to the delivery of the metric and those schemes which make a minimal contribution		Schemes currently identified against the metric in the BCF Impact Assessment were reviewed by both Risk Working Groups and a list of schemes was agreed ACTION: SR to reflect the rationalised list of core schemes in an updated version of the BCF Impact Assessment and corresponding pivot table	1		
Need to identify childrens schemes outside of the BCF that directly impact on the metric		The revised version of the BCF submission to include an appendix of non-BCF schemes which make a measurable contribution to the delivery metric. These will be included toward evidencing delivery of the DToC metric	3		
To identify schemes outside of the BCF Programme which make a contribution to the delivery of the metric		The revised version of the BCF submission to include a caveat noting that other, non-BCF schemes contribute to the delivery of the metric. However, due to complexity and pragmatism these scheme will be noted and not discretely included in monitoring delivery of the metric			

Metric Name: Five – Patient / Service User Experience

Risk / Issue	Theme / Projects Affected	Mitigation Steps	Prioritisation Score (In the boxes mark top 3 with 1 being highest, then 2, then 3) Group 1 Group 2 Group 3
In the absence of a national metric Outcomes Framework submissions to be reviewed to identify appropriate measures		Outcome Framework submissions to be reviewed	☐ ☐ ☐
In the absence of a national metric National Voices submissions (40 key statements) to be reviewed to identify commonality between LPT and LCC		National Voices submissions to be reviewed	☐ ☐ ☐
			☐ ☐ ☐
			☐ ☐ ☐
			☐ ☐ ☐
			☐ ☐ ☐

Metric Name: Six – Falls

Risk / Issue	Theme / Projects Affected	Mitigation Steps	Prioritisation Score (in the boxes mark top 3 with 1 being highest, then 2, then 3) Group 1	Group 2	Group 3
Number of the schemes are about future delivery (prevention) and will not see results/impact on metrics immediately in year 1	First Contact Housing offer LAC	Longer term prevention schemes still need to be prioritised and developed but clarity is needed in presentation of these schemes against this metric that they will deliver later and need measurables	2		
EMAS service – a proven scheme which is likely to deliver against the metric quickly is not within the BCF plan(or therefore linked to this metric)	Urgent response Falls	Propose the addition of the EMAS non conveyance/falls service and cost into the BCF, adjust other schemes as needed to find the resource required. Ensure this is a joint scheme between EMAS/LA and NHS so that operational protocols and local pathways are aligned to support non conveyance	1		
Elderly frailty service business case	Elderly frailty service	Needs to show alignment to falls prevention			
There should be a link in the falls prevention section of the BCF to Medicines Use Reviews and their role in preventing falls	Case management of over 75s LTC Hospital discharge	change of medication or a medicines review should prompt consideration of impact on risk factors for falls.			
Case finding through implementing a number of better prevention services across the BCF could lead to greater demand on certain services e.g. carers support, equipment, assistive technology	All areas but esp. unified prevention and LTCs	Assessing the impact of case finding on other elements of the BCF/other aspects of the health and care system should be factored into the impact assessment action plan.			

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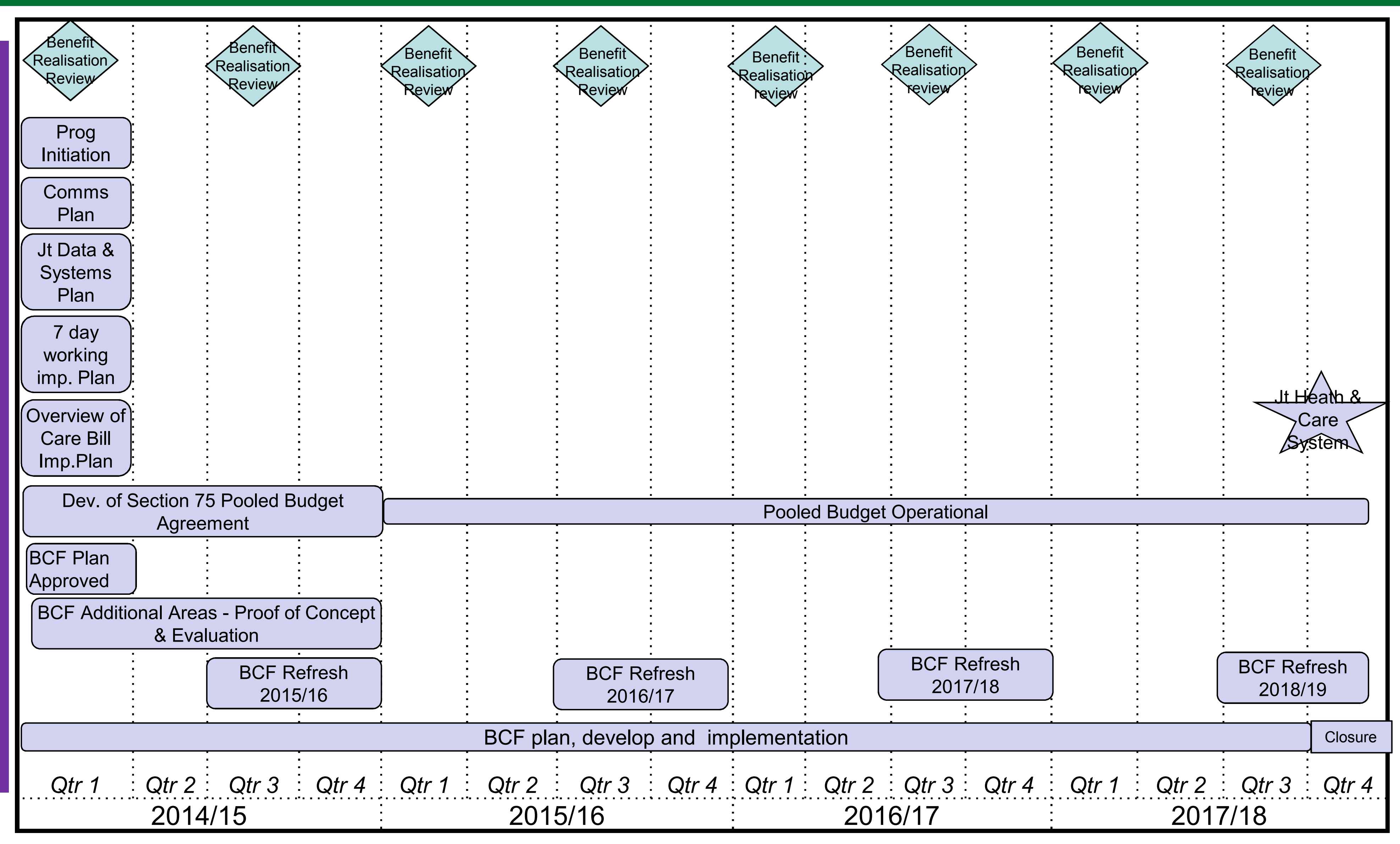
APPENDIX 4

