APPENDIX A

Leicestershire Better Care Fund Plan – 2017/18 – 2018/19

DRAFT AS AT 8 MARCH 2017 V.8

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:	
Date submitted:	Narrative Interim Submission Narrative Final Submission
Minimum required value of BCF pooled budget: 2017/18	
Total 2017/18 BCF Plan	

Authorisation and signoff (to complete for *XX XXXXX* Submission)

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

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

Signed on behalf of the Leicestershire County Council	
By	John Sinnott
Position	Chief Executive
Date	

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

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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

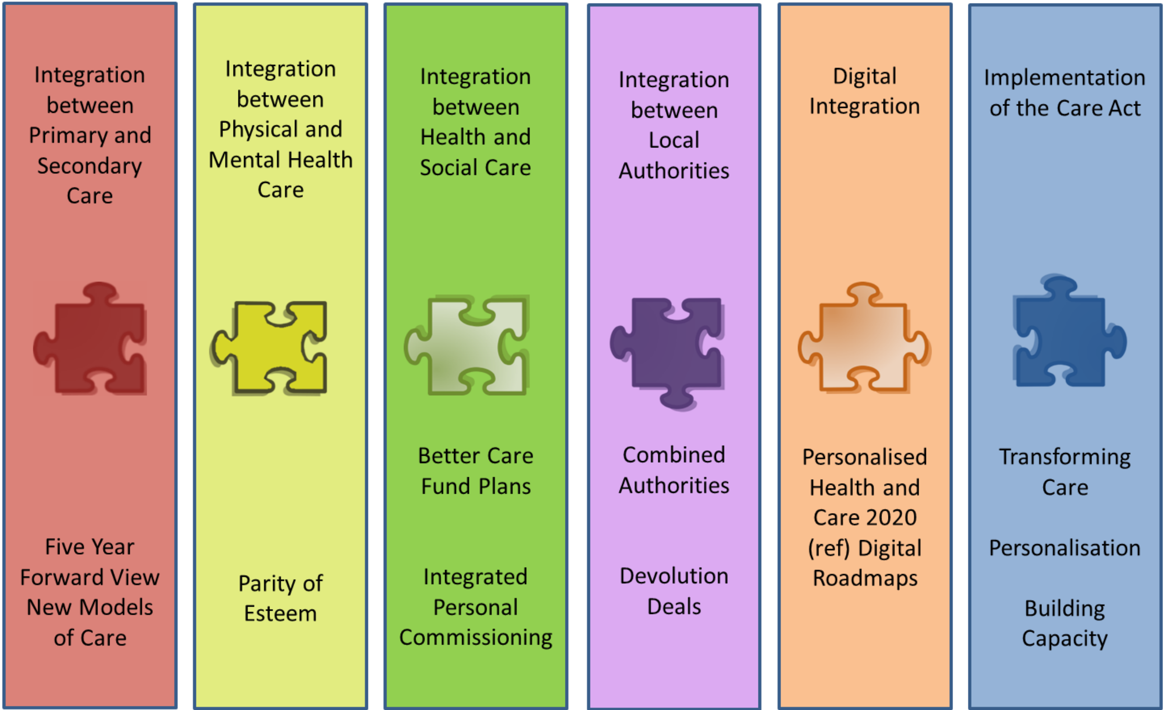
> We will create a strong, sustainable, person-centred, and integrated health and care system which improves outcomes for our citizens.

Our vision is built upon four fundamental strategic drivers, two of which are local drivers, and two of which are national, as illustrated below:

THE SUSTAINABILITY AND TRANSFORMATION PLAN FOR : LEICESTER, LEICESTERSHIRE AND RUTLAND http://www.bettercareleicester.nhs.uk/	LEICESTERSHIRE'S JOINT HEALTH AND WELLBEING STRATEGY http://politics.leics.gov.uk/documents/s124188/JHWS%20App%20A.pdf
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/publications/our-publications/principles-integrated-care http://www.england.nhs.uk/wp-content/uploads/2013/05/nv-narrative-cc.pdf

1.2 National Policy Context

The diagram below shows the main "pillars" of national policy that continue to promote and drive integration across health and care.



Nationally the health and care system is implementing and testing a range of approaches as follows:

- New models of NHS care per the NHS England Five Year Forward View
- New models of adult social care, focusing on personalisation and demand management
- New ways of delivering integrated care, including new organisational forms across health and care
- New digital technologies and data sharing capabilities across health and care systems
- New approaches to back office, estate sharing and workforce development, across public sector organisational boundaries
- New approaches to integrated commissioning, at both personal and population levels, including how pooled budgets, contracting and tariffs are evolving
- New opportunities and flexibilities arising from devolution where applicable.

Translating national policy into the practical reality on the ground is a complex task, which is being undertaken in the context of ongoing austerity. Partner organisations are facing unprecedented levels of demand with correspondingly large saving requirements.

Learning from good practice internationally, nationally and locally is essential to progress integration. This includes assessing and adopting lessons learned from horizontal and vertical integration models, whether internationally, or from UK Vanguard sites, and learning lessons and innovating from the perspective of our local health and care economy to become more integrated and sustainable for the future.

The 2015 Comprehensive Spending Review set out the government's intention that by 2020 health and social care will be integrated. Since 2015 the National Better Care Fund policy has provided a framework for a joint planning approach and a pooled budget mechanism between Clinical Commissioning Groups (CCG) and Local Authorities (LA) in order to support this ambition.

The central role of integration in transforming health and care has been reaffirmed through NHS national policy during 2016/17. This can be seen in particular via:

- The NHS planning guidance for 2017/18 published in September 2016.
- The expectations placed on the 44 area Sustainability and Transformation Plans (STP) which have been developed in 2016/17.

1.3 Home First and the LLR Sustainability and Transformation Plan

The vision for the Leicester, Leicestershire and Rutland (LLR) health and care system is that people will be cared for at home or in their own community, whenever possible, and for as long as possible.

