Meeting: **Health and Wellbeing Board**

Date/Time: **Thursday, 22 June 2017 at 2.00 pm**

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

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

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

Membership

Mr. E. F. White CC (Chairman)

John Adler	Rick Moore
Mr. R. Blunt CC	Mr. I. D. Ould CC
Karen English	Cllr. P. Posnett
Dr Andy Ker	Cllr. P. Ranson
Dr Satheesh Kumar	Toby Sanders
Dr Mayur Lakhani	Mike Sandys
Chief Supt Andy Lee	John Sinnott
Roz Lindridge	Jane Toman
Cllr. Kirk Master	Jon Wilson
Paul Meredith	

AGENDA

Item		Report by
1.	Appointment of Chairman. To note that Mr E F White CC has been appointed Chairman.	
2.	Appointment of Vice Chairman. To note that Dr Andy Ker, as Chairman of the Integration Executive, has been appointed Vice Chairman.	
3.	Minutes of the meeting held on 16 March 2017 and Action Log.	(Pages 3 - 16)

4. To advise of any other items which the Chairman has decided to take as urgent elsewhere on the agenda.

5. Declarations of interest in respect of items on the agenda.

6. Position Statement by the Chairman.

Strategy.

7.	Better Care Fund 2017/18 - 2018/19.	Director of Health and Care Integration	(Pages 17 - 42)
8.	STP Update - Integrated Locality Teams.	Director of Health and Care Integration	(Pages 43 - 50)

The latest Integrated Locality Teams Bulletin is attached.

9.	Summary Care Record.	West Leicestershire and East Leicestershire and Rutland CCG	(Pages 51 - 54)

Performance.

10.	Better Care Fund Quarterly Performance Report.	Director of Health and Care Integration	(Pages 55 - 66)
11.	'It's not in my head': Patient Experiences of Fibromyalgia.	Healthwatch	(Pages 67 - 90)

Governance.

12.	Healthwatch Recommissioning.	Chief Executive	(Pages 91 - 94)

13. Date of next meeting.

The next meeting of the Health and Wellbeing Board will be held on Thursday 20 July at 2.00pm.

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

Agenda Item 3

Minutes of a meeting of the Health and Wellbeing Board held at County Hall, Glenfield on Thursday, 16 March 2017.

PRESENT

PRESENT

Leicestershire County Council

Mr. E. F. White CC (In the Chair)	Paul Meredith
Mr. Dave Houseman MBE, CC	John Sinnott
Mr. I. D. Ould CC	Jon Wilson

Clinical Commissioning Groups

Karen English
Dr Andy Ker

Leicestershire District Councils

Cllr Pam Posnett
Cllr Pauline Ranson

University Hospitals of Leicester NHS Trust

John Adler

Leicestershire Partnership NHS Trust

Dr Satheesh Kumar

In attendance

Lynn Aisbett, Leicestershire District Councils
Lord Willy Bach, Police and Crime Commissioner
Angela Bright, West Leicestershire CCG
Wendy Hoult, NHS England
Vivienne Robbins, Leicestershire County Council
Dr Chris Trzcinski, West Leicestershire CCG
Ch Supt Sian Walls, Leicestershire Police

355. Minutes and Action Log.

The minutes of the meeting held on 5 January 2017 were taken as read, confirmed and signed.

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

356. Urgent Items.

There were no urgent items for consideration.

357. Declarations of interest.

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

No declarations were made.

358. Position Statement from the Chairman.

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

- Focus on improving end of life care across Leicester, Leicestershire and Rutland;
- A selection of national publications.

The difficulties in meeting patients' wishes for end of life care were recognised. A discussion had taken place at a meeting of the System Leadership Team earlier that day regarding proposals for a more integrated approach in this area, building on good work which had already taken place.

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

359. Change to the Order of Business.

The Chairman sought and obtained the consent of the Board to vary the order of business from that set out on the agenda.

360. Better Care Fund Plan 2017/18 - 2018/19.

The Board considered a report of the Director of Health and Care Integration which provided an overview of the progress to refresh and submit the Leicestershire Better Care Fund (BCF) Plan, including an update on the refreshed spending plan and outcome metrics for 2017/18 and 2018/19 as at 7 March 2017. A copy of the report marked 'Agenda Item 7' is filed with these mintues.

The target for permanent admissions of older people to residential and nursing care homes had been set on the basis that the Help to Live at Home procurement was not yet completed and there were other developments linked to the Home First workstream of the Sustainability and Transformation Plan (STP) that would be implemented over the next 12 months and support improvements later in the year. It would not be appropriate to have a more challenging target in this area until stability had been achieved and the emerging improvements to be led by the Home First workstream were scoped and delivered.

It was clarified that the Home First workstream was intended to provide services for people in crisis who needed additional support to prevent them from going into hospital or to support discharge (e.g. step up services, as well as step down services on hospital discharge). This workstream would not address general capacity issues within the social care workforce. However, a workforce strategy would be implemented during the next

financial year to support social care providers to develop capacity. It was intended that this would be funded through the additional adult social care grant allocation.

RESOLVED:

(a) That the Better Care Fund Plan for 2017/18 – 2018/19 be approved for submission to NHS England in line with the national timetable, and subject to the publication of the national BCF guidance and any further amendments required;

(b) That the Chief Executive of Leicestershire County Council, following consultation with the Chairman of the Health and Wellbeing Board be authorised to make any amendments to the Better Care Fund Plan 2017/18 – 2019/20 in the light of the national guidance, prior to its submission to NHS England;

(c) That the final Better Care Fund Plan for 2017/18 – 2019/20 be submitted to the next meeting of the Health and Wellbeing Board for assurance, along with a progress update on the process and timescale for national assurance via NHS England.

361. Sustainability and Transformation Plan Update.

The Board considered a report of Better Care Together which provided an update on the progress of the Leicester, Leicestershire and Rutland Sustainability and Transformation Plan (STP). A copy of the report marked 'Agenda Item 5' is filed with these minutes.

It was noted that the national decision regarding the capital funding required to deliver the STP had been deferred until the Autumn Statement. In the meantime, it would be important to continue work which did not require capital funding, such as Home First and the Integrated Locality Teams. This would ensure that sustainable community services were in place.

RESOLVED:

That the update on the progress of the Leicester, Leicestershire and Rutland Sustainability and Transformation Plan be noted.

362. Safeguarding Boards Business Plans 2017/18.

The Board considered a report from the Independent Chair of the Safeguarding Boards which set out the draft proposed Business Plan priorities for the Leicestershire and Rutland Local Safeguarding Children Board and the Leicestershire and Rutland Safeguarding Adults Board for 2017/18. A copy of the report marked 'Agenda Item 12' is filed with these minutes.

RESOLVED:

(a) That the Business Plan priorities 2017/18 for the Leicestershire and Rutland Safeguarding Children Board and Safeguarding Adults Board be noted;

(b) That the Board thank Paul Burnett for his work as Chairman of the Safeguarding Board and wish him well in his retirement.

363. Ofsted Inspection of Services for Children in Need of Help and Protection, Children Looked After and Care Leavers.

The Board considered a report of the Director of Children and Family Services which advised of the outcome of the recent Ofsted inspection of children's social care services in Leicestershire and presented the Action Plan which had been developed to address the recommendations in the Ofsted Report and to set out the way forward for the development of the Council's Children and Families Service. A copy of the report marked 'Agenda Item 13' is filed with these minutes.

It was noted that the inspection findings were in line with the Council's own self-assessment and that work had therefore already started on a number of the development areas identified by Ofsted.

Partnership engagement had been identified as a strength although areas such as access to the Child and Adolescent Mental Health Service (CAMHS) and services for children with disabilities required improvement.

RESOLVED:

(a) That the content, grades and recommendations of the Ofsted inspection report on children's social care services in Leicestershire be noted;

(b) That the Children and Family Services Improvement Plan which was developed in preparation for the inspection and charts progress made be noted;

(c) That the Action Plan which has been prepared in response to the recommendations in the Ofsted Report and includes proposals for the future development and improvement of services to children and families be noted.

364. Blueprint for General Practice: Delivering the General Practice Five Year Forward View.

The Board considered a report from Better Care Together which set out how the development and resilience of general practice would be ensured and would assist in bringing about the system-wide transformation required to focus on prevention and the moderation of demand growth. A copy of the report marked 'Agenda Item 6' is filed with these minutes.

GPs were facing an increase in workloads due to both rising demand and a requirement for surgeries to be open for longer hours. The GP Five Year Forward View could not require GPs to change how they worked but it was intended to support GPs and to find ways of working with them to deliver sustainable change.

The workforce evidence highlighted risks for Leicester, Leicestershire and Rutland (LLR), such as the fact that 60 percent of nurses were aged over 50 and recruitment and retention issues across primary care. It was intended that the GP Five Year Forward View would help to make Leicestershire an attractive place to work and would offer GPs new ways of working such as portfolio careers.

Work already undertaken in LLR provided a good foundation for the GP Five Year Forward View. The STP model was developing place based services around localities, for example through Integrated Locality Teams. GPs were at the centre of this model. A preventative approach was also being developed through the STP to promote self-care

and self-referral into services such as the Stop Smoking Service. It was hope that this would reduce the number of GP appointments needed in the future.

RESOLVED:

That the Blueprint for General Practice: Delivering the General Practice Five Year Forward View, be noted.

365. Proposal for Joint Commissioning of a Dementia Community and Hospital In-Reach Service for Leicester and Leicestershire.

The Board considered a report of the Director of Adults and Communities which provided information on the proposals for the future joint commissioning of a dementia community and hospital inreach support service and sought agreement for the use of Better Care Fund monies for this purpose. A copy of the report marked 'Agenda Item 8' is filed with these minutes.

RESOLVED:

(a) That the proposal for joint commissioning of a Dementia Community and Hospital Inreach Service, to support the ambitions of the Leicester, Leicestershire and Rutland Sustainability and Transformation Plan and improve the support pathway for people affected by dementia, be approved;

(b) That the proposal for a 10% efficiency saving against the current allocation of Better Care Fund resources, resulting in a contribution of £287,000 per annum, be approved.

366. Sport England Local Delivery Pilot Bid.

The Board considered a report of the Director of Public Health which outlined the emerging Leicestershire bid to be a Sport England Local Delivery Pilot site and sought the Board's support for the bid. A copy of the report marked 'Agenda Item 9' is filed with these minutes.

Arising from discussion the following points were raised:-

(i) The bid and its focus on walking were welcomed as walking was an accessible form of physical activity and also had a positive effect on mental health and reducing social isolation. A range of approaches would be used to promote walking programmes, details of which would be confirmed later in the bidding process.

(ii) It would be important to ensure that motivational techniques were used to encourage inactive people to walk and for people to not use the car for short journeys. Other barriers which prevented people from walking would also need to be addressed. It was hoped that Loughborough University would have insight to support this part of the scheme.

An announcement was expected in May regarding which bids had successfully progressed to the next stage.

RESOLVED:

That the Local Delivery Pilot Bid to Sport England and initial expression of interest be supported.

367. Leicester, Leicestershire and Rutland Suicide Prevention Strategy and Action Plan 2017 - 2020.

The Board considered a report of the Director of Public Health which provided an update on the work of the Leicester, Leicestershire and Rutland (LLR) Suicide Audit and Prevention Group and sought approval for the LLR Suicide Prevention Strategy and draft action plan for 2017-20. A copy of the report marked 'Agenda Item 10' is filed with these minutes.

Arising from discussion the following points were raised:-

(i) Concern was expressed that the Strategy did not make an explicit link to schools or children in care. The Board was assured that a lot of work, including anti-bullying initiatives, was undertaken in schools to support the mental health of children and young people.

(ii) There were no significant differences between the national picture and local statistics for Leicestershire. Audits were undertaken each year to consider local practice and prevention. It might also be useful to identify local suicide hotspots.

(iii) It was suggested that the Strategy could be more ambitious and aim for a target of zero suicides. However, it was acknowledged that this would be challenging.

(iv) Leicestershire Partnership Trust had developed an e-learning package for its staff, based on the experiences of people who had survived a suicide attempt. The Trust was currently considering the procurement of an app called 'Stay Alive' which helped people to form strategies to keep themselves safe.

RESOLVED:

(a) That the purpose and work of the Leicester, Leicestershire and Rutland Suicide Audit and Prevention Group be noted;

(b) That the draft Leicester, Leicestershire and Rutland Suicide Prevention Strategy and Action Plans (2017 – 2020) be approved;

(c) That the Unified Prevention Board be requested to take forward Leicestershire specific work actions and report back to the Health and Wellbeing Board when appropriate.

368. Pharmaceutical Needs Assessment 2018.

The Board considered a report of the Director of Public Health which highlighted its responsibility to publish a Pharmaceutical Needs Assessment (PNA), the timescale to do so and the proposed governance structure to enable the production of the PNA. A copy of the report marked 'Agenda Item 11' is filed with these minutes.

RESOLVED:

(a) That the report be noted;

(b) That the delegation of the assurance role to the Integration Executive be approved;

(c) That the proposal to form a project team and an interagency Leicester, Leicestershire and Rutland wide reference group and the draft terms of reference for the project team be approved;

(d) That further reports on progress be submitted to the Health and Wellbeing Board and that the final Pharmaceutical Needs Assessment be submitted to the Board for approval in March 2018.

369. Transformation Plan for Mental Health and Wellbeing for Children and Young People - Refresh 2016/17.

The Board considered a report from Leicester City CCG which presented the refresh of the Mental Health and Wellbeing Transformational Plan delivered through the Future in Mind – Children and Young People's Mental Health and Wellbeing Transformation Programme. A copy of the report marked 'Agenda Item 14' is filed with these minutes.

Arising from discussion the following points were raised:-

(i) Members of the Board welcomed the progress that had been made in this area, in particular with the eating disorder service which was now in place. It was acknowledged that the CAMHS service was still under a lot of pressure as referral rates had increased. More early help services were needed to help address this issue, although difficulties with procurement had led to delay in implementing the early help offer.

(ii) It was clarified that home visiting referred to the crisis home response service. A phased approach was being taken to the implementation of this service. Phase 1, employing and training staff, had been completed. Phase 2 was expected to be implemented in April or May. This phase would see the service up and running.

(iii) It would be important to ensure that the performance dashboard did not just rely on process data. It would also need to reflect the impact that the Programme was having on the child's journey and progress being made towards wellbeing.

(iv) Funding for the programme during 2017/18 was in the CCGs baseline budget. It was earmarked for Future in Mind, although not a ring-fenced grant. It would be spent on the workstreams as planned. The allocation for 2016/17 had been omitted from the report.

(v) It was requested that more consideration be given to identifying priority areas for development. For example, looked after children were the group with the highest risk of mental health issues and also the group that had the most difficulty accessing services. It might be appropriate to take a more innovative approach in this area, such as through joint commissioning.

RESOLVED:

That the content of the refreshed transformation plan be noted and that the document be approved prior to publication on the CCG and Local Authority websites.

370. Leicester, Leicestershire and Rutland Health Protection Assurance Report.

The Board considered a report of the Director of Public Health which provided details of the role that the LLR Health Protection Board and more recently the LLR Health Protection System Assurance Group was carrying out to provide assurance for whole system health protection across LLR. The report also provided an update on health protection performance, key incidents and risks that had emerged from October 2015 to the end of December 2016. A copy of the report marked 'Agenda Item 15' is filed with these minutes.

There was a growing awareness of air quality and its impact on health. Evidence linked premature mortality to air quality. The Board was assured that Public Health was represented on an LLR-wide air quality group and also developing a health impact assessment for large developments which would address issues including active travel and measures for improving air quality.

RESOLVED:

(a) That the Health Protection Board Report October 2015 – December 2016 be received;

(b) That the specific health protection issues that have arisen locally and steps taken to deal with these be noted.

371. Health and Wellbeing System Performance Report Quarter 3.

The Board considered a joint report from the County Council Chief Executive and the Arden/GEM Commissioning Support Performance Service which presented an update on overall health and wellbeing system performance issues using a number of locally and nationally agreed metrics and standards. A copy of the report marked 'Agenda Item 16' is filed with these minutes.

It was suggested that consideration be given to how performance data was presented to the Board in future, to ensure that it was meaningful and focused on key issues affecting the local health and care system.

With regard to urgent care performance, it was noted that there had been an improvement in ambulance handover times during February but referral to treatment performance had declined because elective care had been suspended for a short period as a result of the challenging emergency care position. Demand and capacity continued to present a challenge.

RESOLVED:

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

372. Urgent Care Enter and View Report.

The Board considered a report which presented the findings of Healthwatch Leicestershire's visit to four Urgent Care Centres/Walk-in Centres across Leicestershire. A copy of the report marked 'Agenda Item 17' is filed with these minutes.

It was noted that a more consistent Urgent Care offer across Leicester, Leicestershire and Rutland formed part of the Vanguard Programme and was therefore being overseen by the A&E Delivery Board. It was recognised that there was work to do and a procurement exercise was planned as part of the development of Urgent Care.

RESOLVED:

(a) That the findings from the visits be noted;

(b) That it be noted that there are four separate sets of recommendations from each Urgent Care Centre for commissioners and providers to address.

373. The Lived Experiences of Hospital Discharge.

The Board considered a report of Healthwatch Leicestershire which presented the findings of a survey of patients, carers and staff members on the issue of hospital discharge. A copy of the report marked 'Agenda Item 18' is filed with these minutes.

A response to the recommendations set out in the report had been produced by the University Hospitals of Leicester NHS Trust (UHL) and was circulated to members of the Board. A copy of the response is also filed with these minutes.

UHL had found the report helpful and insightful and felt that the recommendations were practical and were being acted upon.

RESOLVED:

(a) That the findings be noted and that health and social care partners be urged to consider actions to improve services, systems and processes outlined in the findings report;

(b) That the response from the University Hospitals of Leicester NHS Trust be welcomed.

374. Better Care Fund Quarterly Performance Report.

The Board considered a report of the Director of Health and Care Integration which provided assurance regarding the national quarterly reporting requirements for the Better Care Fund. A copy of the report marked 'Agenda Item 19' is filed with these minutes.

RESOLVED:

That it be noted that the quarter three 2016/17 BCF return was approved by representatives on the Integration Executive by 2 March and submitted to NHS England on 3 March.

375. Actions following the December Board Development Session.

The Board considered a report of the Director of Health and Care Integration which provided an update on the actions that had been taken following the Board Development Session on 15 December 2016. A copy of the report marked 'Agenda Item 20' is filed with this agenda.

It was suggested that the communications plan should reflect local work as well as national campaigns.

RESOLVED:

(a) That the progress that has been made with the actions arising from the Board Development Session held in December be noted;

(b) That the updated Code of Conduct for Co-opted Members of the Health and Wellbeing Board, attached as Appendix A to this report, be approved;

(c) That the actions outlined at paragraph 11 of this report be agreed for discussion at the Board Development Session on 18 April.

376. Date of next meeting.

It was noted that the next meeting of the Board would take place on 1 June 2017 at 2.00pm.

[The meeting was subsequently rearranged for 22 June 2017 at 2.00pm].

2.00 - 4.20 pm CHAIRMAN
16 March 2017

No.	Date	Action	Responsible Officer	Comments	Status
254(e)	07/01/16	Receive progress reports on the CAMHS Transformation Plan, including performance information with regard to the outcomes framework on a regular basis.	Paul Meredith	A report is scheduled for the November meeting of the Health and Welbeing Board	GREEN
326c)	17/11/16	Develop a delivery plan and performance framework for the Joint Health and Wellbeing Strategy to monitor progress against the Strategy and reported to the Health and Wellbeing Board in due course.	Mike Sandys	The delivery plan and performance framework for the Joint Health and Wellbeing Strategy will be discussed at the Board Development Session on 2 August	GREEN
345(b)	05/01/17	Ask the Director of Public Health to develop a prevention wrap-around offer for the Integrated Locality Teams and report on progress with this to a future meeting of the Board.	Mike Sandys	This is being developed and a report will be submitted to the Health and Wellbeing Board on 20 July	GREEN
349(c)	05/01/17	Submit a report on progress with the delivery of the Summary Care Record v2.1 to a future meeting of the Health and Wellbeing Board.	Vikesh Tailor	A report is on the agenda for the June meeting of the Health and Wellbeing Board	GREEN
349(d)	05/01/17	Submit a report on the Local Digital Roadmap to a future meeting of the Health and Wellbeing Board.	Vikesh Tailor	A report is scheduled for the September meeting of the Health and Wellbeing Board.	GREEN

No.	Date	Action	Responsible Officer	Comments	Status
360	16/03/17	(a) That the Better Care Fund Plan for 2017/18 – 2018/19 be approved for submission to NHS England in line with the national timetable, and subject to the publication of the national BCF guidance and any further amendments required; (b) That the Chief Executive of Leicestershire County Council, following consultation with the Chairman of the Health and Wellbeing Board be authorised to make any amendments to the Better Care Fund Plan 2017/18 – 2019/20 in the light of the national guidance, prior to its submission to NHS England; (c) That the final Better Care Fund Plan for 2017/18 – 2019/20 be submitted to the next meeting of the Health and Wellbeing Board for assurance, along with a progress update on the process and timescale for national assurance via NHS England.	Cheryl Davenport	A report is on the agenda for the June meeting of the Health and Wellbeing Board. This report confirms that the Better Care Fund Plan has not yet been submitted to NHS England as the technical guidance has not yet been received.	AMBER
367(c)	16/03/17	Request the Unified Prevention Board to take forward Leicestershire specific work actions from the LLR Suicide Prevention Strategy and Action Plan and report back to the Health and Wellbeing Board when appropriate.	Mike Sandys	Six monthly updates from the Unified Prevention Board are scheduled for the Health and Wellbeing Board.	GREEN
368(d)	16/03/17	Submit further reports on progress to the Health and Wellbeing Board and submit the final Pharmaceutical Needs Assessment for approval in March 2018.	Caroline Boucher	A report is scheduled for the September meeting of the Health and Wellbeing Board.	GREEN

No.	Date	Action	Responsible Officer	Comments	Status
375(c)	16/03/17	Discuss the actions identified during the December Board Development Session at the Board Development Session on 18 April.	Rosemary Palmer	The Board Development Session was subsequently rescheduled for 31 July.	GREEN

This page is intentionally left blank

Agenda Item 7

Leicestershire County Council

HEALTH AND WELLBEING BOARD: 22 JUNE 2017

BETTER CARE FUND PLAN 2017/18 – 2018/19

REPORT OF THE DIRECTOR OF HEALTH AND CARE INTEGRATION AND DIRECTOR OF ADULTS AND COMMUNITIES

Purpose of the Report

1. The purpose of this report is to update the Health and Wellbeing Board on the preparation and submission of Leicestershire's Better Care Fund Plan for 2017/18 – 2018/19 and on the inclusion of additional resources allocated to the County Council for adult social care as announced by the Government in March 2017.

Recommendation

2. It is recommended that:

a) The draft BCF Expenditure Plan attached as Appendix A to this report be approved;

b) The preparations and governance arrangements for the submission of Leicestershire's Better Care Fund (BCF) Plan for 2017/18-2018/19 to NHS England be noted;

c) With regard to the additional adult social care grant allocation of £19.7m announced by the Government in the Spring Budget:-

(i) that it be noted that this funding is allocated to the County Council for the purposes indicated in the grant conditions but will be incorporated into the BCF Plan as required by the BCF Policy Framework;

(ii) the agreement reached with NHS partners on the spending of the grant be welcomed, and

(iii) the impact of additional grant on the BCF pooled budget from April 2017 be noted;

c) The timescale for updating the rolling BCF Section 75 Agreement and associated governance arrangements be noted.

Policy Framework and Previous Decisions

3. The BCF Policy Framework was introduced by the Government in 2014, with the first year of BCF Plan delivery being 2015/16. In February 2014, Leicestershire County Council's Cabinet authorised the Health and Wellbeing Board to approve the BCF Plan and plans arising from its use.

4. The draft BCF submission was considered by the respective Boards of the two County Clinical Commissioning Groups on 14 March 2017 prior to being approved by the Health and Wellbeing Board on 16 March 2017. The Health and Wellbeing Board also authorised the Chief Executive to make any amendments to the Plan in the light of the national guidance prior to it being submitted to NHS England.

5. At the time of writing this report, the BCF Policy Framework has been published, but the technical BCF guidance for 2017/18-2018/19 is still awaited, having been delayed nationally since November 2016. No date has yet been confirmed for the formal submission of BCF plans to NHS England, but the timeframe is anticipated to be within six weeks of the technical guidance being published.

Background

6. The purpose of the BCF is to transform and improve the integration of local health and care services, in particular to reduce the dependency on acute hospital services by providing more integrated community-based support.

7. The strategic framework is set by BCF national policy requirements, BCF national conditions, BCF metrics, CCG commissioning intentions, and key local authority duties with respect to integration and the Care Act 2014.

8. Locally, the introduction of the Leicester, Leicestershire and Rutland (LLR) Sustainability and Transformation Plan (STP) essentially reframes priorities and financial plans across the LLR health and care economy.

9. High priorities within the integration agenda nationally and locally include:
    - Keeping people out of statutory and acute provision wherever possible.
    - Sustaining adult social care within new models of care locally.
    - Ensuring there is a cohesive plan for data integration at population and care planning levels.
    - Implementing seven-day services.
    - Improving hospital discharge.
    - Developing an infrastructure and platform for joint commissioning.

Vision and Aims of the Leicestershire BCF Plan

10. The vision for Leicestershire's integration programme, as set out in the BCF Plan is to "*create a strong, sustainable, person-centred, and integrated health and care system which improves outcomes for our citizens"*.

11. The aims of the Leicestershire BCF Plan are:

1. Develop and implement new models of provision and new approaches to commissioning, which maximise the opportunities and outcomes for integration.	**2. Deliver measurable, evidence based improvements to the way our citizens and communities experience integrated care and support.**	**3. Increase the capacity, capability and sustainability of integrated services, so that professionals and the public have confidence that more can be delivered in the community in the future.**
4. Support the reconfiguration of services in line with: • **The LLR STP** • **New integrated models of health and care.**	**5. Manage an effective and efficient pooled budget across the partnership to deliver the integration programme.**	**6. Develop an integrated health and care system by 2020/21, including the local approach to devolution where applicable**

BCF National Conditions

12. The *Integration and Better Care Fund Policy Framework 2017/18 – 2018/19*, which was published on 31 March 2017 confirms the national conditions and metrics which will apply to BCF Plans with effect from April 2017. (https://www.gov.uk/government/publications/integration-and-better-care-fund-policy-framework-2017-to-2019)

13. The national conditions require that Plans must:

a. Be jointly agreed including approvals via the local Health and Wellbeing Board;
b. Maintain protection of adult social care services;
c. Demonstrate commitment to investment in out-of-hospital services;
d. Deliver improvements in managing transfers of care (e.g. delayed hospital discharges).

