APPENDIX A

Leicestershire Better Care Fund Plan – 2016/17

Local Authority	Leicestershire County Council
Clinical Commissioning Groups	West Leicestershire CCG
	East Leicestershire and Rutland CCG
Boundary Differences	East Leicestershire and Rutland CCG spans populations within both Leicestershire County Council and Rutland County Council. East Leicestershire and Rutland CCG have also co-produced the Rutland BCF plan with Rutland County
Date agreed at Health and Well-Being Board:	10th March 2016 19th April 2016
Date submitted:	Narrative Interim Submission March 21 Narrative Final Submission April 25
Minimum required value of BCF pooled budget: 2016/17	**£39,103,965**
2016/17	**£39,419,213**

Authorisation and signoff (to complete for April 25 Submission)

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

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

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

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

CONTENTS

SECTION 1: OUR VISION FOR HEALTH AND CARE INTEGRATION

1.1 Our Vision

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

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

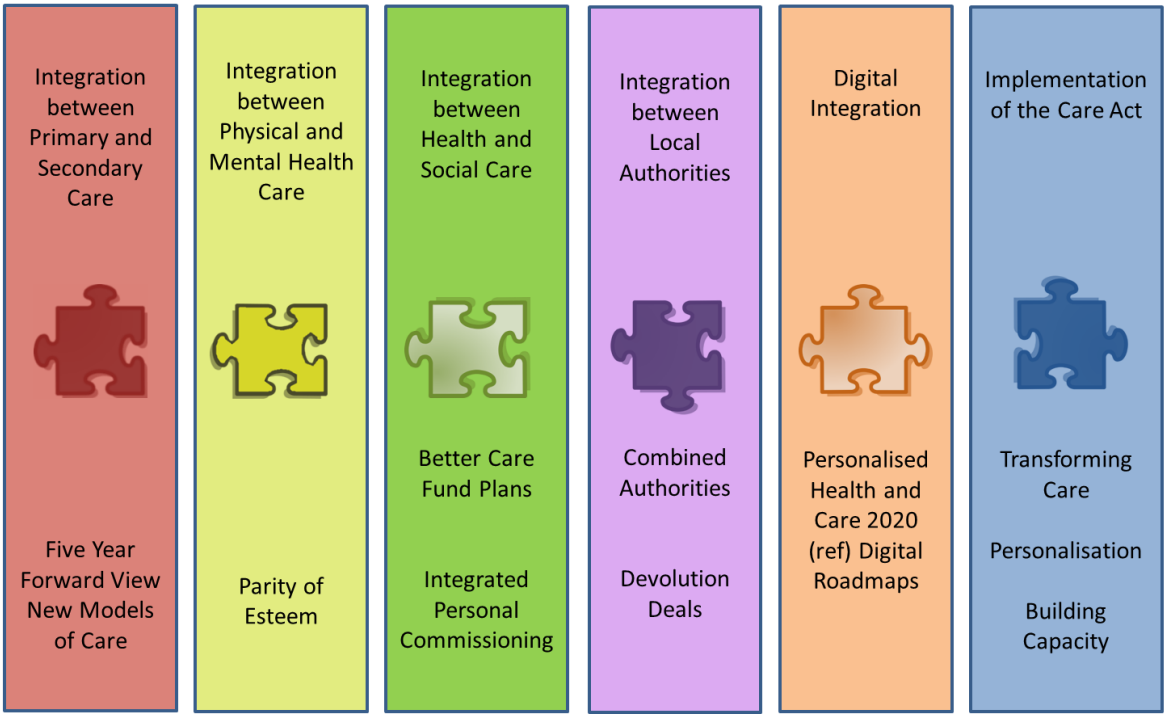
Our vision in 2014 was built upon four fundamental strategic drivers, two of which are local drivers, and two of which are national, all of which still continue to be fundamental to our integration plans from 2016/17 onwards.

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

1.2 The Impact of Medium Term Policy and Planning Developments

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

How National Policy Developments are promoting and driving integration



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

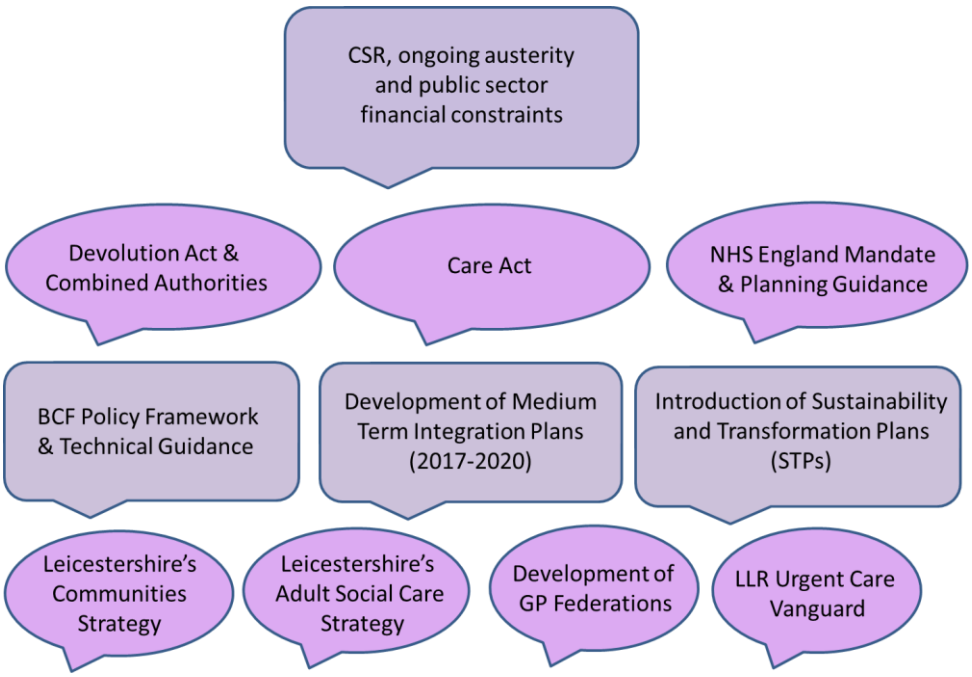
- New models of care
- New ways of delivering integrated care
- New approaches to integrated commissioning at both personal and population levels
- New approaches and flexibilities for pooled budgets, contracting and tariffs
- New opportunities and flexibilities for devolution
- New digital technologies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

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

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

In order to refresh our BCF plan for 2016/17 we have reflected on the impact of the policy pillars on our local vision and approach, our progress to date and the milestones we still need to achieve. We have also considered how related local developments connect with our BCF plan and how our BCF plan contributes to system level delivery within Leicester, Leicestershire and Rutland (LLR).