Integrated Health & Social Care High Level Programme Plan

Cheryl Davenport

Integrated Health & Social Care High Level Programme Plan

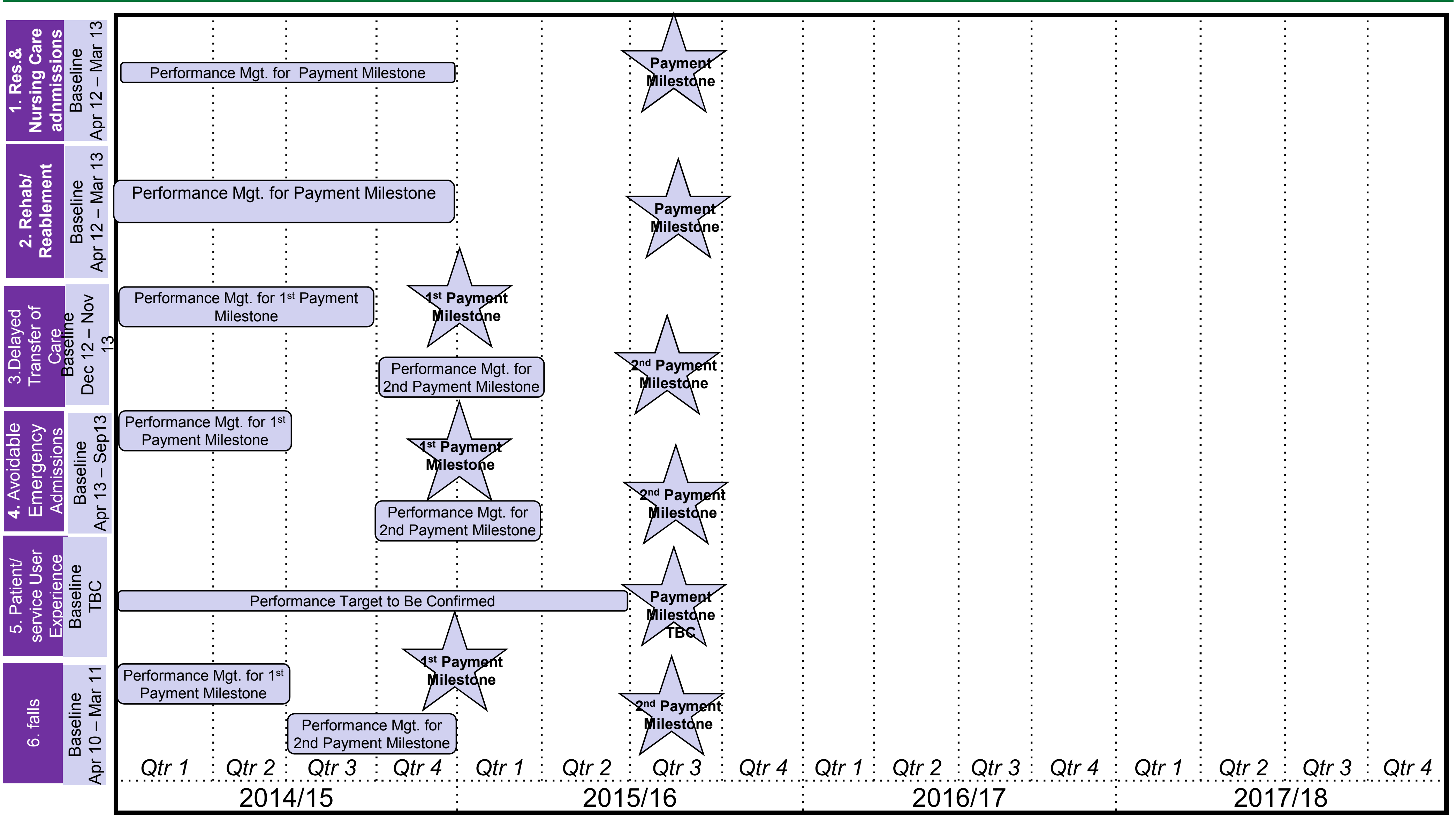


Programme Initiation Activities

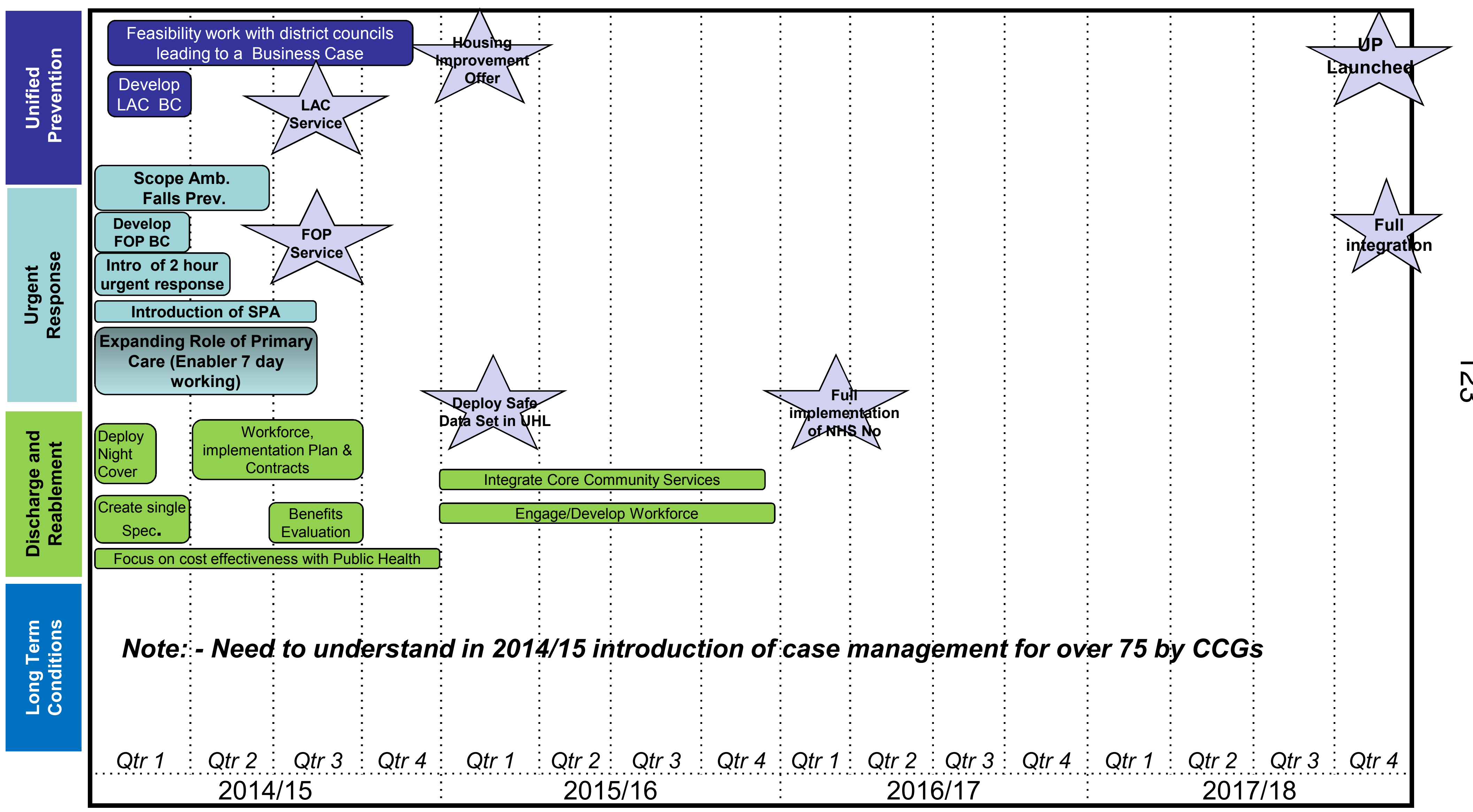
Defined and approved within 1st Quarter

- Programme Plan and Initiation Document
- Governance and Reporting
- Programme Organisation Structure and Resources (People, Facilities and Finance)
- Financial Plan and Monitoring Arrangements
- Benefits Management Strategy and Plan
- Quality Strategy and Plan including Programme Success Criteria
- Programme Change Control Approach
- Communication Plan and Stakeholder Analysis
- Risk and Issue Management Approach
- Data Sharing and Integration Plan including Adopting NHS number
- Identify Cross Programme Dependencies, Constraints and Assumptions

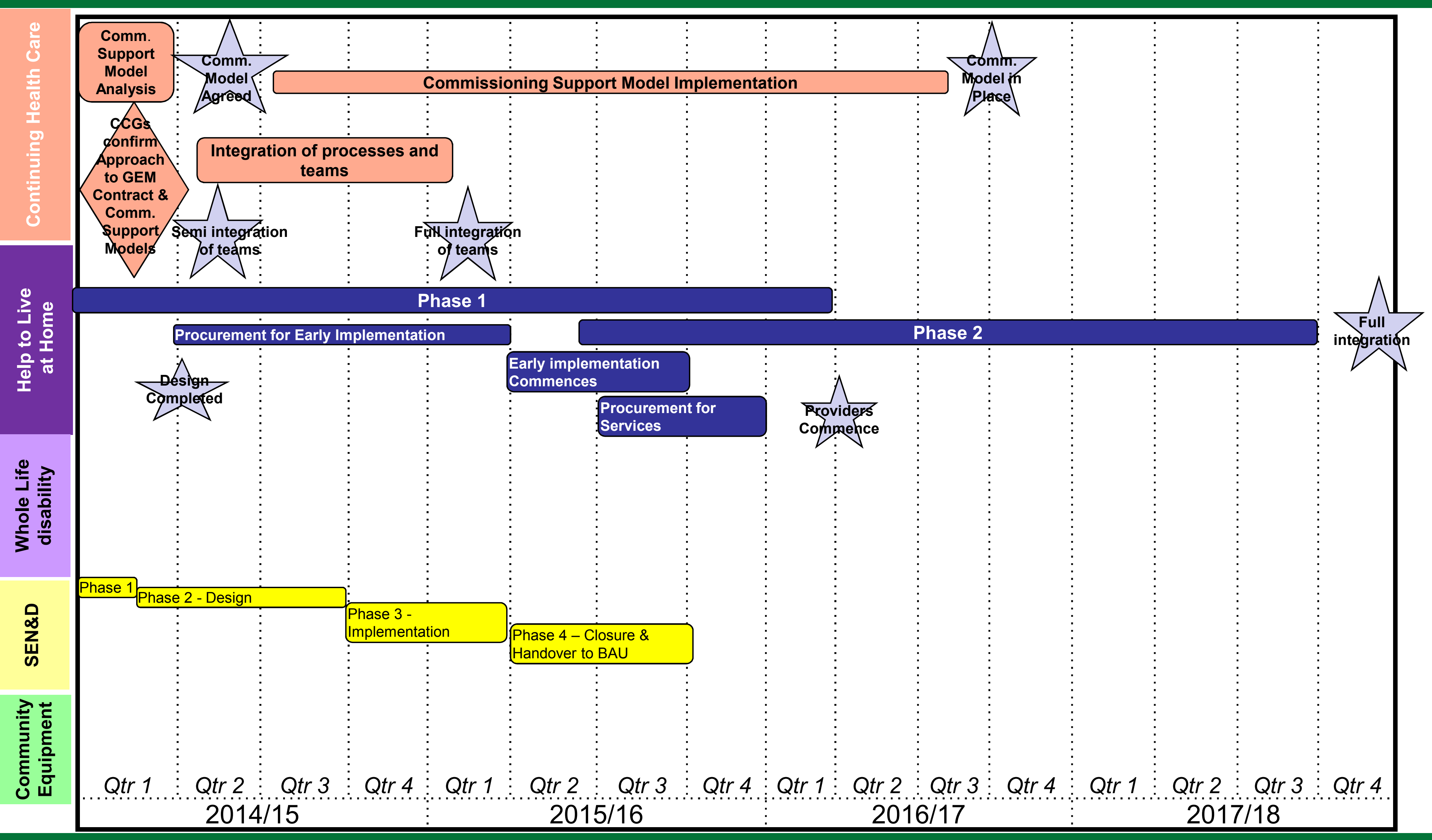
Integrated Health and Social Care
Performance Metrics Plan



Integrated Health and Social Care
High Level BCF 4 Core Themes Plan based on 2 year submission



Integrated Health and Social Care High Level Workstream Plan



Programme Dependencies

Dependency	Status
LLR Five Year Strategic Plan (BCF) (Communication & Engagement plan in particular)	
Leicestershire Joint Health and Wellbeing Strategy	
BCF Plan submission and approval	
Joint Implementation Plan for Data and Information Sharing	
Implementation of the Care Bill - Impact Analysis	
Workforce Development including terms and conditions e.g. Joint implementation plan for 7 day working	

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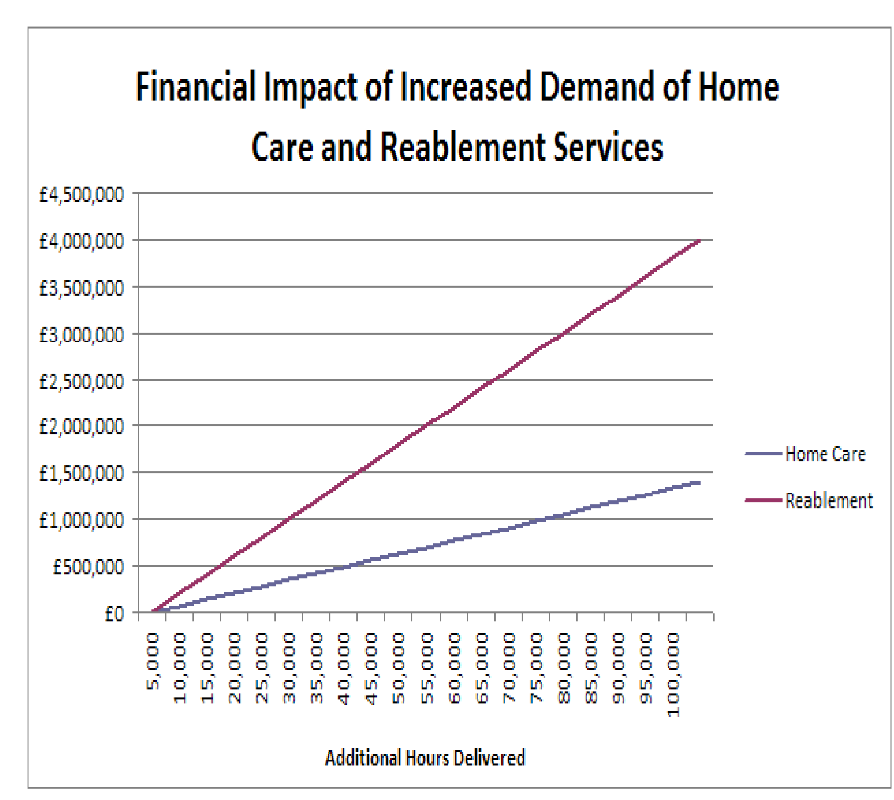
APPENDIX 5
POTENTIAL SCENARIOS

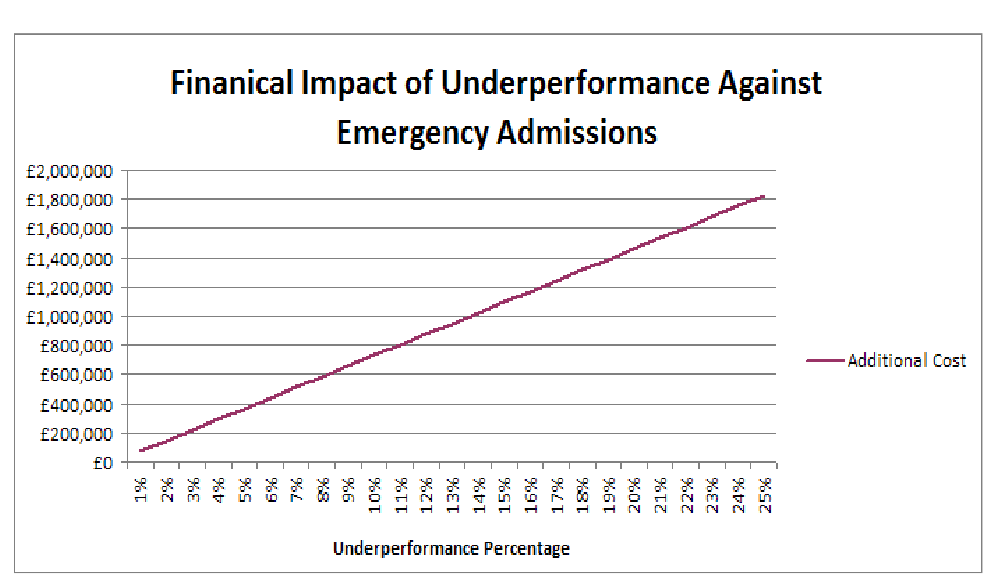
Increased Demand - Home Care

Delivered Hours	Home Care £'000	Reablement £'000
5,000	£70,000	£200,000
10,000	£140,000	£400,000
15,000	£210,000	£600,000
20,000	£280,000	£800,000
25,000	£350,000	£1,000,000
30,000	£420,000	£1,200,000
35,000	£490,000	£1,400,000
40,000	£560,000	£1,600,000
45,000	£630,000	£1,800,000
50,000	£700,000	£2,000,000
55,000	£770,000	£2,200,000
60,000	£840,000	£2,400,000
65,000	£910,000	£2,600,000
70,000	£980,000	£2,800,000
75,000	£1,050,000	£3,000,000
80,000	£1,120,000	£3,200,000
85,000	£1,190,000	£3,400,000
90,000	£1,260,000	£3,600,000
95,000	£1,330,000	£3,800,000
100,000	£1,400,000	£4,000,000



Rates of Underperformance Against Emergency Admissions Trajectory - Target Emergency Admissions 4300

% Und. Perf.	Add Em Admiss	Additional Cost
1%	43	£73,100
2%	86	£146,200
3%	129	£219,300
4%	172	£292,400
5%	215	£365,500
6%	258	£438,600
7%	301	£511,700
8%	344	£584,800
9%	387	£657,900
10%	430	£731,000
11%	473	£804,100
12%	516	£877,200
13%	559	£950,300
14%	602	£1,023,400
15%	645	£1,096,500
16%	688	£1,169,600
17%	731	£1,242,700
18%	774	£1,315,800
19%	817	£1,388,900
20%	860	£1,462,000
21%	903	£1,535,100
22%	946	£1,608,200
23%	989	£1,681,300
24%	1032	£1,754,400
25%	1075	£1,827,500



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This template is to be used for part 2 of HWB BCF plans and replaces the original template available on the NHS England BCF webpage. The new version contains more information in the metrics section and is locked in order to assist in the NHS England assurance process .