14. There is also an expectation that the BCF Plan will continue to show progress on the previous national conditions set out in the 2016/17 BCF Plan. These include data sharing, case management for people with multiple conditions, and developing seven-day services. They are still fundamental to transforming integrated care and are expected to be addressed at system level as part of the 44 Sustainability and Transformation Plans in place across the country.

15. In terms of the national condition targeted to managing transfers of care, each local BCF Plan must evidence in particular how the Department of Health's '*high impact changes for improving hospital discharge'* are being implemented locally.

16. The High Impact Changes Framework https://www.local.gov.uk/sites/default/files/documents/Impact%20change%20model%20managing%20transfers%20of%20care%20(1).pdf provides a basis for each health and care system to assess their local position and identify where further changes are needed so that all the evidence-based and recommended interventions are made.

17. The grant conditions associated with the new adult social care allocation reference the importance of improved hospital discharge and the Government expects a proportion of the allocation be spent on this priority, according to local gaps and needs.

18. A number of specific activities have been completed locally in order to agree the priorities for meeting the national conditions within the BCF Policy Framework.

19. When submitted to NHS England, the BCF Expenditure Plan (Appendix A) will be accompanied by a supporting narrative document setting out the detail of how each of the national conditions will be met. An overview of the approach to several of these condition is given below:

a) **National Condition to maintain investment in Adult Social Care from the CCG minimum contribution.**

- This investment is separate from the additional allocation for adult social care for LAs [Local Authorities] announced in the spring budget, which comes with distinct grant conditions – see c) below.

- The BCF investment plan requires an inflationary uplift in the CCG contribution in support of adult social care of 1.79% in 2017/18 and 1.9% in 2018/19, when compared with investment levels in 2016/17. The Leicestershire BCF plan has ensured that the required investment level per the CCG contribution is in place and the priorities for this investment have been agreed with NHS partners.

b) **National Condition: Disabled Facilities Grant (DFG) Allocations**

- Funding allocations for major adaptations in the home will continue to be routed via the BCF to each district council in line with national policy. Growth funding has been issued by the Government in line with the expectations set out in the 2015 comprehensive spending review. The 2017/18 allocations for each District Council are -

Leicestershire	**£3,349,869**
Blaby	£499,481
Charnwood	£846,293
Harborough	£385,744
Hinckley and Bosworth	£439,674
Melton	£259,427
North West Leicestershire	£572,989

Oadby and Wigston	£346,261

- The BCF Policy Framework confirms upper tier authorities are required to passport the DFG allocation in full to each District Council, unless local agreement has been reached to direct resources to other strategic housing priorities.

- During 2016/17 significant work has been undertaken with District Councils to forecast DFG demand across Leicestershire to inform the local position, and quarterly reporting is in place to compare actual demand against the allocations made.

- Where individual Districts wish to consider the use of DFG funds for other strategic housing solutions, this will be welcomed and supported by Health and Wellbeing Board partners, given the transformation already being undertaken via the Lightbulb Housing Service.

c) **The additional adult social care allocation announced in the Spring Budget (£19.7m non-recurrent grant over three years)**

- In response to this announcement additional working sessions with Adult Social Care, CCGs, NHS providers and the LLR A&E Delivery Board took place in April and May in order to ascertain how best to prioritise this additional funding which, whilst allocated to the County Council, in accordance with the grant conditions set by the Government and the BCF Policy Framework, must be included within the local BCF pooled budget.

- The funding is being allocated in the form of a Section 31 (Local Authority) Grant on a non-recurrent basis. Therefore, any expenditure against the grant must be targeted to relieving short-term service pressures, provide transformational capacity, or manage demand in the longer term.

- The proposed allocation of the funding (set out in Appendix A) has been welcomed and supported by NHS partners.

- There are clear areas of spend identified in support of adult social care service capacity, as well as investment in priorities within the high impact assessment for hospital discharge and the STP Home First workstream.

- A proportion of the investment is specifically targeted to the BCF national condition **"Managing Transfers of Care"** which is measured in terms of our performance on delayed discharges from hospital (DTOCs).

- The grant conditions are set out below. These were sent to upper tier Local Authorities (Appendix B) and reinforced by the *Integration and Better Care Fund Policy Framework 2017/18 – 2018/19*.

"Grant paid to a local authority under this determination is to be spent on adult social care and used for the purposes of meeting adult social care needs, reducing pressures on the NHS – including supporting more people to be discharged from hospital when they are ready – and stabilising the social care provider market.

A recipient local authority must:

- *pool the grant funding into the local Better Care Fund, unless the authority has written Ministerial exemption;*
- *work with the relevant Clinical Commissioning Group(s) and providers to meet National Condition 4 (Managing Transfers of Care) in the Integration and Better Care Fund Policy Framework and Planning Requirements 2017-19; and*
- *provide quarterly reports as required by the Secretary of State."*

20. The Government has made clear that part of this funding is intended to enable local authorities to quickly provide stability and extra capacity in local care systems.

Local Commissioning Requirements

21. A number of other local commissioning requirements have informed the refresh of Leicestershire's BCF Plan, highlighting the interdependencies between it and the health and care system-wide redesign associated with the LLR STP. These are:

- BCF funding for urgent care has been transposed into the new model of urgent care service commissioned by CCGs from April 2017.
- Investments associated with core discharge support services operating across University Hospitals Leicester and Leicestershire Partnership Trust and social care are essential to support system flow and improve performance on discharge delays.
- Investments and services are already being redesigned for 2017/18, linked to the STP Home First workstream, so these components have been ring-fenced in the financial refresh for this purpose.
- The existing local rehabilitation and reablement services which are funded via the BCF will also be reviewed through the new STP Home First workstream in 2017/18.
- The existing case management services in both CCGs ("integrated care" in the East Leicestershire and Rutland CCG and "proactive care" in the West Leicestershire CCG) are assumed as core components of the future Integrated Locality Teams development in LLR, and will be redesigned during 2017/18.
- The work plan will include the roll-out of the new Lightbulb Housing Service across Leicestershire, between May and October 2017.

BCF National Metrics

22. BCF plans for the period 2017/18 – 2018/19 will be assessed against four national BCF metrics. As before these will be reported nationally, on a quarterly basis, to NHS England. These are as follows:

    a. Reducing the number of total emergency admissions:
    b. Effectiveness of reablement at 91 days;
    c. Improving delayed transfers of care; and
    d. Reducing permanent admissions to care and nursing homes.

23. Work to review each of the BCF metrics for Leicestershire has already been completed, conducted in the context of:

    - Assessing current performance and trends in performance for each of these metrics.
    - The impact of CCGs' Operating Plans 2017/18 – 2018/19;
    - The impact of Leicestershire's Adult Social Care Strategy;
    - The existing and new priorities and investments within the BCF Plan 2017/18 – 2018/19, including the impact of the new adult social care allocation;
    - The impact of new models of care being implemented via the LLR STP over the next two years, (for example the expected improvements via the LLR Home First workstream, which focuses on hospital discharge and reablement).

24. As a result of this analysis, and using the methodology from the 2016/17 BCF technical guidance targets have been developed for each of the metrics for 2017/18 – 2018/19. Publication of final national technical guidance for 2017/18 – 2018/19 is still awaited, and it will be necessary to assess if there is anything further required in this guidance before the Plan is submitted.

Partnership Engagement and Customer Insight

25. Wide ranging engagement across all partners has been undertaken to refresh the BCF Plan as shown in Appendix C.

26. Findings from service user engagement activities across the health and care economy have also been used to inform the BCF refresh, a selection of which are listed below:

    - Service user metrics have been analysed to assess improvements in the experience of local people using integrated care and support across settings of care in Leicestershire, including the quality of life score in the Adult Social Care Outcome Framework, support for people with Long Term Conditions via the GP survey, and experience of coordination of care and support on discharge from CQC (Care and Quality Commission) surveys;
    - A Better Care Together customer insight survey undertaken in 2015/16 focused on the views and experiences of carers;

- Engagement with service users undertaken for the introduction of the "Help To Live At Home" domiciliary care services, used to shape the outcomes and service model;
- Engagement with service users across eight BCF schemes as part of the evaluation conducted with Loughborough University and Leicestershire Healthwatch, focused particularly on admissions avoidance;
- Engagement and customer insight analysis undertaken for the Lightbulb Housing Project which informed the service model;
- Engagement with service users on integrating customer services points of access across health and care, used to inform the future options and solutions for a LLR-wide operating model;
- Engagement undertaken by Leicestershire Healthwatch, reported bi-monthly to the Leicestershire Health and Wellbeing Board, with thematic analysis on areas such as mental health, primary care access, urgent care and hospital discharge;
- Findings and recommendations from local authority scrutiny bodies; and
- Feedback from LLR engagement events for Better Care Together and the STP.

Resource Implications

27. Since the last report to the Health and Wellbeing Board in March 2017, and after the County Council agreed its Medium Term Financial Strategy (MTFS) for 2017/18 – 2018/19, the Government has confirmed the local authority allocations within BCF plans from April 2017, including the additional social care allocation announced in the Spring Budget. It has also confirmed the Disabled Facilities Grant Allocations for each district council.

28. The County Council has prepared an initial expenditure plan which has been agreed with NHS partners and which details how the additional adult social care grant funding will be allocated over the next three years through the BCF pooled budget. The BCF Plan for 2017/18 – 18/19 has also been updated to reflect this and the updated Plan now has a pooled budget totalling £52m for 2017/18 and £56m for 2018/19.

29. Appendix A details the initial updated expenditure plan for the Leicestershire BCF. This sets out the individual line items of expenditure planned, drawing on the combination of funding sources as per the summary table at paragraph 35. Line items which draw specifically on the new adult social care allocation, and which are subject to the grant conditions detailed above, are highlighted in the table for ease of reference.

BCF Funding Implications

30. There are three national sources of funding, which are allocated to each local authority area and placed into local BCF pooled budgets. The three blocks below illustrate the total national allocations in each case (£millions) -

31. In line with the announcements made in the 2015 Comprehensive Spending Review, local upper tier authorities were expected to benefit from "Improved BCF" (iBCF) allocations from 2017/18 onwards, however, the amount received per area depends on the ability of the council to raise funding from the social care precept.

32. Leicestershire County Council included a 2% Council Tax adult social care precept in 2017/18, and the MTFS assumes a further 2% for both 2018/19 and 2019/20 in line with Government rules.

33. On 8 March 2017, the Government announced £2bn of additional support to adult social care nationally, to be allocated in the form of a non-recurrent grant over three years.

34. Leicestershire's share of this grant has been confirmed as £19.7m over three years; £9.5m in 2017/18, £6.8m in 2018/19 and £3.4m in 2019/20.

35. The table below provides a summary of the Leicestershire BCF allocations, setting out the source of funds as at April 2017 for the two-year period:

		2016/17 £000	2017/18 £000	2018/19 £000
CCG Mandatory Minimum Contribution*	ELRCCG	15,559	15,832	16,129
	WLCCG	20,477	20,844	21,240
CCG Local Additional Contribution**	ELRCCG		1,195	1,195
	WLCCG		1,367	1,367
Total CCG Allocation		**36,036**	**39,238**	**39,931**

iBCF (LA allocation) – Autumn 2015 spending review announcement (recurrent)	0	0	5,582***
iBCF (LA Allocations) – Spring 2017 Budget announcement (non-recurrent)	0	9,526	6,837***
Disabled Facilities Grant Allocation	3,067	3,350	3,644***
LCC Miscellaneous	315		
Total BCF	**39,418**	**52,114**	**55,994**

Key:
** Ring-fenced from CCG Allocation, including inflationary uplift, as reflected in CCG Operating Plans 2017-19.*
*** Inclusion of the Intensive Community Support Service (Phase 2) in the BCF pooled budget, with effect from April 2017.*
**** Indicative LA allocations for 2018/19.*

36. Notwithstanding the additional allocation, significant financial pressure remains on all public sector partners, which in turn has affected the BCF expenditure plan. These pressures are caused primarily by two issues:-

    a) The requirement from the two County CCGs that up to £2m of savings should be sought in the BCF Plan in 2017/18, to support the significant financial risks affecting NHS commissioners in 2017/18;

    b) The social care capital grant being removed from the BCF in 2016/17 and replaced with an unfunded uplift in DFG allocations.

37. The financial pressures relating to the 2016/17 DFG allocation have been mitigated via a contribution from Leicestershire County Council's allocation, on a non-recurrent basis.

Implications for the County Council MTFS

38. The additional adult social care allocation amounts to £19.7m over the three years 2017/18 – 2019/20. The funding is noted as non-recurrent. Whilst the additional monies are very welcome, it will not meet the total requirement for a sustainable adult social care service in the longer term, and the outcome of the Government's announcement regarding longer term sustainable models is awaited.

39. The funding position for the County Council with the addition of the new grant is set out below:

£ millions	2016/17	2017/18	2018/19	2019/20
ASC base funding (inc. 2% precept)	130	133	137	145
ASC Support Grant + Improved BCF		2	6	11
Supplementary funding		10	7	3
Total Funding Available	**130**	**145**	**150**	**159**
Forecast of expenditure on ASC	**130**	**138**	**147**	**157**
Available for investment (estimate)	**0**	**7**	**3**	**2**

40. As can be seen from the table above, the additional allocation partially meets the requirements of ensuring a sustainable adult social care market and meeting the known and anticipated social care needs as previously reported in the County Council's Medium Term Financial Strategy.

41. In addition, the Council is able to commit additional one-off investment of £11.6m over the period to transform local services, improve integrated care arrangements and help manage transfers of care.

42. The BCF expenditure plan at Appendix A is a provisional plan. It includes a number of areas that will be subject to further refinement as individual components are scoped and delivered, including some that are linked to the new adult social care allocation, and the final plan submitted to NHS England could be subject to adjustments in light of any final technical guidance and any feedback received during the BCF plan assurance process.

Section 75 Agreement

43. The BCF is operated as a pooled budget under Section 75 of the NHS Act 2006. The budget is managed through a Section 75 agreement between the County Council and the two County CCGs. This is a rolling agreement, which was originally approved by Leicestershire County Council's Cabinet in July 2014.

44. Assurance is required locally and nationally that the BCF Section 75 Agreement has been extended for a further 12 months and plans are in place, via the Integration Executive, to undertake this work between June and July 2017 (subject to confirmation of the national BCF submission timetable).

BCF Plan Submission

45. The BCF Plan submission to NHS England is expected to take place in the next few weeks and will comprise the following components:

- A narrative document setting out how the local plan will deliver health and care integration. Specifically with respect to each of the BCF national conditions and metrics, it must demonstrate how this will be achieved and measured. The draft narrative document was approved by the Health and Wellbeing Board in March 2017, with authority being given to the Chief Executive of the County Council, following consultation with the Chairman of the Health and Wellbeing Board, to make any amendments in order to finalise the document once the national technical guidance is issued.
- A technical submission, using a template provided by NHS England. This will include a breakdown of the BCF expenditure plan and supporting financial analysis, baseline and trajectories for each of the metrics, assurance against each national condition.
- Assurance that the local plan has been developed through engagement with a wide range of partners and approved by these partners, and ultimately by the Health and Wellbeing Board.
- Additional documentation relating to the delivery of the BCF Plan including a programme plan, risk register, and governance structure (to be included in the supporting materials).

46. A regional and national assurance process for BCF plans is outlined in the BCF Policy Framework. This has involvement from both local government and NHS England, however the dates for this process are to be confirmed.

Background Papers

Better Care Fund Policy Framework 2016-17 - http://ow.ly/74k9309bePG

Integration and Better Care Fund Policy framework 2017 – 19 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/607754/Integration_and_BCF_policy_framework_2017-19.pdf

Report to the Health and Wellbeing Board Report on 5 May 2016 'Better Care Fund Plan Final Submission and Assurance' - http://ow.ly/ahgj309bf47

Report to the Cabinet on 17 June 2016 'Disabled Facilities Grant/BCF report' http://politics.leics.gov.uk/documents/s120067/supplementary%20BCF%20Plan%20DFG%20report.pdf

Report to the Health and Wellbeing Board on 15 September 2016 'BCF/Disabled Facilities Grants' http://politics.leics.gov.uk/documents/s122300/DFG%20Report.pdf

Report to the Cabinet on 16 September 2016 'BCF/Disabled Facilities Grants' http://politics.leics.gov.uk/documents/s122380/BCF%20DFG%20Report.pdf

Report to the Health and Wellbeing Board on 5 January 2017 'Better Care Fund Refresh 2017/18' - http://ow.ly/30DZ309bfTt

Report to Health Overview and Scrutiny on 1 March 2017
http://politics.leics.gov.uk/documents/s126760/FEB%202017%20HOSC%20BCF%20REFRESH%20REPORT.pdf

Leicester, Leicestershire and Rutland Sustainability and Transformation Plan -
http://www.bettercareleicester.nhs.uk/Easysiteweb/getresource.axd?AssetID=47665

Report to the Health and Wellbeing Board on March 16, 2017
http://politics.leics.gov.uk/documents/s127292/BCF%20Refresh.pdf

Officers to Contact

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

Jon Wilson, Director of Adults and Communities, Leicestershire County Council
Tel: 0116 305 7454 Email: jon.wilson@leics.gov.uk

Appendices

- Appendix A – Provisional BCF Expenditure Plan
- Appendix B – Improved Better Care Fund Letter
- Appendix C – BCF Refresh Engagement Activities
- Appendix D – BCF Risk Register

Relevant Impact Assessments

Equality and Human Rights Implications

47. Developments within the BCF Plan are subject to an equality impact assessment and the evidence base supporting the BCF Plan has been tested with respect to Leicestershire Joint Strategic Needs Assessment. An equalities and human rights impact assessment has been undertaken which is provided at - http://ow.ly/1sgC309cJUu. The assessment concluded that the impact of the BCF is neutral and therefore a full assessment was not required.

48. The document underwent an annual review by Leicestershire County Council's (Adults and Communities Department) Equalities Group on 14 March 2017.

Partnership Working

49. The delivery of the BCF Plan and the governance of the associated pooled budget are managed in partnership through the collaboration of local authority and NHS commissioners and providers in Leicestershire.

50. Day to day oversight of delivery is undertaken by the Integration Executive, an officer subgroup of the Health and Wellbeing Board. This group includes representation from District Councils and Leicestershire Healthwatch.

51. The delivery of the Leicestershire BCF ensures that a number of key integrated services are in place which contributes to the system wide transformation being implemented through the LLR STP, the five-year plan to transform health and care across Leicester, Leicestershire and Rutland. This programme of work is called *Better Care Together* and has resulted in the publication of the LLR STP.

Risk Assessment

52. The risk register for the BCF plan has been fully updated in light of the new two year planning requirement, and the impact of the updated national conditions, metrics, and the context of the financial framework/financial pressures affecting the Leicestershire BCF plan.

53. The updated risk register has been reviewed in detail by partners including at the Integration Finance and Performance Group on 12th May 2017 and the Integration Executive on 23rd May 2017.

54. A copy of the updated register is attached as Appendix D to this report.

55. Key risks affecting the refreshed BCF Plan at this stage are characterised as a combination of:

- Overall LLR system level risks (service, financial and transformational), per the LLR STP, and
- Specific risks affecting the Leicestershire BCF plan/pooled budget (arising from both the LLR system level risks and the national policy position for the BCF).

56. The following is a summary of key risks associated with the BCF refresh as at May 2017 -

a) Impact of the 2017/18 financial position across the health and care economy – risk that partners are forced to address immediate/short term system pressures versus investing in medium term solutions/ transformation, e.g. per the STP priorities.

b) Lack of financial headroom within the Leicestershire BCF Plan, including lack of reserves and contingencies from 2017/18 onwards.

c) Increased significant risks in CCG financial plans from 2017/18 onwards.

d) Ongoing urgent care pressures, including the ongoing upward trend of emergency attendances/admissions and deterioration in Delayed Transfers of Care (DTOC) performance experienced in 2016/17.

e) Reliance on the delivery of further in-year savings from service review and redesign across a number of BCF service lines in order to deliver a more sustainable medium term financial plan.

f) A number of these BCF service lines are subject to work being led by STP workstreams during 2017/18, with key milestones and quantifiable impact in some areas still to be confirmed.