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



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

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

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

- National submissions related to combined authorities and devolution deals.

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

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

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

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

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

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

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

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

Urgent Care

- The demands on the acute care system are the local health and care economy's greatest risk to sustainability. Total emergency admissions in Leicestershire have risen again over the past 12 months. In 2014/15 there were 60,447 non-elective admissions for Leicestershire residents, and in 2015/16 the forecast out turn is 62,432. Analysis by the LLR Urgent Care Board shows that a proportion of the growth in 2015/16 has occurred in the 0-10 and 20-40 age groups. Further analysis is underway to establish the detailed reasons behind the increase.
- In the meantime it can be demonstrated that three of the four emergency admissions avoidance schemes in Leicestershire (GP seven day services pilots were the fourth) have delivered measurable impact in 2015/16 in terms of admissions avoidance in the BCF target cohort (older people).
- This is evidenced in falls non conveyance figures for example, data from Care and Healthtrak, clinical audit and independent academic evaluation outputs which support/triangulate these findings.
- In terms of hospital admissions avoidance, the 2016/17 BCF plan includes further improvements to the models of care and pathway redesign for the four existing schemes implemented in 2015/16, based on our evaluation findings.
- A further admissions avoidance scheme is being implemented in 2016/17 targeted to adults with cardio/respiratory conditions who attend at the Glenfield Hospital site, which will deliver a consistent ambulatory pathway to prevent a large number of short stay admissions.
- Sustaining our good DTOC performance achieved in 2015/16 relies on existing interventions continuing to maintain their impact, and any additional actions to be prioritised locally from the eight high impact changes self-assessment tool recently published by the Department of Health.
- A more rigorous implementation plan for falls prevention is being implemented in 2016/17 as part of a new LLR wide falls strategy. The Leicestershire BCF will continue to be an important part of the delivery plan for this strategy.
- Developing an integrated approach to housing solutions by mobilising a range of housing support (including DFGs) to deliver measurable health and wellbeing benefits will be a key feature of our workplan in 2016/16, through the development of the Lightbulb Service business case in conjunction with District Councils.

Financial Constraints

- Financial allocations and the scale of financial pressure and savings required across the partnership impact on the ability of partners to commit to new initiatives, unless funds are reallocated between existing commitments, schemes are decommissioned or transformation funds can be accessed, especially for delivering ROI within a one to three year horizon.
- Despite this, partners must maintain delivery across the BCF plan metrics and national conditions as well as deliver a medium term view of transformation for years three to five. To do this even more rigour to benefits realisation, with more sophisticated, integrated and co-produced methodologies for predictive modelling and measuring impact will be required and greater alignment will be needed between the local BCF plans, the medium term integration plan (to 2020) and the LLR-wide five year plan/STP.
- The 2016/17 BCF plan will include a focus on developing a commissioning framework for integrated commissioning across LA and NHS partners – more details of this can be found on page 21. This will have emphasis on seeking further savings and value for money for joint commissioning, as well as assuring quality and driving further innovation in models of integrated provision.

Data Integration

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

1.5 Our Ambition for Integration for 2016/17 and Beyond

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

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

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

1.6 Aims of the Leicestershire BCF Plan 2016/17

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

The revised aims are as follows:

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

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

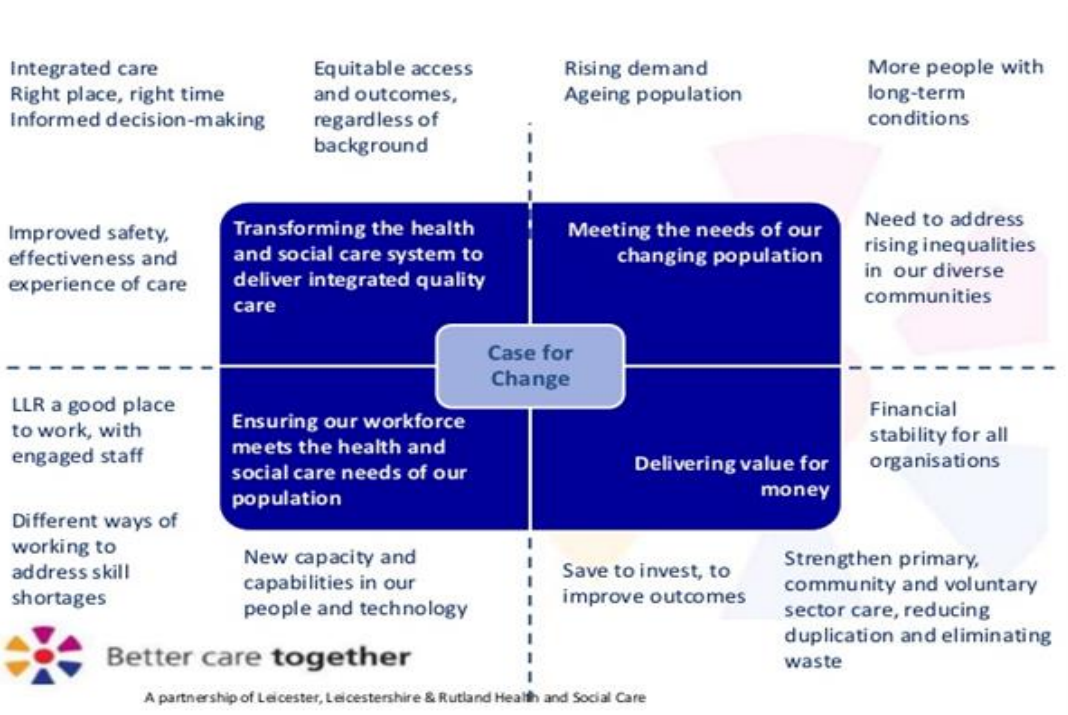
SECTION 2: LOCAL CASE FOR CHANGE

2.1 Summary Overview of Case for Change Analysis

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

Theme 3 of the BCF (Integrated Urgent Response) contains seven schemes targeted to reducing emergency admissions by 2.49% in 2016/7. These include a community based assessment service for frail older people, case management for the over 75s including via seven day services, a new falls service to avoid unnecessary admissions for older people, extends the seven day services offer within primary care, and provides an improved ambulatory pathway for people with respiratory and cardiac problems.

