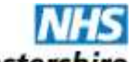
Better Care Fund

Progress Update November 2016

NHS
East Leicestershire and Rutland Clinical Commissioning Group



West Leicestershire Clinical Commissioning Group

University Hospitals of Leicester

NHS Trust

Leicester Partnership

NHS Trust

East Midlands Ambulance Service

NHS Trust

Hinckley & Bosworth Borough Council

Some history…

- Following the introduction of BCF policy in late 2013, the Leicestershire plan was developed during 2014, with support from all partners in the health and care system.

- The plan was then subject to a regional and national assurance process during 2014. Process led by NHSE and LGA

- A refreshed BCF plan was developed for 2016/17 which built on the progress made during 2015/16.

- The BCF plan for 2016/17 was approved by NHSE in July 2016.

Reminder of BCF National Requirements

BCF National Conditions 2016/17

- BCF plans to be jointly agreed
- Protection of adult social care
  - Proportion of the plan must be targeted to maintain provision of social care services
- Implementation of 7 day services – in particular to:
  - Prevent admissions/support discharges
  - Support delivery of the national clinical standards for 7 day working
- Agreement to invest in NHS commissioned out of hospital services
- Agreement on local action plan to reduce delayed transfers of care

BCF National Conditions (2)

- Better data sharing between health and social care
  - Based on the NHS number as the identifier
- Joint assessment and accountable lead professional for high risk populations
  - Risk stratification of populations (via GP practice)
  - Integrated coordinated care
  - Designated accountable professional for complex case management
- Agreement to acute sector impact of BCF plan
  - Agreement on the financial/contractual implications of the reductions in emergency admissions to be achieved via the BCF
- BCF Governance via a Section 75 agreement

BCF Metrics – 5 National, 1 local

Reduce the total number of emergency admissions in 2016/17 by 2.49% (e.g. reduce by 1,517 admissions)

Increase the number of service users still at home 91 days after discharge

Reduce the number of emergency admissions due to falls (Local metric)

Reduce the number of delayed transfers of care

Reduce the number of permanent admissions to residential and nursing homes

Improve patient/service user experience

Our vision for Health and Care Integration in Leicestershire

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

Leicestershire's BCF Plan Aims: 2016/17

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

Leicestershire BCF's Components 2016/17

Theme 1:
Unified Prevention Offer

Local Area Coordination
Lightbulb Housing Support
Assistive Technology
Carers Support Service
Falls Pathway

Theme 2:
Integrated, Proactive Care for Long Term Conditions

Risk Stratification
Integrated Case Management/Care Plans
Virtual Wards

Theme 3:
Integrated Urgent Response

24/7 Crisis Response
Falls non conveyance
Older Persons Unit
Acute Visiting Service
Ambulatory Care on CDU

Theme 4:
Hospital Discharge and Reablement

Housing Discharge Enablers
Residential Reablement
Care Packages Review Team
Help to Live at Home

Enablers

First Contact Plus

Adoption of NHS number

Data Sharing using Care & Health Trak

Locality Integrated Teams

Health and social care protocol

Integrated Points of Access

BCF Governance Chart 2016/17

Leicestershire Health and Wellbeing Board

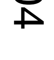
Leicestershire Integration Executive (commissioners and providers)

LCC Cabinet

Integration Performance and Finance Group (Section 75/pooled budget-commissioners only)

CCG Boards

Integration Operational Group (commissioners and providers)



BCT Workstreams

Frail Older People:
- LLR Falls Pathway

Urgent Care/Hospital Discharge :
- Older Persons Unit
- Glenfield CDU
- Integrated Reablement
- Integrated Discharge

Unified Prevention

- Carers Support
- First Contact Plus
- Local Area Coordination
- Lightbulb Housing Project
- Assistive Technology
- Dementia Support
- Falls Prevention
- Care Act (prevention elements)

CCG Lead

- Integrated, proactive case management for people with long term conditions
- 7 day working in primary care

Adult Social Care Lead

- Adoption of NHS Number
- Delivery of adult social care protected services within the BCF

Our progress so far in 2016/17

BCF Metrics – Progress to Date

Metric		Target	Current	Status
	Permanent admissions of older people to residential and nursing care homes, per 100,000 population, per year	606.4	605.7	GREEN
	Proportion of older people who were still at home 91 days after discharge from hospital into reablement/rehabilitation services	84.2%	89.4%	GREEN
	Delayed transfers of care from hospital per 100,000 population	231.91	357.19	RED
	Total non-elective admissions into hospital per 100,000 population, per month	724.37	748.57	AMBER
	Patient/service user experience - patients satisfied with support to manage long term conditions	62.2%	63.6%	GREEN
	Emergency admissions for injuries due to falls in people aged 65 and over, crude rate per 100,000 population per month	139.76	126.85	GREEN

BCF Theme 1 – Unified Prevention Offer

- Developing a model for social prescribing and a core menu of prevention services that sit behind the social prescribing “front door”.
  - Design a core menu of effective prevention services to wrap around integrated locality teams.
  - Design a consistent approach to social prescribing – proactively targeting the menu of prevention services to specific cohorts of people who will most benefit from them in the community.

- *Social prescribing definition – a means of enabling primary care service to refer patients with social, emotional or practical needs to a range of local, non-clinical services, often provided by the voluntary and community sector.*

Theme 1 – Unified Prevention Offer

- **First Contact Plus**

  - Provides one point of contact for a range of wellbeing support
  - Facilitates early help via information, advice and onward referral to a broad range of preventative services.
  - New web-based referral system which will facilitate efficient clinical referral (e.g. from GPs) and also self-referral and "self-help" via public facing options.
  - Clinical referrals launched Nov 16.