Our entire model of care is being transformed across LLR so that "home first" becomes a reality. This means tackling the over reliance on acute care, and ensuring our community based services are integrated, consistent, reliable and resilient.

For home first to operate successfully, rapid, easy access to the appropriate level of care and support outside of hospital on a 24/7 basis is required, with person centred care coordinated effectively across organisational boundaries and professions. If an emergency admission to hospital does occur, then the 'home first' principle also applies, so that, if someone is admitted to hospital and after necessary interventions and treatment, the system's primary aim will be to return that person to the home address from which they came

Over the past two years some core components of the home first model have been developing in LLR, through the Better Care Fund Plans operating across Leicester City, Leicestershire and Rutland, and other transformational programmes of work such as the LLR Urgent Care Vanguard. These have included for example consolidating hospital discharge routes into five streamlined pathways across LLR, introducing new urgent care services such as the acute visiting service, and integrating housing support alongside health and care.

Some elements of integration have started to take shape over the past two years but we are now entering a further phase of redesign within the STP, where remaining variations in care pathways and delivery across the LLR area can be fully addressed and where medium term solutions will be implemented across the system. The development of the STP has led

partners to achieve consensus on the top priorities across the system, and renew their collective commitment to achieve a much greater level of integration across care pathways and organisations over the next few years.

The table below shows the mapping we have undertaken to demonstrate how the integration policy pillars are reflected in the LLR STP and its delivery arrangements, with mapping to the supporting strategies which underpin the STP across the health and care system.

LLR SUSTAINABILITY AND TRANSFORMATION PLAN		
Integration Policy Pillars	**Supporting Strategies**	**Delivery Plan** *New models of provision, new approaches to commissioning and enablers which maximise integration*
Primary & Secondary Mental & Physical Health & Social	Medium Term Financial Strategies (MTFS) of LAs Operating Plans of NHS Organisations Joint Health & Wellbeing (Board) strategies, including place based provision	• BCF plans/pooled budgets • Adult Social Care Strategies • Early Help and Prevention Review • Integrated Locality Teams/MSCPs supported by Integrated Points of Access • Redesigned Urgent Care (Vanguard) Model • Primary Care Resilience Strategies • Mental Health Recovery and Resilience Hubs • CAMHS Transformation Plan • Integrated Commissioning (e.g. Domiciliary Care, Care and Nursing Homes Placements)
Digital Integration	LLR Digital Roadmap	• Electronic Summary Care Record • Interoperability Programme • PI Care and Health & ACG tools
Integration between Local Authorities	Combined Authority (Leicester City & Leicestershire)	• Economic Growth Plan • Sector Growth Plan for Health and Social Care • Integrated Housing Service (Lightbulb) • One Public Estate
Personalisation & Choice	NHS Consultation Adult Social Care Strategies NHS England Mandate	• Integrated Personal Commissioning • Transforming Care (LD) • Young People Elements (Supporting Leicestershire Families)

Achieving a greater level of shared understanding and a more integrated, robust and dynamic model of how the health and care system operates now and in the future is a key feature of the ongoing leadership of the STP.

The co-production of the STP has enabled the health and social care community across LLR to plan together more confidently and set out more clearly how new models of care will be implemented across organisational boundaries.

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 STP therefore represents a combined LLR strategy supported by joint planning assumptions and delivery arrangements for the partners across the health and care economy.

The diagram below (*this is a draft diagram*) illustrates how the overarching framework and aims of the LLR STP are being supported by Leicestershire County's CCG operating plans and the MTFS of Leicestershire County Council, through the with the BCF plan and pooled budget.