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

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

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

Section 5.9 and 5.10 of this document provide:

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

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

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

3.1 Progress Achieved by the 2015/16 BCF Plan

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

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

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

3.2 Progress by Theme

Implementation of the integration programme in Leicestershire continues at pace.

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

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

3.3 Progress with BCF Enablers in 2015

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

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

A systematic approach has been undertaken.

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

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

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

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

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

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

In parallel with the above:-

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

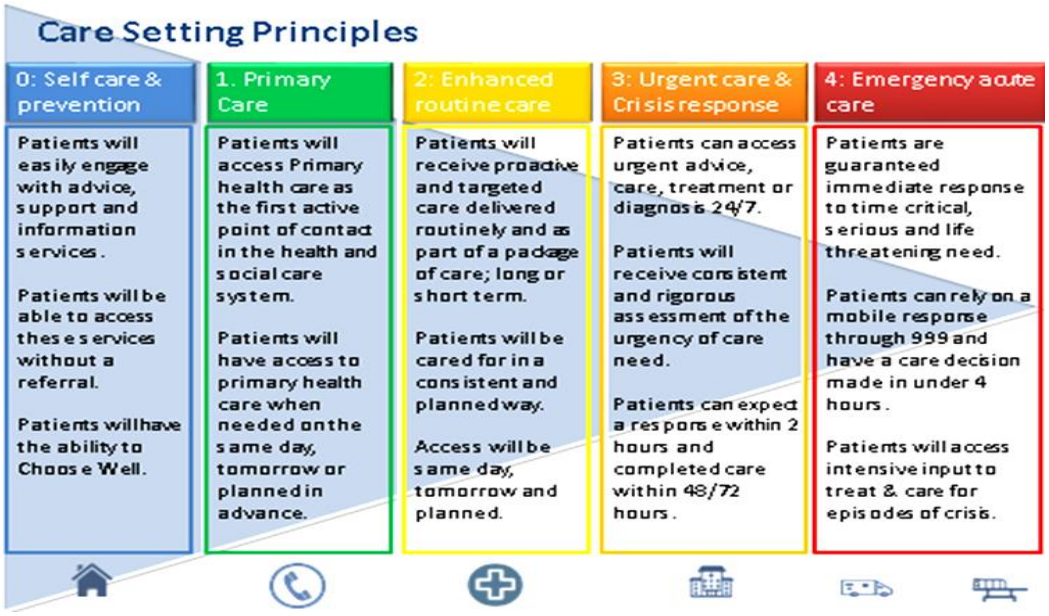
SECTION 4: OUR PLANS FOR 2016/17

4.1 Our Model for Integrated Care in Localities

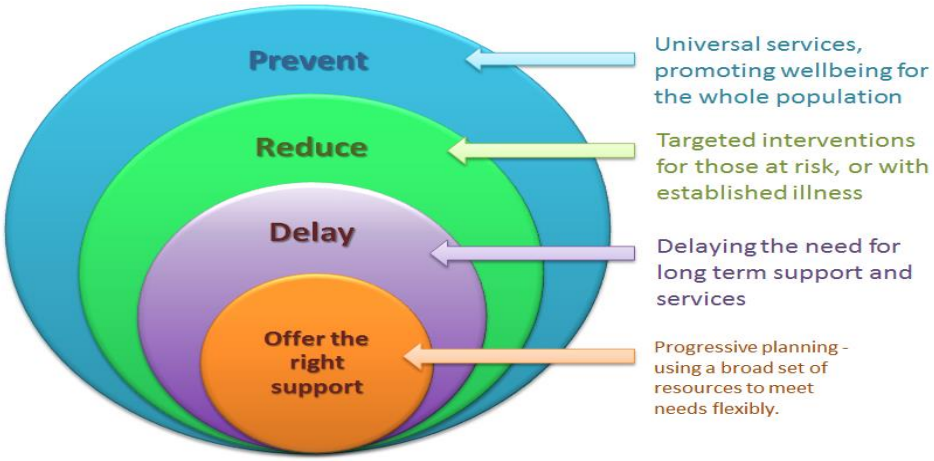
New models of integrated care are being designed via co-production and collaboration in Leicestershire, using some important design principles. In summary these are:

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

Keogh Care Setting Principles Reference Diagram



Leicestershire Adult Social Care Strategy Reference Diagram



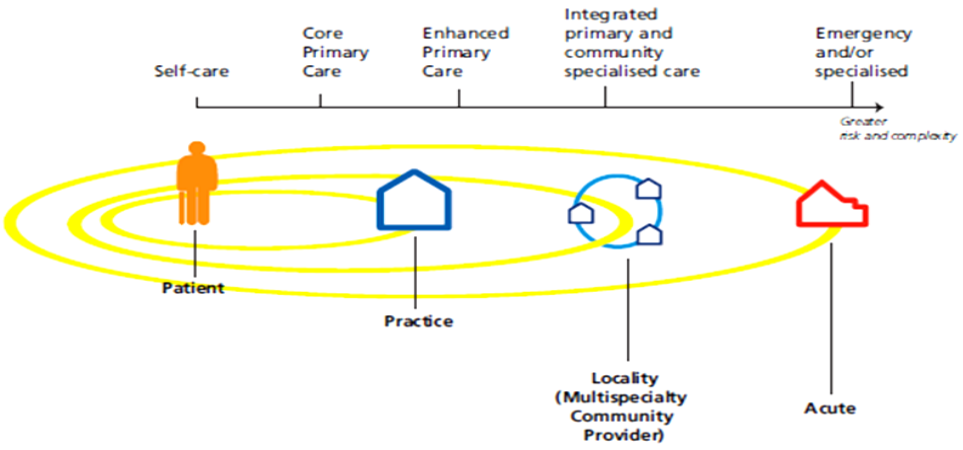
By applying these principles we are designing a new model of integrated care for Leicestershire's localities. During 2015 we have started to put in place the foundations of this model, and during 2016 we will be consolidating it.

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

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

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

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



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

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

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

4.2 Our Framework and Workplan for Integrated Commissioning

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

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

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

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

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

SECTION 5: DELIVERY OF THE BETTER CARE FUND NATIONAL CONDITIONS

5.1 Maintaining Provision of Social Care Services

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

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

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

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

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

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

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

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

The Council's 2016/17 MTFS shows an increased financial allocation for growth totalling £23m in Adult Social Care for the next four years with £5.6m towards meeting increased demographic pressures in 2016/17.