This new template should be used for submitting final BCF plans for the 4th April

The three tabs containing tables have been protected so that the structure can not be modified in a way that will impede the collation of all HWB plans. However, for the finance tables whole rows can still be inserted by right clicking on the row number to the left of the sheet and clicking 'insert'.

Association

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16. It is important that these figures match those in the plan details of planning template part 1 . Please insert extra rows if necessary

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15 /£	Minimum contribution (15/16) /£	Actual contribution (15/16) /£
Leicestershire County Council	Y	£ 4,607,600	£ 3,083,000	£ 3,220,500
NHS West Leicestershire CCG	N	£ 1,968,000	£ 20,073,000	£ 20,073,000
NHS East Leicestershire & Rutland CCG	N	£ 1,022,000	£ 15,187,000	£ 15,187,000
NHS England (14/15 existing health transfer and BCF preparation funds)	N	£ 10,653,000		
BCF Total		**£ 18,250,600**	**£ 38,343,000**	**£ 38,480,500**

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Leicestershire County Council currently holds an ear-marked reserve totalling £6m for implementation of the Better Care Fund. £1.3m of the reserve has been held back to act as a contingency for potential under performance, this equates to 3% of Better Care Fund expenditure in 2015/16. The remaining reserve funding is being used to support delivery of the schemes included in the Better Care Fund. The management of risk is an issue that will be addressed as part of developing the Pooled Budget Section 75 agreement.

Contingency plan:		2015/16	Ongoing
Outcome 1: Reduction of permanent admissions to residential care.	Planned savings (if targets fully achieved)	TBC	TBC
	Maximum support needed for other services (if targets not achieved)	TBC	TBC
Outcome 2: Increase in proportion of older people still at home 91 days after discharge.	Planned savings (if targets fully achieved)	TBC	TBC
	Maximum support needed for other services (if targets not achieved)	TBC	TBC
	Planned savings (if targets fully achieved)	TBC	TBC

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please add rows to the table if necessary.

BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
		Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£	Recurrent /£	Non-recurrent /£
First Contact	Leicestershire County Council	£ 158,900				£ 161,600			
Carers Services	independent	£ 360,000	£ 10,000			£ 450,000			
Time Banking	Leicestershire County Council		£ 72,000						
Advice & Information	Leicestershire County Council		£ 4,000						
Carers Assessments (Care Bill Implications)	Leicestershire County Council					£ 275,000			
Specialist Support to People with Dementia & Carers	Independent Sector	£ 294,000				£ 320,000			
Strengthening Autism Pathway	Leicestershire County Council & National Autistic Society	£ 162,800				£ 94,900			
Assistive Technology	Leicestershire County Council	£ 984,000				£ 995,000			
Assistive Technology (replacement equipment)	Leicestershire County Council		£ 1,444,500						
Local Area Co-ordination	Leicestershire County Council	£ 240,000				£ 600,000			
Disabled Facilities Grants	Blaby District Council					£ 256,000			
Disabled Facilities Grants	Charnwood Borough Council					£ 425,000			
Disabled Facilities Grants	Harborough District Council					£ 199,000			
Disabled Facilities Grants	Hinckley & Bosworth Borough Council					£ 250,000			
Disabled Facilities Grants	Melton Borough Council					£ 133,000			
Disabled Facilities Grants	North West Leicestershire District Council					£ 298,000			
Disabled Facilities Grants	Oadby & Wigston Borough Council					£ 178,000			
NHS - LD Short Breaks	Leicestershire Partnership NHS Trust					£ 844,000			
Integrated Crisis Response Service (Health & Social Care)	Leicestershire County Council	£ 1,038,700				£ 2,000,000			
Health & Social Care Older Frail Service	To be confirmed	£ 1,000,000				£ 2,000,000			
Ambulance Falls Prevention	To be confirmed	£ 50,000				£ 100,000			
Expanded Role of Primary Medical Care	To be confirmed	£ 300,000				£ 750,000			
HART Reablement	Leicestershire County Council	£ 432,000				£ 432,000			
Intermediate Care	Leicestershire Partnership NHS Trust	£ 580,000				£ 580,000			
Integrated Residential Reablement	Independent Sector	£ 556,000				£ 556,000			
Hospital to Home	RVS	£ 72,000				£ 72,000			
HART Scheduling System	Leicestershire County Council		£ 95,000				£ 130,000		
Patient Transfer Minimum Data Set	To be confirmed		£ 90,000						
Bridging Service	To be confirmed	£ 500,000				£ 750,000			
Strengthening Mental Health Discharge Provision	Leicestershire County Council	£ 254,800				£ 260,700			
NHS - Step Down	WLCCG & ELRCCG					£ 529,000			
NHS - Intensive Community Service	WLCCG & ELRCCG					£ 1,821,000			
NHS - Assertive InReach	WLCCG & ELRCCG	£ 569,000				£ 569,000			
NHS - Reablement	WLCCG & ELRCCG					£ 4,132,000			
Social Care - Residential Respite	Independent Sector	£ 742,600				£ 742,600			
Social Care - cost pressures linked to new models of working	Leicestershire County Council	£ 220,000				£ 1,640,000			
Proactive Care (West Leics)	Leicestershire Partnership NHS Trust	£ 540,000				£ 540,000			
Long Term Conditions (East)	Leicestershire County Council	£ 460,000				£ 460,000			
Pathway to Housing	Leicestershire County Council		£ 72,200						
Memory Plus Service Evaluation	Leicestershire County Council		£ 10,000						
Improving Quality in Care Homes	Leicestershire County Council	£ 486,300				£ 501,300			
IT Enablers - Data sharing, care plans, t/health & t/care	To be confirmed					£ 650,000			
Social Care - Nursing care packages	Independent Sector	£ 2,995,200				£ 3,360,600			
Social Care - Sustainable community services	Independent Sector	£ 1,466,000				£ 1,876,000			
Social Care - Increasing demographic pressures	Independent Sector	£ 1,741,000				£ 4,584,000			
Social Care - Protection of community care packages	Independent Sector					£ 3,852,000			
Better Care Fund Programme Leads	Leicestershire County Council	£ 164,100				£ 26,000			
Better Care Fund - Programme Support	Leicestershire County Council	£ 85,500				£ 86,800			
Total		£ 16,452,900	£ 1,797,700	£ -	£ -	£ 38,350,500	£ 130,000	£ -	£ -

Association

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Outcomes and metrics

Please provide details of how your BCF plans will enable you to achieve the metric targets, and how you will monitor and measure achievement

Expected outcomes and benefits have been identified throughout the BCF narrative plan (template 1) where we have outlined our vision and aims for this work through the 4 BCF themes and the individual components under each theme. Since the draft BCF submission, a significant piece of impact assessment work has been undertaken which analysed the impact of the components of the BCF on the 6 metrics. An appendix to the narrative plan (Appendix 3) summarises the analysis undertaken. Performance against the metrics will be governed by the Integration Executive which meets monthly and is overseeing the delivery of the BCF plan, reporting to the Health and Wellbeing Board. The Integration Executive comprises all partners including providers. In summary the expected benefits and outcomes of the BCF plan are as follows
1. Admissions to residential and care homes; (ASCOF) - expected benefits of reduction will be people supported to remain independent. This will also support Leicestershire County Council to deliver improved alternatives to residential care such as Supported Living and Home Base Support that enables individuals to remain independent and within their communities.
2. Effectiveness of reablement; (ASCOF) - the key benefits to having an effective reablement provision is that we will reduce average length of stay by a maximum of 3 days in particular those patients who are admitted following a fall or have a risk of fall. We will also be monitoring the impact on the 30 day readmission rate. There will be process efficiencies in referrals and choices by integration of provision across health and social care, reducing inter-team referrals.
3. Delayed transfers of care; (NHSOF) - 2% reduction in delayed transfers of care will have a significant benefit to patients who can be better supported within their home environment. A strengthened and integrated intermediate care with additional capacity of a Intensive Community Support team will enable patients to be transferred to an appropriate care setting much more effectively. This metric closely links with the effectiveness of reablement and admissions to residential care homes as it demonstrates pathway monitoring.
4. Avoidable emergency admissions; (NHSOF) - increasing capacity and capability in community and primary care settings will enable a more responsive, needs led service, managed through a single co-ordination point, operating on a 24/7 basis and deliver an urgent response within 2 hours. The ambition is that this will impact on 20 avoidable admissions per week saved. The 2% reduction is reflective of our plans as a health and social care community to scale up in 2015/16.
6. Injuries due to falls in people aged 65 and over; (PHOF) - this is our local measure which will enable us to monitor the effectiveness of the prevention programme of work in particular with our frail older population, inclduing via an urgent response in the community to support someone who has fallen but can potentially remain in their own home.. This links with the improved housing offer which will enable a more rapid response to patients identified that require adaptations or alternative options that ensure that they are safe and independent within their homes. Furthermore the proactive and integrated care model involves risk stratification and proactive care planning for patients who can be supported to manage their long term conditions using the MDT approach - measuring the injuries due to falls will enable us to monitor the effectiveness of these plans.

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

We plan to use the national metric once it has been developed

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

The development of our metrics and trajectories has been undertaken in partnership, with analysts from local CCGs, Local Authority, Public Health and the Greater East Midlands Commissioning Support Unit collabrating on this work. This work has also involved analysts from the Leicester City BCF team to cross check local assumptions between the 2 plans, particuliary in relation to impact on the acute sector. Agreement to the fianl trajectories has been reached through an impact assessment workshop, further supported by strategic input at the March 25, 2014 meeting of the Integration Executive. Final recommendations for the BCF submission were received at the April 1, 2014 meeting of the Health and Wellbeing Board. Our initial impact analysis for the BCF plan has demonstrated where further work is needed on data quality and the performance indicators for each of the components of the BCF plan that contribute to one or more of the 6 metrics and this has been factored into our programme plan. For example the need to look at the contributions made in the DTOC trajectory from acute, community and mental health bed days, and the need to capture more effectively destination at 91 days post discharge for the reablement metric. The assurance process for ongoing delivery will involve a BCF dashboard for the metrics being monitored through the Integration Executive.
Performance management plans will be proposed by the Integration Executive, approved by the HWB Board, and enacted with the provider by the lead/co-ordinating commissioner where applicable.

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

N/A

Association

Outcomes and metrics

Please complete all pink cells:

Metrics		Baseline*	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	762.7	N/A	718.7
	Numerator	930		939
	Denominator	121930		130645
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services *NB. This should correspond to the published figures which are based on a 3 month period i.e. they should not be converted to average annual figures. The metric can be entered either as a % or as a figure e.g. 75% (0.75) or 75.0*	*Metric Value*	0.78	N/A	0.82
	Numerator	395		480
	Denominator	505		584
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	292.7	288.2	287.7
	Numerator	12429	13915	9348
	Denominator	530769	536515	541600
		(State time period and select no. of months)	Apr - Dec 2014 (9 months)	Jan - Jun 2015 (6 months)
Avoidable emergency admissions per 100,000 population (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	124.1	121.7	121.7
	Numerator	9913	4907	4907
	Denominator	665557	672049	672049
		(State time period and select no. of months)	Apr - Sep 2014 (6 months)	Oct 2014 - Mar 2015 (6 months)
Patient / service user experience *For local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used*			N/A	
		(State time period and select no. of months)		*(State time period and select no. of months)*
Local measure *Injuries due to falls in people aged 65 and over*	*Metric Value*	168.2	162.2	162.2
	Numerator	2322	2500	2543
	Denominator	115044	128466	130645
		(State time period and select no. of months)	*(State time period and select no. of months)*	*(State time period and select no. of months)*

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APPENDIX C

HEALTH AND WELLBEING BOARD: 1 APRIL 2014

REPORT OF THE DIRECTOR OF HEALTH AND CARE INTEGRATION

SUPPLEMENTARY BRIEFING PAPER ON BETTER CARE FUND METRICS AND TRAJECTORIES

Introduction

1. Since the draft submission of the Better Care Fund (BCF) Plan an impact analysis has been undertaken to assess the impact of the proposals on the six metrics.

2. The attached analysis was reviewed and finalised by the Integration Executive at their meeting on March 25, 2014 and the following recommendations are made for the Health and Wellbeing Board's approval.