1.4 Key Challenges for the Delivery of Leicestershire BCF Plan and the LLR STP

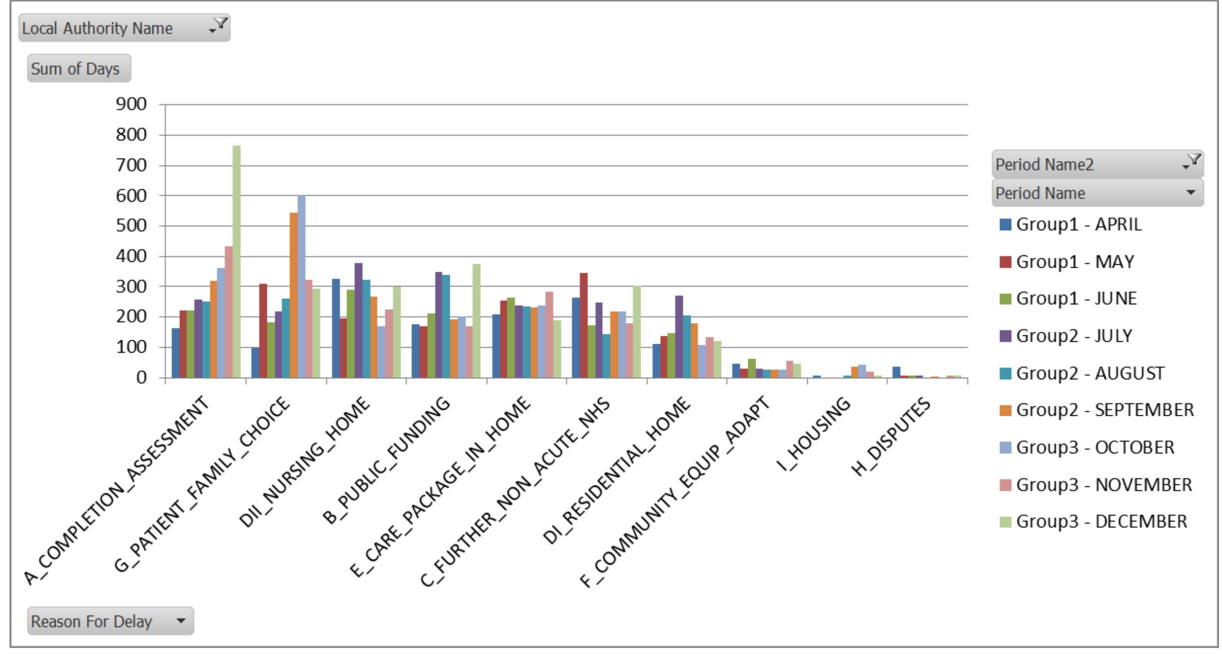
1.4.1 Urgent Care

- 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 again exceeded CCG commissioned levels over the past 12 months.
- In 2014/15 there were 58,479 non-elective admissions for Leicestershire residents
- In 2015/16 the outturn for non-elective admissions was 60,090 (increase of 1.5%)
- In 2016/17 the forecast outturn for emergency admissions is 61,424 against a plan for 59,030 (increase of 2.2% on 2015/16 levels)
- Analysis by the LLR Urgent Care Board shows that a proportion of the growth over the last 12- 18 months has occurred in the 0-10 and 20-40 age groups.
- The four emergency admissions schemes implemented within the 2015/16 BCF plan have been evaluated in conjunction with Loughborough University, and along with other elements of urgent care system redesign/reviews, have informed the model of integrated urgent care designed by the LLR urgent care vanguard.
- This new model of urgent care and its associated capacity planning assumptions have been reflected in the LLR STP and CCG operating plans, and an LLR wide procurement for new urgent care services to commence from April 1st has recently been concluded.
- One of the BCF schemes from 2016/17, the Loughborough Older People's Assessment Unit, has been decommissioned as result of the BCF evaluation process, however other components such as the falls non conveyance pathway and the acute home visiting service (part of primary care seven day services investments) have proved very effective and are being commissioned recurrently within the new urgent care model.

- In terms of a continued focus on hospital admissions avoidance, the 2017/18 BCF plan includes implementing a further emergency admissions avoidance scheme that was tested earlier in 2016/17, which focuses on short stay cardio-respiratory patients.
- The overall trajectory for emergency admissions avoidance for the BCF for 2017/18 – 2018/19 has been aligned with CCG operating plans and further information about this metric can be found in section 4.6 of this report.

1.4.2 Hospital Discharge

- We set a modest improvement on the DTOC target for 2016/17 based on the performance achieved in 2015/16 and with the emphasis on seeking further improvement in the non-acute settings of care.
- However sustaining our good DTOC performance achieved in 2015/16, has proved very challenging in 2016/17 and a marked deterioration has occurred.
- Performance for quarters one, two and three was 287.04, 357.19 and 382.17 days delayed per 100,000 population aged 18+ per month, against targets of 236.66, 231.91 and 214.66 respectively.
- Delays due to patients waiting for the completion of an assessment rose dramatically in December, almost doubling from the November level.
- Patient or family choice was a major cause of delayed days in September and October.
- Delays due to public funding peaked in July and August but have also seen an increase again in December.

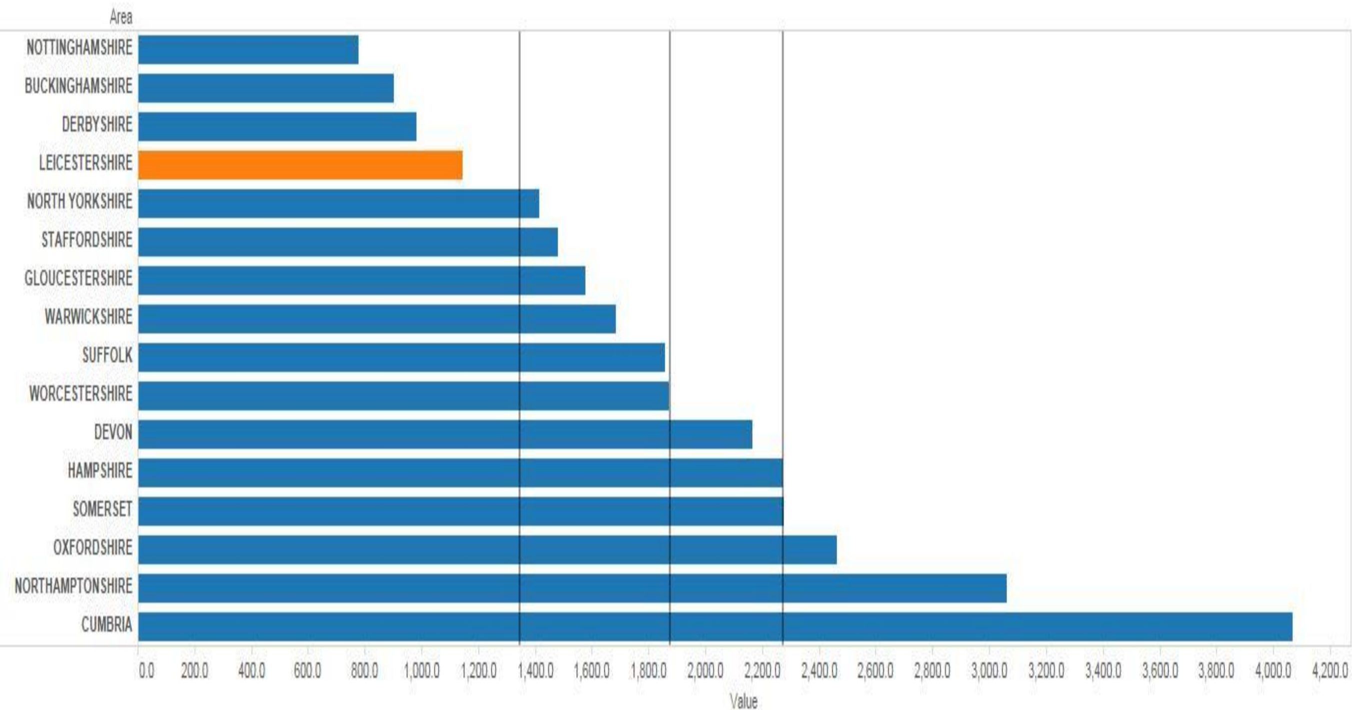


- There are a number of reasons for the current performance ranging from:
  - The volumes of emergency admissions activity generally across the system.
  - The impact of the transition to the domiciliary care contracts in the county, particularly in the period October-December 2016.