This page is intentionally left blank

BETTER CARE FUND REFRESH 2017/18 & 2018/19 - DRAFT

Scheme Name	ASC Allocation Code	2017/18 SPENDING PLAN				2018/19 SPENDING PLAN				2019/20 SPENDING PLAN			
		West Leics CCG £'000	East Leics & Rutland CCG £'000	Leics County Council £'000	Total Budget £'000	West Leics CCG £'000	East Leics & Rutland CCG £'000	Leics County Council £'000	Total Budget £'000	West Leics CCG £'000	East Leics & Rutland CCG £'000	Leics County Council £'000	Total Budget £'000
BCF1 - Unified Prevention Offer													
First Contact Plus		93.6	71.2	.0	164.8	94.6	71.9	.0	166.5	94.6	71.9	.0	166.5
Total Unified Prevention Offer		**93.6**	**71.2**	**.0**	**164.8**	**94.6**	**71.9**	**.0**	**166.5**	**94.6**	**71.9**	**.0**	**166.5**
BCF2 - Home First													
Care Act Support Pathway		257.9	196.1	.0	454.0	257.9	196.1	.0	454.0	257.9	196.1	.0	454.0
Carers Health and Wellbeing Service		7.8	5.9	.0	13.7	.0	.0	.0	.0	.0	.0	.0	.0
Intermediate Care		313.0	267.0	.0	580.0	313.0	267.0	.0	580.0	313.0	267.0	.0	580.0
Reablement (NHS protected)		2,419.0	1,713.0	.0	4,132.0	2,419.0	1,713.0	.0	4,132.0	2,419.0	1,713.0	.0	4,132.0
Intensive Community Support phase 1 (NHS protected)		951.0	870.0	.0	1,821.0	951.0	870.0	.0	1,821.0	951.0	870.0	.0	1,821.0
Intensive Community Support phase 2 (CCG additional allocation)		1,367.3	1,195.5	.0	2,562.7	1,367.3	1,195.5	.0	2,562.7	1,367.3	1,195.5	.0	2,562.7
Step Down (NHS protected)		300.0	229.0	.0	529.0	300.0	229.0	.0	529.0	300.0	229.0	.0	529.0
Residential Respite Service (ASC protected)		421.8	320.8	.0	742.6	421.8	320.8	.0	742.6	421.8	320.8	.0	742.6
Health & Social Care Protocol Training		58.1	44.2	.0	102.3	14.5	11.0	.0	25.5	.0	.0	.0	.0
Increased demand for Nursing Care Packages (ASC protection)		2,044.4	1,554.9	.0	3,599.3	2,044.4	1,554.9	.0	3,599.3	2,044.4	1,554.9	.0	3,599.3
Increased demand for Home Care Service (ASC protection)		6,273.0	4,771.0	.0	11,044.0	6,273.0	4,771.0	.0	11,044.0	6,273.0	4,771.0	.0	11,044.0
Discharge Pathway 3 - Non-weight bearing pathway		48.5	36.9	.0	85.4	48.5	36.9	.0	85.4	48.5	36.9	.0	85.4
Community Hospital Link Workers		118.7	90.3	.0	209.0	118.7	90.3	.0	209.0	118.7	90.3	.0	209.0
Primary Care Coordinators (NHS protected)		208.0	184.0	.0	392.0	208.0	184.0	.0	392.0	208.0	184.0	.0	392.0
Assessment and Review (ASC protected)		931.5	708.4	.0	1,639.9	931.5	708.4	.0	1,639.9	931.5	708.4	.0	1,639.9
Improving Mental Health Discharge		154.3	117.3	.0	271.6	154.3	117.3	.0	271.6	154.3	117.3	.0	271.6
Bradgate Unit - develop an integrated discharge pathway/team	2.3	.0	.0	100.0	100.0	.0	.0	40.0	40.0	.0	.0	.0	.0
Home First Programme Team	3.1	.0	.0	200.0	200.0	.0	.0	100.0	100.0	.0	.0	.0	.0
Project Manager - Step Up/Step Down	3.3	.0	.0	50.0	50.0	.0	.0	25.0	25.0	.0	.0	.0	.0
Home First Commissioning Officer	3.4	.0	.0	50.0	50.0	.0	.0	25.0	25.0	.0	.0	.0	.0
HART Capacity	3.5	.0	.0	250.0	250.0	.0	.0	250.0	250.0	.0	.0	.0	.0
Integration of health & social care rehab/reablement services inc. 24 hour crisis response	3.6	.0	.0	150.0	150.0	.0	.0	250.0	250.0	.0	.0	.0	.0
Investment in telecare/telehealth to support ILT & Home First programmes	3.7	.0	.0	100.0	100.0	.0	.0	200.0	200.0	.0	.0	.0	.0
Provision of enhanced carer support services in line with new carers strategy	3.8	.0	.0	100.0	100.0	.0	.0	200.0	200.0	.0	.0	200.0	200.0
Development of interim bed capacity (D2A)	3.9	.0	.0	400.0	400.0	.0	.0	750.0	750.0	.0	.0	850.0	850.0
Stabilising the social care provider market		.0	.0	2,994.4	2,994.4	.0	.0	1,618.9	1,618.9	.0	.0	600.5	600.5
Total Home First		**15,874.3**	**12,304.3**	**4,394.4**	**32,572.9**	**15,822.9**	**12,265.2**	**3,458.9**	**31,546.9**	**15,808.4**	**12,254.2**	**1,650.5**	**29,713.0**
BCF3 - Integrated Housing Support													
Assistive Technology	7.4	.0	.0	760.0	760.0	.0	.0	680.0	680.0	.0	.0	700.0	700.0
Lightbulb - Housing Discharge Enabler	7.4	.0	.0	114.0	114.0	.0	.0	.0	.0	.0	.0	.0	.0
Disabled Facilities Grants													
* Blaby DC		.0	.0	499.5	499.5	.0	.0	499.5	499.5	.0	.0	499.5	499.5
* Charnwood BC		.0	.0	846.3	846.3	.0	.0	846.3	846.3	.0	.0	846.3	846.3
* Harborough BC		.0	.0	385.7	385.7	.0	.0	385.7	385.7	.0	.0	385.7	385.7
* Hinckley and Bosworth BC		.0	.0	439.7	439.7	.0	.0	439.7	439.7	.0	.0	439.7	439.7
* Melton BC		.0	.0	259.4	259.4	.0	.0	259.4	259.4	.0	.0	259.4	259.4
* North West Leicestershire BC		.0	.0	573.0	573.0	.0	.0	573.0	573.0	.0	.0	573.0	573.0
* Oadby and Wigston BC		.0	.0	346.3	346.3	.0	.0	346.3	346.3	.0	.0	346.3	346.3
Sub Total Disabled Facilities Grants		***.0***	***.0***	***3,349.9***	***3,349.9***	***.0***	***.0***	***3,349.9***	***3,349.9***	***.0***	***.0***	***3,349.9***	***3,349.9***
Total Integrated Housing Support		**.0**	**.0**	**4,223.9**	**4,223.9**	**.0**	**.0**	**4,029.9**	**4,029.9**	**.0**	**.0**	**4,049.9**	**4,049.9**
BCF4 - Integrated Domiciliary Care - Help to Live at Home (HTLAH)													
Community Based Review Team		234.3	178.2	.0	412.5	234.3	178.2	.0	412.5	234.3	178.2	.0	412.5
CCG Reablement		662.2	519.4	.0	1,181.6	662.2	519.4	.0	1,181.6	662.2	519.4	.0	1,181.6
Back Office Support		56.8	43.2	.0	100.0	56.8	43.2	.0	100.0	56.8	43.2	.0	100.0
3 OT Posts & Specialised Equipment for double handed care to single handed care	1.2	.0	.0	220.0	220.0	.0	.0	50.0	50.0	.0	.0	.0	.0
Extend HTLAH Project	4.1	.0	.0	200.0	200.0	.0	.0	.0	.0	.0	.0	.0	.0
Additional review capacity for HTLAH transitions	4.2	.0	.0	60.0	60.0	.0	.0	.0	.0	.0	.0	.0	.0
Commissioning, QIT and brokerage	4.3	.0	.0	100.0	100.0	.0	.0	.0	.0	.0	.0	.0	.0
Investment in dom care market to increase capacity	6.8	.0	.0	100.0	100.0	.0	.0	1,000.0	1,000.0	.0	.0	.0	.0
Integrated Domiciliary Care		**953.3**	**740.8**	**680.0**	**2,374.1**	**953.3**	**740.8**	**1,050.0**	**2,744.1**	**953.3**	**740.8**	**.0**	**1,694.1**
BCF5 - Integrated Locality Teams													
Proactive Care Model		540.0	.0	.0	540.0	540.0	.0	.0	540.0	540.0	.0	.0	540.0
Integrated Care Teams		.0	430.0	.0	430.0	.0	430.0	.0	430.0	.0	430.0	.0	430.0
Cardiorespiratory (LTC QIPP)		273.3	169.0	.0	442.3	273.3	169.0	.0	442.3	273.3	169.0	.0	442.3
LLR Community Stroke & Neurology Rehabilitation Service		174.4	103.9	.0	278.3	174.4	103.9	.0	278.3	174.4	103.9	.0	278.3
Implementation of Care Coordinators for Integrated Locality Teams	2.1	.0	.0	100.0	100.0	.0	.0	100.0	100.0	.0	.0	.0	.0
Integrated Locality Teams		**987.7**	**702.9**	**100.0**	**1,790.6**	**987.7**	**702.9**	**100.0**	**1,790.6**	**987.7**	**702.9**	**.0**	**1,690.6**
BCF6 - Integrated Urgent Care													
End of Life Night Nursing Service		142.0	109.7	.0	251.8	142.0	109.7	.0	251.8	142.0	109.7	.0	251.8
Released funding for Crisis Response Service - Night Nursing Service		86.0	62.3	.0	148.3	86.0	62.3	.0	148.2	86.0	62.3	.0	148.2
Additional funding for Crisis Response Service - Night Nursing Service (Holding Line)				.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
Crisis Response Service (CRS) - Social Care		321.3	244.3	.0	565.6	324.5	246.8	.0	571.3	324.5	246.8	.0	571.3
Loughborough Super Hub		890.0	.0	.0	890.0	890.0	.0	.0	890.0	890.0	.0	.0	890.0
Reallocation of Rapid Assessment for OPU (ELRCCG)		.0	776.0	.0	776.0	.0	776.0	.0	776.0	.0	776.0	.0	776.0
Home Visiting Centre		1,278.5	622.5	.0	1,901.0	1,278.5	622.5	.0	1,901.0	1,278.5	622.5	.0	1,901.0
Total Integrated Urgent Care		**2,717.8**	**1,814.8**	**.0**	**4,532.6**	**2,721.0**	**1,817.3**	**.0**	**4,538.3**	**2,721.0**	**1,817.3**	**.0**	**4,538.3**
BCF7 - Integrated Points of Access													
50% contribution to the phase 2 implementation costs	2.4	.0	.0	600.0	600.0	.0	.0	230.0	230.0	.0	.0	.0	.0
Total Integrated Points of Access		**.0**	**.0**	**600.0**	**600.0**	**.0**	**.0**	**230.0**	**230.0**	**.0**	**.0**	**.0**	**.0**
BCF8 - Integrated Data													
PI Care and Healthtrak		36.1	27.4	.0	63.5	36.1	27.4	.0	63.5	36.1	27.4	.0	63.5
Total Integrated Data		**36.1**	**27.4**	**.0**	**63.5**	**36.1**	**27.4**	**.0**	**63.5**	**36.1**	**27.4**	**.0**	**63.5**
BCF9 - Integrated Commissioning													
Improving Quality in Care Homes		288.7	219.5	.0	508.2	291.6	221.8	.0	513.4	291.6	221.8	.0	513.4
Integrated approach to the commissioning of residential & nursing home provision		51.7	39.3	.0	91.0	6.8	5.2	.0	12.0	6.8	5.2	.0	12.0
Care Homes - SME for Commissioning Group, support to EHCH bid. Proj Mgr Integrated Commissioning of Care Homes	3.2	.0	.0	100.0	100.0	.0	.0	50.0	50.0	.0	.0	.0	.0
Post Diagnostic Community & In-Reach Service for people affected by Dementia		203.7	162.5	.0	366.2	193.0	153.9	.0	346.9	193.0	153.9	.0	346.9
LD Short Breaks		588.0	256.0	.0	844.0	588.0	256.0	.0	844.0	588.0	256.0	.0	844.0
Personal budget, Community Life Choices & Supported Living Review Team	1.1	.0	.0	850.0	850.0	.0	.0	.0	.0	.0	.0	.0	.0
Multi-disciplinary review team for top 100 high cost placements	1.3	.0	.0	170.0	170.0	.0	.0	80.0	80.0	.0	.0	.0	.0
Reviewing working age mental health in residential care (s117)	1.4	.0	.0	70.0	70.0	.0	.0	.0	.0	.0	.0	.0	.0
Support for new extra care facility	1.5	.0	.0	70.0	70.0	.0	.0	30.0	30.0	.0	.0	.0	.0
Health support for new extra care facility	1.5	.0	.0	50.0	50.0	.0	.0	.0	.0	.0	.0	.0	.0
CHC Commissioning capacity to support new CHC end to end process & ensure transfer to assess D2A pathways	2.2	.0	.0	90.0	90.0	.0	.0	60.0	60.0	.0	.0	.0	.0
Resources to support commissioning for better outcomes	7.3	.0	.0	20.0	20.0	.0	.0	20.0	20.0	.0	.0	.0	.0
Total Integrated Commissioning		**1,132.1**	**677.3**	**1,420.0**	**3,229.4**	**1,079.4**	**636.9**	**240.0**	**1,956.3**	**1,079.4**	**636.9**	**.0**	**1,716.3**
BCF10 - Transforming Care													
Investment in Residential Care/Supported Living/Reablement Unit	5.1	.0	.0	250.0	250.0	.0	.0	750.0	750.0	.0	.0	1,000.0	1,000.0
Contribution to capital costs of Transforming Care accommodation costs	5.2	.0	.0	500.0	500.0	.0	.0	.0	.0	.0	.0	.0	.0
Case Managers for Transforming Care to support inpatient reductions	5.3	.0	.0	50.0	50.0	.0	.0	25.0	25.0	.0	.0	.0	.0
Total Transforming Care		**.0**	**.0**	**800.0**	**800.0**	**.0**	**.0**	**775.0**	**775.0**	**.0**	**.0**	**1,000.0**	**1,000.0**
BCF11 - BCF Enablers													
Care Act Enablers		42.7	32.4	.0	75.1	42.7	32.4	.0	75.1	42.7	32.4	.0	75.1
Integration Programme Management		197.1	149.7	52.6	399.4	199.0	151.2	53.1	403.3	199.0	151.2	53.1	403.3
Specialist OD support to develop TOM	6.1	.0	.0	30.0	30.0	.0	.0	.0	.0	.0	.0	.0	.0
Implement Customer Portal	6.2	.0	.0	50.0	50.0	.0	.0	.0	.0	.0	.0	.0	.0
IT infrastructure to support integrated discharge team, self service and mobile working	6.3	.0	.0	150.0	150.0	.0	.0	.0	.0	.0	.0	.0	.0
Apprenticeship scheme for gaps in market, e.g. home care	6.4	.0	.0	100.0	100.0	.0	.0	100.0	100.0	.0	.0	.0	.0
Development of external workforce	6.5	.0	.0	65.0	65.0	.0	.0	.0	.0	.0	.0	.0	.0
Additional HR/OD Support	6.6	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0	.0
Support to develop PA market	6.7	.0	.0	50.0	50.0	.0	.0	.0	.0	.0	.0	.0	.0
Additional TU Business Consultancy Capacity	7.1	.0	.0	60.0	60.0	.0	.0	50.0	50.0	.0	.0	.0	.0
Additional Department Support for Transformation	7.2	.0	.0	100.0	100.0	.0	.0	100.0	100.0	.0	.0	.0	.0
Total BCF Enablers		**239.8**	**182.1**	**657.6**	**1,079.5**	**241.7**	**183.6**	**303.1**	**728.4**	**241.7**	**183.6**	**53.1**	**478.4**
Total BCF Schemes Spend (Recurrent)		**22,034.7**	**16,520.8**	**3,349.9**	**41,905.4**	**21,936.7**	**16,446.0**	**3,349.9**	**41,732.5**	**21,922.2**	**16,435.0**	**3,349.9**	**41,707.0**
Total ASC Allocation Spend (Non-Recurrent) & LCC recurrent		**.0**	**.0**	**9,526.0**	**9,526.0**	**.0**	**.0**	**6,837.0**	**6,837.0**	**.0**	**.0**	**3,403.6**	**3,403.6**
TOTAL BCF SPEND		**22,034.7**	**16,520.8**	**12,875.9**	**51,431.4**	**21,936.7**	**16,446.0**	**10,186.9**	**48,569.5**	**21,922.2**	**16,435.0**	**6,753.5**	**45,110.6**
CONTINGENCY													
CCG Contingency		500.0	500.0	.0	1,000.0	500.0	500.0	.0	1,000.0	500.0	500.0	.0	1,000.0
Risk Pool		500.0	500.0	.0	1,000.0	500.0	500.0	.0	1,000.0	500.0	500.0	.0	1,000.0
Cost Improvement Target		-823.9	-493.3	.0	-1,317.2	-329.6	-121.5	.0	-451.1	-315.1	-110.5	.0	-425.6
iBCF (Autumn 2015 Spending Review Announcement) still to be allocated		.0	.0	.0	.0	.0	.0	5,582.0	5,582.0	.0	.0	11,400.0	11,400.0
TOTAL CONTINGENCY		**176.1**	**506.7**	**.0**	**682.8**	**670.4**	**878.5**	**5,582.0**	**7,130.9**	**684.9**	**889.5**	**11,400.0**	**12,974.4**
TOTAL EXPENDITURE		**22,210.8**	**17,027.5**	**12,875.9**	**52,114.2**	**22,607.1**	**17,324.5**	**15,768.9**	**55,700.4**	**22,607.1**	**17,324.5**	**18,153.5**	**58,085.0**

CCG BCF Minimum Funding Allocation	20,843.5	15,832.0		**36,675.5**	21,239.8	16,129.0		**37,368.8**	21,239.8	16,129.0		**37,368.8**
CCG BCF Additional Funding Allocation	1,367.3	1,195.5		**2,562.7**	1,367.3	1,195.5		**2,562.7**	1,367.3	1,195.5		**2,562.7**
iBCF Supplementary Funding (Social Care Allocation - Spring 2017)			9,526.0	**9,526.0**			6,837.0	**6,837.0**			3,403.6	**3,403.6**
iBCF (Autumn 2015 Spending Review Announcement)			.0	**.0**			5,582.0	**5,582.0**			11,400.0	**11,400.0**
DFG Allocation			3,349.9	**3,349.9**			3,349.9	**3,349.9**			3,349.9	**3,349.9**
Total Allocation	**22,210.8**	**17,027.5**	**12,875.9**	**52,114.1**	**22,607.1**	**17,324.5**	**15,768.9**	**55,700.4**	**22,607.1**	**17,324.5**	**18,153.4**	**58,085.0**
Over/Underspend Commitment	**.0**	**.0**	**.0**	**.0**	**.0**	**.0**	**.0**	**.0**	**.0**	**.0**	**.0**	**.0**

This page is intentionally left blank

Department of Health

Tamara Finkelstein
Director General, Community Care
Department for Health
Richmond House
79 Whitehall
Westminster,
London
SW1A 2NS

Department for Communities and Local Government

Dr Jo Farrar
Director General, Local Government and Public Services
Department for Communities and Local Government
2 Marsham Street
Westminster
London
SW1P 4DF

22/03/2017

Dear Chief Executive,

We would like to thank you for all the work you do to support older and disabled people and for your particular efforts to work with the NHS to tackle the challenge of rising demand. I am sure you will have welcomed the Chancellor's announcement in the Spring Budget 2017 on Wednesday 8 March that councils will receive an additional £2 billion over the next three years for social care. £1 billion of this will be provided in 2017-18, ensuring that you can start to fund more care packages immediately. This additional funding is to be spent on adult social care and used for the purposes of meeting adult social care needs, reducing pressures on the NHS - including supporting more people to be discharged from hospital when they are ready - and stabilising the social care provider market.

The new funding will be paid as a DCLG grant to councils. You are best placed to determine what is needed to maintain a diverse and sustainable market locally and ensure the funding reaches the social care frontline swiftly. We believe that distributing the funding based on a 90% (improved Better Care Fund) and 10% social care relative needs formula (RNF) split ensures that the funding is distributed according to social care need.

We are attaching a small number of conditions to the grant, to ensure that the money is spent on adult social care services and supports improved performance at the health and social care interface. The grant will be pooled into the Better Care Fund, to support a continuing agreement with your local NHS. The Integration and Better Care Fund Policy Framework for 2017-19 is due to be published later this week. We encourage you to have early discussions with your Health and Wellbeing Boards (HWBs) to ensure swift agreement of your spending plans, and councils should feel free to spend the grant, including to commission care, subject to the conditions set out in the grant determination, as soon as plans have been locally agreed.

Local authorities and CCGs have a joint responsibility to implement each of the best practices set out in the High Impact Change Model for reducing delayed transfers of care, developed by the Local Government Association (LGA), NHS England and NHS Improvement (NHSI). Every council and NHS Trust in England should agree arrangements for a Trusted Assessor model to be used, as appropriate. The agreed arrangements should be in line with the guidance on the use of Trusted Assessors, which

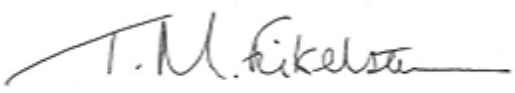
will be published shortly. A copy of the High Impact Change Model is attached. The formal Grant Determination will follow in due course, but we thought it helpful for you to see a draft of the conditions it will contain. DCLG will also be writing to s151 officers, asking them to certify that the additional funding provided in the Budget will be additional to existing plans for spending on adult social care in 2017-18.

We will be expecting to see improvement in how many people are waiting for discharge from hospital and how long they are waiting. The Government has published the NHS England Mandate which sets out the clear expectation that the total level of delayed transfers of care will be reduced to no more than 3.5% of occupied hospital beds and we expect local authorities will want to work with NHS partners to jointly deliver this requirement. NHS has provided information around the current delayed transfers of care levels which will be helpful in informing your local BCF discussions. You will find also find it helpful to see the latest trust level data showing delays attributable to the NHS and social care https://www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/2016-17-data/

DH and DCLG are developing, in consultation with the ADASS, LGA, NHS E and NHSI, a set of metrics – including, but broader than, DTOCs – to assess patient flow across the NHS and social care interface. Following the development of the metrics we will ask the Care Quality Commission (CQC) to carry out targeted reviews in a small number of areas, starting as soon as is practical from May 2017. These reviews will be focused on the interface of health and social care and not cover wider council social care commissioning. This should lead to a tailored response to ensure those areas facing the greatest challenges can improve rapidly.

In the longer term, the Government is committed to establishing a fair and more sustainable basis for funding adult social care, in the face of the future demographic challenges the country faces. We will bring forward proposals to put the state funded system for meeting the care and support needs of older people on a more secure and sustainable long-term footing in a Green Paper later this year.

This is a significant investment in the vital social care services you provide for your community. The Department of Health and Department for Communities and Local Government are committed to continuing to work with Local Authorities.



TAMARA FINKELSTEIN
Director General, Community Care

JO FARRAR
Director General, Local Government and Public Services

(copied to Chairs of A&E Boards and NHS Regional Directors)

Appendix C – BCF Refresh Engagement Activities

The table below provides detail of activities planned between October 2016 and June 2017 evidencing how the BCF refresh has been undertaken, with the engagement of all stakeholders.

Date	Purpose	Audience
13th Oct 16	Initial workshop to review the existing BCF schemes	Integration Operational Group
25th Oct 16	Briefing on BCF refresh progress	WLCCG Finance & Planning Subgroup
28th Oct 16	Review of Disabled Facilities Grants spend	LCC and District Council Reps
1st Nov 16	Briefing on BCF refresh progress	Integration Executive
1st Nov 16	Review of Adult Social Care protection schemes	ELRCCG, WLCCG & LCC Strategy and Finance Leads
7th Nov 16	Briefing on BCF refresh progress	LPT Executive Team
8th Nov 16	Briefing on BCF refresh progress	LPT Community Health Service – Senior Divisional Group
8th Nov 16	Briefing on BCF refresh progress	UHL Executive Strategy Board
10th Nov 16	Further evaluation of BCF schemes review.	Integration Operational Group
22nd Nov 16	Briefing on BCF refresh progress	WLCCG Finance & Planning Subgroup
5th Dec 16	Briefing on BCF refresh progress	ELRCCG Executive Management Team
5th Dec 16	Briefing on BCF refresh progress	WLCCG Corporate Management Team
6th Dec 16	Briefing on BCF refresh progress	ELRCCG Integrated Governance Committee
6th Dec 16	Update on progress of the BCF refresh	Integration Executive
7th Dec 16	Briefing on BCF refresh progress	Healthwatch Leicestershire
8th Dec 16	Further evaluation of BCF schemes review.	Integration Operational Group
19th Dec 16	Detailed review of BCF spending plan for 2017/18-2018/19 and further prioritisation. Decision on Risk Pool levels for 2017/18.	Integration Finance & Performance Group
20th Dec 16	Review of progress on BCF refresh	ASC Transformation Delivery Board
3rd Jan 17	Briefing on BCF refresh progress	Integration Executive
5th Jan 17	Presentation on planning guidance and approach to BCF refresh/emerging priorities to seek feedback from the H&WB Board	Health and Wellbeing Board
5th Jan 17	Briefing on BCF refresh progress	District Councils Chief Executive
6th Jan 17	BCF Schemes Risk Impact Assessment Session	ELRCCG, WLCCG and LCC BCF Leads
19th Jan 17	Workshop to review proposed schemes and investment levels within BCF plan	Integration Executive Workshop
26th Jan 17	Briefing on BCF refresh progress	LCC Transformation Delivery Board
7th Feb 17	Update on final BCF submission	ELRCCG Integrated Governance Committee
7th Feb 17	Assurance on final BCF submission	Integration Executive
13th Feb 17	Update on final BCF submission	ELRCCG Executive Management Team
13th Feb 17	Update on final BCF submission	WLCCG Corporate Management Team

14th Feb 17	Briefing on BCF refresh progress	UHL Executive Strategy Board
14th Feb 17	Briefing on BCF refresh progress	LPT Community Health Service – Senior Divisional Group
15th Feb 17	Update on BCF submission	ASC Transformation Delivery Board
20th Feb 17	Briefing on BCF refresh progress	LPT Executive Team
28th Feb 17	Presentation on the BCF Refresh Process	VAL Health and Social Care Forum
28th Feb 17	Review BCF Submission	WLCCG Finance & Planning Subgroup
1st Mar 17	Assurance on the BCF submission	Health Overview and Scrutiny Committee
7th Mar 17	Briefing on BCF refresh	LCC Strategy & Coordination Group
9th Mar 17	Briefing on BCF refresh progress	District Councils Chief Executive
9th Mar 17	Briefing on BCF refresh progress	All Member Briefing: Health & Care
10th Mar 17	Assurance on the BCF submission	LCC Cabinet
14th Mar 17	Sign-off of draft BCF submission	ELRCCG Board
14th Mar 17	Sign off of draft BCF submission	WLCCG Board
15th Mar 17	Update on BCF submission	A&E Delivery Board
16th Mar 17	Final sign-off of draft BCF submission.	Health and Wellbeing Board
29th Mar 17	Update on Integration Programme	LCC A&C Senior Leadership Team
4th Apr 17	Briefing on BCF Refresh and iBCF allocation	Integration Executive
5th Apr 17	Briefing on iBCF allocation	A&E Delivery Board
10th Apr 17	Update on iBCF allocation	ELRCCG Executive Management Team
10th Apr 17	Update on iBCF allocation	WLCCG Corporate Management Team
11th Apr 17	Briefing on iBCF allocation	ELRCCG Governing Body
11th Apr 17	Briefing on iBCF allocation	WLCCG Board
21st Apr 17	Detailed review of iBCF expenditure plan	ELRCCG, WLCCG, LCC ASC, LPT and UHL representatives
24th Apr 17	Review of iBCF expenditure plan	ELRCCG and WLCCG Finance Directors
25th Apr 17	Report on iBCF plan for local agreement	WLCCG Finance & Planning Subgroup
2nd May 17	Report on iBCF plan for local agreement	ELRCCG Integrated Governance Committee
12th May 17	Review of BCF expenditure plan	Integrated Finance & Performance Group
19th May 17	Update on Integration Programme	Leicestershire Fire & Rescue Service Executive Team
30th May 17	Briefing on BCF plan and iBCF	LCC Strategy & Coordination Group
12th Jun 17	General programme update & briefing on BCF refresh and iBCF plan	LPT Executive Team
13th Jun 17	General programme update & briefing on BCF refresh and iBCF plan	LPT Community Health Service – Senior Divisional Group
13th Jun 17	General programme update & briefing on BCF refresh and iBCF plan	UHL Executive Strategy Board
18th Jun 17	Assurance on the iBCF allocation and update on BCF plan submission	Health Overview & Scrutiny Committee
22nd Jun 17	Assurance on the iBCF allocation and update on BCF plan submission	Health & Wellbeing Board
23rd Jun 17	Assurance on the iBCF allocation and update on BCF plan submission	LCC Cabinet

Governance arrangements will be finalised for final sign-off of the BCF Plan following the release of the national BCF guidance.