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

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

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

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

There are also two new areas of investment which have been included for 2016/17. The result of this is an overall uplift in the level of adult social protection within the 2016/17 BCF plan, totalling £17,025,776, representing an increase of £970,688.

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

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

5.1.2 Progress on Implementation of the Care Act

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

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

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

5.1.3 Leicestershire's Care Act Allocation

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

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

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

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

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

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

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

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

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

	In 2014/15 £	From 1 April 2015 to 30 September 2015 £
Total amount your council spent on direct payments to carers	297,067	119,185

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

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

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

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

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

5.2 Seven Day Services across Health and Social Care

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

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

- Reduced admissions
- Reduced variation in:
  - Length of stay by day of week
  - Mortality by day of week
  - Re-admittance by day of week (variation 1.8% between highest and lowest number across 7 days from Q2 2016)
  - Access to diagnostics (achievement of clinical standards 2, 5, 6 & 8)

- Reduced delays in clinical decision making
- Reduction in decompensation especially for the elderly
- Reduced risk especially for longer lengths of stay e.g.; falls, HAI rate.

5.2.1 Local Progress

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

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

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

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

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

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

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

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

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

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

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

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

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

Significant progress has already been made across Medicine, Surgery, Women's and Children's achieving CS02, CSO5 and CS06 – however the main challenge will be achievement of CS08. This will be addressed by completing a gap analysis to determine what can be achieved within existing resources e.g. by redesign, and what will need additional investment.

Other key actions for UHL include:

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

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

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

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

5.3.1 NHS Number as the Consistent Identifier

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

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

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

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

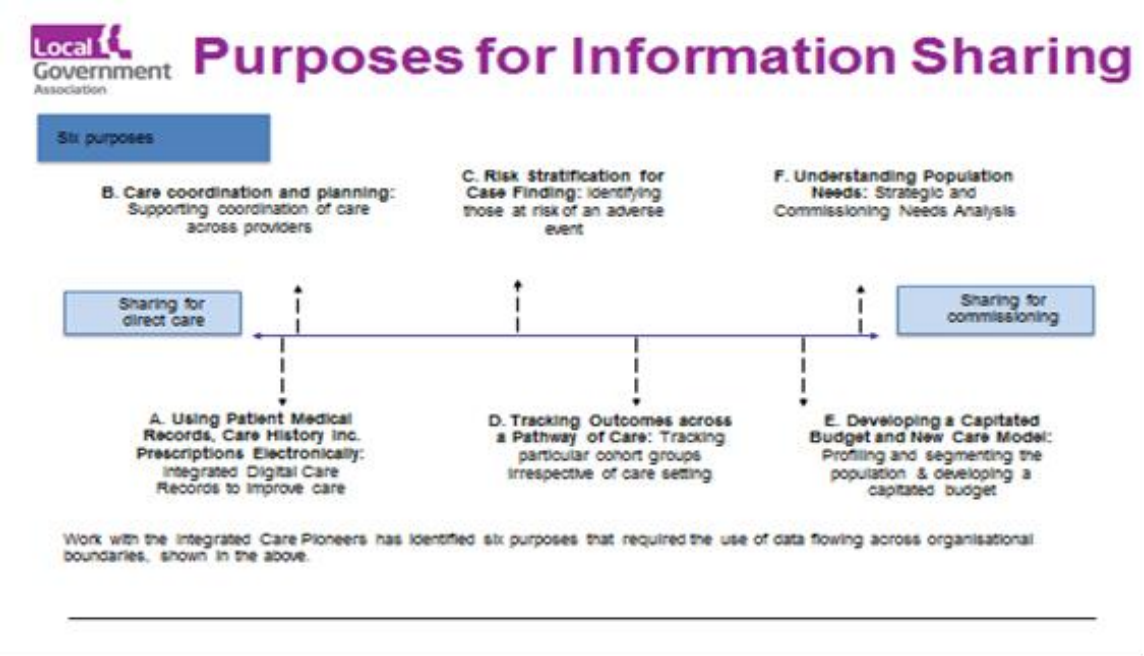
Some scoping discussions are also underway with other agencies including fire and police in terms of the applicability of the Care and Healthtrak tool when working collectively with vulnerable people.

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

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

5.3.2 Data Sharing

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



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

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

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

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

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

5.3.3 Implementation of Care and Healthtrak

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

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

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

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

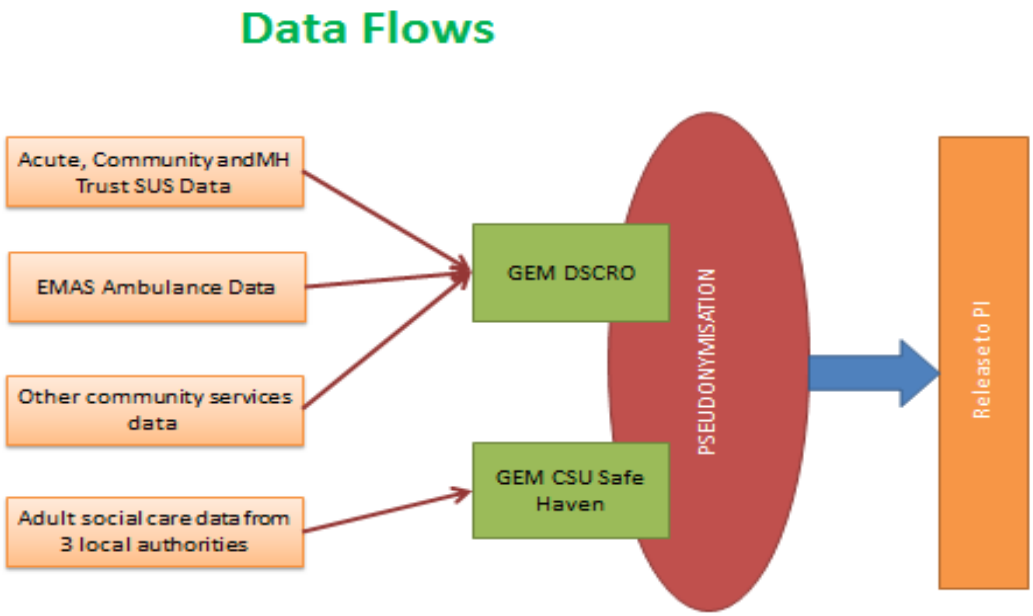
Dashboards and bespoke analysis are now being produced to analyse trends in how patients are using the health and care system and the impact of changes that are being made, such as the introduction of new elements of the urgent care system.