3. It should be noted that each trajectory shows the impact of the improvement over a two year period in line with BCF requirements and the data supplied with the technical guidance. Following discussion at the Integration Executive meeting, and to help with understanding the total impact of our plan over this period for Leicestershire's population, we have shown two views of the expected improvement in each case:

   I. The impact of the improvement based on the expected population growth over the period; and

   II. The impact of the improvement if the population had remained the same (static).

Recommendations

4. The Health and Wellbeing Board is recommended to approve the submission of the metrics per the analysis in the attached paper with the following caveats:

   a. Further work is required to improve data quality for recording reablement at 91 days.

   b. The delayed transfers of care metric is subject to change due to further national work/consultation in 2014/15. Locally however we need to create a tier of analysis below this metric which looks at the source data by

setting (e.g. community, mental health and acute) and the impact of BCF interventions in each setting.

c. We have done further work on the metric for avoidable emergency admissions and expressed this as an illustrative trajectory over a five year period. This is shown in NHSE Template One on page 17, with supporting narrative indicating the improved pace of delivery (stretch to be applied) from 2015/16 onwards, in line with CCG operating plan/five year plan intentions.

d. The Integration Executive will build on this approach and oversee work to develop a five year trajectory for each metric during Q1 2014/15 which will link to the development of the LLR five year strategy by June 2014. In terms of stretching our level of ambition across the system, this work is an essential next step.

e. In terms of measuring patient experience, we continue to await national guidance for this metric.

f. The numerator for the falls metric currently increases over the course of the proposed trajectory. Further analysis is needed on the impact of the proposed schemes to deliver against this metric – see g. below

g. The Integration Executive should assess the potential introduction of an additional BCF scheme for the falls metric. This is because the schemes currently in the plan will not deliver sufficiently against this metrics in the first 18 months, but remain valid for prevention in the longer term. The feasibility of the EMAS falls prevention scheme should be explored, as this has good evidence from elsewhere in the East Midlands and could be a very effective addition to the integrated urgent response theme of the BCF. Based on the Northamptonshire scheme an indicative figure for part year effect in 2014/15 has been factored into the financial plan, while feasibility work is carried out.

h. There will be an ongoing programme of work on BCF impact analysis overseen by the Integration Executive. This will include:

    i. Confirming/developing performance indicators for each of the component schemes, so that the contribution of each component of the BCF plan to one or more of the 6 metrics can be further assured/challenged.

    ii. Strengthening the evidence base for the BCF

i. At the time of writing this report, the contract between Clinical Commissioning Groups and the University Hospitals of Leicester is being

finalised, so any update on this, which impacts on BCF assumptions, will be taken verbally at the meeting.

Officer to Contact

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0116 305 4212/07770 281610

LEICESTERSHIRE COUNTY COUNCIL

BETTER CARE FUND IMPACT ANALYSIS

1. INTRODUCTION

The Leicestershire Better Care Fund (BCF) Plan for 2014/15 and 2015/16 will be submitted on 4 April 2014. This will compromise an updated BCF plan with a supporting financial and performance outcome template submission. The aim of this paper is to present the findings of an impact analysis of the thirty-seven components of the BCF plan against the plans of the six outcome metrics. NHS England provided technical guidance for the preparation of baselines and trajectories for each metric, including an indication of what would constitute a statistically significant improvement based on the population size.

2. FINDINGS FROM METRIC REVIEWS

Since the original BCF submission on 14 February 2014 a detailed impact analysis has been undertaken of the (five) national and (one) local metrics against which delivery of the BCF plan will be assessed. This initial impact assessment was presented for discussion at a multiagency workshop held on 12 March 2014. The findings are presented below.

2.1. METRIC 1: 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. Chart 1 shows a bar chart illustrating the proposed trajectory detailed in Table 1 below. The line chart shows that validation of this metric using BCF base data and the statistical significance calculator (see Appendix B) has ratified the proposed trajectory.

Chart 1.1 Chart 1.2

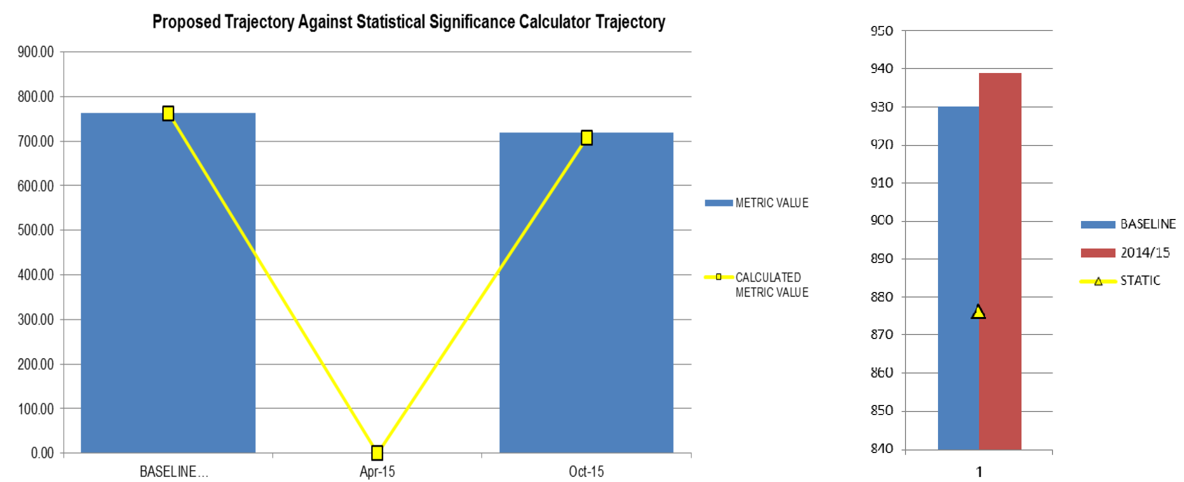


Table 1

	BASELINE (Apr-12 – Mar-13)	Apr-15 PAYMENT	Oct-15 PAYMENT (Apr-14 – Mar-15)
NUMERATOR	930		939
DENOMINTOR	121,930		130,645
METRIC VALUE	762.73		718.74

The proposed trajectory is for a reduction from 762.73 permanent admissions per 100,000 population per year to 718.74 (or 5.77%) by 31 March 2015 (this is against a national benchmark of a reduction of 13%). It is noted that the numerator for the October 2015 payment is 939 which is an increase of 9 (0.97%) against the baseline of 930. Chart 1.2 illustrates this increase in the numerator. This chart also shows the effect of discounting population growth which would result in 54 fewer permanent admissions to residential or nursing care.

2.2. METRIC 2: 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. Chart 2 shows a bar chart illustrating the proposed trajectory detailed in Table 2 below. The line chart shows that validation of this metric using BCF base data and the statistical significance calculator (see Appendix B) has ratified the proposed trajectory.

Chart 2.1 Chart 2.2

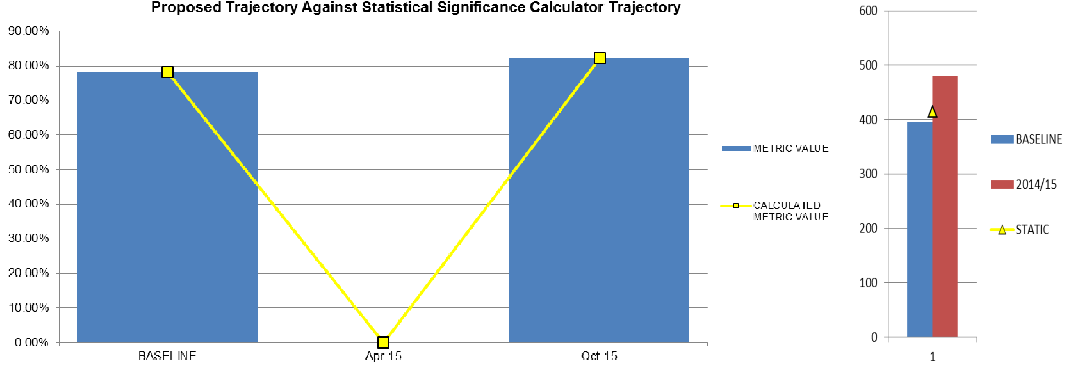


Table 2

	BASELINE (Apr-12 – Mar-13)	Apr-15 PAYMENT	Oct-15 PAYMENT (Apr-14 – Mar-15)
NUMERATOR	395		480
DENOMINTOR	505		584
METRIC VALUE	78.22%		82.19%

The proposed trajectory is for an increase from 78.22% of service users still at home 91 days after discharge to 82.19% (or 5.08%) by 31 March 2015 (this is against a national benchmark of an increase of 6%). It is noted that an action plan is being developed to improve the data quality to more accurately measure the 91-day period from discharge. Chart 2.2 shows the effect of discounting population growth on the number of older people who were still at home 91 days after discharge. It is noted however, that the percentage delivery against this indicator remains the same.

2.3. METRIC 3: 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. Chart 3.1 shows the cumulative monthly rate of delayed bed days per 100,000 population for the baseline period, 2014/15 and Q1 2015/16. Chart 3.2 shows the reduction in cumulative bed days comparing the end of the baseline period with 2014/15.

Chart 3.1 Chart 3.2

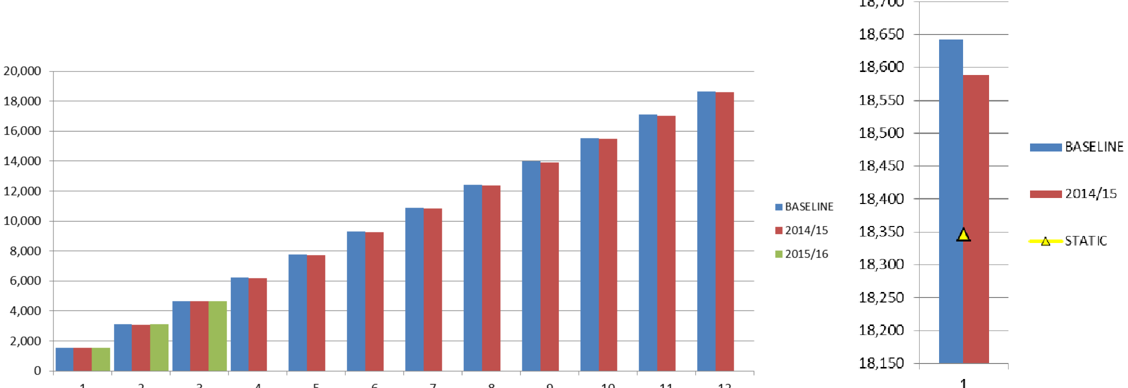


Table 3

	BASELINE (Apr-12 – Mar-13)	Apr-15 PAYMENT (Apr-14 – Dec-14)	Oct-15 PAYMENT (Jan-15 – Jun-15)
NUMERATOR	12,429	13,915	9,348
DENOMINTOR	530,769	536,515	541,600
METRIC VALUE	292.71	288,18	287.67

Table 3 shows the proposed trajectory to be submitted for this indicator. The proposed trajectory is for a decrease from a baseline of 292.71 delayed bed days per 100,000 per month to 288.18 (1.55%) by 31 December 2014 followed by a further reduction to 287.67 (0.18%) by 30 June 2015. This is against a national benchmark of a reduction of 4%. Chart 3.2 also shows the effect of discounting population growth which would result in a further reduction of 242 delayed bed days at the end of 2014/15.

2.4. METRIC 4: Avoidable emergency admissions (composite measure)

This is a nationally defined metric measuring delivery of the outcome to reduce avoidable emergency admissions which can be influenced by effective collaboration across the health and care system. This is a composite measure of:

- Unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages)
- Unplanned hospitalisation for asthma, diabetes and epilepsy in children
- Emergency admissions for acute conditions that should not usually require hospital admission (all ages)
- Emergency admissions for children with lower respiratory tract infections

Chart 4.1 Chart 4.2

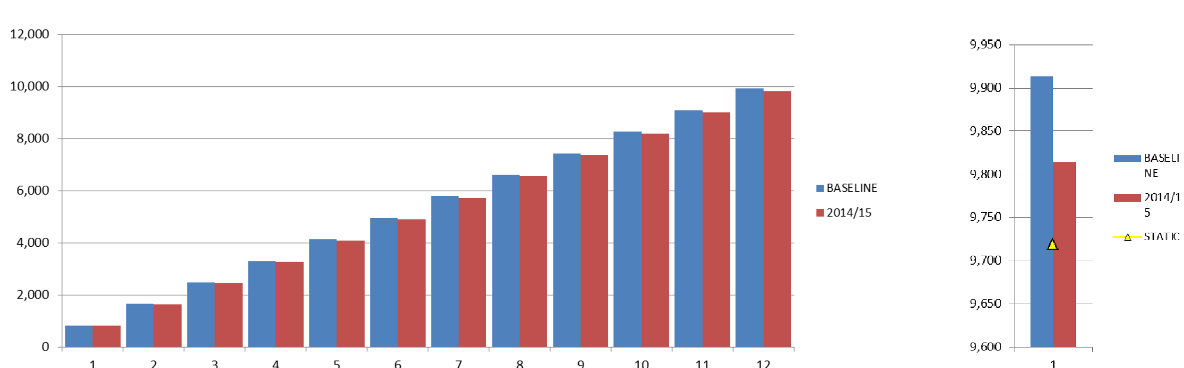


Chart 4.1 shows the cumulative monthly rate of emergency admissions per 100,000 population for the baseline period, 2014/15 and Q1 2015/16. Chart 4.2 shows the

reduction in cumulative bed days comparing the end of the baseline period with 2014/15.