Appendix E - BCF Programme Risk Register

Likelihood	Consequences				
	1 (Insignificant)	2 (Minor)	3 (Moderate)	4 (Major)	5 (Catastrophic)
1 (Rare)	1	2	3	4	5
2 (Unlikely)	2	4	6	8	10
3 (Possible)	3	6	9	12	15
4 (Likely)	4	8	12	16	20
5 (Almost certain)	5	10	15	20	25

Risk Number	Risk Description: describe the cause (hazard), and effect (risk)	Original Likelihood Score	Original Impact Score	Original Risk rating	Risk Level	Date Added to Risk Register	Mitigating Actions/Controls Required	Responsible Person	Reviewed Likelihood Score	Reviewed Impact Score	Reviewed Risk rating	Risk Movement from last assessment ◄►/▼/▲	Risk Status
BCF1	If Health and Care partners fail to deliver an integrated care programme, within the national guidance, financial envelope and key milestones of the agreed BCF plan, then it could lead to the non-achievement of a number of national conditions and performance thresholds which could result in elements of the BCF funding being withheld.	3	3	**9**	**High**	**Sep-14**	Well established multiagency governance structure since 2014. Monthly reporting, including rigorous performance reporting, on overall progress into governance structure at operational and strategic level. Consolidation of reporting into STP PMO for LLR-wide assurance. Section 75 agreement refreshed at least annually and reviewed on a quarterly basis by the IFPG. Quarterly reporting via NHSE on national template for BCF assurance. Detailed programme plan - reviewed monthly. Evaluation of BCF schemes. Proactive comms plan in place with dedicated microsite for Health and Care Integration. Wide ranging engagement plan undertaken for the BCF plan across all partners. Alignment of the key risk(s) into LCC and NHS partners risk registers.	Cheryl Davenport	2	3	**6**		**Open**
BCF2	If BCF delivery costs are greater than estimated, or reviews of schemes do not identify sufficient financial benefits, then the programme will not achieve the cost improvement plan required.	3	3	**9**	**High**	**Apr-17**	£1m efficiency target set for 2017/18 BCF Plan. Agreement reached during refresh as to where the saving should be made. Maximise use of the ASC allocation in support of financial pressures. Good level of confirm and challenge into financial assumptions across partners, review of Business Cases and investment proposals on a multiagency basis. Proactive financial management across BCF schemes monthly, and report progress to the IFPG quarterly including performance against efficiency target. Monthly summary provided via Programme Highlight Report to Operational Group and IE. Liaise with Project Leads regarding progress on programme reviews (e.g. Home First Project Lead on the baseline review of all current reablement spend, activity and outcomes). Annual refresh of BCF plan with strong focus spending plan. Re-profile spending plan where applicable within service lines to better match milestones if any significant variances occur. Agreement in section 75 to be able to off-set an overspend in one scheme against underspends in other schemes. Engagement as needed in internal/external audit processes and reviews to test controls and improve processes based on recommendations where applicable.	Cheryl Davenport	2	3	**6**		**Open**
BCF3	If national policy changes to the BCF source/type/amount of funds then the BCF plan may need to be significantly amended, e.g. the Improved BCF and Disabled Facilities Grants (DFG) allocations, etc.	3	2	**6**	**Medium**	**Feb-16**	Close monitoring of national policy and allocations. Engagement and reporting via LCC Cabinet and other partners. Early & regular engagement with Districts on planning assumptions from 2017, and quarterly monitoring of spend implemented from April 2017. Early engagement/agreement with NHS partners on the new ASC allocation to ensure maximum effect. Mitigation via LCC for the DFG 2016/17 financial pressures for 2017/18 affecting the BCF plan. This mitigation has been applied on a non-recurrent basis. Recurrent solution is part of the BCF efficiency target. Development of the Lightbulb business case and service roll-out targets greater efficiencies from DFG processes/allocations across Leicestershire. Proactive management of political and reputational impact of DFG allocations across officers & members in two tier system. Approval of Lightbulb business case via LCC and Districts.	Cheryl Davenport/ Jon Wilson	3	2	**6**		

Risk Number	Risk Description: describe the cause (hazard), and effect (risk)	Original Likelihood Score	Original Impact Score	Original Risk rating	Risk Level	Date Added to Risk Register	Mitigating Actions/Controls Required	Responsible Person	Reviewed Likelihood Score	Reviewed Impact Score	Reviewed Risk rating	Risk Movement from last assessment ◄►/▼/▲	Risk Status
BCF4	If ASC protection levels are not sufficient or demand outstrips assumptions then it could impact delivery against the BCF national conditions and metrics.	2	3	**6**	**Medium**	**Sep-14**	Annual refresh, and review with partners, of ASC protection allocation to meet BCF guidance and stakeholder requirements. Ensure elements for ASC protection map clearly to the conditions/metrics in the BCF and STP workstreams and that the components have clear, measurable benefits. Ongoing analysis between ASC MTFS assumptions and the BCF Plan. Any residual risk/shortfall identified to be addressed in the wider County Council MTFS planning process through review of growth and savings requirements. Using ASC allocation to maximum effect to support the ASC strategy based on prevent, delay, reduce & demand. ASC Transformation Board in place to govern delivery of MTFS savings and transformation work linked to the strategy. LCC risk pool for HTLAH savings assumptions linked to the MTFS. Capacity and demand modelling within STP to improve service and financial planning assumptions for ASC. LLR Urgent Care action plan & dashboard in place which is tracking the impact on ASC against key metrics. New workstream of STP focused on discharge, recovery and reablement (Home First). Application of the PI tool and simulation modelling to key ASC activities. New LCC BI strategy focuses on providing improved analytical tools and outputs to support costing, activity modelling, and performance management in ASC.	Cheryl Davenport/ Jon Wilson	2	3	**6**		**Open**
BCF5	If schemes in place aimed towards achieving the four BCF outcome metrics (non-elective admissions, delayed transfer of care, permanent admissions to care homes, reablement 91 days post discharge) do not have the level of impact expected then this could result in: * CCGs being unable to release the planned level of funding during the financial year * providers not being able to extract the required level of capacity from the system. * ASC being unable to deliver transformation and savings plan. * Leicestershire BCF Plan being escalated upwards to NHSE.	3	3	**9**	**High**	**Sep-14**	Set realistic stretch projections on outcome metrics in consultation with key partners. KPIs beneath the main metrics to seek further assurance on delivery/impact of specific interventions with dedicated analyst time to support data capture, analysis and reporting. Ongoing review of the impact of individual BCF schemes against BCF metrics and trajectories, and an evaluation programme. New performance dashboard (April 2017) to provide further insight for decision making purposes. Challenge given to provide assurance on progress. Annual process for reviewing the addition/exclusion of BCF schemes as part of BCF refresh process. Evidence base/analysis for proof of concept/business case development to be linked more clearly to trajectory assumptions. Clear line of sight from BCF plan to acute contract activity and financial assumptions/STP capacity planning. Scenarios addressed in risk sharing agreements where applicable. (Commissioner only) IFPG in place to govern delivery of s75 pooled budget and performance management on quarterly basis locally, and in support of NHSE quarterly returns. Alignment with STP reporting dashboards, e.g. logic models for Home First and Integrated Teams, new DTOC dashboard. Refresh LLR DTOC assessment (high impact changes tool). Oversight of performance quarterly to HWBB and other key partners.	Cheryl Davenport	3	2	**6**		**Open**

Risk Number	Risk Description: describe the cause (hazard), and effect (risk)	Original Likelihood Score	Original Impact Score	Original Risk rating	Risk Level	Date Added to Risk Register	Mitigating Actions/Controls Required	Responsible Person	Reviewed Likelihood Score	Reviewed Impact Score	Reviewed Risk rating	Risk Movement from last assessment ◄►/▼/▲	Risk Status
BCF6	If the BCF plan is not aligned with the LLR-wide strategic programmes (including the STP programme) then it could potentially result in duplication or an uncoordinated programme across partners.	2	3	**6**	**Medium**	**Sep-14**	As part of the BCF refresh, complete mapping exercise to ensure that key components are mapped and governed within the STP programme where appropriate. Clear programme plan and project roles for delivering service lines within the BCF, which includes matrix working with STP workstream programme leads where applicable. Representation from the LA on the LLR SLT and STP workstreams (where appropriate). STP updates included in All Member Briefings on a regular basis. HWBB has a 'confirm and challenge' role for two themes of the STP (Integrated Teams and Community Hospitals), and receive six-monthly updates on the STP programme as a whole. LCC Cabinet engaged in the development of the STP 5 year plan. Ensuring that the Integrated Points of Access Programme is formally adopted into the STP.	Cheryl Davenport	1	3	**3**		**Open**
BCF7	If the overall BCF plan and individual BCF schemes within it, are not sufficiently or robustly planned, and risks are not effectively managed, then the programme may result in: * overspend on the BCF spending plan, and non-achievement of saving targets. * delays/slippage on delivering the BCF programme. * commissioning decisions not supporting the integration programme objectives. * lack of contingency plan/effective alternative schemes if parts of the BCF plan is failing. * inadequate change control process in place.	3	2	**6**	**Medium**	**Mar-17**	Structured approach to annual refresh of the BCF Plan. High level & detailed programme plans. Expenditure realistically profiled to plan. Contingency agreement per the pooled budget. Governance via Integration Programme governance. Operational Group will ensure challenge is applied to all phasing of the schemes to ensure that implementation happens in the right order. Monthly highlight report monitor progress of the overall programme. Proactive integration/BCF team, working at pace, maintaining excellent relationship management with all agencies, chasing delivery of actions and managing the BCF budget on a daily/weekly/monthly basis - all delivered via matrix working across the health and care system. Dependencies being mapped with STP delivery plans e.g. digital roadmap, Urgent Care, Integrated Locality Teams and Home First workstreams. Process in place for tracking efficiency programme. Process in place for new funding requests which requires detailed information on scheme. Full business case development for significant schemes, to be signed-off through relevant governance routes. Annual development session of the HWBB to check alignment of commissioning intentions across partners. Joint commissioning priorities identified via the integration work programme.	Cheryl Davenport	2	3	**6**		**Open**
BCF8	Lack of visibility/engagement across wider stakeholders including the public and VCS.	2	2	**4**	**Medium**	**Sep-14**	Comms & engagement plan in place. Annual refresh and reviewed quarterly. Extensive engagement during BCF refresh - evidenced in annual submissions. Regular stakeholder bulletins, All Member briefings & engagement with partner organisations including LCC, Districts, CCGs, UHL, LPT, Healthwatch etc. BCF Plan public summary, plan on a page. Dedicated comms resource for the BCF. Also same comms resource for STP programmes (e.g. comms resource for Home First, Integrated Teams and Integrated Points of Access). Microsite in place for online presence. Leading communications and engagement for key elements of the STP – e.g. integrated locality teams. More targeted engagement planned with front-line staff for 2017/18. Dissemination programme for showcasing local practice regionally and nationally e.g. via ADASS, BCF national channels and webinar/conference/academic channels e.g. cascade of SIMTEGR8 outputs.	Cheryl Davenport	1	2	**2**		**Open**

Risk Number	Risk Description: describe the cause (hazard), and effect (risk)	Original Likelihood Score	Original Impact Score	Original Risk rating	Risk Level	Date Added to Risk Register	Mitigating Actions/Controls Required	Responsible Person	Reviewed Likelihood Score	Reviewed Impact Score	Reviewed Risk rating	Risk Movement from last assessment ◄►/▼/▲	Risk Status
BCF9	If there is insufficient capacity or expertise available within the Integration Programme Team, then it could impact on the delivery of the BCF programme.	2	2	**4**	**Medium**	**Sep-14**	BCF programme plan in place. Operational Group meet monthly to ensure detailed oversight & remedial action where necessary. Project Managers assigned to individual schemes where applicable with matrix working into STP workstreams. Refresh of staff resource plan factored into the BCF refresh process annually. Interim resource supporting the delivery of key areas of work where necessary (e.g. falls) STP workstreams are being populated with programme resources, STP PMO resourcing TBC in early 2017/18. Reviewed business continuity arrangements of BCF/Integration team based at LCC. Weekly team meetings to manage resource and delivery within the integration team. 6 month planning sessions for the integration/BCF programme plan to ensure forward resource planning and remedial action as needed. Link in with STP enabling workstreams, e.g. OD, IM&T, etc. LCC hosted programme team is well supported by LCC corporate departments and technical expertise (e.g. procumbent).	Cheryl Davenport	2	2	**4**		**Open**

Integrated Locality Teams

Leicester, Leicestershire and Rutland

LLR Integrated Teams Programme Board Bulletin No. 4: May 2017

Welcome to the fourth edition of the Leicester, Leicestershire and Rutland (LLR) Integrated Locality Teams bulletin. This edition focuses on the decisions of the April Programme Board and key pieces of work completed over the last month.

Development of Integrated Locality Teams – how to guide

The 'how to guide' is currently being distributed through Integrated Locality Teams and GP practices.

Further work is continuing to develop the specific information needed by individual professionals e.g. concentrating on the roles/requirements of GPs, social care staff and community health service staff. This will also be shaped by the work in test beds across LLR.

Summary Care Record (SCR 2.1) and Integrated Care Planning

The Programme Board received an update from Clare Sherman (IM&T Lead - Leics City CCG) on Summary Care Records.

The three CCGs have successfully bid for funding under the Estates Technology Transformation Fund (ETTF). This will enable the delivery of shared records across LLR between health and social care colleagues.

The first stage is the implementation of the new Summary Care Record functionality (SCRv2.1) - this functionality allows additional information to be added to a patient's Summary Care Record, once patient consent is obtained.

A related piece of work is the new 'Integrated Care Plan' template which will allow clinicians to record consent and enter additional information for key areas such as Long Term Conditions and End of Life.

It is anticipated this work will allow faster access to information, along with quicker diagnosis and treatment for patients.

The programme will be completed in three phases:

Phase 1 - SCR 2.1 is being rolled out across LLR GP practices
- All SystmOne practice training will be completed by the end of April 2017
- EMIS practice training to be completed by mid-May 2017

Phase 2 - Provider services and secondary care - focuses on providers viewing the data captured by practices through the most appropriate tool

Phase 3 – Adult Social Care – the information shared will not allow for read and write functionality, but will enable colleagues to be able to view – this will be helpful for the work of ILT's

Test beds

The Programme Board were updated on the test bed proposals received and informed that some great ideas had been received.

The ILT test bed proposals will be signed off and monitored by each CCG's governance implementation group – the Programme Board will not approve these. Progress of the approved test beds will be monitored through reports at future Programme Boards.

Approved test beds	Scope	ILT/ CCG	Objectives
One Home One Practice and wrap around services for Care Homes	The focus cohort will be care home patients across both Oadby and Wigston. There is the potential for improvements in wrap around services and also an opportunity to explore a One Home One Practice model in Oadby. The aim of the project is as a locality to explore the adopting of a one home one GP practice model where feasible. In addition the team will look at the wrap around services in support of the care home and how the various teams can work smarter to improve not only the care given but also the working practices for the teams.	Oadby and Wigston - ELRCCG	The objective of the test bed is to understand and significantly improve the structure and access to health and social care services wrapped around care home patients. To restructure registration of care home patients to match one care home to one practice across the locality with the aim of standardising GP capacity for care home patients and approach to care plan management.
MDT working	The focus cohort will be care home patients across both Oadby and Wigston. There is the potential for improvements in MDT working. The aim of the project is as a locality, and initially as a locality team, to look at MDT working and how to integrate and facilitate care homes in MDT practice.	Oadby and Wigston – ELRCCG	The objective of the test bed is to understand and significantly improve the engagement and implementation in MDT working.
Wellness Advisors	The focus for this test bed will be patients who have registered or walk-in access to Rutland GP practices. The project will provide access to non-clinical help and advice / support services for these patients. The aim of the project is to test the model of embedded staff within a GP practice who provide help and support to patients who are in need of support but not necessarily of a clinical nature.	Rutland - ELRCCG	The objective of the test bed is to provide access to help and advice / support services for registered patients within GP practice.
Teleconference/ video conference MDT	The test bed will test primary care based Multi-disciplinary Team (MDT) meetings for risk stratified red/amber End of Life patients under the care of South Blaby practices. The focus cohorts will be: • Green, Amber and Red EoL patients • 3-5 patients monthly who community nurses are concerned about	Blaby and Lutterworth – ELRCCG	The objective is to improve attendance at complex care planning MDT meetings across the sub-locality, improving engagement in End of Life care planning, proactive care planning reviews and crisis management. These planned activities will enable other aspects of the EoL and Urgent Care system.

Structured intervention programme for high risk ILT patients	All practices in N&EL, Central and N&W HNN. The focus cohort will be high risk patients from within the Integrated Locality Teams cohort. Each Practice will be given an allocated number of such patients to proactively call in for care planning and discussion at MDT meetings during the course of the year. The components of this scheme are: *1.* Registration of the PIC GP patients on clinical system and flagging with a code as the intervention group. *2.* Discussion of patient's case at MDT *3.* Proactive invitation to patient (and carer if relevant) to attend for two proactively planned 20 minute appointments during the year for the purpose of care planning and self-management education discussions. *4.* Potential referral to one or more community services such as social care or mental health services or the lifestyle hub depending on the individual's goals.	• North & East Leicester – LCCCG • Central – LCCCG • North West - LCCCG	The objective of the test bed is to: • Create a template to be used on S1 to allow practices to deliver a structured programme of care • Deliver a personalised care plan for each patient on the scheme – a copy to be given to the patient and a copy stored in the clinical record for viewing by relevant personnel • Reduction in emergency attendances and admissions in the intervention group compared to CCG average and to patients previous utilisation • Reduction in average number of medicines prescribed in the intervention group compared to CCG average for this age group
Face to face MDT	The scope of this test bed is to test face to face MDTs through co-ordinating MDTs in practices in the two sub localities in N&EL.	North & East Leicester - LCCCG	The objective of the test bed is to develop an ILT by having face to face MDTs in practices to enhance patient care and prevent unnecessary admissions.
Proposal to test dedicated pharmacy team support for care homes	The focus will be selected Care Homes in NEL HNN. Selection will be based on intelligence from LC CCG Nursing Quality team or City Council Care Home Quality and Contracts Team. The plan is eventually to get to all Care Homes. The focus cohort will be high–risk patients living in identified intervention care homes identified via pharmacist reviews of care records. The second focus cohort will be all care home residents in selected care homes.	North East Leicester - LCCCG	The objective of the test bed is to: • Reduce medicines waste (and therefore cost and potential patient harm) in selected care homes • Reduce burden of polypharmacy in selected patients • Improve prescribing , dispensing and storage of medicines practice
Face to face MDTs	All practices in South HNN. The focus cohorts will be: • PIC GP patients • ILT cohort –	South Leicester – LCCCG	The objective of the test bed is through the South Integrated Teams Programme general practices, social care, acute and community teams will work with commissioners to introduce a new model of care focussing on four key areas:

	- Frailty - Having five or more chronic conditions - Predicted to spend three or more times the average in secondary care • Patients where intervention from ASC and LPT will be valuable • Likewise ASC/ LPT to identify patients who could value GP intervention The test bed will be coordinated through the two sub localities in South – *Meridian* and *Pasley Road*		1. Increasing prevention and self-management 2. Developing accessible and responsive unscheduled primary and community care 3. Developing extended primary and community teams 4. Securing specialist support in non-acute settings
Co-ordination of community care for frail patients discharged from UHL and Loughborough hospitals	The focus cohorts will be: • People with a frailty marker regardless of age • Adults with five or more long term conditions • Adults whose acute care costs are predicted to be three times the average over the next twelve months The project will involve introducing a Hospital Discharge Community Care Co-ordinator and a standard operating procedure to work to. Capacity will be created from existing LPT resources at the appropriate grade.	Charnwood - WLCCG	The objective of the test bed is to: • Develop co-ordinated care for the identified cohort of patients, post discharge from hospital. • Have joined up care for the patients, with clear lines of communication between GP, adult social care, community health and therapy teams. • Explore opportunities and benefits for new ways of working across a multi-disciplinary workforce.
Multidisciplinary 'Best Practice' working across three sub localities in Hinckley and Bosworth	The project will involve testing the benefits of holding quarterly 'Best Practice' meetings with health and social care to discuss case studies, to learn lessons, celebrate what's going well, share service updates and best practice. The focus cohorts will be patients/ service users who fall into a minimum of one of the three cohort's i.e. 1. People with a frailty marker regardless of age 2. Adults with five or more long term conditions 3. Adults whose acute care costs are predicted to be three times the average over the next twelve months	Hinckley and Bosworth - WLCCG	The objective of the test bed is to: • Understand the benefits of holding sub-locality MDTs • Understand what information is most helpful to share • Understand the best ways of sharing information across teams • Determine who needs to be part of a sub-locality MDT

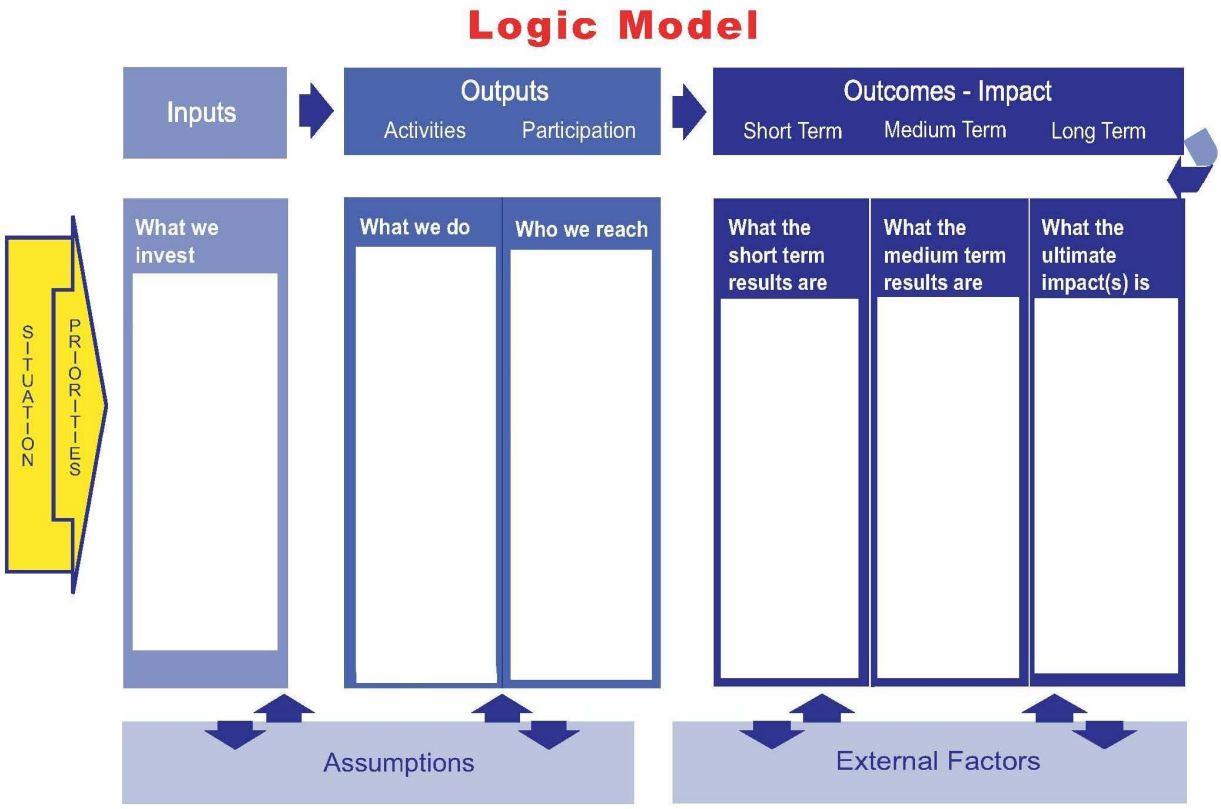
Practice pharmacist completing medication reviews for care home residents	The test bed will be tested with one GP practice and one care home in the first instance and use the learning to expand the PDSA to further care homes if successful. The focus cohort will be care home residents who fall into a minimum of one of the three cohort's i.e. 1. People with a frailty marker regardless of age 2. Adults with five or more long term conditions 3. Adults whose acute care costs are predicted to be three times the average over the next twelve months	Hinckley and Bosworth – WLCCG	The objective of the test bed is to test the feasibility of a practice pharmacist undertaking medication reviews for residents in a care home.
Locality multi-disciplinary networking	Locality level multi-disciplinary networking to involve all ILT care partners. The scheduled monthly NWL Federated Locality Meetings will be re-structured with one hour of the meeting being dedicated to Integrated Teams to offer an opportunity for networking and improvement. Feedback from all multi-disciplinary partners indicated that the most useful part of previous "MDT meetings" and larger group discussions was that they enabled communication and relationship building which, in turn, highlighted and spread good practice and enhanced understanding of what services and/or interventions were available – all improving patient outcomes and experience.	North West Leicestershire - WLCCG	The objective of the test bed is to: • Improve and focus communications and working relationships between all ILT care partners • Increase awareness and understanding of care partners across all ILT care partners • Generate inclusively agreed ideas/topics for further test bed PDSAs

Logic Model

A logic model has been developed to describe the Integrated Locality Team programme's inputs, outputs, outcomes, assumptions and interdependencies.

Logic models are a useful, graphical, way to summarise the relationships between the different components of a programme. They help to explain the 'theory of change' or in other words, how the 'intervention' will lead to the intended outcomes.

Logic models come in many shapes and sizes - below is an example logic model template. It is a live document/framework and will be updated as we learn more from the pilot teams



Each test bed will be asked to develop its own logic model to enable the programme to monitor the interventions and outcomes, and take a consistent approach to overall programme performance.

QIPP

Gill Killbery provided an update to the Programme Board on the QIPP savings. An STP level review of the QIPP is currently being completed – an updated QIPP for ILT's will be presented to the next Programme Board.

Memorandum of Understanding (MoU)

A draft MoU has been developed to help facilitate the work of ILT's. The Programme Board have been asked to review and comment on the document. Programme board will consider all feedback received at the May Board. The outcome will inform a paper to SLT in due course.

Implementation Plan

An implementation plan has been finalised at LLR level for the Integrated Locality Team's programme, which details key milestones across 2017/18. This is also designed to help inform the development of local implementation plans across each CCG footprint.

For more information about the development of Integrated Locality Teams in LLR visit our webpages:

www.healthandcareleicestershire.co.uk/health-and-care-integration/integrated-locality-teams/

To find out about the local arrangements and work in progress in your area please contact the relevant CCG implementation lead in the first instance:

- **West Leicestershire** (Charnwood, NW Leicestershire and Hinckley and Bosworth) – Arlene.Neville@westleicestershireccg.nhs.uk
- **East Leicestershire and Rutland** (Melton/Rutland/Harborough, Oadby and Wigston, Blaby and Lutterworth) - Paula.Vaughan@EastLeicestershireandRutlandccg.nhs.uk
- **Leicester City** – Rachana.Vyas@leicestercityccg.nhs.uk

If you have any feedback about this edition of the bulletin, or suggestions for future bulletins, please contact our communications lead sally.kilbourne@leics.gov.uk.

This page is intentionally left blank

Agenda Item 9

Leicester City Clinical Commissioning Group
West Leicestershire Clinical Commissioning Group
East Leicestershire and Rutland Clinical Commissioning Group

HEALTH AND WELLBEING BOARD: 22 JUNE 2017

REPORT OF LEICESTER CITY CCG, WEST LEICESTERSHIRE CCG AND EAST LEICESTERSHIRE AND RUTLAND CCG

SUMMARY CARE RECORD

Purpose of report

1. The purpose of this report is to provide an update to the Health and Wellbeing Board on the Leicester, Leicestershire and Rutland (LLR) Electronic Record Sharing project, focusing around Summary Care Record (SCR) v2.1.

Link to the local Health and Care System

2. The LLR Sustainability and Transformation Plan is building on the Better Care Together programme that identified five key strands for change which contribute to closing the health, wellbeing and care and quality gaps:-
   a. New models of care: to deliver more care and support in the community through Integrated Locality Teams (ILT)
   b. ILTs will be responsible for joining up and coordinating the care provided by multiple professionals to patients within their defined place (locality)
   c. Professionals will have access to a shared record to improve the quality and outcome of patient care: the Summary Care Record
   d. All plans are built on a collaborative relationships and consensus
   e. Access to summary care records by all relevant providers will be essential to achieve this

Recommendation

3. The Health and Wellbeing Board is recommended to note the update on the LLR Electronic Record Sharing project

Policy Framework and Previous Decisions

4. The Health and Wellbeing Board received a report about the Summary Care Record and Care Planning at its meeting on 5 January 2017 and asked for an update at a future meeting.

Background

5. The three CCGs successfully bid for funding under the Estates Technology and Transformation Fund (ETTF) to enable the delivery of shared records across LLR between health and social care colleagues.

6. The Electronic Record Sharing project has three distinct phases:-

(a) Phase 1 was centred around Primary Care and the roll-out of an Integrated Care Planning template, which feeds the Summary Care Record with additional information, when explicit patient consent is recorded. The template also enables the recording of that consent. SystmOne and EMIS versions of the template have been rolled out, and all practices have received training. The aim is that by October 2017 half of all LLR care plan patients with long term conditions will have an enhanced SCR with additional information.