5.3.4 Information Governance and the Care and Healthtrak Tool

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

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

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



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

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

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

5.3.6 Integrated data for Care Delivery

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

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

Key focus areas for 2016/17 are:

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

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

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

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

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

5.3.7 LLR Integrated Points of Access Project

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

5.3.8 Assurance on Interoperability /APIs

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

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

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

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

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

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

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

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

5.3.9 Assurance on Information Governance

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

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

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

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

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

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

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

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

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

5.3.10 Engagement with the public regarding data sharing

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

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

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

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

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

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

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

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

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

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

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

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

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

5.4 Accountable Professional for Case Management

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

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

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

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

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

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

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

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

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

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

include care home staff trained in reablement and that have supported/managed the patient)

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

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

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

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

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

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

- Side by Side – a new initiative that allows people with dementia to choose a volunteer who will accompany them on out and about activities/hobbies

- Memory Support Service: The service will provide emotional support, information and guidance on living well with dementia and enable a better understanding of the condition and support the development of self-management skills. The service also offers home visits for one to one support and telephone support.
- Singing for the Brain includes people with dementia, carers and family members.
- An information programme for South Asian families. This programme is for carers at the point of diagnosis
- Carers Information and Support Programme (CRiSP) aimed at family members and friends who support a person with a recent diagnosis of dementia

Supporting information can be found in Appendix 9 and 10.

5.5 Agreement on the Consequential Impact of the Changes Providers

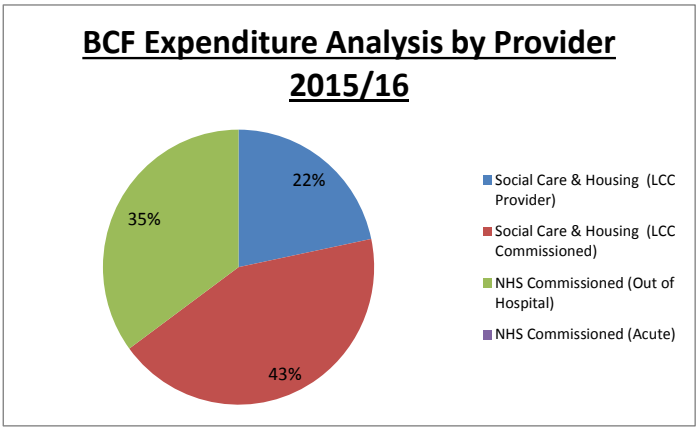
- Approval of the BCF plan by all partners, including agreeing the impact on providers and how BCF schemes are contractualised, is an essential part of the governance associated with the Leicestershire Integration Programme. In Section 8 of this document there is a summary of all the engagement undertaken in the refresh and approval process for the Leicestershire BCF 2016/17. It should be noted however that co-production with providers and with Healthwatch is a key feature of how we deliver our integration programme on a daily, weekly and monthly basis, as demonstrated in the governance narrative in Section 7 of this document.
- Triangulation of the BCF metrics and trajectories has been an important element of our work as partners between January and April 2016. Due to the delays in the BCF technical guidance and the impact this had on BCF submission dates it is recognised that CCG operating plan dates and BCF submission dates are now not aligned nationally, though this had been the original intention. To mitigate this we are working closely with CCGs to ensure iterations of activity plans are consistent and keep pace with adjustments being made between respective submissions.
- The impact of the BCF emergency admissions schemes trajectories on capacity planning and contract negotiations with our local acute provider have been shared transparently and feedback has been sought specifically from the UHL Executive/Clinical management team on the assumptions being made about the schemes for 2016/17. The impact of the trajectory for emergency admissions for the BCF related activities is that 1,517 admissions are to be avoided by the BCF schemes in 2016/17 which represents a 2.49% reduction.
- Evaluation and lessons learned from implementing the initial four emergency admissions avoidance schemes in 2015 have been shared proactively with NHS providers including ambulance, acute and community trusts, and discussed thoroughly as part of the refresh process undertaken at our Integration Operational Group and Integration Executive.
- Risks to delivery of the BCF including the risks to delivery of the emergency admissions trajectory within the urgent care system have been reflected in the Integration Risk Register.
- Impact on other providers (community services, social care, housing) have also been quantified in terms of investment levels, specification and delivery requirements including refreshing KPIs and trajectories where applicable. The governance at project level and via the Integration Operational Group is designed to ensure the lead commissioner in each case has enacted the contractual requirements.
- In terms of the impact of DFG allocations the BCF plan confirms the commitment to passport a £1.7m DFG allocation to Districts Councils for 2016/17, same as the arrangement in 2015/16. The additional £1.3m DFG allocation which replaced the social care capital grant is being retained within the BCF pooled budget. This is because it is already committed on a range of essential services that benefit all partners and the communities they serve, including elements of housing related support (e.g. for example assistive technology and the housing discharge support schemes at the Bradgate Unit and LRI). The position will be reviewed following consideration of the Lightbulb Business Case with District Councils later in 2016.

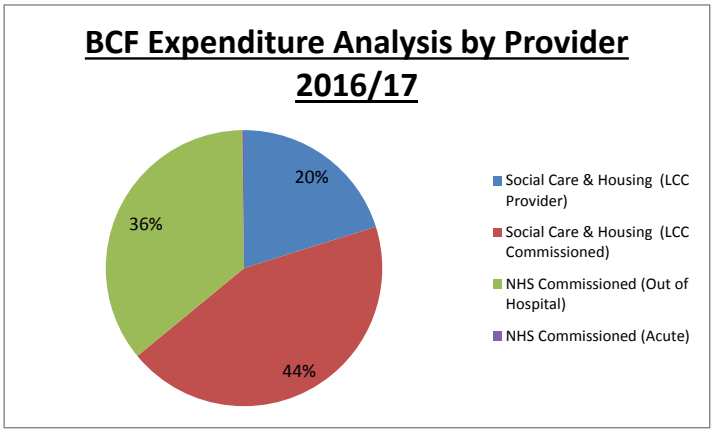
5.6 Agreement to Invest in NHS Commissioned Out of Hospital Services