Table 4

	BASELINE (Apr-12 – Mar-13)	Apr-15 PAYMENT (Apr-14 – Sep-14)	Oct-15 PAYMENT (Oct-14 – Mar-15)
NUMERATOR	9,913	4,907	4,907
DENOMINTOR	665,557	672,049	672,049
METRIC VALUE	124.12	121.69	121.69

Table 4 shows the proposed trajectory to be submitted for this indicator. The proposed trajectory is for a decrease from a baseline of 124.12 emergency admissions per 100,000 per month to 121.69 (1.96%) by 30 September 2014 and then remaining the same at 121.69 until 31 March 2015. Chart 4.2 also shows the effect of discounting population growth which would result in a further reduction of 99 avoidable emergency admissions at the end of 2014/15

2.5. METRIC 5: Patient / service user experience [for local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used]

This will be a nationally defined metric however, at the time of writing this paper the guidance confirming the definition of the metric has not be released. The outcome will be to demonstrate local population/health data, patient/service user and carer feedback has been collated and used to improve patient experience. To provide assurance that there is a co-design approach to service design, delivery and monitoring, putting patients in control and ensuring parity of esteem.

In the absence of this clarity this metric was reviewed as part of the BCF workshop held on 12 March 2014.

2.6. METRIC 6: 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 due to falls in people aged 65 and over. Chart 5.1 shows the cumulative monthly rate of emergency admissions per 100,000 population for the baseline period, 2014/15 the period October 2014 to September 2015. Chart 5.2 shows the increase in cumulative emergency admissions comparing the end of the baseline period with 2014/15 and the period October 2014 to September 2015.

Chart 5.1

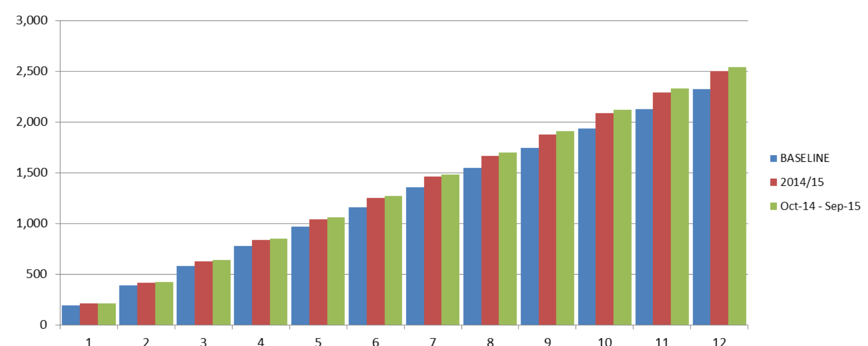


Chart 5.2

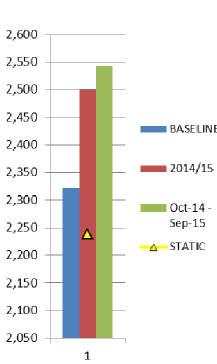
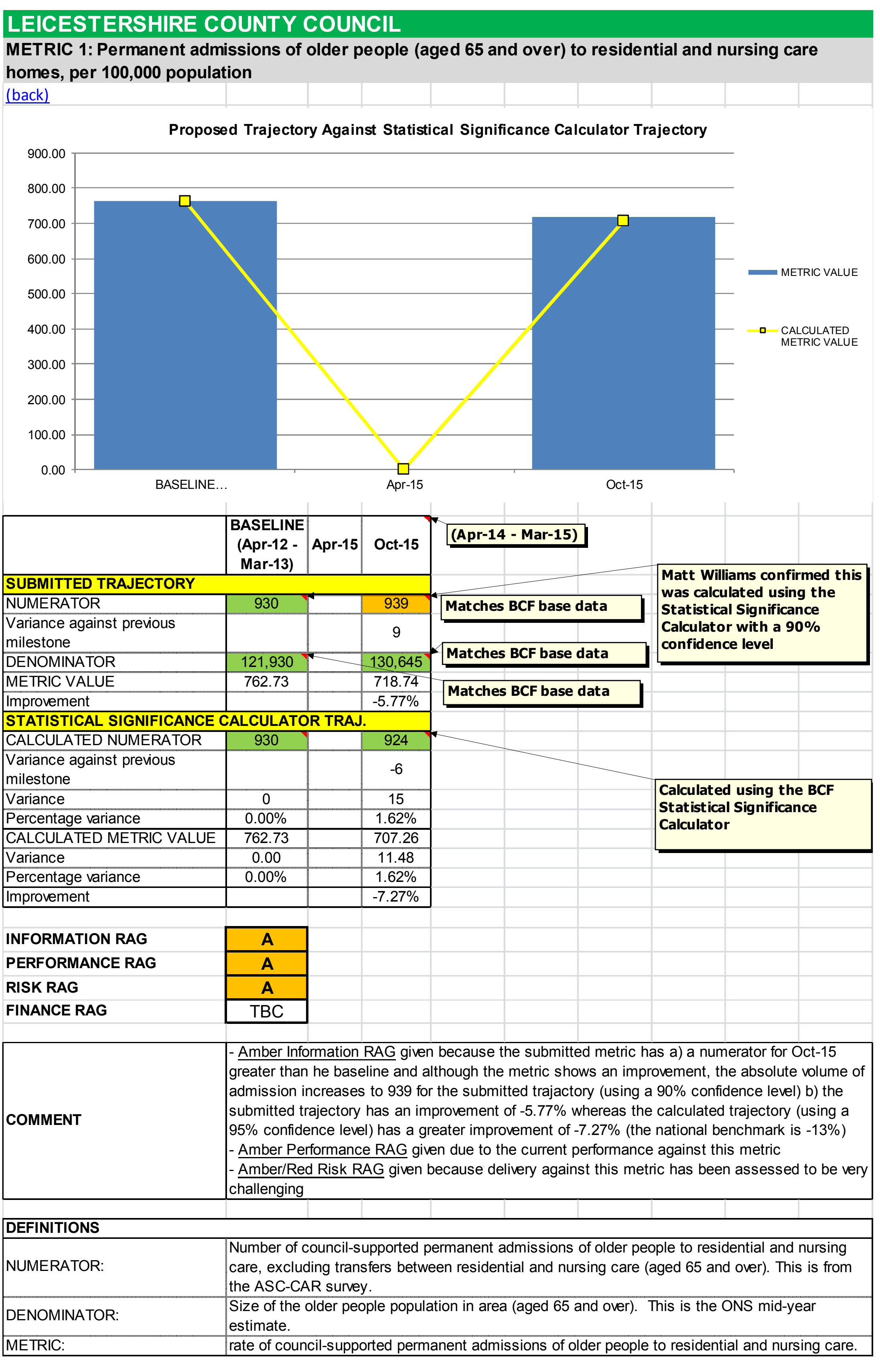


Table 5

	BASELINE (Apr-10 – Mar-11)	Apr-15 PAYMENT (Apr-14 – Mar-15)	Oct-15 PAYMENT (Oct-14 – Sep-15)
NUMERATOR	2,322	2,500	2,543
DENOMINTOR	115,044	128,466	130,645
METRIC VALUE	168.20	162.17	162.21

Table 5 shows the proposed trajectory to be submitted for this indicator. The proposed trajectory is for a decrease from a baseline of 168.20 emergency admissions per 100,000 per month to 162.17 (3.58%) by 31 March 2015 followed by a slight increase to 162.21 (0.02%) by 30 September 2015. Chart 5.2 also shows the effect of discounting population growth which would result in a further reduction of 83 emergency admissions due to falls at the end of 2014/15 in comparison to the baseline.

APPENDIX: BCF Metric Impact Analysis



LEICESTERSHIRE COUNTY COUNCIL

METRIC 1: Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population

(back)

	BASELINE (Apr-12 - Mar-13)	Apr-15	Oct-15
SUBMITTED TRAJECTORY			
NUMERATOR	930		939
Variance against previous milestone			9
DENOMINATOR	121,930		130,645
METRIC VALUE	762.73		718.74
Improvement			-5.77%
STATISTICAL SIGNIFICANCE CALCULATOR TRAJ.			
CALCULATED NUMERATOR	930		924
Variance against previous milestone			-6
Variance	0		15
Percentage variance	0.00%		1.62%
CALCULATED METRIC VALUE	762.73		707.26
Variance	0.00		11.48
Percentage variance	0.00%		1.62%
Improvement			-7.27%

(Apr-14 - Mar-15)

Matches BCF base data

Matt Williams confirmed this was calculated using the Statistical Significance Calculator with a 90% confidence level

Matches BCF base data

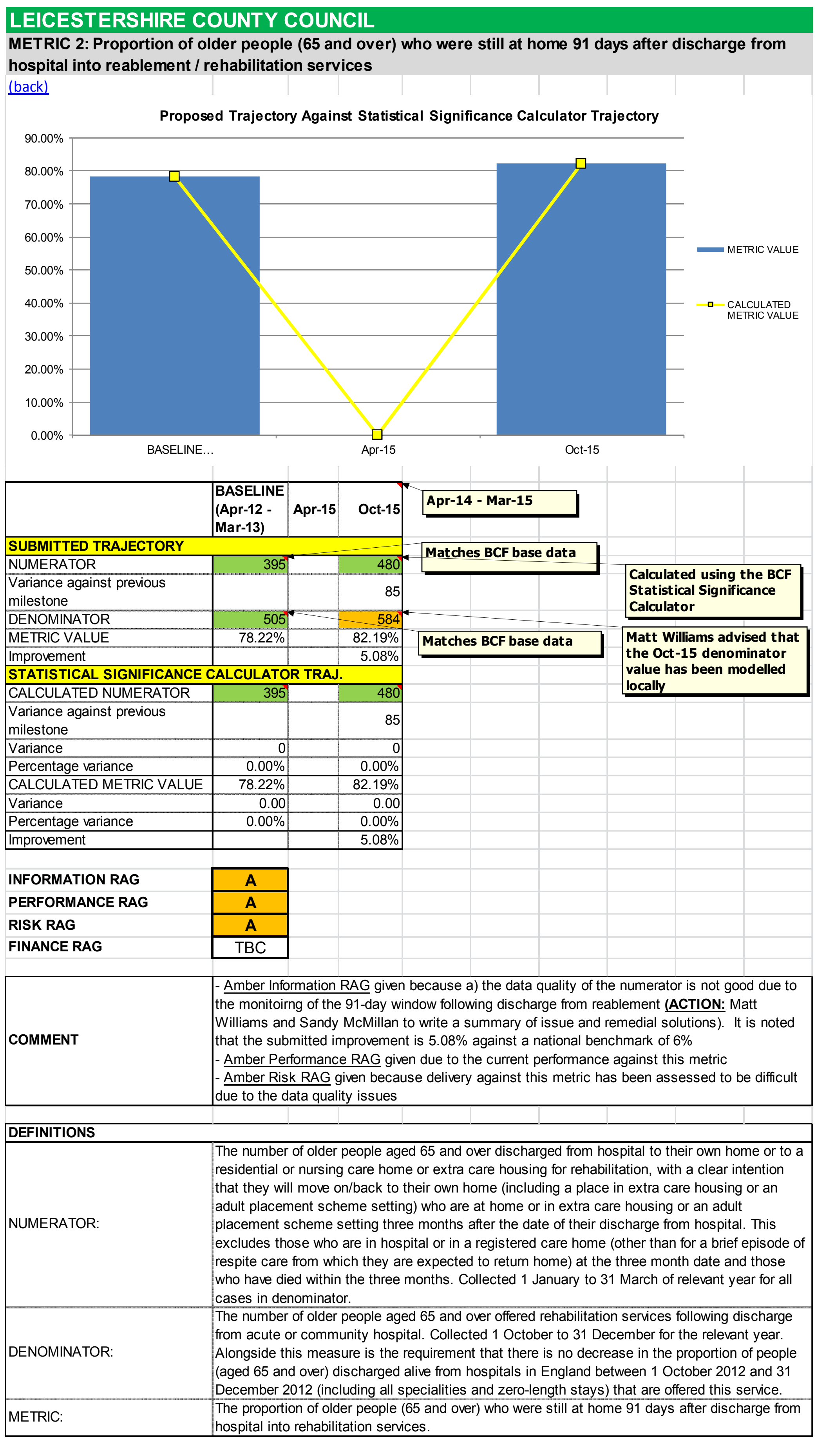
Matches BCF base data

Calculated using the BCF Statistical Significance Calculator

INFORMATION RAG	A
PERFORMANCE RAG	A
RISK RAG	A
FINANCE RAG	TBC

COMMENT	- Amber Information RAG given because the submitted metric has a) a numerator for Oct-15 greater than he baseline and although the metric shows an improvement, the absolute volume of admission increases to 939 for the submitted trajectory (using a 90% confidence level) b) the submitted trajectory has an improvement of -5.77% whereas the calculated trajectory (using a 95% confidence level) has a greater improvement of -7.27% (the national benchmark is -13%) - Amber Performance RAG given due to the current performance against this metric - Amber/Red Risk RAG given because delivery against this metric has been assessed to be very challenging

DEFINITIONS	
NUMERATOR:	Number of council-supported permanent admissions of older people to residential and nursing care, excluding transfers between residential and nursing care (aged 65 and over). This is from the ASC-CAR survey.
DENOMINATOR:	Size of the older people population in area (aged 65 and over). This is the ONS mid-year estimate.
METRIC:	rate of council-supported permanent admissions of older people to residential and nursing care.