(b) Phases 2 and 3 are concentrated around Provider clinicians and Adult Social Care staff respectively accessing SCR. These two phases both kicked off over the past 6 weeks, and are running concurrently.

7. The key challenges in Phase 2 relate to communications (making clinicians aware of the benefits of SCR v2.1) and operations (eg SCR can be accessed directly or via SystmOne / Do PCs have the required software installed? / Do all relevant staff have smartcards and the proper RBAC roles? etc).

8. Some of these issues also apply to Phase 3, but the main challenge is around the governance of sharing information from health to social care.

9. Phase 2 baseline data:

	VIEW REQUESTS BY PROVIDER	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
SCR	UHL	2053	2262	2653	2327	2602
	LPT	221	250	222	242	239

Proposals/Options

10. The aim is to facilitate quicker diagnosis and quicker treatment through quicker access to key medical information via electronic record sharing. Predominantly this is to be achieved via SCR, and / or SystmOne to SystmOne sharing (where applicable). A Medical Ineroperability Gateway (MIG) has also been used in LLR, but the updated SCR (v2.1) makes it the more attractive option going forwards, in terms of cost to benefit ratio.

11. Other options looked at initially included Patient Knows Best, Coordinate My Care and myrightcare, but ultimately it was felt that these created new silos as much as they facilitated record sharing.

Resource Implications

12. Funding is provided via the ETTF, as referred to in paragraph 5.

Background papers

Report on the Summary Care Record and Care Planning submitted to the Health and Wellbeing Board on 5 January 2017 - http://ow.ly/3tT530cy69E

Officer to Contact

James McKean, Project Manager, Electronic Record Sharing
Telephone: 07715035128
Email: james.mckean@leics-his.nhs.uk

Relevant Impact Assessments

Equality and Human Rights Implications

13. Due regard to equality, diversity, community cohesion and human rights in our decision-making process has taken place by NHS Digital on behalf of the NHS regarding the Summary Care Record.

Partnership Working and associated issues

14. Partnership working is undertaken with health and adult social care colleagues across LLR.

This page is intentionally left blank

Leicestershire County Council

HEALTH AND WELLBEING BOARD: 22 JUNE 2017

REPORT OF THE DIRECTOR OF HEALTH AND CARE INTEGRATION

BETTER CARE FUND QUARTERLY PERFORMANCE REPORTING

Purpose of report

1. The purpose of this report is to provide the Health and Wellbeing Board with an update on the Better Care Fund programme, including assurance on the national quarterly reporting requirements for the BCF.

Policy Framework and Previous Decisions

2. The Health and Wellbeing Board approved Leicestershire's current BCF plan in May 2016.
http://politics.leics.gov.uk/documents/s118710/Better%20Care%20Fund%20Plan%20Submission%20and%20Assurance.pdf

3. The day to day delivery of the BCF is overseen by the Leicestershire Integration Executive as agreed by the Health and Wellbeing Board in March 2014. (http://politics.leics.gov.uk/ieListDocuments.aspx?CId=1038&MId=3981&Ver=4). The Integration Executive Terms of Reference have been refreshed, and were approved by the Health and Wellbeing Board in November 2015.

4. NHS England issued BCF implementation guidance in July 2016 https://www.england.nhs.uk/wp-content/uploads/2016/07/bcf-ops-guid-2016-17-jul16.pdf which set out the requirements for quarterly reporting along with the draft templates and analytical tools that are required to be used for this purpose.

Background

5. The BCF plan was initially submitted to NHS England in September 2014 and was implemented during 2014/15 and 2015/16.

6. In line with the national policy requirements, the BCF plan was refreshed for 2016/17 at the beginning of 2016. The final plan was submitted to NHS England on 3rd May. Confirmation was received in July that the plan was fully approved.

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

   - Reduce the dependency on hospital services, in favour of providing more integrated community based support, such as reablement, early intervention and prevention;
   - Promote seven day working across health and care services;
   - Promote care which is planned around the individual, with improved care planning and data sharing across agencies.

Financial Outturn for 2016/17

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

9. The actual outturn for 2016/17 was for £38.7m, with the £0.7m underspend released back to CCGs by agreement to off-set other system/financial pressures.

10. A risk pool of £1m was created within the BCF which would be accessed if the planned reduction of emergency admission was not achieved. The BCF plan also contains a general contingency of £1m. The risk pool and contingency were reviewed on a quarterly basis to ensure that they remain appropriate to the level of financial risks.

11. At the end of quarter two, it was agreed to release the full £1m set aside for under delivery against the emergency admissions risk pool. It should be noted that by the end of October, the BCF had delivered the level of avoided emergency admissions that was set for 2016/17. Therefore this was not due to an underperformance of the target, however due to the continued over performance in terms of emergency admissions activity affecting both Clinical Commissioning Groups (CCG), the risk pool was still need to off-set the cost of this additional activity.

12. It was also agreed that the general contingency (£570k) and uncommitted reserve funding (£769k) be released back to West Leicestershire CCG in recognition that these funds were not committed within the BCF during 2016/17.

13. It was acknowledged that releasing these reserves now would eliminate the opportunity for these to be included in the contingencies/reserves for the BCF budget in 2017/18. Therefore all partners would need to accept the risk this poses to headroom within the BCF for 2017/18 and have a shared plan for mitigations.

14. The Help to Live at Home (HTLAH) contingency pool includes £1m for potential non-achievement of QIPP savings in 2017/18 and a further £0.75m for non-achievement of MTFS savings. At a meeting between the Chief Finance Officers of Leicestershire County Council (LCC), East Leicestershire and Rutland Clinical Commissioning Group (CCG) and West Leicestershire CCG it was agreed that:

    - The CCG element of the contingency (£1m) will be released back to both CCGs in 2016/17.
    - Any issues arising from the HTLAH project that affect the CCG's finances in 2017/18 will be addressed through the use of CCG funds and will not affect the BCF.
    - The remaining £0.75m will continue to be used by LCC to offset the risk of achieving MTFS savings.

Performance against BCF Outcome Metrics at the end 2016/17

15. The BCF plan is measured against six outcome metrics. The following table explains the definition of each metric, the rate of improvement that is being aimed for, and progress at the end of 2016/17.

National Metric (1)	Definition	Trajectory of improvement
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	This is a nationally defined metric measuring delivery of the outcome to reduce inappropriate admissions of older people to residential care.	The target has been set at a rate of 606.4 per 100,000 per population aged 65+. This equates to 827 or fewer admissions in 2016/17. In 2015/16 there were 860 permanent admissions to residential care. Based on April – February data for 2016/17, the current forecast is for 874 admissions this year, a rate of 640.73 per 100,000 population. This will not meet the target. *No improvement in performance*.

National Metric (2)	Definition	Trajectory of improvement
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	This is a nationally defined metric measuring delivery of the outcome to increase the effectiveness of reablement and rehabilitation services whilst ensuring that the number of service users offered the service does not decrease. The aim is therefore to increase the percentage of service users still at home 91 days after discharge.	The target for 2016/17 has been set at 84.2%. The latest data, based on admissions to reablement in October - December and followed up in January - March, shows a success rate of 87.0%. *Target achieved*

National Metric (3)	Definition	Trajectory of improvement
Delayed transfers of care (DTOC) from hospital per 100,000 population (average per	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	Reductions during 2015/16 in delays have focussed on interventions in the acute sector. Therefore the target was set based on reducing the number of days delayed in non-acute settings by 0.5%, while maintaining the rate of days delayed in acute settings at its current low level. The table below shows performance for

<table>
<tr>
<td>month)</td>
<td>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.</td>
<td>each quarter:
<table>
<tr><th>2016/17</th><th>Target</th><th>Actual</th></tr>
<tr><td>Q1</td><td>236.66</td><td>287.04</td></tr>
<tr><td>Q2</td><td>231.91</td><td>357.19</td></tr>
<tr><td>Q3</td><td>214.66</td><td>382.17</td></tr>
<tr><td>Q4</td><td>312.19</td><td>377.10</td></tr>
</table>

Targets for all four quarters of 2016/17 have been missed. The targets were based on good performance in 2015/16 but numbers have increased in 2016/17. However, benchmarking against our CIPFA statistical neighbours shows that we have been in the top quartile for performance for each quarter.

<u>No improvement in performance</u>

Further information on the key issues regarding the DTOC position and actions being taken is provided in para 21.</td>
</tr>
</table>

National Metric (4)	Definition	Trajectory of improvement
Non-Elective Admissions (General & Acute)	This is a nationally defined metric measuring the reduction in non-elective admissions which can be influenced by effective collaboration across the health and care system. Total non-elective admissions (general and acute) underpin the payment for performance element of the Better Care Fund.	The target for 2016/17 is 724.37 per 100,000 per month, based on a 2.49% reduction on the probable number of non-elective admissions for patients registered with GP practices in Leicestershire for 2015/16 (allowing for population growth). This equates to a combined trajectory of 1,517 avoided admissions within the BCF schemes targeted at avoiding emergency admissions. Despite BCF admission avoidance schemes performing well and achieving 2,010 avoided admissions in 2016/17, the number of non-elective admissions continues to rise. System-wide plans are being delivered or developed as part of STP plans to stem the rise in non-elective admissions. The target for non-elective admissions in 2016/17 was 59,030 or 724.37 per 100,000 population per month. For the period April 16 to March 17 there have been 61,966 non-elective admissions, a variance of +2,936. <u>No improvement in performance</u>

National Metric (5)	Definition	Trajectory of improvement
Improved Patient Experience	Selected metric for BCF Plan from national menu: - taken from GP Patient Survey: "In the last 6 months, have you had enough support from local services or organisations to help manage long-term health condition(s)? Please think about all organisations and services, not just health."	This target was set at 62.2% for 2016/17. This is based on the 2015/16 target and a 2% increase in the number of positive replies. Current performance is 63.6% (as at July 2016). (Next data due July 2017). *Target achieved*

Local Metric (6)	Definition	Trajectory of Improvement
Injuries due to falls in people aged 65 and over	This is a locally defined metric measuring delivery of the outcome to reduce emergency admissions for injuries due to falls in people aged 65 and over.	A realistic target was set for 2016/17 which holds the number of falls in the 65-79 age group at the 2015/16 level, while reducing those in the 80+ population by 5% allowing for population growth. The target for emergency admissions for injuries due to falls has been set at 2,287 or fewer admissions, or 1,677.07 per 100,000 population aged 65+. The year-end position is that there were 2,162 admissions during 2016/17 for injuries due to falls; a rate of 1,585.3 per 100,000 per population against the target of 1,677.1 *Target achieved*

Progress against BCF national conditions

16. The revised policy framework and technical guidance for 2016/17 indicated that BCF plans must demonstrate assurance regarding the following:
    - Delivery against five national BCF metrics and a locally selected metric (see para 15);
    - How a proportion of the fund will protect adult social care services;
    - How data sharing and data integration is being progressed using the NHS number;
    - How an accountable lead professional is designated for care planning/care coordination;

- Delivery of Care Act requirements;
- How a proportion of the fund will be used to commission care outside of hospital;
- How seven day services will be supported by the plan;
- That the impact on emergency admissions activity has been agreed with acute providers;
- That there is a locally agreed proactive plan to improve delayed transfer of care from hospital;
- That Disabled Facilities Grant allocations within the BCF will be used to support integrated housing solutions including the delivery of major adaptations in the home;
- Approval of the BCF plan by all partners being assured via the local Health and Wellbeing Board.

17. The Leicestershire BCF plan has been able to provide assurance that most of the national conditions of the plan have been met.

18. The exception to this is the question 'are support services, both in the hospital and in primary care, community and mental health settings available seven days a week to ensure next steps in the patient care pathway, as determined by the daily consultant-led, can be taken'.

19. It was agreed at this stage to state that this national condition was still in progress. This was due to the fact that work is still underway on the Leicester, Leicestershire and Rutland urgent care redesign. As the service was implemented in April 2017, it was reported that the national condition will be fully met by September 2017, to allow time for the changes to embed in.

Overall Performance of the Leicestershire BCF Plan 2016/17

Highlights and Successes

20. Implementation of the integration programme in Leicestershire continues at pace. The following is a summary of the highlights and successes to date:

a) The **emergency admissions reduction** target for the schemes within the Leicestershire BCF plan was to collectively avoid 1,517 admissions (in line with CCG operating plans). During 2016/17, the total number of avoided admissions across the different BCF schemes was 2,010 meaning that the BCF contribution to the target was achieved/exceeded.

b) However, it is acknowledged that the overall number of total non-elective admissions for county CCGs was 61,966 for 2016/17, against a commissioned level of 59,030, a variance of +2,936 (final figures are subject to validation by the new CSU).

c) The Leicestershire Integration Programme has led the work to develop the new **LLR falls pathway**. Each of the stages within the pathway has been developed into an agreed level of service that will form part of the LLR Falls Prevention and Treatment Strategy. The resulting LLR Falls Business Case has been

approved for a first 'proof of concept' year by both county CCGs with some areas of further financial and modelling validation work to be completed in Q2 2017.

d) Some components of the new falls model for LLR have already been tested/ implemented in Leicestershire during in 2016/17. This has included the development of the **Falls Risk Assessment Tool (eFRAT) App** during 2016/17 in conjunction with the De Montfort University Hackathon team and EMAS. The eFRAT is a key part of the admissions avoidance scheme for falls. This is now live on the smartphones of all Leicestershire EMAS paramedics, and is being very well received. This means that every falls patient that does not require conveying to hospital will be assessed for their risk of further falls with the opportunity to signpost and refer to other community based support.

e) A third phase of the app, which will enable other partner organisations to refer patients for assessment or prevention is being scoped, and it is intended that this will go live in September 2017. **The East Midlands Academic Health Sciences Network has selected the Leicestershire eFRAT tool as an innovation that should be adopted and rolled out East Midlands-wide.** Arrangements for this are at an early stage at the time of this report.

f) A new integrated and jointly commissioned domiciliary care service called **Help to Live at Home** was launched on 7th November in Leicestershire. This involved a new specification and contract which was co-produced between county CCGs and Leicestershire County Council. The service has been designed to support the revised discharge pathways which are now in place in LLR. It promotes reablement in the home and integrating domiciliary care providers more effectively with other health and care services, including primary care and prevention services in each locality. While this resulted in nine providers being appointed, during the launch of the service there were some significant operational problems in particular due to one provider exiting the process just before go live. Although the initial transition to the new service proved more difficult than anticipated the position has steadily improved since February 2017. An integrated back office for HTLAH is responsible for booking packages of care for both NHS and local authority partners, provider billing, and contract/performance management reporting.

g) A further phase of outcome based, integrated commissioning across Local Authority and NHS partners, focused on **residential and nursing home placements,** has recently commenced. An outline business case has been developed and the workplan is now underway.

h) During Q4 of 2016/17 BCF funding supported the implementation of the Integrated In-Reach Discharge Team which started on 30th January 2017. This team provides support to identify, transfer and then access suitable patients into a bed based reablement facility, based at **Peaker Park in Market Harborough**. Peaker Park will accept up to 14 patients for reablement.

i) **Further LLR wide work on Integrated Discharge** has led to the creation of Integrated Discharge Team (IDT) to work across a number of wards at the Leicester Royal Infirmary from July 2017 to provide expert discharge advice and assistance helping to get residents home as soon as they are well enough to be

discharged. The aim of the project is to create a single integrated discharge service within UHL. Leicestershire County Council and Leicester City Council hospital social workers, UHL Specialist Discharge Nurses, LPT Primary Care Co-ordinators, UHL therapists and the hospital housing discharge advisers will all be part of the new team. (The new model also draws on funding from the Leicestershire BCF.)

j) The Leicestershire Integration Programme has been leading work to scope opportunities to integrate the various **points of access for community based health and care services** across LLR. Given the integration of health and care teams in locality settings within the new models of care of LLR STP, this area of work looks at opportunities to integrate the multiple points of telephone/referral access for customers and professionals when arranging community based services - with a view to coordinating their care from one integrated point of access in the future. Existing Points of Access/customer call centres across the three councils, LPT and UHL (bed bureau) are fully involved in this work. Progress so far includes adopting a new standardised way of working in existing locations/services, ahead of a gateway review in August 2017, where potential solutions for co-location, integrated management and technology will be considered.

k) Leicestershire's prevention 'one-stop shop' **First Contract Plus** went live at the beginning of October 2016 with a new clinical referrals service, which has had positive feedback from GP's and other partners who utilise this approach to refer patients for advice, information and guidance. The new website developments http://www.firstcontactplus.org.uk/, include online self-referral, which went live on the 7th March 2017, with the ethos of "self-help". The **First Contact Plus** service offers signposting, information and targeted referrals to a broad range of preventative services from smoking cessation to fire safety. Two District Councils are currently working on specific **social prescribing pilots** with a view to creating a model of locality based prevention that will wrap around the new integrated locality teams.

l) The **Lightbulb Housing Offer** is a key part of prevention, offering a joined up support service across housing, health and social care to keep people safe, well, warm and independent at home for as long as possible. The business case for full roll-out was signed off by the Lightbulb Programme Board in September, and has since been approved by the Cabinets of each District and Borough Council and the County Council. Implementation of the new service started in Blaby on the 22nd May 2017, with full roll-out across all parts of Leicestershire in October 2017. This means all parts of Leicestershire will benefit from the same housing offer, with one central point of contact to access all housing support, including major and minor adaptations, home safety, and affordable warmth. **A new housing MOT** will ensure every opportunity is taken to assess and prevent housing problems which could impact on health and wellbeing. **The hospital housing discharge advisers at LRI and Bradgate Unit** were created as an integral part of this service.

m) There are currently 9,550 adult social care service users in Leicestershire County, of which 9,341 (98%) have a validated **NHS number** as a key enabler to data sharing across health and social care including through the **PI Care and Health Trak tool** and, in due course, the **summary care record (SCR2.1).**

n) **SIMTEGR8 evaluation** programme – the second phase of the Leicestershire Integration Programme evaluation approach was completed at the end of March 2017. This was delivered via a research partnership with Loughborough University, Healthwatch and SIMUL8 Corporation. Four integrated care pathways were analysed using simulation modelling, stakeholder workshops and patient experience focus groups.
    - Testing the business case assumptions for the Lightbulb Housing Service model
    - Impact of the Intensive Community Support (ICS) Step Up Service
    - Help to Live at Home capacity and resilience modelling
    - Glenfield CDU short stay/admissions avoidance pathway

Challenges

21. Having achieved good, sustained performance in 2015/16, the BCF DTOC metric is currently rated red and the DTOC target was not achieved in 2016/17. There are a number of system challenges that have affected this position, and a summary of the key issues and actions being taken is given below:

    - Volumes of attendances and admissions at UHL have continued to rise, which has created pressure on the health and care system overall, including the consequences of increased activity on hospital discharge across acute and non-acute sites.

    - Performance on delayed bed days has remained generally good on acute sector sites with the majority of the reason for target failure relating to non-acute sites.

    - Delays in CHC assessments and problems with the discharge to assess pathway have affected the ability to place NHS funded care packages out of hospital in a timely manner. A new CHC end to end process is being implemented via the new CSU with effect from July 2017.

    - The new domiciliary care service, Help to Live at Home, implemented in November 2016, had an impact on DTOC performance during Q3 due to the mobilisation issues, but a period of further intensive work and stabilisation has been undertaken, and the position has improved steadily since February 2017

    - Despite the overall system challenges, local authority delays remain in the top quartile of performance nationally.

    - A task and finish group has been established to work on system wide discharge data, as there are a number of concerns about data flows, data quality, and there is a need to provide one consolidated, integrated set of data/dashboards for the A&E Delivery Board.

    - The LLR self-assessment against the high impact changes for hospital discharge has recently been refreshed and will be considered by the A&E Delivery Board in June 2017.

    - The BCF plan continues to prioritise investment in hospital discharge support/reducing delays. For example the approach to integrated discharge

teams which has been developed for the acute sector is planned to be replicated on the non-acute sites, as part of the BCF plan/home first workstream during 2017/18.

Process to submit the BCF quarterly report to NHS England

22. The BCF Operationalisation Guidance required that a quarterly performance template was submitted to NHS England by 31st May 2017, summarising the final position for quarter four 2016/17.

23. The Integration Executive reviewed the completed template on 23rd May and submitted the required information to NHS England on 31st May on behalf of the Health and Wellbeing Board.

Recommendation

24. The Board is recommended to note the contents of the report and that the quarter four 2016/17 BCF return was approved by the Integration Executive on 23rd May, and submitted to NHS England on 31st May.

Officer to Contact

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

Relevant Impact Assessments

Equality and Human Rights Implications

25. The BCF aims to improve outcomes and wellbeing for the people of Leicestershire, with effective protection of social care and integrated activity to reduce emergency and urgent health demand.

26. An equalities and human rights impact assessment has been undertaken which is provided at:
http://www.leicestershire.gov.uk/sites/default/files/field/pdf/2017/1/11/better-care-fund-overview-ehria.pdf

27. A review of the assessment was undertaken in March 2017.

Partnership Working and associated issues

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

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

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

This page is intentionally left blank

Agenda Item 11

healthwatch Leicestershire

HEALTH AND WELLBEING BOARD: 22 JUNE 2017

REPORT OF HEALTHWATCH LEICESTERSHIRE

'IT'S NOT IN MY HEAD' REPORT

Purpose of report

1. The purpose of this report is to present the findings of Healthwatch Leicestershire's (HWL) **'It's not in my head' report** (**Appendix 1**). HWL gathered the views, opinions and experiences of individuals with Fibromyalgia from all across the UK.

Policy Framework and Previous Decisions

2. The County Council, following the Health and Social Care Act 2012, is required to directly commission a local Healthwatch. The local Healthwatch in turn has a set of statutory activities to undertake, such as gathering local views and making these known to providers and commissioners, monitoring and scrutinising the quality of provision of local services and a seat on the Health and Wellbeing Board.

3. The 'It's not in my head' report highlights the experiences and insights into the impact of Fibromyalgia on individuals' lives. Fibromyalgia Action UK has referenced research that cites there may be 1.5m / 2.9% of the population in the UK who may suffer from this condition.

Context and Background to the project

4. In January 2016 HWL launched a consultation exercise to understand what areas of health and social care people considered a priority for informing HWL's work plan. The responses were analysed and categorised into themes. Overall, we received 442 completed surveys, via post and online. Twenty-five respondents (6 %) talked about the lack of a Fibromyalgia clinic and the need for a specialist nurse in Leicestershire.

5. HWL decided to focus on a targeted approach around specific vulnerable, marginalised and seldom heard groups and people living with Fibromyalgia was chosen for an intervention as part of our approach to ensure healthcare is accessible for all.

6. In February 2016, HWL met with the Shuttlewood Clarke Foundation, Fibromyalgia Friends Together Group (FFTG), following a response to a question put to University Hosptials of Leicester (UHL). As part of the discussion, members of the group spoke about their wish to have a service where they can receive help and advice over the telephone by a Fibromyalgia specialist.

7. HWL met with the FFTG again in April 2016 and through discussions it was decided that HWL would co-produce a survey with feedback from the FFTG and promote it widely to gather the experience of local patients with Fibromyalgia. The aim was to capture experience and insights to feed into UHL and CCGs on service provision.

Key Findings

8. HWL was overwhelmed with the volume of responses as in total 950 individuals with Fibromyalgia completed the survey. 291 responses were received from LLR respondents, 605 from individuals living elsewhere in the UK and 54 individuals did not provide us with information of where they live.

9. These key findings can be found in the main report and alongside this, HWL want to highlight observations and reflections on a number of experiences and insights into the experience of people with Fibromyalgia.

10. It found that Fibromyalgia impacts on individual's quality of life and limits their chances for education, employment and social life. Individuals are sometimes left unable to perform routine chores and look after personal care needs such as eating, bathing and dressing.

11. The length of time taken for a diagnosis contributes to their isolation and frustrations. Despite waiting a long time for diagnosis, there were contradictory views on individual experiences with their GP. HWL broke the responses down by Clinical Commissioning Group (CCG) areas across Leicester, Leicester, Rutland (LLR) and the UK, and the findings were very similar. Over a quarter of individuals across all areas including the UK reported that their GP was neither knowledgeable nor supportive. However, a higher percentage of individuals reported that their GP was both knowledgeable and supportive.

12. The majority of respondents had not experienced misdiagnosis, however it was concerning that over half of respondents from LLR and the UK were not offered information by the NHS on living with Fibromyalgia.

13. Generally, respondents visited their GP monthly, bi-monthly, or quarterly regarding their Fibromyalgia. It is worth noting however, that nearly a quarter of LLR respondents and almost a fifth of UK respondents stated that they did not see their GP regarding Fibromyalgia because they feel their GP is not supportive or knowledgeable about their condition.

14. The majority of individuals from LLR and the UK reported that non-specialist hospital staff do not have much knowledge of or understand Fibromyalgia.

National Fibromyalgia Day

15. To help raise awareness for the long-term condition HWL released key findings from the survey of local people who suffer from this debilitating disease to mark National Fibromyaglia Day on 12 May 2017. (**See Appendix 2**)

Healthwatch England - 'It starts with you' campaign

16. HWL gave a preview of the findings to the Healthwatch England Committee (24 May 2017) as an example of work with a seldom heard group. The feedback was very positive on the deliberative approach taken, engaging and involving with groups and individuals to improve services.

17. Healthwatch England plans to use the report and approach as a case study as part of their 'It starts with you' national campaign that shows how Healthwatch activities can make a significant contribution to helping improve health and care services.

18. HWL is pleased to able to include in the report the positive outcome from the meeting between the Fibromyalgia Friends Together Group and UHL that has resulted in a jointly badged Top 10 Tips leaflet (refer to Report page 27) for those living with the condition. It will be circulated by UHL to 28,000 people including 12,000 professionals which will help to raise awareness of the condition.

'It's not in my head!' Recommendations

19. The findings from the report will be presented to a range of stakeholders who are responsible for commissioning, providing services and the education of health care professionals. The following simple and practical steps that can be taken to make life easier for Fibromyaglia sufferers and their families have been devised:

    a) Develop a **tool kit** that includes a list of local GPs, both private and NHS, who specialise in Fibromyalgia within LLR, including information about Fibromyalgia, the types of treatment that may be beneficial and alternative therapies that are available.

    b) Provide **support for families and carers** of individuals with Fibromyalgia for example, developing a local support group or a local online forum which would allow patients to participate from the comfort of their home.

    c) More **education and training** to existing GPs and those in training regarding Fibromyalgia symptoms and impact on quality of life for the patient, their families and carers. Part of the training should include increasing awareness of local specialist services that GP's can refer patients to.

    d) To address both health and social care needs, commissioners should explore a **multi-disciplinary approach to diagnosis** and service provision for patients, their families and carers.

    e) More **information** to be made available about Fibromyalgia that includes using online platforms and social media to raise public awareness led by public health, commissioners and providers.