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

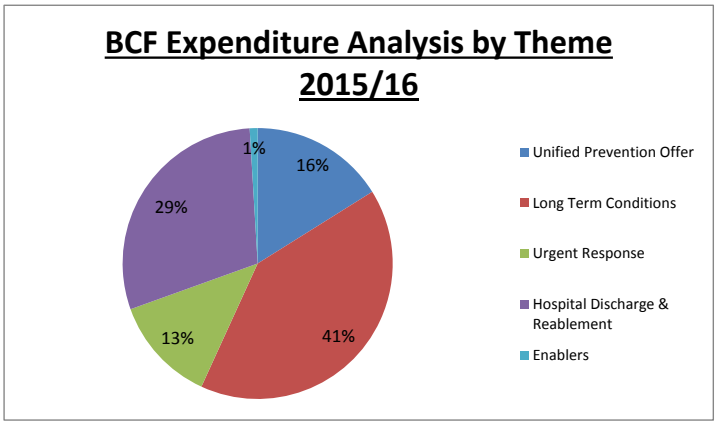
The proportion of the plan invested in these services is illustrated in the following pie chart with a comparison chart provided for 2015/16:

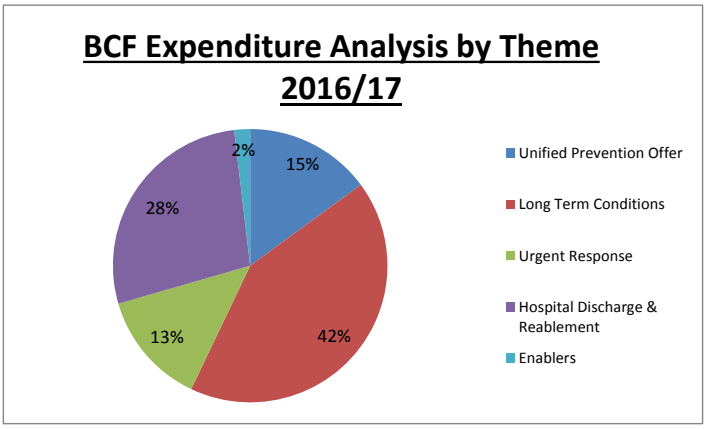
Analysis of Expenditure by Provider	2015/16 £'000	2016/17 £'000
Social Care & Housing (LCC Provider)	8,438	7,942
Social Care & Housing (LCC Commissioned)	16,790	17,298
NHS Commissioned (Out of Hospital)	13,638	14,102
NHS Commissioned (Acute)	0	78
	38,866	**39,419**





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





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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Local Footprint:

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

LLR Footprint

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

Regional and National Reporting

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

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

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

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

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

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

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

- The early benefits of the new community equipment service (and the operational improvements and demand management processes associated with it) have been reviewed by the Integration Executive.

5.7.1 Discharge Developments for 2016/17

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

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

- On 5th May 2016, an LLR Discharge Summit is being held to consider further opportunities to improve local performance.

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

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

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

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

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

5.7.2 DTOC Target for 2016/17 and Risk Pool Decisions

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

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

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

5.7.3 Assurance on delivery in 2016/17

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

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

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

Appendices below includes supporting information as follows:

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

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

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

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

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

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

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

National Metric (4)	Definition	Trajectory of improvement
 **Non-Elective Admissions (General & Acute)**	This is a nationally defined metric measuring the reduction in non-elective admissions which can be influenced by effective collaboration across the health and care system. Total non-elective admissions (general and acute) underpin the payment for performance element of the Better Care Fund.	In 2014/15 there were 58,479 non-elective admissions for Leicestershire residents, In 2015/16 it is likely that there will be 59,957. The proposed target for 2016/17 is 726.38 per 100,000 per month, based on a 2.49% reduction on the probable number of non-elective admissions for patients registered with GP practices in Leicestershire for 2015/16 (allowing for population growth). This equates to no more than 58,836 admissions in 2016/17. This assumption has been aligned with final CCG operational plan targets. All existing admission avoidance schemes have been subject to evaluation in 2015/16, and the results reflected in the development of a trajectory of 1,517 avoided admissions from these schemes in 2016/17.

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

	to the total number of responses to the question.	

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

5.9 Scheme Level Overview with Mapping

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

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

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

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

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

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

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

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

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

5.10 What will our Health and Care System look like as a result of the changes planned in 2016/17?

Long Term Conditions, Frailty and Dementia

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

- Via primary care, people with long term conditions will have their risks assessed and their care plans coordinated by the integrated health and social care team in their locality. They will benefit from:
    - electronic care plans
    - a designated accountable professional for their care
    - a new prevention offer which will target social prescribing interventions such as housing support, carer support, assistive technology and local area coordinators to support vulnerable people and help them remain as independent as possible in the community for as long as possible..

- People with heart failure and atrial fibrillation will benefit from improvements to case management to reduce premature mortality and the risk of stroke.

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

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

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

Integrated Urgent Care

- LLR's urgent care system will be redesigned in line with the models of care proposed by the Vanguard project , with the BCF focused particularly on
    - improving and streamlining points of access into the health and care system on a 24/7 basis
    - delivering a number of the alternative pathways to avoid hospital admission

- 1,500 emergency admissions will be avoided in 2016/17 through improved urgent care pathways funded by the Leicestershire BCF, which include integrating pathways between the ambulance service, NHS Trusts, locality teams and GP practice across on a 24/7 basis.

Hospital Discharge and Reablement

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

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

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

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

Unified Prevention and Social Prescribing

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

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

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

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

Other Benefits

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

- By reconfiguring services and investing in community alternatives, improving delayed discharges, reducing emergency admissions, and creating enhanced locality based services, we can confidently reduce the overall number of inpatient beds in Leicestershire, at key intervals in line with the 5 year plan.

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

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

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

6.1 Financial Context

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

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

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

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

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

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

- That partners will continue to pool the required minimum BCF level of funding in 2016/17 which is £39.1m.
- Additional contributions above the required minimum BCF level of funding total £0.3m.
- That a risk pool of £1m (for emergency admissions performance risk) will be applied to the fund in 2016/17.
- That a contingency reserve of £1m will be applied to the fund in 2016/17.
- That the investment in adult social care protection within the fund will be increased from £16m to £17m.
- That £1.7m of the 2016/17 DFG allocation will be passported directly to Districts for DFG delivery.