LEICESTERSHIRE COUNTY COUNCIL

METRIC 2: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services

(back)

	BASELINE (Apr-12 - Mar-13)	Apr-15	Oct-15
SUBMITTED TRAJECTORY			
NUMERATOR	395		480
Variance against previous milestone			85
DENOMINATOR	505		584
METRIC VALUE	78.22%		82.19%
Improvement			5.08%
STATISTICAL SIGNIFICANCE CALCULATOR TRAJ.			
CALCULATED NUMERATOR	395		480
Variance against previous milestone			85
Variance	0		0
Percentage variance	0.00%		0.00%
CALCULATED METRIC VALUE	78.22%		82.19%
Variance	0.00		0.00
Percentage variance	0.00%		0.00%
Improvement			5.08%

Apr-14 - Mar-15

Matches BCF base data

Calculated using the BCF Statistical Significance Calculator

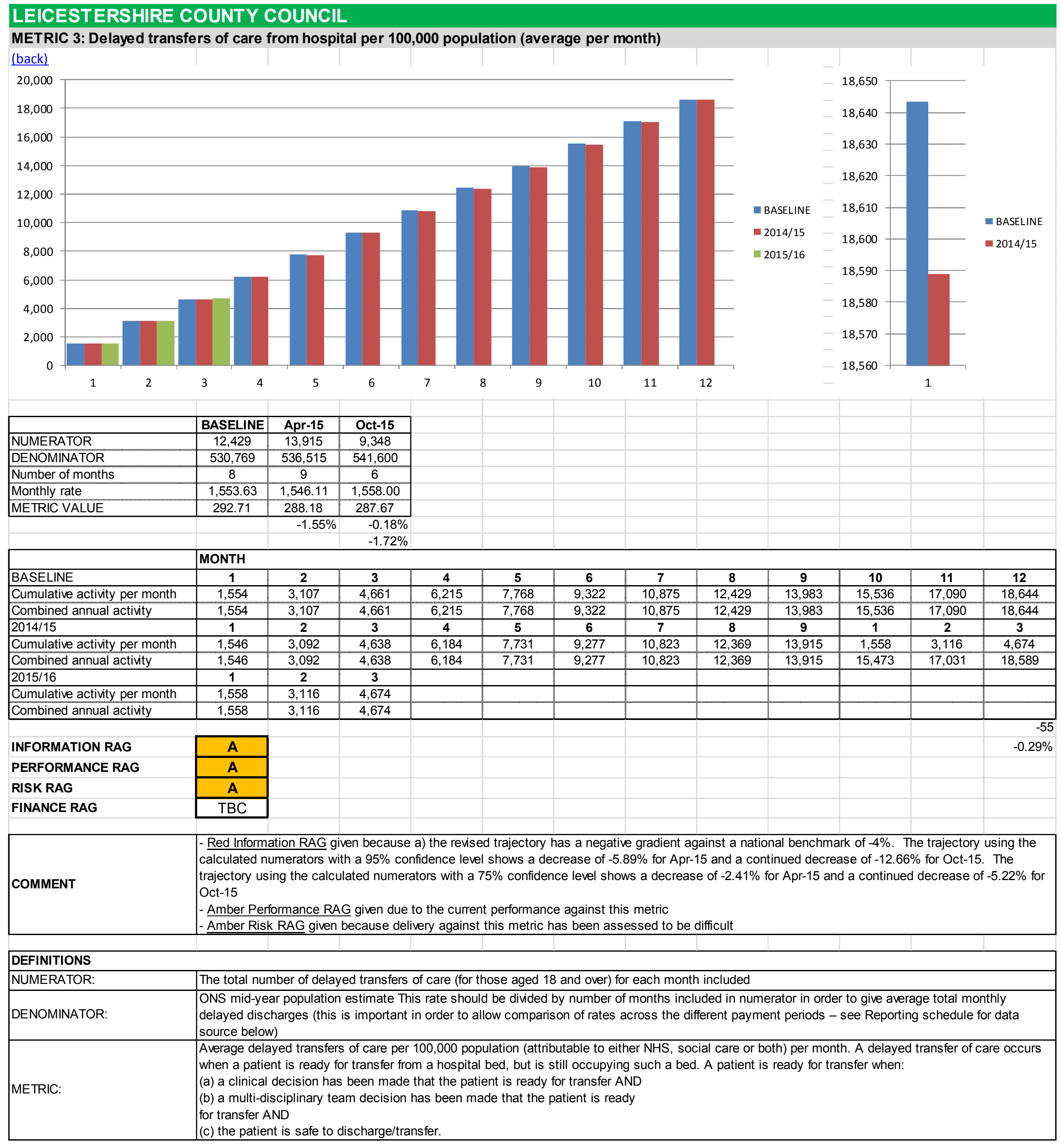
Matches BCF base data

Matt Williams advised that the Oct-15 denominator value has been modelled locally

INFORMATION RAG	A
PERFORMANCE RAG	A
RISK RAG	A
FINANCE RAG	TBC

COMMENT	- Amber Information RAG given because a) the data quality of the numerator is not good due to the monitoirng of the 91-day window following discharge from reablement **(ACTION:** Matt Williams and Sandy McMillan to write a summary of issue and remedial solutions). It is noted that the submitted improvement is 5.08% against a national benchmark of 6% - Amber Performance RAG given due to the current performance against this metric - Amber Risk RAG given because delivery against this metric has been assessed to be difficult due to the data quality issues

DEFINITIONS	
NUMERATOR:	The number of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting) who are at home or in extra care housing or an adult placement scheme setting three months after the date of their discharge from hospital. This excludes those who are in hospital or in a registered care home (other than for a brief episode of respite care from which they are expected to return home) at the three month date and those who have died within the three months. Collected 1 January to 31 March of relevant year for all cases in denominator.
DENOMINATOR:	The number of older people aged 65 and over offered rehabilitation services following discharge from acute or community hospital. Collected 1 October to 31 December for the relevant year. Alongside this measure is the requirement that there is no decrease in the proportion of people (aged 65 and over) discharged alive from hospitals in England between 1 October 2012 and 31 December 2012 (including all specialities and zero-length stays) that are offered this service.
METRIC:	The proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into rehabilitation services.



LEICESTERSHIRE COUNTY COUNCIL

METRIC 3: Delayed transfers of care from hospital per 100,000 population (average per month)

(back)

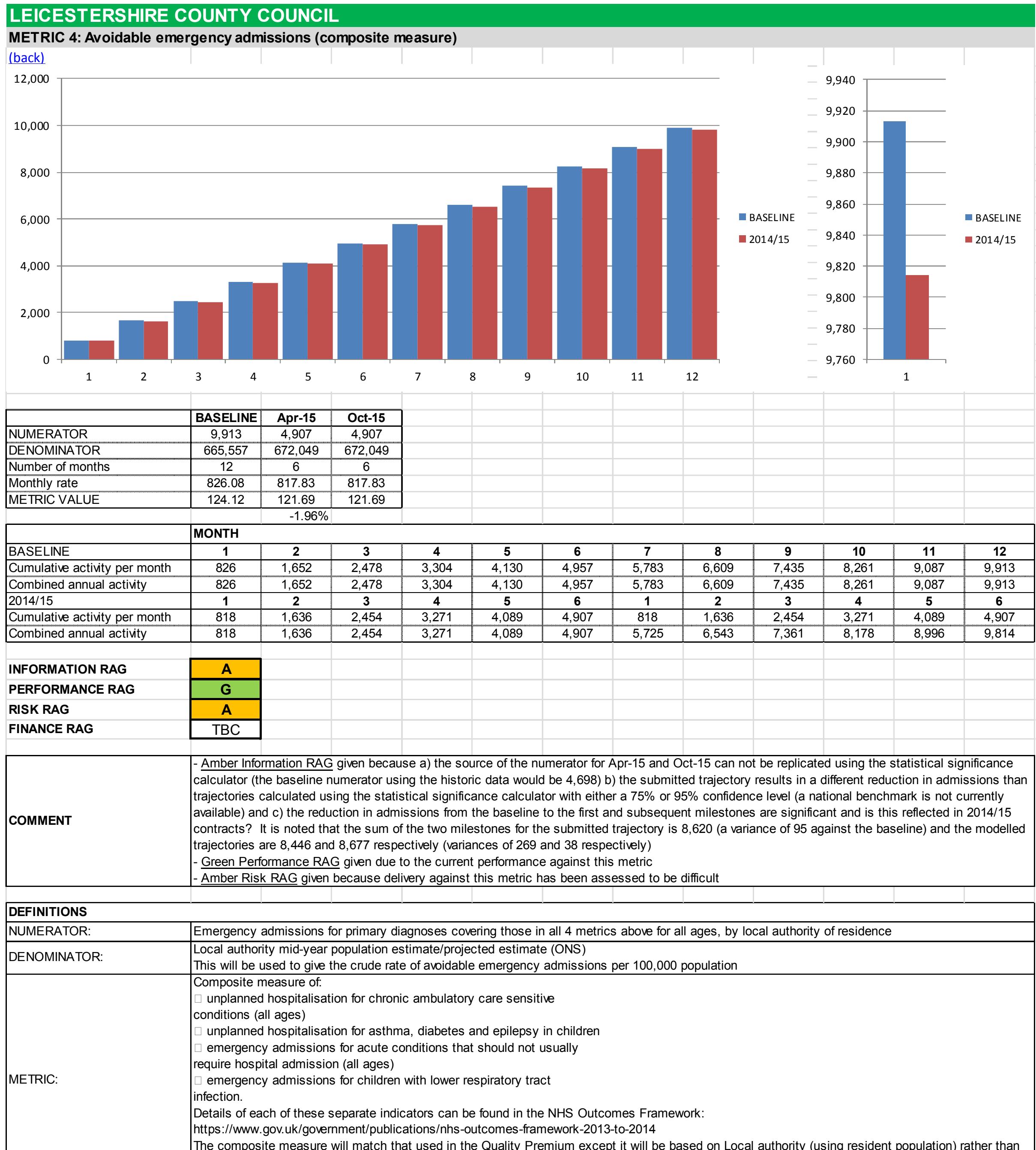
	BASELINE	Apr-15	Oct-15
NUMERATOR	12,429	13,915	9,348
DENOMINATOR	530,769	536,515	541,600
Number of months	8	9	6
Monthly rate	1,553.63	1,546.11	1,558.00
METRIC VALUE	292.71	288.18	287.67
		-1.55%	-0.18%
			-1.72%

	MONTH											
BASELINE	1	2	3	4	5	6	7	8	9	10	11	12
Cumulative activity per month	1,554	3,107	4,661	6,215	7,768	9,322	10,875	12,429	13,983	15,536	17,090	18,644
Combined annual activity	1,554	3,107	4,661	6,215	7,768	9,322	10,875	12,429	13,983	15,536	17,090	18,644
2014/15	1	2	3	4	5	6	7	8	9	1	2	3
Cumulative activity per month	1,546	3,092	4,638	6,184	7,731	9,277	10,823	12,369	13,915	1,558	3,116	4,674
Combined annual activity	1,546	3,092	4,638	6,184	7,731	9,277	10,823	12,369	13,915	15,473	17,031	18,589
2015/16	1	2	3									
Cumulative activity per month	1,558	3,116	4,674									
Combined annual activity	1,558	3,116	4,674									
												-55
												-0.29%

INFORMATION RAG	A
PERFORMANCE RAG	A
RISK RAG	A
FINANCE RAG	TBC

COMMENT	- Red Information RAG given because a) the revised trajectory has a negative gradient against a national benchmark of -4%. The trajectory using the calculated numerators with a 95% confidence level shows a decrease of -5.89% for Apr-15 and a continued decrease of -12.66% for Oct-15. The trajectory using the calculated numerators with a 75% confidence level shows a decrease of -2.41% for Apr-15 and a continued decrease of -5.22% for Oct-15 - Amber Performance RAG given due to the current performance against this metric - Amber Risk RAG given because delivery against this metric has been assessed to be difficult

DEFINITIONS	
NUMERATOR:	The total number of delayed transfers of care (for those aged 18 and over) for each month included
DENOMINATOR:	ONS mid-year population estimate This rate should be divided by number of months included in numerator in order to give average total monthly delayed discharges (this is important in order to allow comparison of rates across the different payment periods – see Reporting schedule for data source below)
METRIC:	Average delayed transfers of care per 100,000 population (attributable to either NHS, social care or both) per month. A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed. A patient is ready for transfer when: (a) a clinical decision has been made that the patient is ready for transfer AND (b) a multi-disciplinary team decision has been made that the patient is ready for transfer AND (c) the patient is safe to discharge/transfer.