- **Local Area Coordinators**
  - Work within the community to identify vulnerable people and resolve low level needs, to avoid escalation to require more costly/formal services.
  - Piloted in 8 areas within Leicestershire.
  - Independent evaluation completed in Autumn 2016
  - Business case being developed by December 2016 ,with options appraisal for a part or full county roll-out.

Theme 1 – Unified Prevention Offer

- **Lightbulb housing offer**
  - Joined up support across housing, health and social care to keep people safe, well, warm and independent at home for as long as possible.
  - Business case signed off by Lightbulb Programme Board. Going through formal sign-off through District and Council governance.
- **Falls pathway**
  - Developing a consistent approach to the prevention and treatment of falls in residents over the age of 65 in LLR.
  - Innovative Falls Risk Assessment Tool implemented with EMAS, now an app based tool, with Leicestershire's good practice being considered by other parts of the country
  - Business case being prepared – due end of December 2016.
- **Carers Services**
  - Support for carers to care efficiently and safely; to look after their own health and well-being; to fulfil their education and employment potential; and to have a life of their own alongside caring responsibilities.

Theme 2 – Long Term Conditions

- Integrated locality working between community nursing and social workers in place so they can 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.

- This model is currently being reviewed and built upon in 2016/17, now that we are implementing Integrated Locality Teams across LLR - one of the top priorities from the Sustainability and Transformation Plan

- Integrated locality teams are being developed during the latter part of 2016/17, and will initially support patients with multiple LTCs, frailty and others who are at risk of high levels of acute care costs if their care is not well managed in the community.

Theme 3 – Integrated Urgent Response: Admissions Avoidance

Five BCF schemes are in place

targeted to avoid 1,517 emergency admissions to hospital

in 2016/17.

As at the end of October 2016 these have avoided a total of 1,756 emergency admissions

Theme 3: Integrated Response: Admissions Avoidance

Integrated Crisis Response Service (2016/17 Target = 432 avoided admissions, 344 avoided by Oct)	• Social care and night nursing element • Offers up 72 hours of support in a care crisis in the community.
Older Persons Unit (2016/17 Target = 240 avoided admissions, 149 avoided by Sept)	• Rapid assessment service based at Loughborough Hospital, Oct 2014-Sept 2016. • Lessons learned fed into Urgent Care Procurement/Pathways for 2017/18.
Loughborough Urgent Care Centre extra care pathways (2016/17 Target = 120 avoided admissions, 5 avoided by Oct)	• Extra care pathways include hyperkalaemia, low risk cardiac pain, congestive cardiac failure, COPD and asthma, gastroenteritis, UTIs, cellulitis, TIA, DVT.
7 day services (2016/17 target = 3,258 avoided admissions, 1,801 avoided by Oct)	• GP referral service, providing a rapid, clinical response to patients with urgent needs at home, who are vulnerable to admission.
Ambulatory Care Glenfield CDU (2016/17 target = 66 avoided admissions, 69 avoided by June)	• 8 week pilot that tested streaming Cardio/Respiratory patients into 2 groups – likely to go home same day / likely to be admitted. • Patients likely to go home benefited from rapid decision making and effective care planning back into the community. • CCGs reviewing future service plans.

Theme 4 – Hospital Discharge and Reablement

- **Help to Live at Home**
  - A new domiciliary care service designed to support people to remain independent for as long as possible through assistance with personal care and also provide help when patients are discharged from hospital.
  - Joint commissioning for joint reablement outcomes across NHS and LA.
  - New service launched 7th November 2016.
  - A number of operational care delivery issues are being experienced at the time of writing this report
- **Integrated Discharge In-reach Team**
  - During Autumn 2016 proposals have been scoped for redesigning discharge support to university hospitals of Leicester, as part of local plans to improve delayed transfers of care.
- **Discharge Housing Support**
  - As part of the model of integrated housing support being developed in Leicestershire, housing expertise is provided at the Bradgate Unit and LRI to support discharges.

Integration Enablers

Integrated LLR Points of Access (POA)

- Why the programme
  - LLR currently has various points of access that receive referrals for community based services, providing support to a range of professionals and the public.
- The Vision
  - To bring together these multiple Points of Access to deliver a consistent way of working.
  - To support the efficient and effective scheduling and delivery of integrated community services across health and social care.
- Progress so far
  - Design work is in progress across all partners at the time of writing this report to agree the operating model.
  - It is anticipated that between January – June 2017 the existing points of access will transition to a new consistent operating model and some options for co-location are already being explored.

Integration Enablers (2)

- **Adoption of NHS number via adult social care IT system**
  - Currently there are 9,550 records of service users in receipt of adult social care services, of which 98% now have a NHS number validated by the NHS.
- **PI Care and Healthtrak**
  - A data integration tool used to track patient journey across the health and care system using the NHS number as the identifier, to analyse patient flows and pathways and measure the impact of changes to the health and care system at both population and individual levels.
  - A team of existing data analysts across the health and care system using the PI tool to create dashboards and analysis to support LLR system wide change
- **Research and Evaluation**
  - Formal independent evaluation of 8 components of our integration programme between 2015/16 and 2016/17, via a research partnership with Loughborough University, Healthwatch and SIMUL8.
  - Integration care pathways analysed using simulation modelling, stakeholder workshops and patient experience focus groups.

Integrated Commissioning

Integrated Commissioning

- Develop an outcome based commissioning framework for integrated commissioning across LA and NHS partners.
- Three immediate areas for focus are:
  - Nursing and residential homes – integrated approach to commissioning across NHS and LA – initial scoping work commenced.
  - Learning Disabilities High Cost Placements (both within and outside LLR)
  - Continuing health care

For Further Information about Leicestershire's Integration Programme

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