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

6.2 Confirmation of the Source of Funds for the Refreshed BCF Plan

Better Care Fund Funding Comparison 2015/16 to 2016/17				
Funding Source	2015/16 £	2016/17 £	Movement £	Movement %
Minimum Contributions				
East Leicestershire & Rutland CCG*	15,187,000	15,559,591	372,591	2.5%
West Leicestershire CCG*	20,073,000	20,476,926	403,926	2.0%
Social Care Capital Grants	1,344,000	0	-1,344,000	-100.0%
Disabled Facilities Grants	1,739,000	3,067,448	1,328,448	76.4%
	38,343,000	39,103,965	760,965	2.0%
Additional Contributions				
Additional Contribution (Reserve funding)	504,800	128,248	-376,552	
Additional LA Contribution - Programme Management	0	50,000	50,000	
Additional Reserve Contribution - Integrating Points of Access	0	137,000	137,000	
	504,800	315,248	-189,552	
Total BCF Funding	**38,847,800**	**39,419,213**	**571,413**	
* Inclusive of Care Act Funding (including non-recurrent element in 2015/16)	1,893,000	1,388,000	-505,000	-26.7%
Health and Social Care Integration Reserve at start of the financial year	5,758,000	4,374,000	-1,384,000	-24.0%

6.3 Our Approach to Risk Sharing

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

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

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

In order to deliver a 2.49% reduction in emergency admissions in 2016/17, the BCF plan is required to deliver 1,517 avoided admissions.

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

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

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

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

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

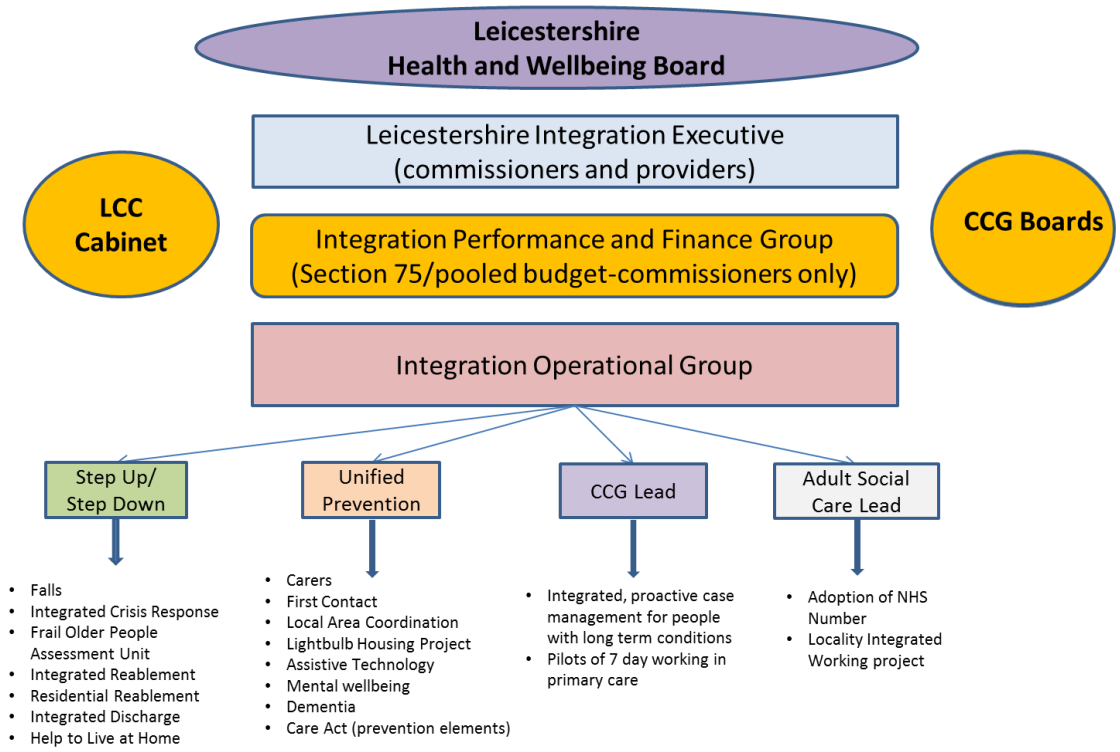
During the prioritisation process for the 2016/17 BCF plan a number of new schemes have been agreed as the next joint priorities for investment from the BCF, subject to business case assessment/approval. If monies are released from the risk pool into the BCF plan in year these items will be ready for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

SECTION 7: GOVERNANCE OF THE LEICESTERSHIRE BCF PLAN

7.1 Summary of Governance Arrangements

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

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



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

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

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

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

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

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

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

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

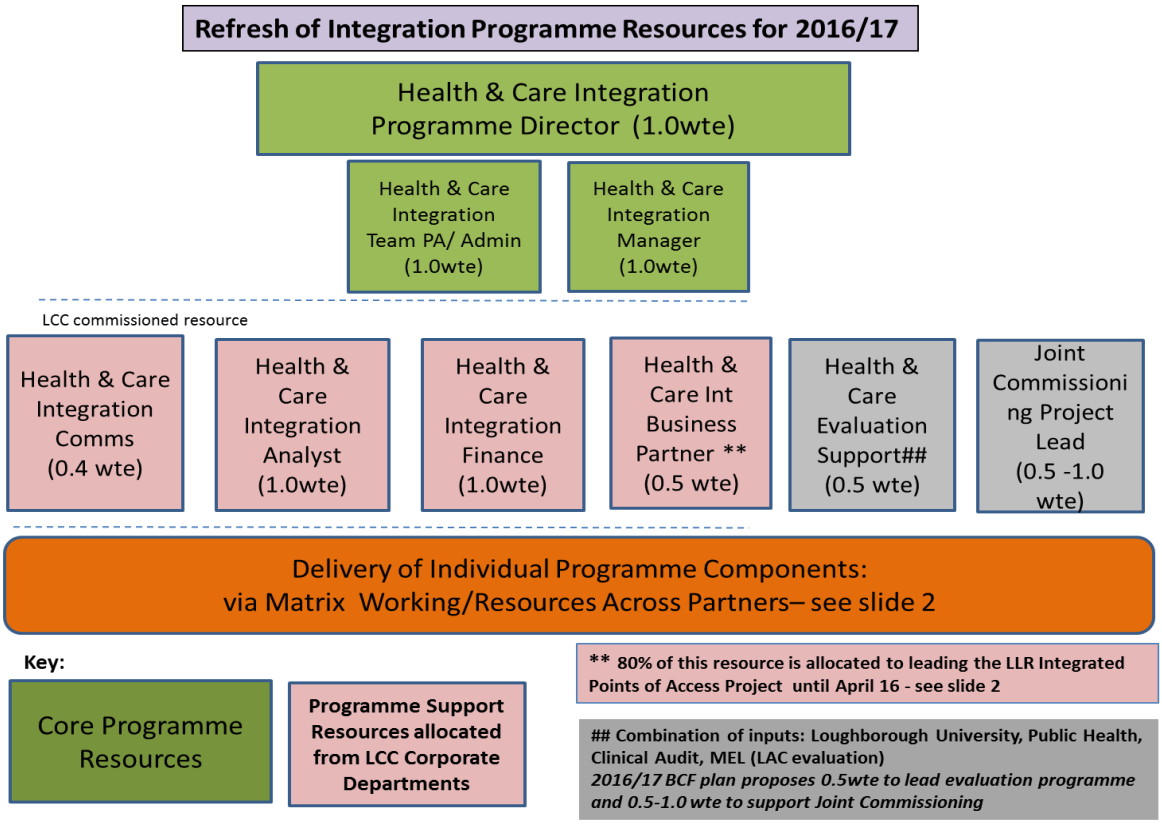
At their meeting 10th March 2016 Board meeting, the Board received further assurance on the progress of the BCF plans and associated submissions. The Board approved that remaining work required be completed by the Integration Executive http://politics.leics.gov.uk/ieListDocuments.aspx?MId=4631 (item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