LEICESTERSHIRE COUNTY COUNCIL

METRIC 4: Avoidable emergency admissions (composite measure)

(back)

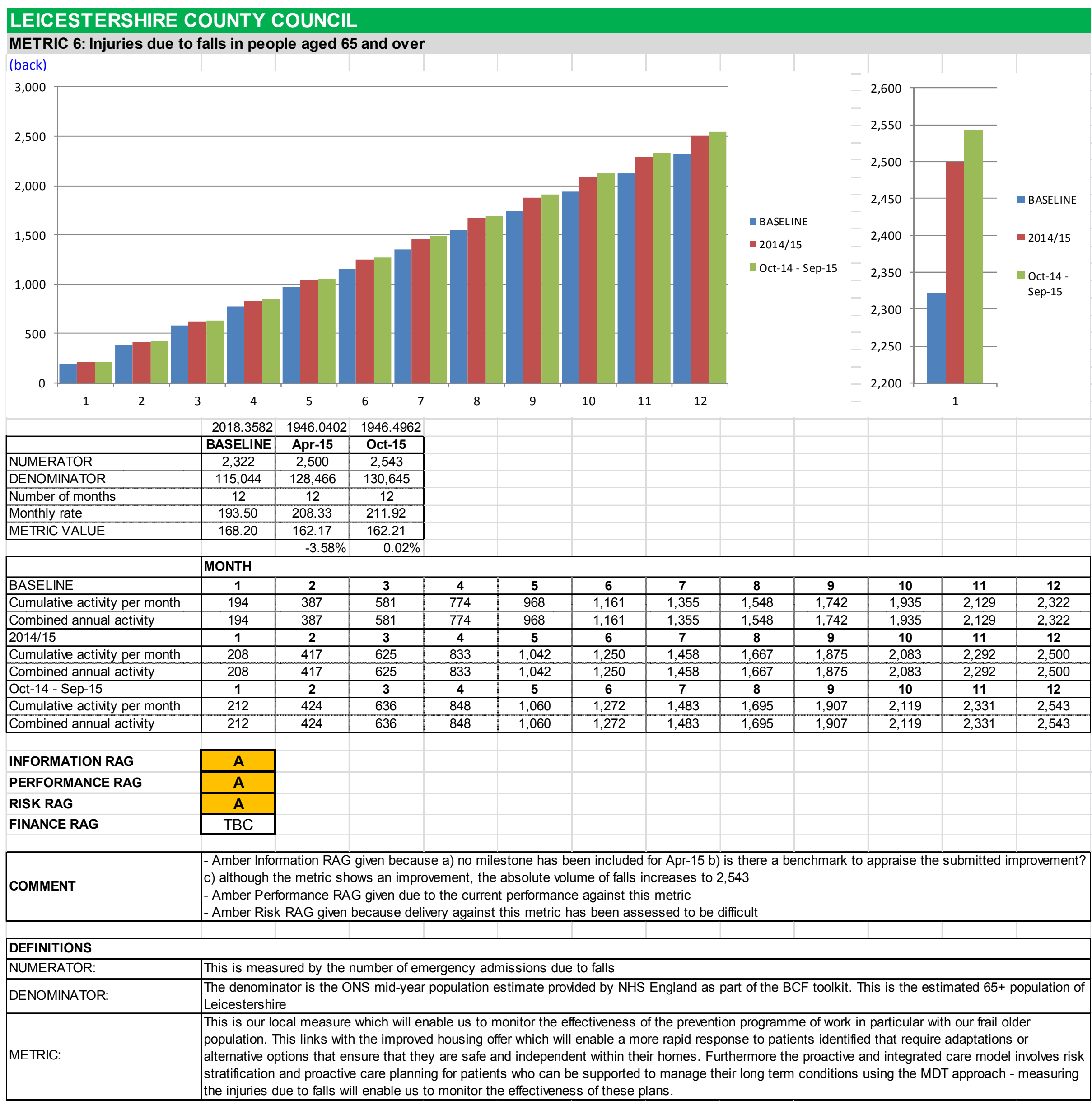
	BASELINE	Apr-15	Oct-15
NUMERATOR	9,913	4,907	4,907
DENOMINATOR	665,557	672,049	672,049
Number of months	12	6	6
Monthly rate	826.08	817.83	817.83
METRIC VALUE	124.12	121.69	121.69
		-1.96%	

	MONTH											
BASELINE	1	2	3	4	5	6	7	8	9	10	11	12
Cumulative activity per month	826	1,652	2,478	3,304	4,130	4,957	5,783	6,609	7,435	8,261	9,087	9,913
Combined annual activity	826	1,652	2,478	3,304	4,130	4,957	5,783	6,609	7,435	8,261	9,087	9,913
2014/15	1	2	3	4	5	6	1	2	3	4	5	6
Cumulative activity per month	818	1,636	2,454	3,271	4,089	4,907	818	1,636	2,454	3,271	4,089	4,907
Combined annual activity	818	1,636	2,454	3,271	4,089	4,907	5,725	6,543	7,361	8,178	8,996	9,814

INFORMATION RAG	A
PERFORMANCE RAG	G
RISK RAG	A
FINANCE RAG	TBC

COMMENT	- Amber Information RAG given because a) the source of the numerator for Apr-15 and Oct-15 can not be replicated using the statistical significance calculator (the baseline numerator using the historic data would be 4,698) b) the submitted trajectory results in a different reduction in admissions than trajectories calculated using the statistical significance calculator with either a 75% or 95% confidence level (a national benchmark is not currently available) and c) the reduction in admissions from the baseline to the first and subsequent milestones are significant and is this reflected in 2014/15 contracts? It is noted that the sum of the two milestones for the submitted trajectory is 8,620 (a variance of 95 against the baseline) and the modelled trajectories are 8,446 and 8,677 respectively (variances of 269 and 38 respectively) - Green Performance RAG given due to the current performance against this metric - Amber Risk RAG given because delivery against this metric has been assessed to be difficult

DEFINITIONS	
NUMERATOR:	Emergency admissions for primary diagnoses covering those in all 4 metrics above for all ages, by local authority of residence
DENOMINATOR:	Local authority mid-year population estimate/projected estimate (ONS) This will be used to give the crude rate of avoidable emergency admissions per 100,000 population
METRIC:	Composite measure of: unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages) unplanned hospitalisation for asthma, diabetes and epilepsy in children emergency admissions for acute conditions that should not usually require hospital admission (all ages) emergency admissions for children with lower respiratory tract infection. Details of each of these separate indicators can be found in the NHS Outcomes Framework: https://www.gov.uk/government/publications/nhs-outcomes-framework-2013-to-2014 The composite measure will match that used in the Quality Premium except it will be based on Local authority (using resident population) rather than CCG geography (GP registered population). http://www.england.nhs.uk/wp-content/uploads/2013/05/qual-premium.pdf



	2018.3582	1946.0402	1946.4962
	BASELINE	Apr-15	Oct-15
NUMERATOR	2,322	2,500	2,543
DENOMINATOR	115,044	128,466	130,645
Number of months	12	12	12
Monthly rate	193.50	208.33	211.92
METRIC VALUE	168.20	162.17	162.21
		-3.58%	0.02%

	MONTH											
BASELINE	1	2	3	4	5	6	7	8	9	10	11	12
Cumulative activity per month	194	387	581	774	968	1,161	1,355	1,548	1,742	1,935	2,129	2,322
Combined annual activity	194	387	581	774	968	1,161	1,355	1,548	1,742	1,935	2,129	2,322
2014/15	1	2	3	4	5	6	7	8	9	10	11	12
Cumulative activity per month	208	417	625	833	1,042	1,250	1,458	1,667	1,875	2,083	2,292	2,500
Combined annual activity	208	417	625	833	1,042	1,250	1,458	1,667	1,875	2,083	2,292	2,500
Oct-14 - Sep-15	1	2	3	4	5	6	7	8	9	10	11	12
Cumulative activity per month	212	424	636	848	1,060	1,272	1,483	1,695	1,907	2,119	2,331	2,543
Combined annual activity	212	424	636	848	1,060	1,272	1,483	1,695	1,907	2,119	2,331	2,543

INFORMATION RAG	A
PERFORMANCE RAG	A
RISK RAG	A
FINANCE RAG	TBC

COMMENT	- Amber Information RAG given because a) no milestone has been included for Apr-15 b) is there a benchmark to appraise the submitted improvement? c) although the metric shows an improvement, the absolute volume of falls increases to 2,543 - Amber Performance RAG given due to the current performance against this metric - Amber Risk RAG given because delivery against this metric has been assessed to be difficult

DEFINITIONS	
NUMERATOR:	This is measured by the number of emergency admissions due to falls
DENOMINATOR:	The denominator is the ONS mid-year population estimate provided by NHS England as part of the BCF toolkit. This is the estimated 65+ population of Leicestershire
METRIC:	This is our local measure which will enable us to monitor the effectiveness of the prevention programme of work in particular with our frail older population. This links with the improved housing offer which will enable a more rapid response to patients identified that require adaptations or alternative options that ensure that they are safe and independent within their homes. Furthermore the proactive and integrated care model involves risk stratification and proactive care planning for patients who can be supported to manage their long term conditions using the MDT approach - measuring the injuries due to falls will enable us to monitor the effectiveness of these plans.