- Problems with CHC referral processes and pathways.
- Problems with flow internally within UHL.

While the overall position has deteriorated, Leicestershire is not exceptional and was in the top quartile for performance each quarter when benchmarked against CIPFA statistical neighbours as illustrated in the chart below.

Q3 performance compared with CIPFA Group



The LLR-wide action plan to improve DTOC performance (and ensure all five discharge pathways are fully implemented in line with the new urgent care vanguard models of care) is overseen by the LLR Discharge Steering Group which reports to the LLR A&E Delivery Board.

Further information on the components of the local action plan and services in support of improving hospital discharge can be found at section 4.2 of this document.

1.4.3 New STP Workstreams for 2017

Integrated Locality Teams

- As part of the STP, a new area of focus is the systematic implementation of integrated locality teams across LLR.
- This large scale transformation programme commenced in Q3 of 2016/17 with a view to implementing new ways of working by April 2017.
- Elements of the existing BCF plans across LLR will be redesigned to meet the new model of care and the outcome of this work will affect commissioning intentions/ contractual arrangements from April 2018
- More information about this development can be found in section 4.5 of this document.

Home First

- As part of the STP a new area of focus is developing the strategic approach to Home First for LLR, setting out the integrated rehabilitation and reablement services which will support step up/step down (admission avoidance and rapid discharge).
- This large scale transformation programme commenced in Q4 of 2016/17 and the scope and key milestones are at an early stage of development at the time of this submission.
- Elements of the existing BCF plans across LLR will be redesigned to meet the new model of care and the outcome of this could affect some contractual services via in year variation within 2017/18 and then medium term commissioning intentions and contractual changes from April 2018.
- Further information about this development can be found in section 4.2 of this document.

These two new areas of work present number of additional challenges to the delivery of the BCF plans in LLR, due to their overall size, scope and complexity, and the fact that existing investments in LLR BCF plans will be redesigned during 2017/18.

Hence there is a need to manage the interdependencies between these elements and ensure the BCF plan funding, deliverables and metrics are aligned to the changes that will take place and that these are translated effectively into commissioning arrangements for year two of this BCF refresh.

Another key challenge is the large scale OD and cultural work needed to enact these changes operationally and build more integrated services across a range of organisations and professional groups.

1.4.4 Financial Context

- Financial allocations, the scale of financial pressure and collective level of savings required across the partnership impact on the ability of all partners to commit to new initiatives, unless funds are reallocated between existing commitments, existing services are decommissioned or transformation funds can be accessed, especially for delivering a return on investment within a one to three year horizon.
- LCC is required to make savings of £16.4m in 2017/18, WLCCG requires savings of £18.7m and EL&RCCG requires savings of £14.8m
- The financial refresh of the BCF for 2017-19 has placed additional emphasis on driving out further savings and creating headroom within the plan where possible.
- A workplan of priority services for further review during 2017, with a view to commissioning decisions to be taken for year two of the BCF plan, has been identified (see section 6).
- The position of adult social care, linked to the council's MTFS, relies on the £17m adult social care protection level agreed within the 2016/17 BCF plan being maintained for 2017/18.
- Despite this, partners must commit to the BCF plan, maintain delivery across the BCF plan metrics and national conditions, as well as deliver a medium term view of transformation linked to the STP.
- 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.
- In 2016/17 we developed a framework for integrated commissioning across LA and NHS partners and commenced the first area of joint work using this framework, a new joint commissioning approach to care and nursing home placements. This work will span two financial years so delivery of the benefits of this work will be seen from 2017/18.
- DFG allocations proved challenging in the 2016/17 BCF plan due to the late publication of the BCF guidance and a late and unexpected change to financial allocations associated with DFGs. Dialogue with Districts has taken place ahead of BCF guidance for 2017/18 being published. The outcome of this is that a proportion of DFG monies previously held back within the BCF plan in 2016/17 will now need to be released to Districts, placing a £1m pressure on the 2017/18 BCF financial plan.

1.4.5 Data Integration

- Although progress has been made on data integration using the NHS number and PI 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.
- The BCF has a dependency on the development of an LLR wide solution for the electronic summary care record – this is a key part of the LLR Digital Roadmap with an expectation of solutions being implemented from 2017/18

1.5 Aims of the Leicestershire BCF Plan 2017 - 19

The aims of the Leicestershire BCF plan have been refreshed in light of the national strategic policy context and the development of the LLR STP.

The revised aims are as follows:

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

2 LOCAL CASE FOR CHANGE

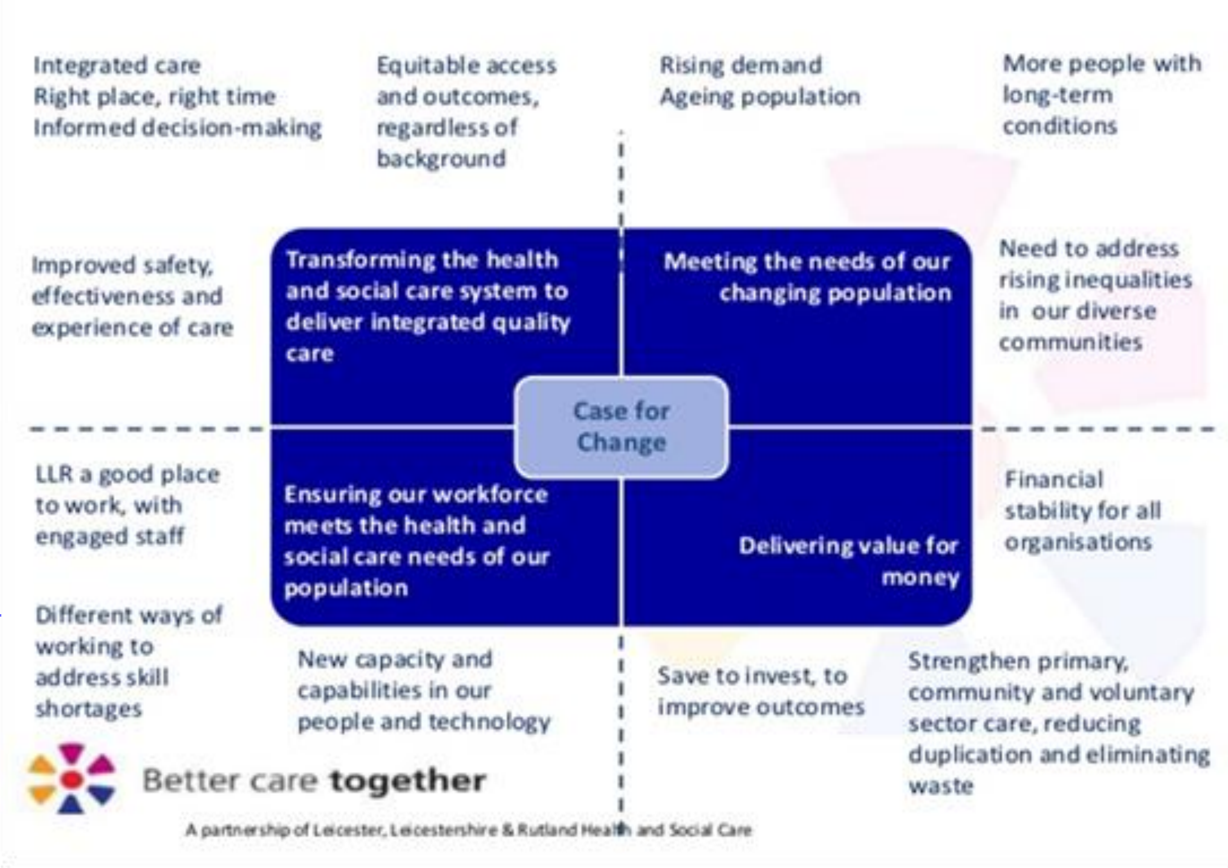
2.1 Summary Overview of Case for Change Analysis

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 2017/18 we have therefore summarised and signposted to these as follows:

2.1.1 Better Care Together

In 2015 The Better Care Together LLR-wide five year plan considered the overall sustainability of our health and care system and the reconfiguration opportunities in LLR, in particular the 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



2.1.2 The LLR Sustainability and Transformation Plan (STP)

In the Autumn of 2016, LLR partners produced the local STP, which was built upon the case for change and strategic foundations of the Better Care Together Programme. A public summary of the STP can be found at this weblink
http://www.bettercareleicester.nhs.uk/Easysiteweb/getresource.axd?AssetID=47665

The priorities contained within the LLR STP respond to the local case for change and tackle three key challenges which are

- Improving health and wellbeing
- improving the quality of care and services
- Achieving a more efficient and sustainable health and care economy which can meets future demands..

2.1.3 Leicestershire's Joint Strategic Needs Assessment and Leicestershire's Joint Health and Wellbeing Strategy

These documents consider the specific health outcomes where improvements are still needed for the local population including for example, improving mental wellbeing.

Our JSNA documents are the key reference points for the case for change per the in depth population health needs analysis http://www.lsr-online.org/leicestershire-2015-jsna.html and our Joint Health and Wellbeing Strategy illustrates how the Health and Wellbeing Board is responding to the priorities highlighted by this analysis
http://politics.leics.gov.uk/documents/s124188/JHWS%20App%20A.pdf, with other sources of supporting information at this weblink.: http://www.lsr-online.org/health-and-wellbeing-leicestershire3.html

Our JSNA includes a helpful infographics interactive webpage, which shows 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.

2.1.4 Public Health Summary Needs Analysis 2016

In support of the BCF refresh we have provided a summary population health needs analysis which can be found at Appendix 1. The analysis is based on the current JSNA and population health profiles for 2016.

2.1.5 Population and Practice Level Risk Stratification

As part of the BCF refresh we have refreshed our population level risk stratification using 2016/17 data via PI Care and Health Trak - the outputs of this analysis are at Appendix 2.

In summary this shows that, from April 2016 to November 2016, 37% 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 55% of the bed days, and 51% 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 (65%) for emergency admissions to UHL for those aged 70 and over are for patients with between two and five long-term conditions. This amounts to over £24.5 million of costs for April - November 2016.

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 74% of the costs for this condition can be attributed to patients aged 70 and over.

The STP workstream for Integrated Locality Teams has used risk stratification at local GP practice population level, via the ACG tool, to identify three cohorts of the population in each locality who should be the focus of improved case management and care coordination in community settings.

They will benefit from a new model of integrated multi-disciplinary working between primary care community nursing/therapists and social care.

The ACG risk stratification tool in GP practice has been used to identify these cohorts which include those with frailty markers, those with 5 or more LTCs and those whose acute care costs are estimated to be 3x the expected levels over the coming 12 months.

2.1.6 Case for Change: LLR's Urgent Care System

This area of work 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.

This work has been based on the new models of care for England as set out by Simon Stevens in in the NHS England Five Year Forward View publication.

LLR's urgent care system has been under unsustainable pressure over a number of years with the health and care economy placing too much reliance on urgent/acute care, when other alternative settings of care should be or are available for local citizens to use.

In 2014 an independent review of the health and care system was undertaken by Dr Ian Sturgess which focused on the root causes of the reliance on emergency and urgent care and how the system as a whole needed to respond and change to provide more anticipatory care in the community.

In 2015, the LLR area was selected as one of the Urgent and Emergency Care Vanguard sites in order to accelerate the necessary changes. As a result of this, during 2016/17 a new system of urgent care has been designed and commissioned which comes into effect from April 2017.

Further information about the implementation of this and the funding from within the BCF which supports the new services can be found at section 4.6 of this document.