Recommendations to the Health and Wellbeing Board

1. To receive the report, key findings and themes.

2. To comment on the recommendations (a) – (e) outlined above.

3. To note the Top 10 Tips on page 27 the report.

4. To note the national profile of the work.

5. Members of the Board are asked to suggest where else this report can be presented to share the findings to inform commissioning and providers for service improvements and performance monitoring.

Officer to Contact

Vandna Gohil, Director
Telephone: 0116 257 5040
Email: Vandna.g@healthwatchleics.co.uk

List of Appendices

20. Appendix A – 'It's not in my head!' Patient Experience of Fibromyalgia Report
21. Appendix B – Preview of the findings for National Fibromyalgia Day 2017 – Press Release

Relevant Impact Assessments

Equality and Human Rights Implications

22. Healthwatch Leicestershire is aware that the Public Sector Equality Duty (PSED) applies to all functions of public authorities that are listed in Schedule 19 Equality Act 2010. Schedule 19 list does not include Healthwatch England or Local Healthwatch organisations, however as bodies carrying out a public function using public funding we are subject to the PSED general duty.

23. Healthwatch Leicestershire is committed to reducing the inequalities of health and social care outcomes experienced in some communities. HWL believes also that health and social care should be based on a human rights platform. It will utilise the Equality Act 2010 when carrying out our work and in influencing change in service commissioning and delivery.

APPENDIX A

healthwatch Leicestershire

‘It’s not in my head!’

Patient experience of Fibromyalgia

Contents

Disclaimer

This report relates to our findings taken from our survey and from the individuals we spoke to at the Fibromyalgia Friends Together Group. Our report does not represent the experiences of all patients with Fibromyalgia but only those who contributed by completing our survey.

Foreword

Fibromyalgia is a chronic and debilitating condition that causes pain all over the body.

It is difficult to diagnose because the symptoms vary and fluctuate and sometimes this can be mistakenly attributed to another condition. What emerges clearly from our findings is that Fibromyalgia impacts a person's ability to function as it interferes with their day-to- day living and has a long-term impact on their quality of life. As a long – term condition, there needs to be long-term care and support.

We hope that the findings of this report will be used to provide support, information and improve access to, treatments and therapies which help patients to better manage their condition and also raise public awareness of Fibromyalgia.

Rick Moore, Chair
Healthwatch Leicestershire

Acknowledgements

We are extremely grateful to all the patients who shared their experiences of Fibromyalgia with us.
Thank you to the Fibromyalgia Friends Together Group at Shuttlewood Clarke Foundation for allowing us to attend and speak to the group.

Executive Summary

Fibromyalgia, is a long-term condition that causes pain all over the body, is not uncommon but relatively few people know about it or understand the symptoms.

At Healthwatch Leicestershire (HWL) we were made aware that services for local people with Fibromyalgia are not meeting their needs.

We designed this study to capture the experiences of people diagnosed with Fibromyalgia and the treatment they receive alongside information and support.

We received 950 responses of which 247 respondents were residing in Leicestershire, 43 in Leicester City, 1 in Rutland and 650 had UK postcodes including Scotland, Wales and Northern Ireland.

When we reviewed all the responses we found that Fibromyalgia impacts on individual's quality of life and limits their chances for education, employment and social life. Fibromyalgia also impacts on the individual's ability to perform routine chores and look after personal care needs such as eating, bathing and dressing.

The length of time taken for a diagnosis contributes to their isolation and frustrations. Despite waiting a long time for a diagnosis, there were contradictory views on individual experiences with their GP. When broken down by Clinical Commissioning Group (CCG) areas across Leicester, Leicestershire and Rutland (LLR) and the UK, findings were very similar. Over a quarter of individuals across all areas including the UK reported that their GP was neither knowledge nor supportive. However, a higher percentage of individuals reported that their GP was both knowledgeable and supportive.

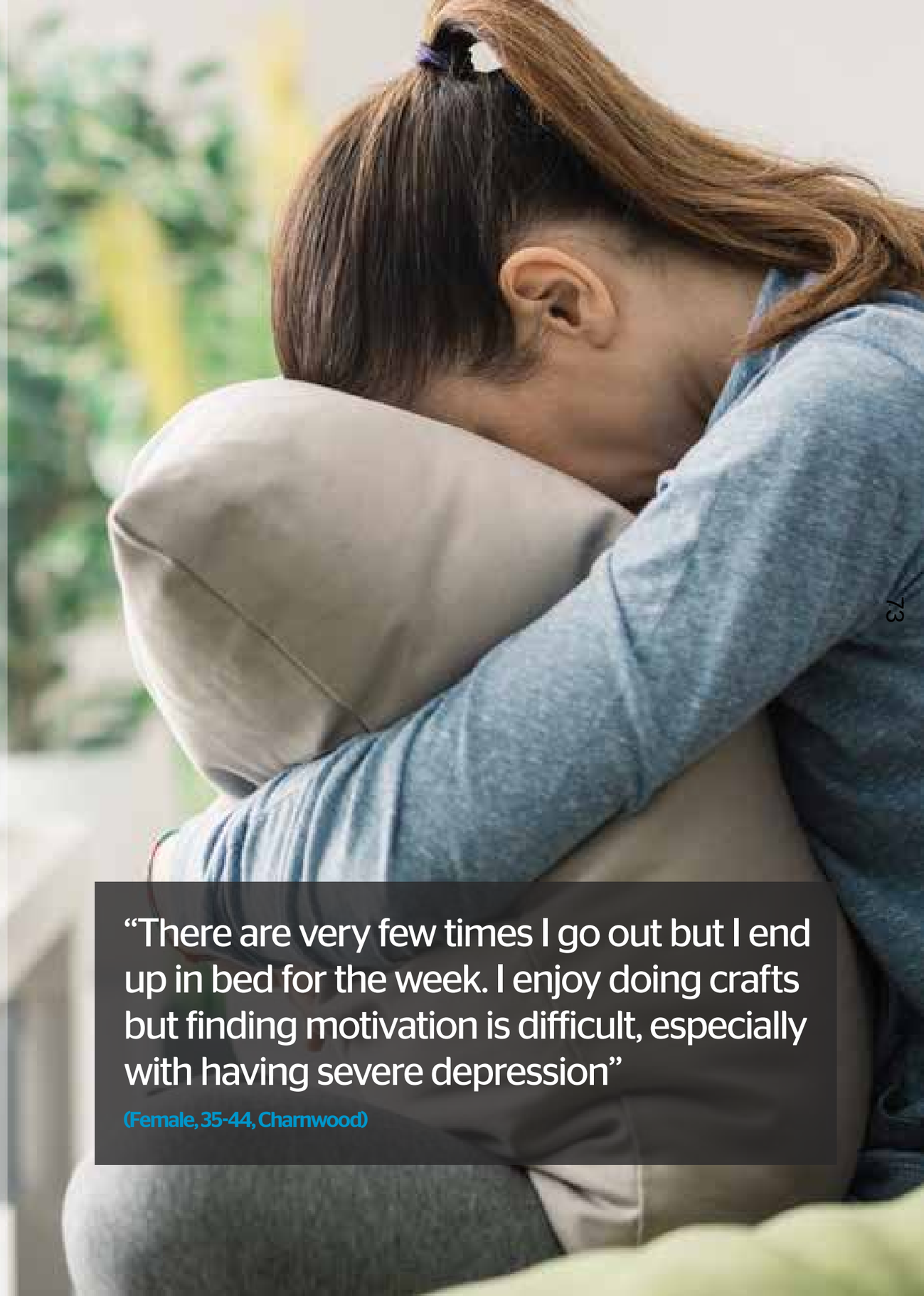
When asked about misdiagnosis, the findings were very similar across LLR and UK respondents. The majority of respondents had not experienced misdiagnosis.

It was concerning however that over half of respondents from LLR and the UK were not offered information by the NHS on living with Fibromyalgia. If patients are not provided with reliable information from a health care professional they may turn to the internet and the quality and accuracy of information gained online is not always reliable.

Generally, respondents visited their GP monthly, bi-monthly, or quarterly regarding their Fibromyalgia. It is worth noting however, that nearly a quarter of LLR respondents and almost a fifth of UK respondents stated that they did not see their GP regarding their Fibromyalgia, this is because they feel their GP is not supportive or knowledgeable of their condition.

Whilst the findings regarding GP services seemed to be positive, experience of secondary services was less favorable. The majority of individuals from LLR and the UK reported that non-specialist hospital staff do not have much knowledge of or understand Fibromyalgia. We received a number of qualitative comments from individuals across LLR and the UK stating that, doctors and medical staff in hospitals do not see Fibromyalgia as a "real thing" and their symptoms are dismissed. There is a clear lack of understanding of Fibromyalgia both in primary and secondary health services and this may prevent individuals from reaching out and accessing services when they are in need of help.

Individuals in LLR and the UK would like to see local specialist clinics and services for Fibromyalgia which are easy to access as well as more awareness of the condition to the public and health care professionals along with information on support groups, exercises and nutrition which will allow them to better cope with Fibromyalgia.



"There are very few times I go out but I end up in bed for the week. I enjoy doing crafts but finding motivation is difficult, especially with having severe depression"

(Female, 35-44, Charnwood)

Introduction

The purpose of this study was to gather the experiences of patients who have Fibromyalgia and access local services. We also wanted to understand what matters most to patients with Fibromyalgia and to identify key health and care issues.

Context and Background

In January 2016 Healthwatch Leicestershire (HWL) launched a consultation exercise to understand what areas of health and social care people consider a priority for informing HWL's work plan. The responses were analysed and categorised into themes. Twenty-five respondents talked about the lack of a Fibromyalgia clinic and the need for a specialist nurse in Leicestershire.

In February 2016, The Shuttlewood Clarke foundation asked us to meet with the Fibromyalgia Friends Together Group (FFTG) following a response to a question put to University Hospitals of Leicester (UHL). As part of the discussion, members of the group spoke about their wish to have a service where they can receive help and advice over the telephone by a Fibromyalgia specialist. They also talked about the need for a local service for people with Fibromyalgia, as the closest clinic to Leicestershire is in London.

We met with the FFTG again in April 2016 and through discussions it was decided that we would co-produce a survey with feedback from the FFTG and promote it widely to gather the experiences of local patients with Fibromyalgia.

The survey was subsequently designed with feedback from the FFTG and launched on Monday 26 September 2016 and was closed on Wednesday 28 December 2016.
We also facilitated a meeting between the FFTG and a representative from UHL.

The meeting was held in November 2016. At the meeting, we gave an update on some key headlines from the findings of the survey and members shared some of their experiences with the Patient and Public Involvement Membership Manager from UHL.

The outcome from the meeting, included an offer from the UHL representative to circulate a leaflet and information produced by the FFTG across the Trust to raise awareness of Fibromyalgia, (see page 27).

Update from the FFTG, May 2017:

> "The Shuttlewood Clarke Foundation Fibromyalgia Friends Together are pleased to be working with Healthwatch to raise awareness of fibromyalgia and improve the services for people living with fibromyalgia. Following a meeting with a representative from the NHS, facilitated by Healthwatch, we have produced our TOP 10 TIPS for living with fibromyalgia which is to be circulated to 28,000 people including 12,000 health professionals; this will certainly help to raise awareness of Fibromyalgia."
>
> Support Services Manager, Shuttlewood Clarke Foundation

What is Fibromyalgia?

We recognise that not everyone is familiar with understanding what Fibromyalgia is, and we hope that the following explanation is helpful to the readers of this report.

Fibromyalgia is a condition that is characterised by chronic widespread pain, fatigue and a combination of associated symptoms. The experience of pain varies for each individual, it can be felt as an ache, a burning sensation often described as head to toe or a sharp stabbing pain. The pain is sometimes continuous and other times it will come and go; the severity of the pain will also vary. Fatigue experienced by individuals' ranges from feeling tired to exhaustion and drained of energy. Fatigue can also come and go[1].

As well as widespread pain and fatigue, individuals with Fibromyalgia may also have:

- Increased sensitivity to pain
- Headaches and migraines
- Non-refreshing sleep
- Stiffness
- Irritable Bowel Syndrome (IBS)
- Fibro-fog – cognitive disturbances including lack of concentration and trouble with learning and remembering new things
- Anxiety and depression
- Painful menstrual cramps

The exact presentation of Fibromyalgia is very variable and this can lead to a delay in diagnosis and frustration on the part of both the patient and clinician. Although Fibromyalgia is not necessarily a degenerative condition, it does often have a very significant impact on the quality of life of the patient and their family and friends[2]. Individuals can find themselves unable to work and experiencing difficulty in performing everyday tasks and chores. As a result of muscle pain and fatigue many Fibromyalgia patients limit their activities including exercise. Consequently, making them physically unfit and making their symptoms worse[3].

1 http://www.fmauk.org/2-uncategorised/52-what-is-fibromyalgia
2 http://journals.sagepub.com/doi/abs/10.1177/1755738016638865
3 http://ukfibromyalgia.com/what-is-fm.php

The exact cause of Fibromyalgia has not yet been found, however it is thought that Fibromyalgia often develops after some sort of trauma which seems to act as a trigger; this could be a fall, accident or injury, childbirth, an operation or an emotional event. This however is not always the case and sometimes Fibromyalgia begins without any obvious trigger.

Diagnosis of Fibromyalgia has always been difficult because the condition cannot be identified in standard laboratory tests or x-rays.

Moreover, many of its signs and symptoms are found in other conditions as well, such as Chronic Fatigue syndrome or Rheumatoid Arthritis[4]. As Fibromyalgia is a difficult condition to diagnose, it is not clear as to how many people are affected by the condition. The NHS estimates that nearly 1 in 20 people may have Fibromyalgia to some degree and the condition affects around seven times more women than men[5].

There is currently no cure or universally agreed treatment for Fibromyalgia. There are no specific NICE guidelines regarding Fibromyalgia in the UK[6]. Referrals to specialists and treatments depends largely upon the individual's GP. This may lead to inconsistent access to treatment within a local authority area, which can result in poor clinical care and inefficient use of resources[7].

There are however, a variety of different treatment approaches that can help, and it is important that GPs are aware of the range of options and are able to discuss strategies for improving symptoms with their patients. The present, treatment for Fibromyalgia focuses on symptom control rather than cure. Mainly, treatment aims to reduce pain and improve sleep. The treatments offered will depend on the severity of the patient's condition and may include physiotherapy, pharmacological pain relief, counselling and cognitive behavioral therapy, dietary and exercise advice and self-management programs[8].

4 http://www.fmauk.org/2-uncategorised/52-what-is-fibromyalgia
5 http://www.nhs.uk/conditions/Fibromyalgia/Pages/Introduction.aspx
6 https://www.nice.org.uk/guidance/conditions-and-diseases
7 Chronic widespread pain, including fibromyalgia: a pathway for care developed by the British Pain Society.
8 http://www.bupa.co.uk/health-information/directory/f/fibromyalgia

Methodology

We worked together with the Fibromyalgia Friends Together Group (FFTG) to design a survey to gather the experiences of patients who have Fibromyalgia.

The questions were designed to gain both quantitative and qualitative data on patient's experiences of local services and of living with symptoms and suffering with Fibromyalgia.

We had three overarching aims:

- **Identify key health and care issues experienced by patients with Fibromyalgia**
- **Understand what matters most to patients with Fibromyalgia**
- **Identify gaps in support services**

The survey was made available online and promoted via the HWL E-news, website and Twitter. It was also cascaded to all HWL contacts and was promoted on the FFTG Facebook page. A member of the FFTG, also shared the survey with Fibromyalgia Action UK, who promoted it on their Facebook page to over 10,000 followers. We believe the latter resulted in a higher response rate than we expected as outlined in this report.

We therefore had to spend more time analysing the comments and feedback. We plan to disseminate the report to a wider audience than originally planned, to include Healthwatch England and other stakeholders.

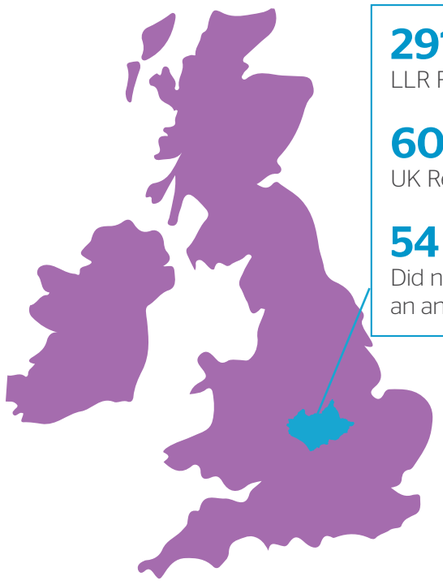
As part our research on Fibromyalgia, we read the reports from Healthwatch Gloucestershire and Healthwatch Trafford to inform our approach.

(http://tinyurl.com/n4zpy3l - December 2016)

Who we spoke to

950
responses to the survey

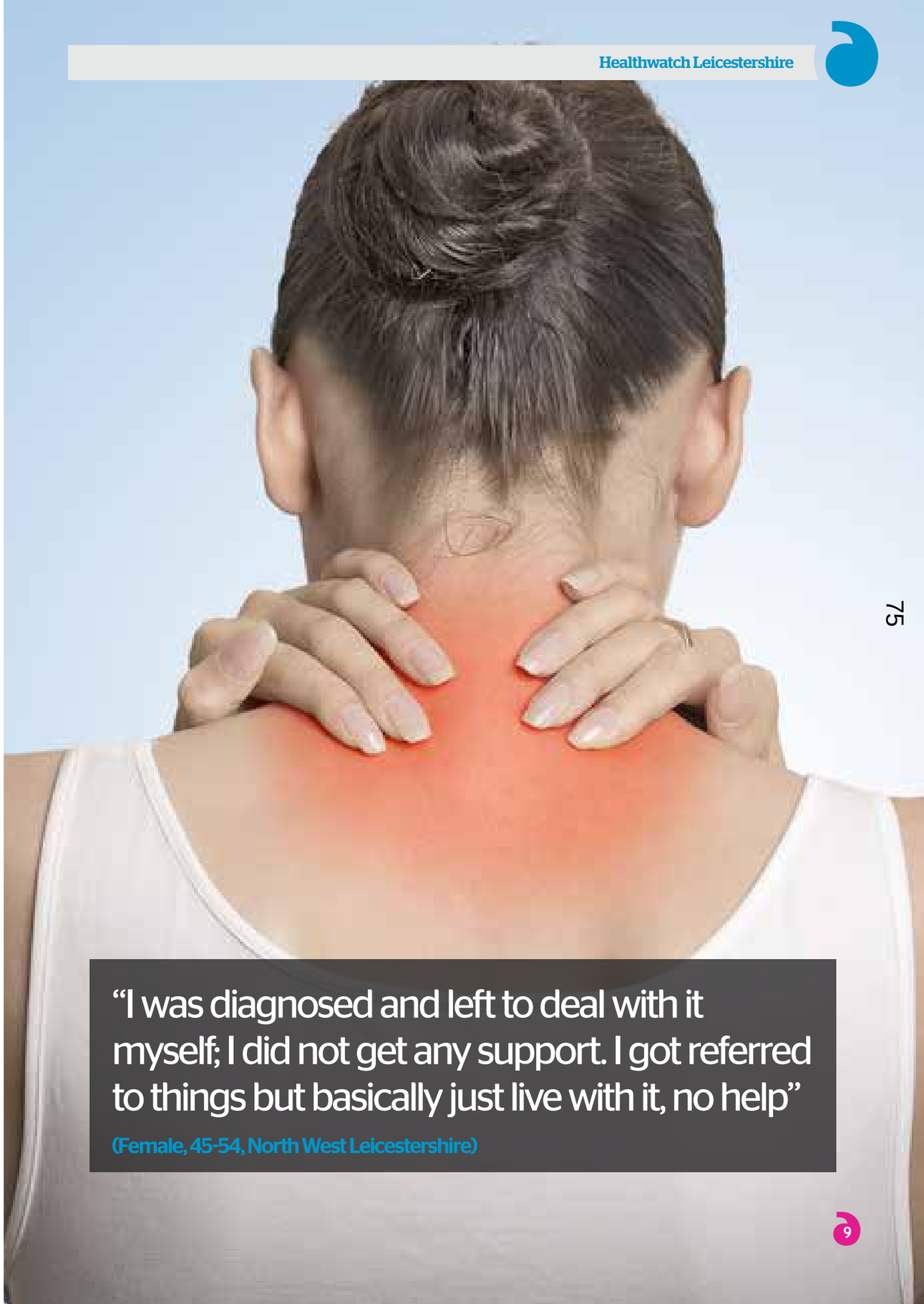
We received a surprising number of responses to this survey with an overall total of 950. A third of which were from respondents living in Leicester, Leicestershire and Rutland (LLR) and others were 'out of area'. Those individuals who were 'out of area' were asked to provide us with a postcode; we received a postcode from 594 respondents from individuals living all across the UK.



291
LLR Respondents

605
UK Respondents

54
Did not provide an answer



"I was diagnosed and left to deal with it myself; I did not get any support. I got referred to things but basically just live with it, no help"

(Female, 45-54, North West Leicestershire)

Main Findings

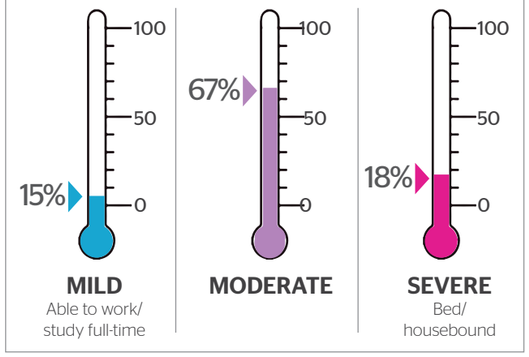
From our initial analysis, there was not much difference between the local LLR response and those from rest of the UK. For this reason, we present the comparative findings with quotes from individuals to support the emerging themes and recommendations.

How would you describe your current level of Fibromyalgia?

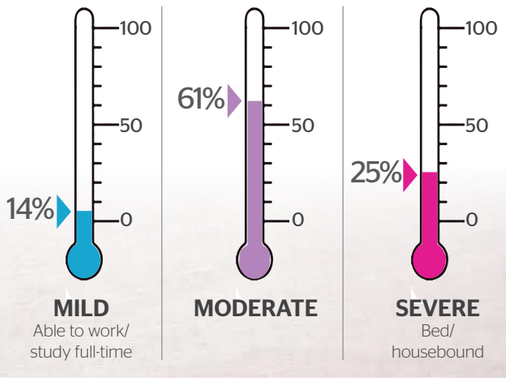
Across LLR, over two thirds of respondents said their level of Fibromyalgia was moderate which meant they were unable to work or study full time. Nearly a fifth of respondents said that their level of Fibromyalgia was severe and thus were bed/housebound. The remainder said that their level of Fibromyalgia was mild, which allowed them to work or study full time.

This was also consistent with those living elsewhere in the UK. Just under two thirds of respondents said their level of Fibromyalgia was moderate and a quarter said their Fibromyalgia was severe and therefore were bed/housebound.
The remainder said that their level of Fibromyalgia was mild, allowing them to work or study full time.

LLR RESPONDENTS



UK RESPONDENTS



If you have a formal diagnosis of Fibromyalgia, who diagnosed you?

Our analysis shows that, a formal diagnosis by a Rheumatologist was the most common from respondents across LLR and also for those living elsewhere in the UK.

LLR RESPONDENTS

Own GP	22%
Another GP at my practice	5%
A Specialist Fibromyalgia Clinic	3%
Rheumatologist	47%
Private doctor or paid service	4%
Physiotherapist	0%
I do not have a formal diagnosis	4%
Other	15%

UK RESPONDENTS

Own GP	16%
Another GP at my practice	3%
A Specialist Fibromyalgia Clinic	3%
Rheumatologist	64%
Private doctor or paid service	1%
Physiotherapist	1%
I do not have a formal diagnosis	1%
Other	11%

How long did it take from first visiting your GP with symptoms to getting diagnosed?

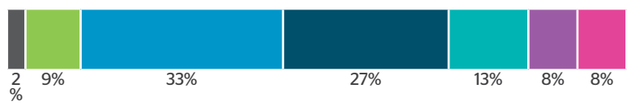
As Fibromyalgia is largely a diagnosis of exclusion, it can take time to carry out tests and receive the results to rule out other conditions. This can explain some of the delay in patients receiving a diagnosis.

Our findings show that respondents across LLR and the UK waited long periods of time living with the symptoms of Fibromyalgia before a proper diagnosis was made.

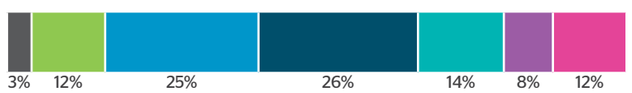
The pattern locally and nationally appears to be similar.

LENGTH OF WAIT FOR DIAGNOSIS

LLR RESPONDENTS



UK RESPONDENTS



KEY:

- Less than 12 months
- 1-2 years
- 2-5 years
- 5-10 years
- 10-15 years
- 15-20 years
- 20 years or more

What are your symptoms?

We wanted to understand more about the type of symptoms individuals experienced. A list of symptoms was compiled when co-designing the survey with the FFTG. Individuals were given the list of symptoms and asked to select all that apply to them.

The findings for LLR and UK respondents was the same for this question. The most common symptom experienced by individuals was pain; followed by fatigue and 'fibrofog'.

SYMPTOM	LLR	UK
Pain	289	598
Fatigue	277	588
'Fibrofog' – loss of concentration	256	563
Depression	202	428
Insomnia	197	439
Irritable bowel syndrome	181	416
Restless leg syndrome	172	390
Other (please specify)	91	204

Those individuals who also selected 'Other' were asked to specify the symptom. The list below represents some answers from both LLR and UK residents.

- Dizziness
- Blackouts
- Numbness
- Anxiety
- Panic attacks
- Weight gain
- Hypersensitivity
- Headaches
- Vertigo
- Raynaud's syndrome

The following are quotes from respondents, which highlight some of the difficulties experienced by individuals with Fibromyalgia and to what extent.