Better Care Fund Spending Plan 2014/15 & 2015/16

Theme	Scheme	High level description of what the spend will be invested in	2014/15 West Leics CCG £'000	2014/15 East Leics & Rutland CCG £'000	2014/15 Total £'000	2015/16 West Leics CCG £'000	2015/16 East Leics & Rutland CCG £'000	2015/16 Total £'000
Unified Prevention Offer	First Contact	Multi agency referral scheme for vulnerable adults. When a staff member from any of the agencies involved in the scheme, such as a volunteer, police officer / police community support officer, environmental health officer, victim support staff, council worker or fire fighter is in contact with a vulnerable adult by; a visit to their home, a telephone call or during their work with them, they can offer to complete one simple checklist to find out if that person has any other particular needs. http://www.leics.gov.uk/firstcontact	90.6	68.3	158.9	92.1	69.5	161.6
Unified Prevention Offer	Carers Services	Covers 3 areas: 1) Carers Support Fund - £85k. Payment to carers of up to £250 to support them in their caring roles. 2) GP Referral Service - £165k. Service to identify and support carers at GP Surgeries. Run as a pilot in North West Leics and Oadby & Wigston, looking to expand countywide in 2015/16 3) Carers respite £200k - currently limited to carers of people with dementia, this service is being remodelled to make it accessible to all carers http://www.leics.gov.uk/index/social_services/asc_support/asc_carer/social_care_short_breaks/asc_time_out_for_you.htm	210.9	159.1	370.0	256.5	193.5	450.0
Unified Prevention Offer	Time Banking	Timebanking is a means of exchange used to organise people and organisations around a purpose, where time is the principal currency. For every hour participants 'deposit' in a timebank, perhaps by giving practical help and support to others, they are able to 'withdraw' equivalent support in time when they themselves are in need. In each case the participant decides what they can offer. Everyone's time is equal, so one hour of my time is equal to one hour of your time, irrespective of whatever we choose to exchange. Because timebanks are just systems of exchange, they can be used in an almost endless variety of settings. http://www.timebanking.org/ http://www.leics.gov.uk/index/social_services/asc_support/asc_general_info/asc_partners/timebanking.htm	41.0	31.0	72.0			
Unified Prevention Offer	Advice & Information (c/f from 2013/14)	Staffing to support the writing of an information and advice strategy for Leicestershire. Costs run into 2013/14.	2.3	1.7	4.0			
Unified Prevention Offer	Carers Assessments (Care Bill Implications)	Part of the BCF includes money for certain aspects of the Care Bill, assessment of carers being one of them. The £275k should allow the County Council complete up to 2800 carers assessments and reviews required to meet the 'carers assessments: no. of people accessing services' proportion of 39.3% as suggested in the Care and Support Impact Assessment. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/275519/Care_and_Support_Legal_Reform.pdf				156.8	118.3	275.0
Unified Prevention Offer	Specialist Support to People with Dementia & Carers	Service commissioned from the voluntary sector (current provider Alzheimers Society) to provide continuity of support for people with dementia and their carers (on a 1:1 basis and through group activities) from diagnosis to end of life. This includes the delivery of advice and information and emotional support.	167.6	126.4	294.0	182.4	137.6	320.0
Unified Prevention Offer	Strengthening Autism Pathway	Temporarily funds 2 FTE Team Senior posts in the Mental Health Care Pathway Team until July 2015. A contract with NAS has also been commissioned where dedicated staff are employed to raise awareness of autism across the county. Part of the contract also includes the provision of a web based Information Hub, a source of resources and help for anybody affected directly, or indirectly by autism. http://www.laih.org.uk/home-page.aspx	92.8	70.0	162.8	54.1	40.8	94.9
Unified Prevention Offer	Assistive Technology	Providing telecare and standalone equipment to c3,600 service users to support them living at home in their community to avoid admission to permanent residential care, reduce the need for more costly services and reduce hospital admissions.	560.9	423.1	984.0	567.2	427.9	995.0
Unified Prevention Offer	Assistive Technology (replacement equipment)	Links to the existing service users in housing related support where the current contracts are currently under review which may result in the need to replace/renew existing equipment.	823.4	621.1	1,444.5			
Unified Prevention Offer	Local Area Co-ordination	Supporting vulnerable people more effectively in the community to reduce reliance on public services. Based on co-ordinators being a single point of contact who identifies and supports vulnerable people before they hit crisis. Recently, Derby City have started a scheme http://www.derby.gov.uk/health-and-social-care/help-for-adults/local-area-coordination/	136.8	103.2	240.0	342.0	258.0	600.0
Unified Prevention Offer	Disabled Facilities Grants	Grants provided by District Councils to adapt homes making them suitable for disabled people.				991.2	747.8	1,739.0
			2,126.2	1,604.0	3,730.2	2,642.2	1,993.3	4,635.5
	Protection of Services:							
Unified Prevention Offer	NHS - LD Short Breaks	Services commissioned by WLCCG & ELRCCG				588.0	256.0	844.0
TOTAL PREVENTION			**2,126.2**	**1,604.0**	**3,730.2**	**3,230.2**	**2,249.3**	**5,479.5**
Long Term Conditions	Proactive Care (West Leics)	Supporting people with long term conditions and frail older people by enabling more alternatives to hospital stays delivered closer to home. Proactive care provides structured interventions those people at highest risk of adverse outcomes (admissions or crisis)	540.0		540.0	540.0		540.0
Long Term Conditions	Long Term Conditions (East)	Similar service to proactive care in West CCG as described above.		460.0	460.0		460.0	460.0
Long Term Conditions	Pathway to Housing	Project set up to support staff and service users when accessing supported living services. The team (2FTE) provide information and advice, identify housing options, ensuring packages of care are outcome based, person centred and cost effective.	41.2	31.0	72.2			
Long Term Conditions	Memory Plus Service Evaluation	Memory Plus supports professional providers of dementia care in the development and delivery of activities using museum objects, reminiscence and multi-sensory approaches. In 2013/14 funds were allocated to develop new resources and provide training, funds this year will be used to evaluate the programme to inform the future delivery of this service. http://www.leics.gov.uk/memory_plus	5.7	4.3	10.0			
Long Term Conditions	Improving Quality in Care Homes	Integrated Support Team – An integrated social care and health team to improve quality in residential care homes, responding quickly and proactively to any breaches and reducing the number of safeguarding incidents. Improving quality will enable homes to support individuals better and avoid unnecessary primary care and hospital involvement.	277.2	209.1	486.3	285.7	215.6	501.3
Long Term Conditions	IT Enablers - Data sharing, care plans, t/health & t/care	One of the conditions for the BCF is to improve data sharing between heath and social care. This allocation is to support that condition, although needs further scoping.				370.5	279.5	650.0
			864.0	704.5	1,568.5	1,196.2	955.1	2,151.3
	Protection of Services:							
Long Term Conditions	Social Care - Nursing care packages	Ongoing provision of c300 nursing care placements enabling these services users to stay outside of the acute sector.	1,707.3	1,287.9	2,995.2	1,915.5	1,445.1	3,360.6
Long Term Conditions	Social Care - Sustainable community services	To support service users' increased dependency for home care and other community based services enabling more people to remain in , or return to their homes.	835.6	630.4	1,466.0	1,069.3	806.7	1,876.0
Long Term Conditions	Social Care - Increasing demographic pressures	Provision of care packages resulting from increased demographic pressures, in particular 18-64 year old service users with increasingly complex needs and dementia in older people. This is in addition to the £21m being funded by the local authority.	992.4	748.6	1,741.0	2,612.9	1,971.1	4,584.0
Long Term Conditions	Social Care - Protection of community care packages	To maintain support levels for existing service users. This will avoid a 20% reduction in all long term support packages.				2,195.6	1,656.4	3,852.0
TOTAL LONG TERM CONDITIONS			**4,399.3**	**3,371.4**	**7,770.7**	**8,989.6**	**6,834.3**	**15,823.9**
Urgent Response	Integrated Crisis Response Service (Health & Social Care)	The long term aim of the Integrated Crisis Response Service is to provide effective short-term support at a point of crisis that will help to maintain someone in their own home, preventing admission to hospital or long-term residential care. The service will provide specialist domiciliary support coordinated with other home based support as appropriate, such as Assistive technology, I-care (meals) and Health Intermediate Care. The service will operate over 7 days, from 7.00am to 10.00pm and provides a short-term intervention for a maximum of 72 hours following referral.	592.1	446.6	1,038.7	1,140.0	860.0	2,000.0
Urgent Response	Health & Social Care Older People's Frail Service	New - consolidating a number of existing services into a rapid assessment and treatment service for frail/complex older people with the potential to offer outpatient and short stay options (e.g. up to 72 hours) which are not readily available in current models of care.	570.0	430.0	1,000.0	1,140.0	860.0	2,000.0
Urgent Response	Ambulance Falls Prevention	Joint health and social care service to prevent unnecessary conveyance to hospital for people who suffer from a fall at home	28.5	21.5	50.0	57.0	43.0	100.0
Urgent Response	Expanded Role of Primary Medical Care	New. Further work needed to develop this but initial thoughts include 7 day working (BCF condition), workforce development and proactive care gp leads.	171.0	129.0	300.0	427.5	322.5	750.0
TOTAL URGENT RESPONSE			**1,361.6**	**1,027.1**	**2,388.7**	**2,764.5**	**2,085.5**	**4,850.0**
Discharge & Reablement	HART Reablement	HART is the Council's Home Care Assessment and Reablement Team. Provides intensive support for up to 6 weeks to help service users maintain their independence in the community. Evidence shows that this type of service can reduce and/or delay the need for longer term, more costly services. http://www.leics.gov.uk/index/social_services/adults/adults_srv/support_home/rehabilitation	246.2	185.8	432.0	246.2	185.8	432.0
Discharge & Reablement	Intermediate Care	LPT's intermediate care team co-works with the County Council's HART service to support hospital discharges, prevent avoidable readmissions and reduce the risk of falls.	313.0	267.0	580.0	313.0	267.0	580.0
Discharge & Reablement	Integrated Residential Reablement	Step down service to support the discharge to assess pathway. Patients are discharged from hospital to a short tem residential care placement for up to 6 weeks where their longer term support needs are assessed. Interventions from HART and other therapies support the service users to go back to their home. The service aims to avoid unnecessary admissions to long term residential care and reduces excess bed days in the acute service. An integrated health and social care service is currently being designed.	316.9	239.1	556.0	316.9	239.1	556.0
Discharge & Reablement	Hospital to Home	A reablement service provided by the RVS for patients who leave hospital with no family/local support. Volunteers work with patients for up to 6 weeks with a range of tasks to rebuild confidence and prevent social isolation, including preparing the patient's home for return from hospital, supporting them to access community activities and befriending.	41.0	31.0	72.0	41.0	31.0	72.0
Discharge & Reablement	HART Scheduling System	A new system to plan/schedule the visits made by HART Care Assistants to make the service more effective and efficient. The costs charged to the BCF are for the initial purchase and set up of the system. Ongoing costs are funded from the savings generated.	54.2	40.9	95.0	74.1	55.9	130.0
Discharge & Reablement	Patient Transfer Minimum Data Set	During 2013/14 clinical, therapeutic and social care partners worked together to agree a minimum data set to enable the safe transfer of patients between care settings. Across LLR agreement has been reached to implement the tool currently being used electronically by South Warwickshire Foundation Trust this has delivered a three day reduction in processing time for discharging older adults, and has smoothed transitions generally across health and social care boundaries. Plans are in place to use the tool across UHL in 2014/15.	51.3	38.7	90.0			
Discharge & Reablement	Bridging Service	Service to reduce delayed transfers of care where a patient no longer has a need for acute inpatient services, but is still too ill to return home, or the support at home cannot be arranged and be in place immediately. New service that still needs to be worked up in detail.	285.0	215.0	500.0	427.5	322.5	750.0
Discharge & Reablement	Strengthening Mental Health Discharge Provision	Approved Mental Health Professionals to carry out assessments and meet increasing demands. Predominantly based in hospital and crisis teams. 6FTE	145.2	109.6	254.8	148.6	112.1	260.7
			1,452.9	1,126.9	2,579.8	1,567.4	1,213.3	2,780.7
	Protection of Services:							
Discharge & Reablement	NHS - Step Down	Services commissioned by WLCCG & ELRCCG				300.0	229.0	529.0
Discharge & Reablement	NHS - Intensive Community Service	Services commissioned by WLCCG & ELRCCG				951.0	870.0	1,821.0
Discharge & Reablement	NHS - Assertive InReach	Services commissioned by WLCCG & ELRCCG	324.3	244.7	569.0	342.0	227.0	569.0
Discharge & Reablement	NHS - Reablement	Services commissioned by WLCCG & ELRCCG				2,419.0	1,713.0	4,132.0
Discharge & Reablement	Social Care - Residential Respite	Ongoing provision of residential respite to service users to prevent carer breakdown and the need for more costly services.	423.3	319.3	742.6	423.3	319.3	742.6
Discharge & Reablement	Social Care - cost pressures linked to new models of working	Maintaining capacity in the social care pathway to support integrated methods of working. This equates to c41 FTE social care staff in hospital and locality teams.	125.4	94.6	220.0	934.8	705.2	1,640.0
TOTAL DISCHARGE & REABLEMENT			**2,325.9**	**1,785.5**	**4,111.4**	**6,937.5**	**5,276.8**	**12,214.3**
Enablers	Better Care Fund Programme Leads	Project leads for Carers, Early intervention & Prevention and Learning Disabilities	93.5	70.6	164.1	14.8	11.2	26.0
Enablers	Better Care Fund - Programme Support	Specific staff support to the overall BCF Programme	48.7	36.8	85.5	49.5	37.3	86.8
TOTAL ENABLERS			**142.3**	**107.3**	**249.6**	**64.3**	**48.5**	**112.8**
		TOTAL BETTER CARE FUND EXPENDITURE	**10,355.2**	**7,895.4**	**18,250.6**	**21,986.1**	**16,495.4**	**38,480.5**
		NOTIFIED BETTER CARE FUND ALLOCATION			**13,643.0**			**38,343.0**
		ADDITIONAL EXPENDITURE FUNDED FROM RESERVES			**4,607.6**			**137.5**

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