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

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

- Service user metrics have been analysed to assess improvements in the experience of local people using integrated care and support across settings of care in Leicestershire, including the quality of life score in the Adult Social Care Outcome Framework, support for people with Long Term Conditions via the GP survey, and experience of coordination of care and support on discharge from CQC surveys;
- A Better Care Together customer insight survey undertaken in 2015/16 focused on the views and experiences of carers;
- Engagement with service users undertaken for the introduction of the "Help To Live At Home" domiciliary care services, used to shape the outcomes and service model;
- Engagement with service users across eight BCF services as part of the evaluation conducted with Loughborough University and Healthwatch, focused particularly on community based services targeted to admissions avoidance;
- Engagement and customer insight analysis undertaken for the Lightbulb Housing Project which informed the service model;
- Engagement with service users on integrating customer services points of access across health and care, used to inform the future options and solutions for an LLR-wide operating model;
- Engagement undertaken by Leicestershire Healthwatch, reported bi-monthly to the Leicestershire Health and Wellbeing Board, with thematic analysis on areas such as mental health, primary care access, urgent care and hospital discharge;
- Findings and recommendations from local authority scrutiny committees and scrutiny panels; and
- Feedback from LLR engagement events for Better Care Together and the STP.

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

- NHSE Benchmarking data (e.g. readmissions within 30 days)
- UHL readmissions report and supporting analysis 2016
- Urgent Care/A&E Board Analysis, including DTOC reporting
- ACG Risk Stratification data from Primary Care
- LA Benchmarking data: e.g. on permanent admissions to residential care and DTOC
- Adult Social Care Performance Reports and Dashboards
- Regional and National BCF analysis /benchmarking
- 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.
- Findings from CQC or reviews/reports by other regulatory bodies
- ECIP Reviews
- LA Peer Reviews

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

There is an ongoing need to focus integrated community based interventions on those with Long Term Conditions (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 shift into proactive and preventative care in community settings. In line with the case for change and the LLR STP priorities arising from this, the Leicestershire BCF plan is comprised of the following key areas in support of health and care integration.

BCF 1 - A unified prevention offer – that is co-designed across the full range of partners, wraps around people, communities and locality teams, and is targeted to maintaining wellbeing and independence.

BCF 2 - Home First - providing an enhanced community care service on a 24/7 basis which support early discharge, prevent readmission, and delivers maximum reablement. Home first is supported by integrated locality teams who ensure those with complex care needs/those at risk of acute care episodes are managed effectively and proactively at home.

BCF 3 – Integrated Housing Support – providing a range of previously fragmented housing support service in one integrated offer targeted to supporting health, wellbeing and independence at home.

BCF 4 – Integrated Domiciliary Care – the new Help to Live at Home service in Leicestershire County has been commissioned jointly by the LA and CCGs. It operated across 18 geographical lots, with services provided by a much smaller number of providers, organised around the same footprints as the new integrated locality teams in LLR

BCF 5 - Integrated locality teams – from April 2017 these will focus on specific cohorts of people where the opportunity to intervene via improved integrated case management will have maximum impact on outcomes, both for the individual and the health and care system as a whole.

BCF 6 - A new model of integrated urgent care - offering clear alternatives to attendance at the A&E department and improved clinical triage and navigation to ensure consistent use of these pathways to actively divert people from acute care where applicable.

BCF 7 - Integrated points of access – providing integrated call handling and a tiered assessment response across health and social care. In particular for service users whose care does not need a purely medical response, and which can be delivered in community settings, providing the interface between integrated locality teams, their service users and the multidisciplinary teams who support them in the community.

BCF 8 - Data Integration – at both population level, so we can track the performance and utilisation of the health and care system, and at individual care management levels so that the delivery of care is supported by a summary care record accessible to professionals across the system.

BCF 9 – **Integrated Commissioning** – between LA and CCG partners, focusing for example on the ongoing stabilisation of the new Help to Live at Home service, and a new approach to joint commissioning for care and nursing homes being developed in 2017/18.

3 OUR TRACK RECORD OF DELIVERY IN 2015/16

3.1 Progress Achieved by the 2016/7 BCF Plan

The 2016/17 Leicestershire BCF Plan was 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.
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 during 2016/17:

Unified Prevention Offer	Integrated, Proactive Care for those with Long Term Conditions
✓ First Contact Plus – launched a new web-based referral system, which facilitates efficient clinical referral and also self-referral and public facing option, during 2016/17. ✓ Piloted and developed business case for new Lightbulb Housing offer to provide joined up support across housing, health and social care to keep people safe, well, warm and independent in their own homes. ✓ Redesigned falls pathway. Each stage within the pathway has been developed into an agreed level of service that will form part of the LLR Falls Prevention and Treatment Strategy. ✓ Developed the model for social prescribing across Leicestershire.	✓ Integrated locality working between community 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. ✓ Integrated locality teams are being developed during Q4 2016/17, and will initially support patients with multiple long term conditions, frailty and others who are at risk of high levels of acute care costs if their care is not well managed in the community.
Integrated Urgent Response	**Hospital Discharge and Reablement**
✓ Achieved 2,138 avoided admissions between 1st April and 31st December 2016. ✓ Launched a new electronic falls risk assessment tool (eFRAT) for paramedics, which has resulted in reduced conveyances to hospital. Integrated working with community health services has enabled fallers to stay in their home while receiving nursing and therapy services required. ✓ Piloted ambulatory care scheme within the Clinical Decisions Unit at Glenfield Hospital for cardiorespiratory patients. ✓ Urgent Care System in LLR has undergone a service redesign and reprocurement process in 2016/17. New services to commence in April 2017, which incorporate a number of the emergency admissions avoidance schemes funded and tested within the Leicestershire BCF.	✓ Launched a new jointly commissioned domiciliary service, called Help to Live at Home, on 7th November. It promotes reablement in the home and integrating domiciliary care providers more effectively with other health and care services, including primary care and prevention services in each locality. ✓ New Integrated Discharge In-Reach team set up in January 2017 to identify, transfer and then assess suitable patients into bed based reablement. ✓ As part of Lightbulb, the Hospital Housing Discharge support service involves housing specialists working directly with patients and hospital staff to identify and resolve housing issues that are a potential barrier to discharge and to help prevent readmissions. Service demonstrating impressive results.