"Unable to cope with more than one thing at a time"
(Female, 25-34, Blaby)

"I feel like I'm not human, like I'm going to cave in literally!"
(Female, 45-54, North West Leicestershire)

"I regularly have fluid cysts in my breast which need to be aspirated. I also lose my balance and fall easily."
(Female, 45-54, Northamptonshire)

"Appetite changes and I actually have days where I just collapse as my body will not physically hold me up"
(Female, 25-34, Burton-on-Trent)

In which ways, if any, has Fibromyalgia affected your daily life?

It is important to understand what extent an individual's life is affected by their Fibromyalgia to be able to design and implement interventions to help them. Individuals were given a choice of eight statements and asked to select all that applied to them. The table below shows the amount of times each statement was selected by respondents living in LLR and the UK.

Statement	LLR	UK
Ability to enjoy recreational hobbies	250	536
Ability to perform routine chores (such as household chores, shopping or getting around)	243	552
Ability to socialise with family/friends	237	530
Ability to work/study (including voluntary work)	233	514
Ability to look after personal care needs (such as eating, bathing, dressing or getting around the house)	138	346
Other (please specify)	43	74
Divorce or separation from spouse	23	62
None of the above	9	4

Nearly all respondents living in LLR and the UK, said that Fibromyalgia had affected their quality of life in some way. A very small number of individuals selected 'None of the above' from the list of statements, suggesting that Fibromyalgia affects the majority of patients in one way or another.

Those who selected 'Other' were asked to specify the ways in which their daily lives were affected. The list below represents some answers from both LLR and UK residents.

- Affects my caring role
- Disturbed sleeping patterns
- Isolation
- Limited driving and mobility
- Parenting duties affected
- Unable to exercise
- Lack of libido

The following are quotes from respondents, which highlight to what extent their Fibromyalgia impacts on their daily lives.

"Relationships with family & friends has been affected as they don't understand Fibromyalgia"
(Female, 45-54, Charnwood)

"I work one day a week then it takes about 4 days to recover"
(Female, 35-44, Harborough)

"I simply exist now, I no longer have a life"
(Female, 35-44, Stafford)

"Whilst my children were growing up I missed out on having energy to play and take them to events also day to day care of them was exhausting so I was unable to enjoy my motherhood and their childhood"
(Female, 35-44, Charnwood)

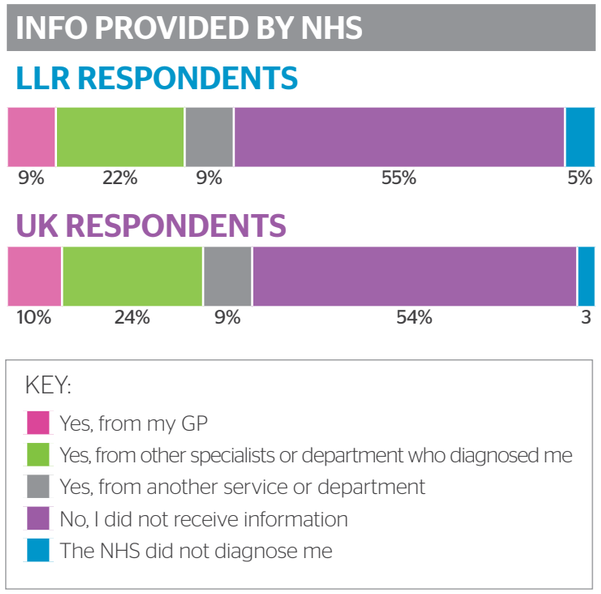
Were you offered any information from the NHS on living with the condition?

We wanted to find out what support and sources of help was available and provided by healthcare professionals working within the NHS to individuals with Fibromyalgia.

We found that over half of LLR and UK respondents who were diagnosed by the NHS, were not offered any information on Fibromyalgia, which is very concerning. Nearly a quarter of all respondents said they received some information from the specialist or department that diagnosed them.

A small number of respondents said they received information from another service, department or from their GP.

It is important that individuals with Fibromyalgia are provided with information from a healthcare professional upon diagnosis. If patients are not provided with information they may turn to the internet where the quality and accuracy of information gained online is not always reliable.

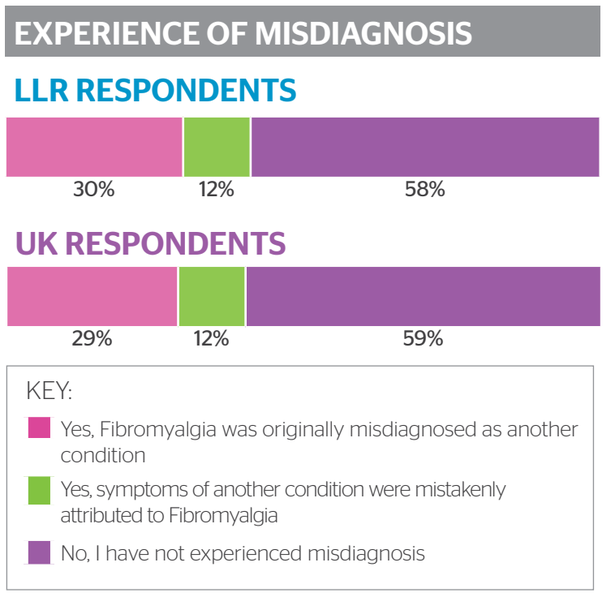


Have you experienced any misdiagnosis?

From our findings, diagnosis across LLR and the UK appears to be fairly similar. What is interesting, is that the number of respondents who have and have not experienced misdiagnosis is very similar across both groups.

It can be dangerous for individuals who may have experienced symptoms of another condition mistakenly attributed to Fibromyalgia, particularly if it is a serious or life-threatening condition as this could lead to delays in treatment.

Individuals who have experienced Fibromyalgia being misdiagnosed as another condition, may receive treatment that is unnecessary and ineffective. This would mean that Fibromyalgia patients would suffer longer periods of time without targeted treatment.



Word cloud to show some of the conditions individuals were misdiagnosed with

We asked individuals to specify which condition they were misdiagnosed with or their symptoms were mistakenly attributed to. Below is a list from both local and national respondents:

The word cloud above represents many different conditions, syndromes, diseases and symptoms. This finding can explain to some extent the difficulty GPs and other healthcare professionals face when attempting to diagnose a patient with Fibromyalgia.

The following are quotes from respondents, which highlight the difficulties they experienced when getting a diagnosis of Fibromyalgia.

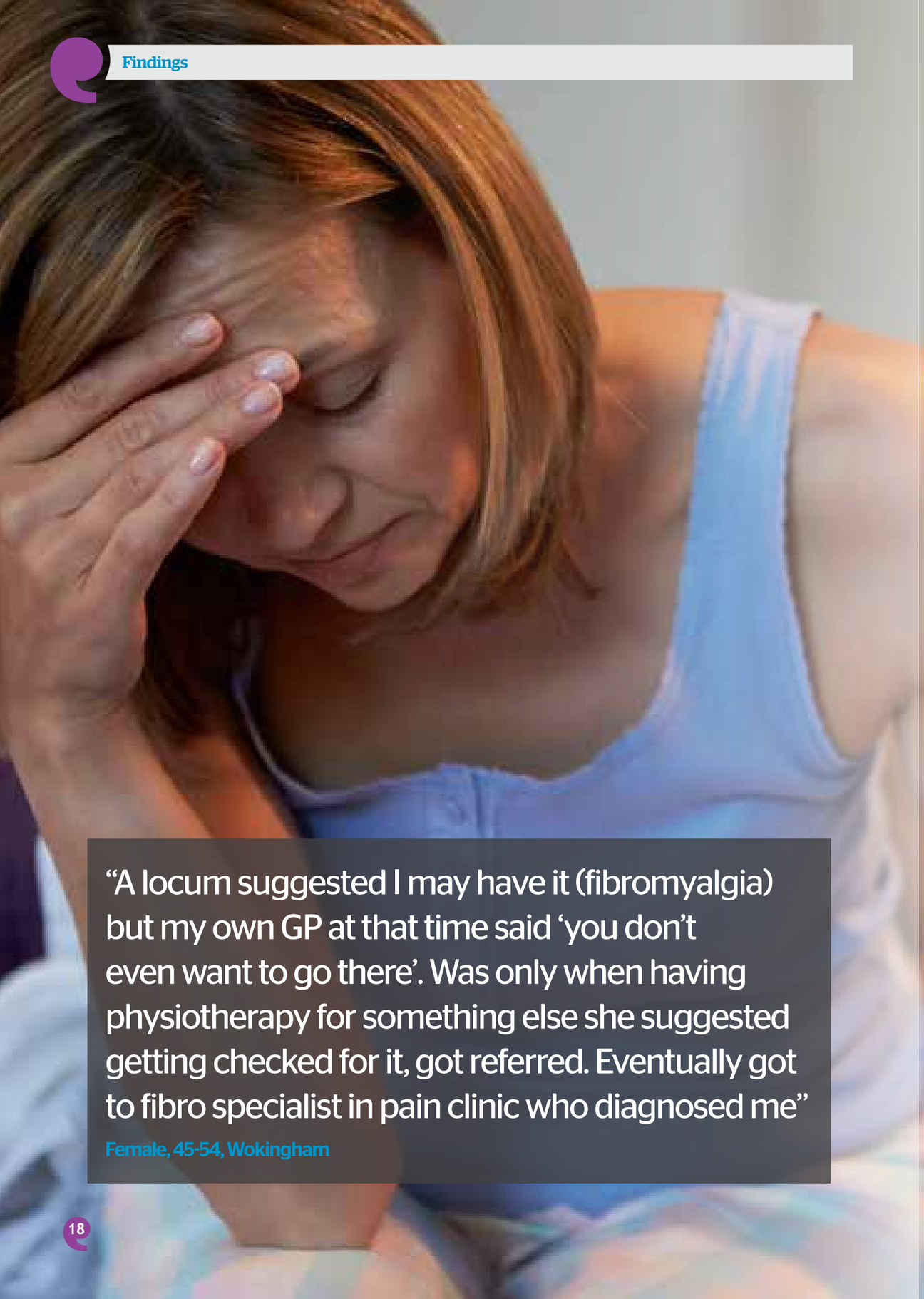
"A bad back from wear and tear is what my GP said. I paid for a chiropractor who found I had extra ribs. I went back to the GP, he said this was the causing the pain"
(Female, 25-34, Leicester City)

"There is nothing clinically the matter with you; perhaps it's in your head"
(Female, 65-74, North West Leicestershire)

"I was told it was due to menopause and nothing could be done about it"
(Female, 35-44, Charnwood)

"I was treated for rheumatoid arthritis for 6 years then they changed my diagnosis to fibromyalgia"
(Female, 45-54, Newton Abbey, Northern Ireland)

"I have a spinal cord injury which was dismissed as fibro when I complained of pain. I was also told I didn't have a disability and it was nothing "loosing 10 kilos wouldn't solve. So start walking further each day". I was so humiliated I left it 2 years and got progressively worse."
(Female, 25-34, Hinckley & Bosworth)



"A locum suggested I may have it (fibromyalgia) but my own GP at that time said 'you don't even want to go there'. Was only when having physiotherapy for something else she suggested getting checked for it, got referred. Eventually got to fibro specialist in pain clinic who diagnosed me"

Female, 45-54, Wokingham

How does your GP talk about Fibromyalgia?

286
LLR responses to this question

Individuals were asked how their GP talks about Fibromyalgia and they were asked to choose from 4 statements. 286 individuals living in LLR answered this question.

We present the findings by Clinical Commissioning Group (CCG) area.

KEY: MY GP IS:

- Knowledgeable AND supportive
- Not knowledgeable BUT supportive
- Knowledgeable but NOT supportive
- Neither knowledgeable/supportive

The findings across all 3 CCG areas are not hugely different. Over a quarter of respondents across all 3 areas reported that their GP is neither knowledgeable nor supportive. However, in certain areas a higher percent of respondents reported that their GP is both, knowledge and supportive.

We also looked at the responses from individuals living in the UK, to see whether there were any noticeable differences. Interestingly, the findings were similar to individuals living in LLR.

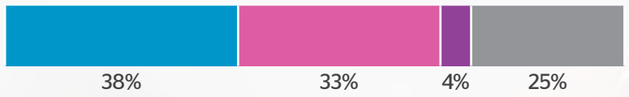
As the number of respondents from each CCG area and the UK is different, we are unable to compare and contrast findings directly between them.

West Leicestershire CCG -

189 respondents answered, **3** skipped

East Leicestershire & Rutland CCG -

55 respondents answered, **1** skipped



Leicester City CCG -

42 respondents answered, **1** skipped

UK Respondents -

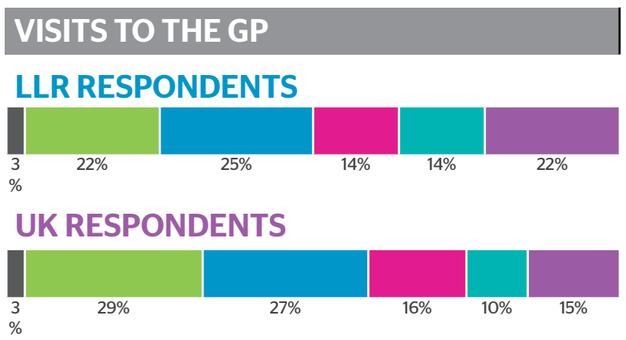
596 respondents answered, **9** skipped

The overall findings suggest that in some areas of LLR and the UK, GP's are knowledgeable, supportive and understand the impact of Fibromyalgia on their patients. However, in other areas it appears that there is a general lack of understanding of the condition by GP's and this is concerning as patient's may feel that they have nowhere to go for help. CCG's should consider providing more training and information for GP's who are not very knowledgeable about Fibromyalgia and as a result appear to not be supportive.

Regarding your Fibromyalgia, how often do you see your GP on average each year?

Overall, respondents visited their GP on a monthly, bi-monthly and quarterly basis regarding their Fibromyalgia. There is a small number of individuals both locally and nationally who visit their GP on a weekly basis. Nearly a quarter of LLR respondents and almost a fifth of UK respondents reported not visiting their GP regarding their Fibromyalgia.

VISITS TO THE GP



"I had to 'fight' for pain clinic referral"
(Female, 55-44, Charnwood)

Regarding your Fibromyalgia, which specialist services, if any, has your GP referred you to?

Our findings showed that LLR respondents were mostly referred to Rheumatology, followed by Pain Management and Physiotherapy. Similar findings were also reported by UK respondents. Individuals were allowed to select more than one option for this question.

A number of people from LLR (78) and the UK (104), said they had not been referred to any specialist services by their GP.

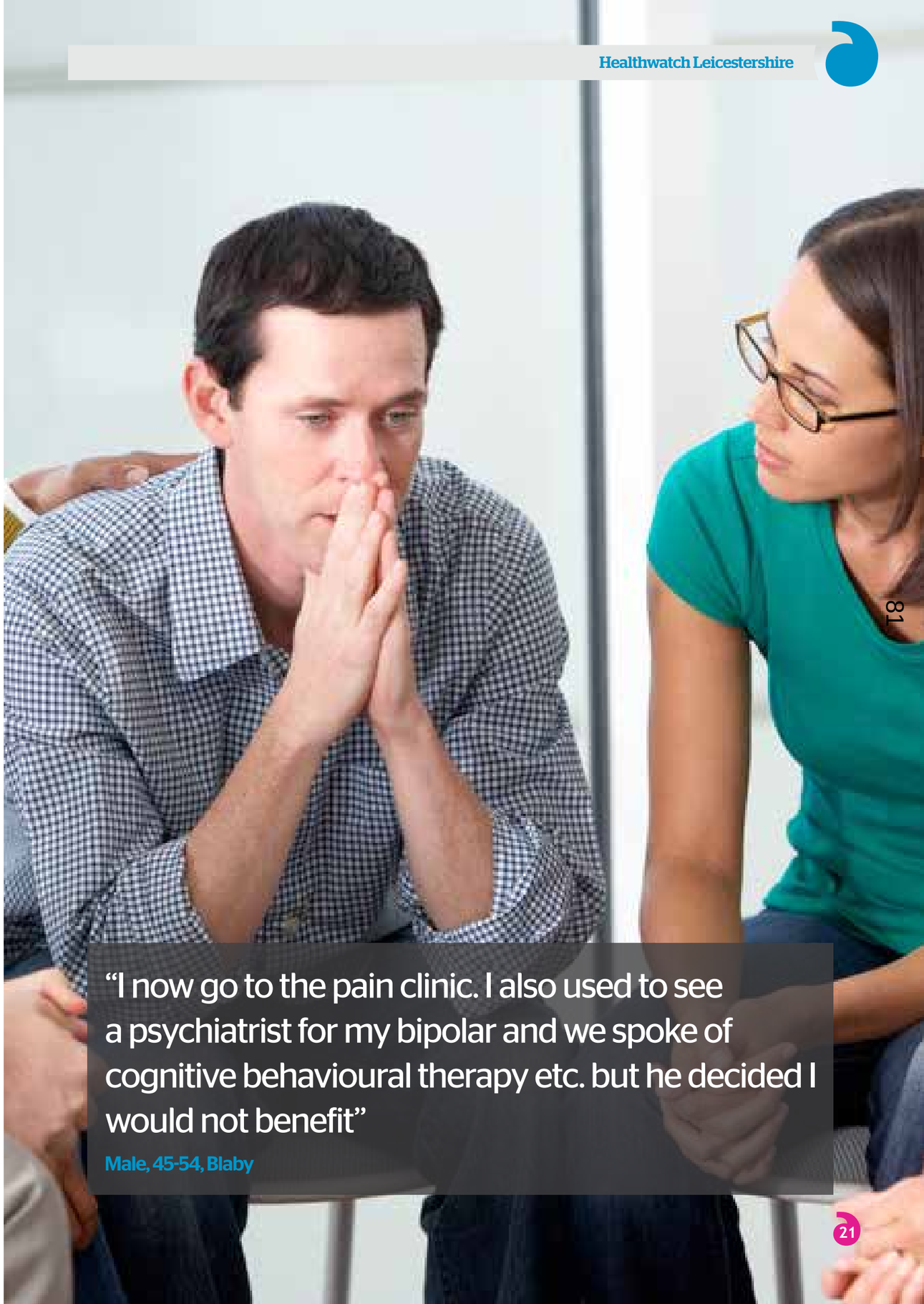
REFERRAL TO SPECIALIST

Rheumatology		Pain Management		Physiotherapy	
LLR	UK	LLR	UK	LLR	UK
147	317	116	207	111	258

The following are quotes from respondents who selected 'Other' and highlight some of the difficulties they experienced to get a referral to a specific clinic or specialised treatment.

"I was never asked to see anyone, and was just given pills and left to get on with it"
(Female, 45-54, North West Leicestershire)

"Guy's hospital were helpful, but the referrals they suggested were not followed up by GP practice"
(Female, 55-64, Harrow)



"I now go to the pain clinic. I also used to see a psychiatrist for my bipolar and we spoke of cognitive behavioural therapy etc. but he decided I would not benefit"
Male, 45-54, Blaby

Do you find that (non-specialist) hospital staff have knowledge of Fibromyalgia and understand your condition?

We asked respondents how they felt about the knowledge and understanding of non-specialist hospital staff regarding Fibromyalgia. Nearly a fifth of respondents in LLR and outside of LLR said that they feel non-specialist hospital staff understand Fibromyalgia, treat them appropriately and have some knowledge of the condition.

In both cases however, the majority of respondents in LLR and the UK reported that non-specialist hospital staff do not have much knowledge of or understand Fibromyalgia. This is concerning and suggests that these is a lack of knowledge in primary and secondary services across LLR and rest of the UK.

In respect to your Fibromyalgia, is there anything else about hospital services that you would like to mention?

We received over 250 responses to this question. The majority of the comments were negative. The following are illustrative examples of individual experiences and opinions regarding hospital services.

LLR respondents

UK respondents

"Most hospital A&E doctors simply laugh at the suspected fibromyalgia- to them it's a 'made up' condition"
(Female, 16-24, Hinckley & Bosworth)

"I think they just tell you anything to get rid of you. They tell you it's not real it's all in your head that you are imagining it"
(Male, 25-34, Merseyside)

"I was diagnosed and left to deal with it myself; I did not get any support. I got referred to things but basically just live with it, no help"
(Female, 45-54)

"It doesn't seem to be taken seriously by the majority of medical staff I've met
(Female, 55-64, Harborough)

"Since 1998 I have had nothing but disbelief about my pain now i feel like a cripple most days, walking about my flat in pain and confusion with no support from any agencies whatsoever"
(Male, 45-54, Sheffield)

"My GP didn't recognise my symptoms so I paid privately for a referral to see a Rheumatologist who was mortified I had been suffering for so many years"
(Female, 45-54, North Lincolnshire)

"There should be more support groups and more knowledge about this condition. More help and clinics also a support nurse we could ring when need be"
(Female, 65-74, Charnwood)

"Please take it seriously and don't give me that pity look and say "but you're so young!" I'm aware but that doesn't help does it!"
Female, 25-34, Leicester City

Are you currently having any treatments for the condition?

The overwhelming majority of respondents are receiving treatment for their condition. This reflects the frequency of visits to the GP for prescriptions and on-going treatment.

LLR respondents

56% respondents stated that they are currently receiving treatments.

44% said they are not. currently receiving treatments.

UK respondents

62% respondents stated that they are currently receiving treatments.

38% said they are not. currently receiving treatments.

What treatments are you having now or had previously?

This question gave respondents the opportunity to provide a qualitative answer.

We organised the feedback by type of medication, treatment and therapies in order to gain a better understanding of ways in which Fibromyalgia patients cope and manage their condition.

LLR respondents

UK respondents

Fibromyalgia Specific Meds
Savella
Duloxetine

Anti-depressants
Fluoxetine
Mirtazapine
Sertraline

Simple Analgesia
Paracetamol
Ibuprofen
Co-codamol
Nurofen
Ralgex spray

Strong analgesia
Morphine
Oxycontin
Oramorph Sulphate
Zomorph
Ligocaine Infusion
Tramadol

Neuropathic analgesia
Amitriptyline
Gabapentin
Pregabalin

Steroids
Betnovate ointment
Steroid injections

Other medication
Zolmitripan
Calcium tablets
Lansaprozole
Sleeping pills
Thyroid medication

Medical therapies (GP referral)
Pain management course
Stem cell treatment
Cognitive Behavioural Therapy
Complementary therapies
Physiotherapy
Rheumatology

Alternative Holistic therapies
Acupuncture
Hydrotherapy
Reflexology
Full body massage (private)
Tens machine

What difference (if any) are the treatments having on your condition?

We gave respondents the opportunity to tell us what difference, if any, their medication or treatment has had on their Fibromyalgia. We received similar responses from LLR and UK respondents.

We have listed below the recurring themes from the qualitative comments.

- Manages depression and anxiety
- Eases pain temporarily
- Aids sleep
- Less nausea
- Eases fatigue temporarily
- Weight gain
- Helps a little with mobility
- Acupuncture relaxes muscles
- No difference, worsens symptoms
- Effects of medication wear of quickly
- Hydrotherapy is very relaxing
- "Takes the edge off"

What support locally would you like to see for Fibromyalgia sufferers?

We asked respondents what support they would like to see locally for individuals with Fibromyalgia. As this question allowed respondents to provide a qualitative response, all responses were analysed and grouped into the below categories.

Services/Facilities

- Local specialist clinics
- Specialist Fibromyalgia Nurse
- Home visits from GP
- Helpline with specialist support
- Transportation services
- Annual/ monthly review of symptoms and medication

Support and information for Professionals and Employers

- Guidance for employers
- More awareness of the condition for employers
- Less judgement from health professionals

Support and information for Patients

- More public awareness campaigns
- Local support groups
- Fitness classes
- Domestic services
- Education on nutrition
- Protection in workplace
- Availability of treatments on NHS
- Support for spouses/family
- Lectures from health professionals

> "A lot of health care staff don't understand and a lot of the times when I explain I have Fibromyalgia it gets brushed off as if it wasn't a real health issue."
> (Female, 25-34, North West Leicestershire)

Recommendations

The findings from our report will be presented to a range of stakeholders who are responsible for commissioning, providing services and the education and training of Doctors. There are some simple and practical steps that can be taken to make life easier for Fibromyalgia sufferers and their families, such as:

1. A **tool kit** that includes a list of local GPs both private and NHS who specialise in Fibromyalgia within LLR, including information about Fibromyalgia, the types of treatment that may be beneficial and what alternative therapies are available.
2. Provide **support** for families and carers of individuals with Fibromyalgia for example, developing a local support group or a local online forum which would allow patients to participate from the comfort of their home.
3. More **education and training** to existing GPs and those in training regarding Fibromyalgia symptoms and impact on quality of life for the patient, their families and carers. Part of the training should include increasing awareness of local specialist services that GP's can refer patients to including pain management services, hydrotherapy, hyperbaric oxygen therapy, counselling and cognitive behavioural therapy to enable patients to cope better with this debilitating long-term condition.
4. To address both health and social care needs, commissioners should explore a **multi-disciplinary** approach to diagnosis and service provision for patients, their families and carers.
5. More **information** to be made available about Fibromyalgia that includes using online platforms and social media to raise public awareness led by public health, commissioners and providers.

Conclusion

There are clear issues with diagnosis, pain management and support that impacts on the lives of Fibromyalgia suffers and their well-being. This invariably has a knock-on impact for their family and wider relationships.

Fibromyalgia sufferers are a seldom heard group suffering in silence, who are patiently waiting for their voices to be heard and it is not something that is 'in their head'.

We hope that the findings of this report will be used to provide support, information and improve access to, treatments and therapies which help patients to better manage their condition and also raise public awareness of Fibromyalgia.

Fibromyalgia Friends Together

Fibromyalgia is a recognised illness. The main symptoms of Fibromyalgia are widespread pain, profound fatigue, headaches, depression, increased sensitivity, fibro fog and irritable bowel.

These are our **Top 10 Tips** for living with fibromyalgia.

01 **Support Group -**
Join a Fibromyalgia support group such as Fibromyalgia Friends Together, it is really useful to talk to people who understand what you are going through.

02 **Pace Yourself -**
Take time to come to terms with your diagnosis and learn to manage your symptoms. Organise and prioritise your workload as you won't be able to do as much as you used to. Be kind to yourself and accept help from wherever possible.