At their meeting on 5th May 2016 the Board will receive the final BCF submission for assurance.

7.3 Integration Programme Resources and Programme Management

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

7.3.1 Core Programme Team



7.3.2 Matrix Management for Programme Delivery across the Partnership

Unified Prevention Delivery

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

Falls Project Manager 1.0 wte - to Oct 2016

Unified Prevention Design & Performance Specialist 1.0 wte

Lightbulb:

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

Integrated Urgent Care Delivery

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

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

0.8 wte project lead for LLR Integrated Points of Access

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

Hospital Discharge & Reablement Delivery

Matrix working with Help to Live at Home Programme

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

Matrix working with

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

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

Long Term Conditions Delivery

Matrix working with BCT LTC Lead

Matrix working with LTC delivery resources in each CCG

Matrix working with integrated locality teams

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

Enablers and Emerging Priorities

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

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

Personal budgets –1.0 wte leading (EL&RCCG)

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

Joint commissioning framework

Joint commissioning for nursing and residential homes – scoping in progress

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

7.4 Measuring the Impact of the Leicestershire Better Care Fund Plan

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

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

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

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

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

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

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

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

7.5 Programme Milestones for 2016/17

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

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

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

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

7.6 Programme Risk Register

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

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

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

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

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

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

7.7. Equality and Human Rights Impact Assessment

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

SECTION 8: SUMMARY OF ENGAGEMENT UNDERTAKEN

8.1 Refresh Engagement Activities

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

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

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

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

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

8.2 HTLAH Provider Workshops

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

	providers in coordinating support for individuals from community resources and assistive technology. These events provided an opportunity to appraise the Market of the delivery model under development, compared and contrasted to the current model, and supported the development of the new model utilising the knowledge and expertise of the Market. Topics discussed were: • Reablement in practice; Assistive Technology; Social Capital and developing community resources. • Outcomes commissioning: the current market experience; delivering to outcomes, putting the service user/patient at the heart of support planning
30th July/5th Aug 2015	Two market engagement events were undertaken in July and August 2015, providing an opportunity to explore with both existing and prospective Service Providers the benefits and challenges of the chosen strategic options considered in the development of this business case. These engagement events included live voting to ascertain the market view of chosen strategic options. This was supplemented by an anonymised survey of indicative bidding intentions against the 18 draft lots across 7 localities. This was made available to all delegates with the aim of: • Helping the programme in understanding if lots are commercially viable and likely to attract bids in the procurement phase • Contributing to informing the development of the provider delivery model as part of the Full Business Case • Helping to develop the approach to support market readiness in respect of Lead Provider, Sub-contracting and Consortia arrangements
22nd/24th Sep 2015	Two market engagement events were undertaken in September 2015 facilitate informal provider networking and information sharing opportunities.
10th/11th Dec 2015	Two events held to give providers an update on HTLAH Procurement process and progress; Continuing Healthcare (CHC) requirements; Introduction to the Abridged Joint Service Specification and Service elements and rates. The sessions were facilitated with: • Table top discussions • 'Ask the Audience' Voting
11th Feb 2016	A bidders day event was held to launch the PQQ

8.3 Evaluation Study Engagement Workshops

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

Date	Aim	Scheme
11th Sept 15	Stakeholder workshops – to review the computer simulation of the patient pathway for each intervention; test scenario's about future improvements to the scheme; and make recommendations of future actions to the Integration Programme.	Integrated Crisis Response Service – Night Nursing Service
11th Sept 15		Older Persons Unit
29th Oct 15		7 Day Services in Primary Care
29th Oct 15		Rapid Response Falls Service
10th Nov 15	User workshops – to review a computer simulation model of the service; to engage patients with the process of avoiding emergency admissions; and to explore ways of measuring patient satisfaction.	Integrated Crisis Response Service – Night Nursing Service
10th Nov 15		Older Persons Unit
2nd Feb 16		Rapid Response Falls Service

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

8.4 Microsite Development

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

APPENDICES

Appendix 1 Raising our Ambitions for Integration

Appendix 2 Public Health Summary Needs Analysis

Appendix 3 Vanguard Value Proposition and Work Plan

Appendix 4 Population Level Risk Stratification

Appendix 5 Operations Group RAG rating results

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

Appendix 7 IM&T Programme Plan

Appendix 8 BCT Clinical Workstream IM&T Requirements

Appendix 9 EL&RCCG Accountable Professional supporting information

Appendix 10 WLCCG Accountable Professional supporting information

Appendix 11 Emergency Admissions P4P Metric 2015 Scheme Level Breakdown

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

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

Appendix 14 LLP RAP from Urgent Care Board

Appendix 15 DTOC Monthly Reporting April 2015 – January 2016

Appendix 16 Integration Executive Programme Performance Dashboard

Appendix 17 Risk Register