3.3 Progress with BCF Enablers in 2016/17

Progress with BCF Enablers in 2016/17
• The Leicestershire Integration Programme has been leading work to scope opportunities to integrate the various points of customer access across the health and care economy in LLR. Extensive service development and design activity workshops were undertaken, which involved all partners co-designing the principles and model of service, and gathering more detailed baseline and performance data across partners. • Care and Healthtrak is now a business as usual tool for measuring the impact of care pathway developments in LLR. Customised dashboards are in place which reveal otherwise unachievable insights into patient journeys across the health and care system and how services across health and care impact upon each other. • Individual trajectories developed for each of the emergency admissions avoidance schemes with ongoing performance management and data quality improvements. • Formal independent evaluation of four components of the Integration Programme, via a research partnership with Loughborough University, Healthwatch Leicestershire and SIMUL8. Integrated care pathways analysed using simulation modelling, stakeholder workshops and patient experience focus groups. • At December 2016, there was 9,550 adult social care service users of which 9,341 (98%) have a validated NHS number as a key enabler to data sharing across health and care. • Launched Health and Care Integration Website for Leicestershire http://www.healthandcareleicestershire.co.uk/. • Social isolation campaign launched in autumn 2016 http://www.healthandcareleicestershire.co.uk/health-and-care-integration/reducing-loneliness/. • Integration Stakeholder Bulletins published monthly featuring our progress and case studies http://www.healthandcareleicestershire.co.uk/health-and-care-integration/health-and-care-integration-newsletters/. • Work of the Integration Programme promoted via @leicshwb twitter feed.

3.4 How we refreshed our BCF Plan for 2017/18 – 2018/19

A systematic approach has been undertaken.

Leicestershire's (multiagency, director level) Integration Executive has overseen this work on behalf of the Leicestershire Health and Wellbeing Board.

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.

In order to refresh the Leicestershire BCF plan for 2017/18 in summary we have undertaken the following activities: -

- Considered the strategic context of the integration policy pillars on our local vision and plans
- Examined our progress to date and the milestones we still need to achieve to become an integrated health and care system by 2020/21.
- Clarified the contribution the Leicestershire BCF plan and pooled budget will continue to make to deliver specific components of the system level transformation set out within Leicester, Leicestershire and Rutland's Sustainability and Transformation Plan,
- Completed a full financial refresh, in line with the significant financial pressures and risks affecting all partner organisations
- Completed a review across all BCF plan components, led by the integration operational group. This has included taking account of evaluations and service reviews completed in 2016/17, in accordance with our workplan, assessing current risks and issues affecting plan delivery, and identifying priority service lines where further work needs to be undertaken in our 2017/18 workplan
- Undertaken a significant programme of engagement across all partners.
- Assessed the implications of the BCF policy framework and technical guidance

The following section sets out in more detail the approach we have taken:

The BCF plan was divided into categories for the refresh:

1. Elements of the plan 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 remain in this category and if additional review work should be undertaken either now or in the future

2. Elements of the plan which were new in 2016/17 and subject to evaluation/commissioning decisions either by December 2016 or post December 2016.

3. Elements of the plan which were emerging for 2017/18

4. Elements of the plan which were already planned to be decommissioned by March 31 2017.

5. Elements of the plan where funding was assumed to be recurrent but services would be redesigned during 2017/18 - in particular for Home First and Integrated Urgent Care.

The Integration Operational Group worked through a series of workshops and meetings between October and December 2016 to review the plan in detail, creating an action plan by commissioner, compiling evidence from a range of sources including the findings of formal evaluations being undertaken, emerging business cases/proposals, and routine performance and service information/decisions gathered via existing governance processes.

The group directed actions and clarifications over this 3 month period, ensuring these elements could be reflected in CCG operating plans, and NHS and LA contractual requirements for 2017/18.

Initial recommendations from these outputs were made to the Integration Executive at their meetings in November and December 2016 to inform the first cut of the BCF refresh by 20 December 2016.

This deadline was set locally in the absence of national guidance for the 2017/18 BCF, but was deemed necessary by partners, to align with the submission of CCG operating plan on December 23, 2016.

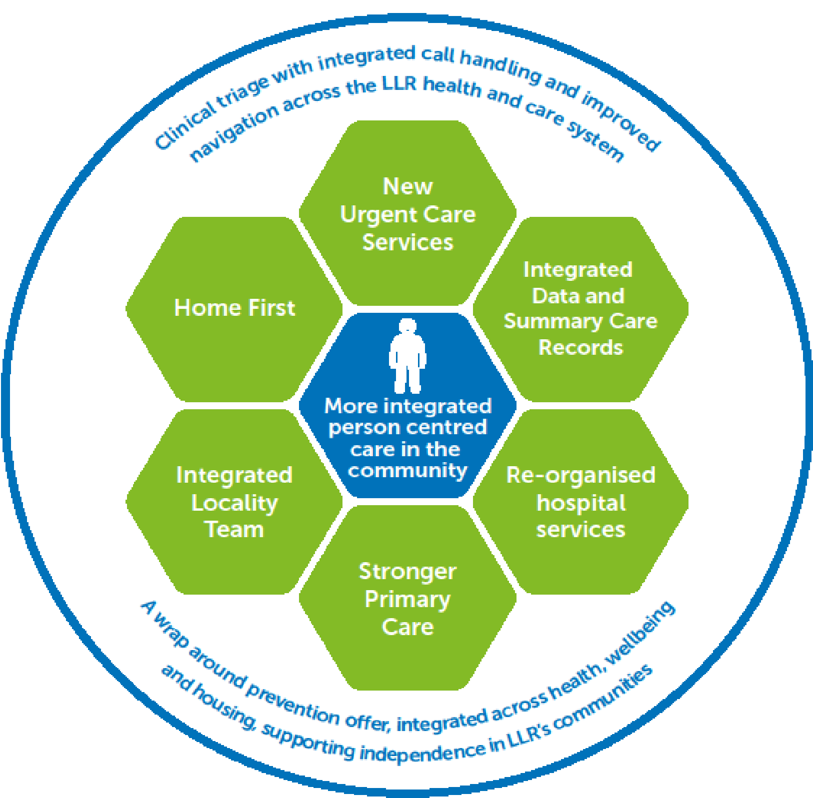
In parallel with the above:-

- A full financial refresh was undertaken, profiling the plan for 2017/18.
- A review of Adult Social Care protection was undertaken in conjunction with CCGs.
- 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 2016 – confirm and challenge was applied to these trajectories on a multiagency basis ensuring alignment to the assumptions in CCG operating plans and the STP.
- 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.