03 **Health Professional -**
Try to find a GP that understands and recognises fibromyalgia. Keep a food and pain diary and take it with you to all appointments. Ask for a referral to a rheumatologist, pain clinic, physiotherapist or dietitian and be persistent

04 **Treatment -**
Fibromyalgia is different for everyone, so it's important to learn how it affects you. There is no one treatment or medication that works for all; what suits one person will not necessarily suit another.

05 **New Symptoms -**
Do not ignore new symptoms; it is not always fibromyalgia. If you are not sure, see your GP.

06 **Complementary Therapies -**
Try complementary therapies such as Acupuncture, Reflexology or Aromatherapy. Hyperbaric Oxygen Chamber Treatment, available at MS therapy centres, has shown promise in helping people with pain and insomnia. A hot bath or shower can help to ease aches and pains.

07 **Relaxation -**
Stress often increases symptoms, therefore it is important to relax as much as you can. Learn how to relax by joining a relaxation or mindfulness class; do whatever it takes for you to switch off, reading, painting, knitting, music, visiting family or friends.

08 **Exercise -**
It is better to keep moving if you can. Take gentle exercise such as walking or swimming, or join an exercise class such as Yoga, Tai Chi, Pilates etc.

09 **Information -**
Fibromyalgia Action UK is the registered charity for Fibromyalgia where you can get a variety of information. Seek support online, there are many sites supporting Fibromyalgia. Our Facebook group is Fibromyalgia Friends Together Leicestershire. Use the internet as a tool but recognise not all information is correct.

10 **Benefits -**
Apply for any relevant benefits as these can make your life much easier. Keeping a diary of symptoms will help you complete the forms. Help is available at your local CAB office. If you have difficulty walking apply for a Blue badge

Contact:
kathleen@shuttlewood-clarke.org
07860 639693 or 01530 244914
Shuttlewood Clarke Foundation
Ulverscroft Grange, Whitwick Road, Ulverscroft, Leicestershire. LE67 9QB

Fibromyalgia Friends Together meet on the third Thursday of the month at Ulverscroft Manor, Priory Lane, Ulverscroft, Leicestershire. LE67 9PH

healthwatch Leicestershire

Shuttlewood Clarke Foundation
Registered Charity 803525

NHS University Hospitals of Leicester NHS Trust

Demographics

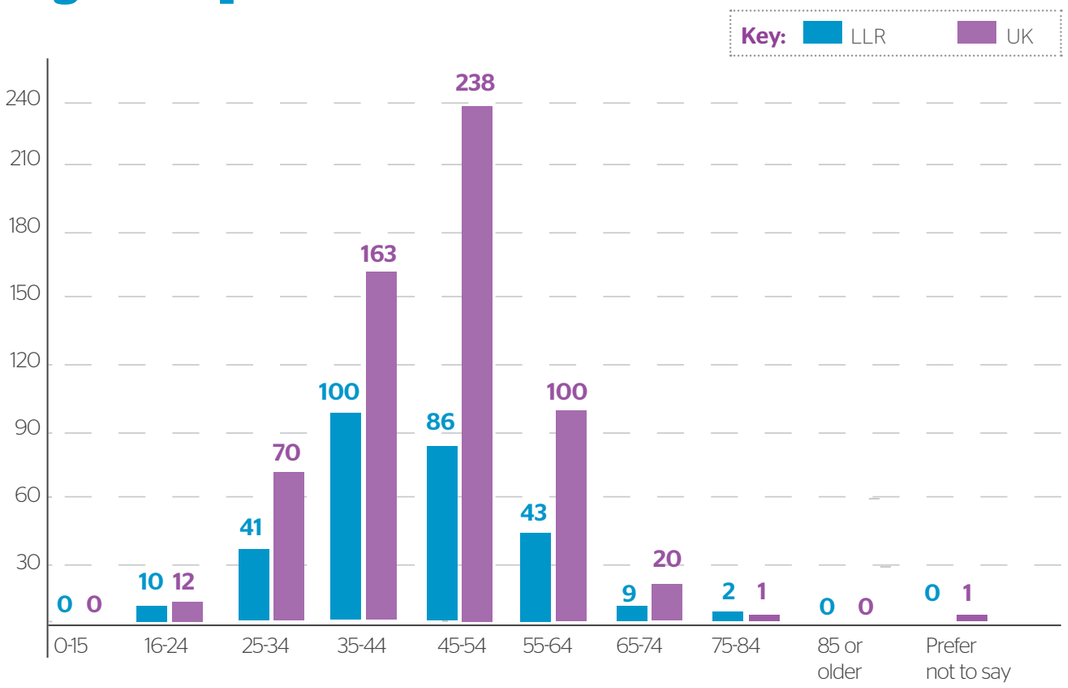
As part of the survey we asked respondents for their gender, age, ethnicity and which district or borough they lived. The responses that we were given are as follows:

Gender

	LLR	UK
MALE	23	18
FEMALE	265	584
TRANSGENDER	1	0

LLR & UK: 4 - PREFER NOT TO SAY

Age of respondent



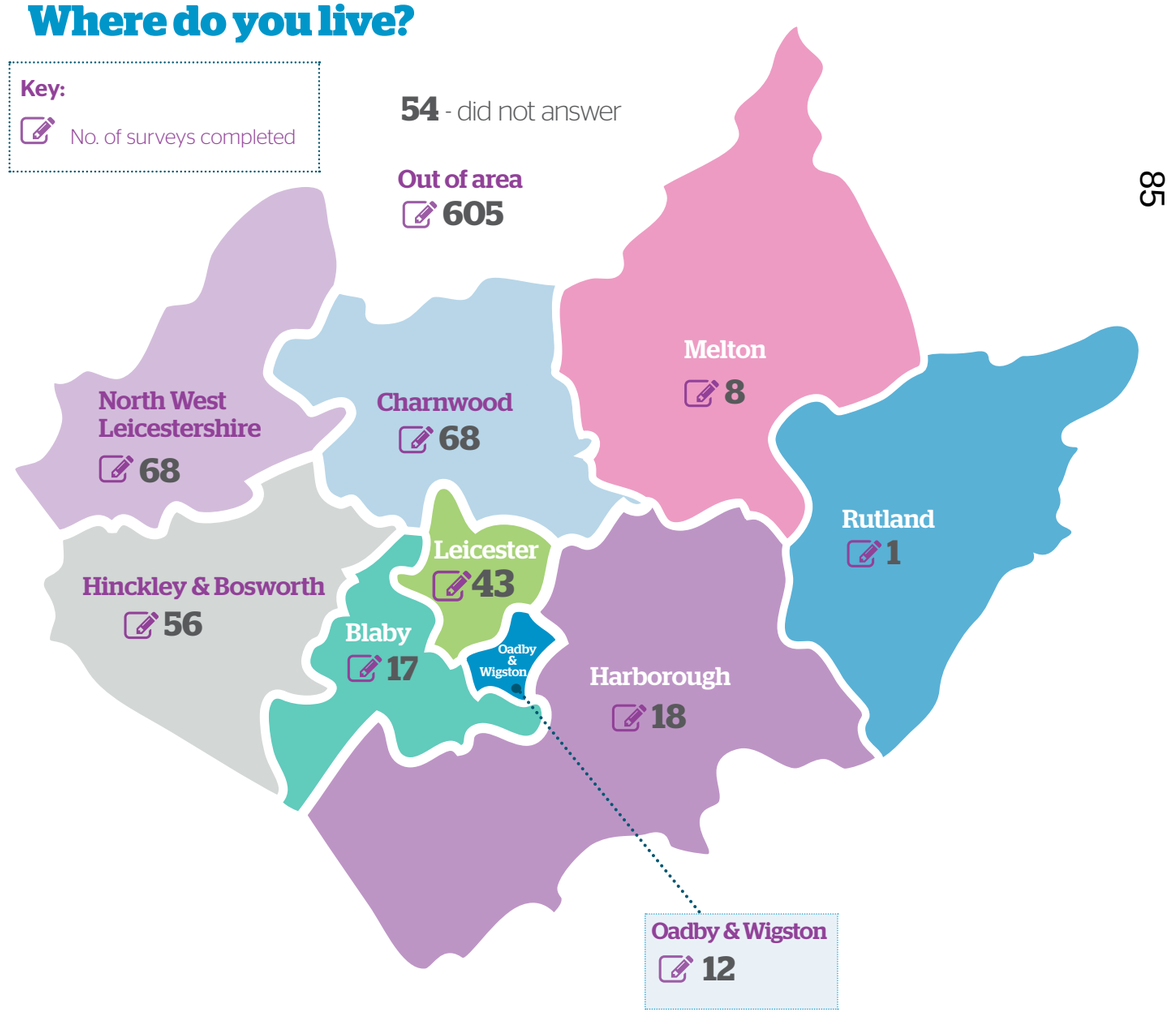
Ethnicity

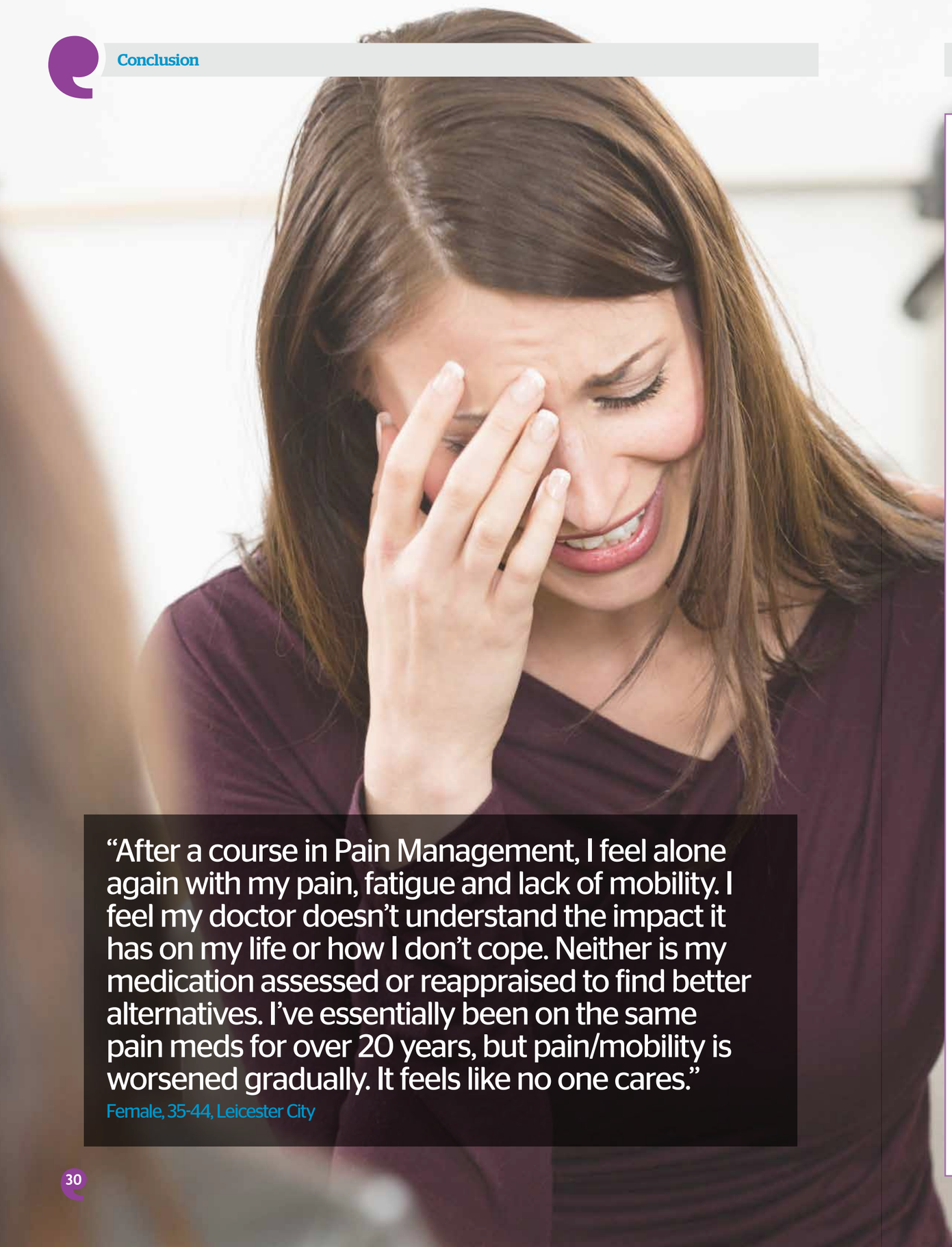
We asked respondents what their ethnic group was the majority of respondents from both LLR and the UK were English/Welsh/Scottish/ Nrthern Ireland/British.

LLR respondents

UK respondents

Where do you live?





"After a course in Pain Management, I feel alone again with my pain, fatigue and lack of mobility. I feel my doctor doesn't understand the impact it has on my life or how I don't cope. Neither is my medication assessed or reappraised to find better alternatives. I've essentially been on the same pain meds for over 20 years, but pain/mobility is worsened gradually. It feels like no one cares."

Female, 35-44, Leicester City

Useful Contacts

LOCAL SUPPORT GROUPS & ORGANISATIONS:

Fibromyalgia Friends Together Group

Ulverscroft Manor, Priory Lane, Markfield, Leicestershire
01530 244914
hello@shuttlewood-clarke.org
www.shuttlewood-clarke.org/about-us/

Leicestershire Fibromyalgia and ME/CFS Meet up group

Heathley Park, Groby Road, Leicester, LE3 9QH
07795 661 061
Leicestershire.fibro.meet.ups@gmail.com
www.leicestershirefibromeetups.weebly.com

Market Harborough ME/CFS and Fibromyalgia Support Group

harboromefm@gmail.com

Ashby Fibromyalgia and ME Group

Sally Cordy
ashbymegroup@googlemail.com

NATIONAL SUPPORT GROUPS & ORGANISATIONS:

Fibromyalgia Action UK

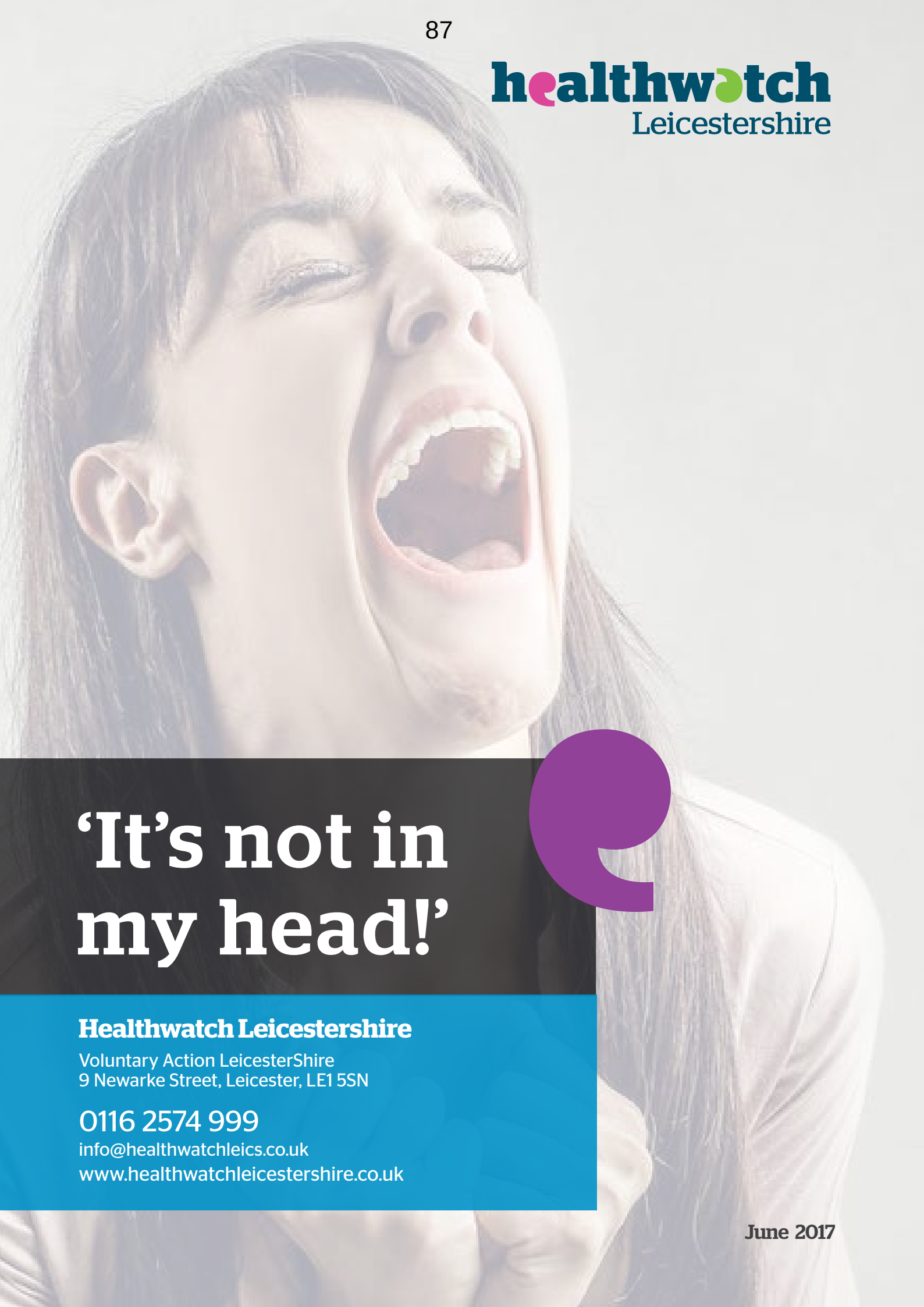
Unit S1, Troon Way Business Centre, Humberstone Lane, Leicester, LE4 9HA
National general helpline: 0300 999 333
UK Welfare benefits helpline: 0300 999 0055
www.fmauk.org/

Fibromyalgia Online Support Group – MD Action

www.mdjunction.com

Campaign to recognize Fibromyalgia as a disability in the UK
www.change.org/p/uk-parliament-make-fibromyalgia-a-disability #MAKETHEMHEAR @ FibroPetition

healthwatch
Leicestershire



‘It’s not in my head!’

Healthwatch Leicestershire
Voluntary Action LeicesterShire
9 Newarke Street, Leicester, LE1 5SN

0116 2574 999
info@healthwatchleics.co.uk
www.healthwatchleicestershire.co.uk

June 2017

This page is intentionally left blank

APPENDIX B

FOR IMMEDIATE RELEASE

Contact Person	Vandna Gohil
Company Name	Healthwatch Leicestershire
Telephone Number	0116 257 5016
Email Address	Vandna.g@valonline.org.uk
Web site address	www.healthwatchleicestershire.co.uk

Thursday, 11 May 2017

Fibromyalgia Awareness Day 12 May 2017

To help raise awareness for the long-term condition called fibromyalgia, Healthwatch Leicestershire is releasing key findings from their recent survey of local people who suffer from this debilitating disease.

In January 2016, Healthwatch Leicestershire were made aware in January that local services for people with fibromyalgia were not meeting their needs. They launched a survey the following September to find out why.

Fibromyalgia is a chronic and currently incurable condition that causes pain all over the body. It can often be difficult to diagnose as symptoms vary and fluctuate and can be mistakenly attributed to another condition.

What emerges clearly from the findings of Healthwatch Leicestershire's survey is that fibromyalgia impacts on both a person's day-to-day living and their long-term quality of life.

The survey received a total of 950 responses from people all over the UK with just under 300 people responding from Leicester, Leicestershire and Rutland (LLR).

Fibromyalgia is largely a diagnosis of exclusion; it can take time to carry out tests and receive the results to rule out other conditions.

- **89% of LLR respondents lived with the symptoms of fibromyalgia for 2 to 20 years before a proper diagnosis was made.**

- **47% of LLR respondents were diagnosed with the disease by a Rheumatologist.**

- **Over half of LLR respondents who were diagnosed by the NHS, were not offered any information on fibromyalgia.**

Whilst the findings regarding GP services appeared positive, the reported experiences of secondary services were less favourable. The majority of individuals from LLR reported that non-specialist hospital staff do not have much knowledge or understanding of fibromyalgia. Healthwatch received a

number of qualitative comments from individuals across LLR stating that, doctors and medical staff in hospitals do not see fibromyalgia as a “real thing” and their symptoms are dismissed.

> ***“Most hospital A&E doctors simply laugh at the suspected fibromyalgia- to them it's a made- up condition"***

Female, 16-24, Hinckley & Bosworth

> ***“A lot of health care staff don't understand and a lot of the times when I explain I have Fibromyalgia it gets brushed off as if it wasn't a real health issue.”***

Female, 25-34, North West Leicestershire

Healthwatch Leicestershire are due to publish all the findings in their report titled ‘It’s not in my head!’ at the end of May.

They will present the report to local stakeholders responsible for commissioning and providing local services. In the report, Healthwatch recommends five simple and practical steps that can be taken to make life easier for fibromyalgia sufferers and their families.

Healthwatch Leicestershire worked closely with The Shuttlewood Clarke Foundation and Fibromyalgia Friends Together Group throughout this project. Kathleen Wass, The Support Services Manager at Shuttlewood Clarke Foundation commented;

> ***“We’re pleased Healthwatch are raising awareness of Fibromyalgia and are working to improve the services for people living with the disease.***
>
> ***Following a meeting with a representative from the local NHS, facilitated by Healthwatch, we have produced our top 10 tips for living with fibromyalgia, which is to be circulated to 28,000 people including 12,000 health professionals; this will certainly help to raise awareness of Fibromyalgia.”***

To download a copy of the report ‘It’s not in my head!’ visit www.healthwatchleicestershire.co.uk on 30 May 2017.

- ENDS –

Notes to Editors

About Healthwatch Leicestershire
Healthwatch Leicestershire is an independent consumer champion for health and social care in Leicestershire. The organisation helps to shape and improve local health and social care in our community. Healthwatch Leicestershire is part of the Healthwatch England a national network, established by the Government to ensure local patients and users have a greater input to shaping and designing local services.

Agenda Item 12

Leicestershire County Council

HEALTH AND WELLBEING BOARD: 22 JUNE 2017

REPORT OF THE CHIEF EXECUTIVE

HEALTHWATCH LEICESTERSHIRE RECOMMISSIONING

Purpose of report

1. The purpose of this report is to provide an update on progress with recommissioning a Healthwatch service for Leicestershire.

Link to the local Health and Care System

2. The purpose of Healthwatch is to promote continuous improvement in local health and social care services and achieve improved outcomes for local people. The contract scope includes services that are related to all of the work-streams of Better Care Together and are delivered within the context of the local strategic framework including the Joint Health and Wellbeing Strategy, Better Care Fund Plan and the developing Sustainability and Transformation Plan.

Recommendation

3. It is recommended that the Health and Wellbeing Board note this report.

Policy Framework and Previous Decisions

4. A Review of Healthwatch Leicestershire and proposals for subsequent recommissioning were reported to the Health and Wellbeing Board on 17th November 2016 when it was resolved that the report be noted.

5. At its meeting on 13th December 2016 the County Council Cabinet considered the Review of Healthwatch Leicestershire and resolved:-
   a) That the outcome of the review to support the recommissioning of a Healthwatch service for Leicestershire be noted;
   b) That it be noted that the recommendations of the review report will be considered by Leicester and Rutland Healthwatch commissioners to explore opportunities for increased collaboration and joint working;
   c) That the Chief Executive be authorised to -
      I. Procure a new provider of the Healthwatch Leicestershire service which will be a freestanding social enterprise;
      II. Extend the current contract with Voluntary Action Leicestershire as necessary, potentially up until 31 March 2018, if this is required for market development and/or in order to align procurement timescales with other local Healthwatch services.

Background

6. The Healthwatch Leicestershire (HWL) contract is currently delivered by Voluntary Action Leicestershire. The contract has been extended to 31st March 2018 to align with the Healthwatch contracts of the City Council and Rutland Council so as to enable joint commissioning.

7. Key recommendations of the Review of Healthwatch Leicestershire included those that a future Healthwatch service provider should be independent (with control of its own finances, strategic direction and working practices) and that there should be effective collaboration and partnership working with other local Healthwatch organisations which could potentially be achieved through (amongst other things) joint commissioning.

Recommissioning proposals and consultation

8. To progress the recommissioning process, discussions have been held with Healthwatch commissioners at Leicester City Council and Rutland County Council and a joint public consultation is proposed with a view to potentially commissioning a joint service with the procurement process led by Leicester City Council.

9. A public consultation is proposed to be carried out between late July and early September 2017, after consideration of participation in the process by Rutland County Council Cabinet on 18th July. The consultation will seek views on the proposed service model and specification principles. The consultation questionnaire will be accessible via the web sites of Healthwatch and commissioning authorities. Market testing to get more detailed feedback from potential bidders is to be carried out beforehand.

10. Whilst a range of social enterprises will be eligible to bid for the tender the specification and evaluation method statement will reflect the importance that commissioning partners place on financial, strategic and organisational independence and an organisational focus on the delivery of Healthwatch services. It is proposed that the contract will be for 3 years with the option to extend for up to a further two years.

Resource Implications

11. Department of Health funding for Healthwatch and associated contracts (Independent NHS Advocacy Services (ICAS) and Deprivation of Liberty Safeguards (DOLS) in hospitals) is provided via the Local Reform and Communities Voices Grant (LRCVG). The potential pooled budget for a joint Leicester, Leicestershire and Rutland Healthwatch service is c£422,000pa.

Timetable for Decisions

12. It is proposed that the Healthwatch tender will be advertised in September 2017 and awarded in December 2017 with a start date of 1st April 2018.

Background papers

Report to the Health and Wellbeing Board on 15 September 2016
http://ow.ly/I01W30cydKk

Report to the Health and Wellbeing Board on 17 November 2016
http://politics.leics.gov.uk/documents/s124178/Healthwatch%20Review.pdf

Circulation under the Local Issues Alert Procedure

None

Officer to Contact

Kristy Ball, Communities Team Leader, Leicestershire County Council
Telephone: 0116 305 8099
Email: Kristy.ball@leics.gov.uk

Sarah Carter/Mike Thomson, Communities Business Partner/Policy Officer, Leicestershire County Council Tel: 0116 305 8098 /0116 305 7090
Email: sarah.carter@leics.gov.uk mike.thomson@leics.gov.uk

Relevant Impact Assessments

Equality and Human Rights Implications

13. Healthwatch Leicestershire is committed to reducing inequalities in health and social care outcomes and this priority will be reflected in future commissioning.

Partnership Working and associated issues

14. Partnership working is fundamental to the work of Healthwatch Leicestershire and will be central to the future service specification.

This page is intentionally left blank