4 OUR PLANS FOR 2017/18 – 2018/19

In this refresh of the BCF plan we've updated the original four themes, and now have nine BCF components (referenced 1-9 below and the corresponding spending plan at Appendix 4), with clear alignment to the priorities and workstreams of the LLR STP.

The diagram below illustrates how the key workstreams of the LLR STP will together deliver the integrated, care in the community that is needed to make our health and care system person centred, accessible and sustainable for the future.



Section 4.1 – 4.19 below outline how the Leicestershire BCF plan will deliver (and fund) key elements of the work.

4.1 BCF 1 - Unified Prevention Offer

The STP calls for an increased focus on prevention so that in the medium term people are supported to self-care, and that where possible we prevent, reduce or delay the need for statutory services by investing in low level support and supporting people to make positive choices to maintain their health, wellbeing and independence for as long as possible. It is recognised that many of these interventions are non-medical and can be provided from a range of partners and sources, including informal community based support.

The Leicestershire BCF has, since its inception placed priority on developing a Unified Prevention Offer for Leicestershire's communities, building on community assets and building community capacity in conjunction with the Council's Communities Strategy.

With leadership from Public Health and District Councils, in conjunction with other council services, NHS partners, Fire, Police, and the voluntary sector, the Unified Prevention Board has led work to develop the approach to social prescribing during 2016/17.

The BCF plan continues to include investment for First Contact as a single point of access to refer and navigate into the local menu of non-medical interventions.

The menu includes public health lifestyle services, local area coordinators who provide vulnerable people with low level support in their community, and a range of wellbeing services such as support for carers and falls prevention.

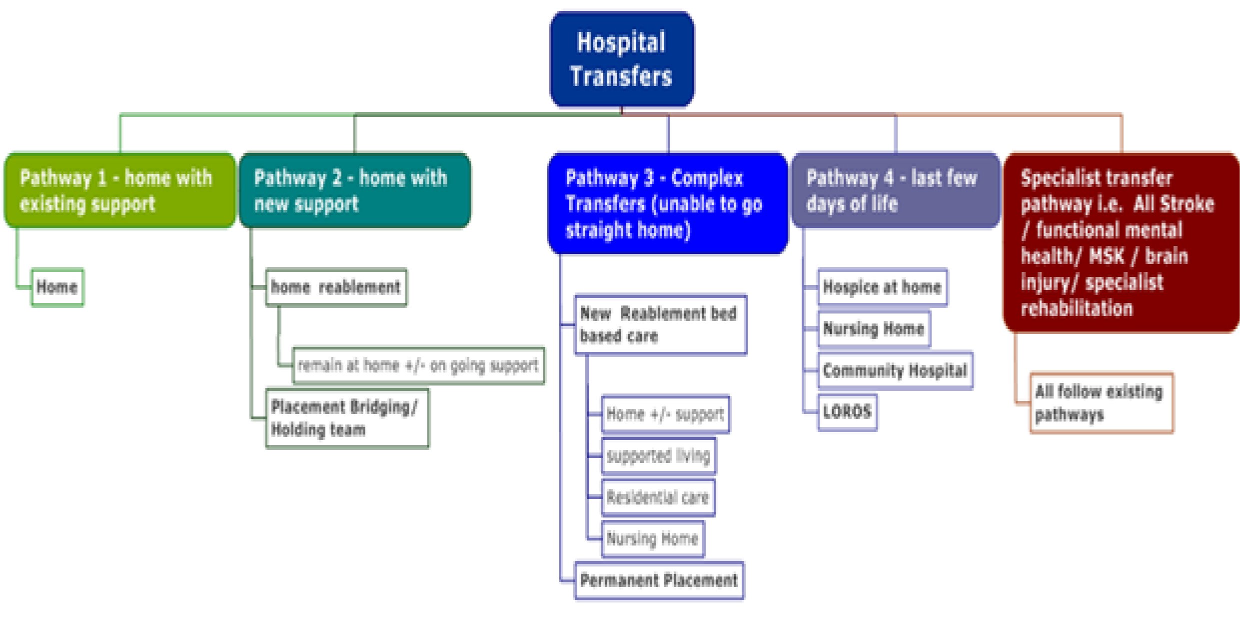
First Contact also provides the front door into Leicestershire new integrated housing service, called Lightbulb.

Lightbulb provides a one stop shop for assessing and coordinating housing support including hospital discharge housing support, affordable warmth, aids and adaptations, home maintenance, home safety and future housing options.

4.2 BCF 2 - Home First & Our Local Action Plan to Improve Hospital Discharge

The overarching model of care across LLR is the 'Home First' model. In practical terms this means everyone should ask: "Why is this patient not at home?" or "How best can we keep them at home?" During 2016/17, LLR has redesigned its discharge pathways from over 50 ways out of hospital into five distinct pathways, designed to make Home First a reality in our health and care system in the future.

4.2.1 LLR Discharge Pathways as at February 2017



Each pathway follows the key principles of 'Home First' which include:

- Discharge to Assess
- Trusted Assessor
- Reducing the number of Continuing Healthcare (CHC) assessments completed in the acute setting.

4.2.2 Discharge to Assess

This approach links into the ''home first' philosophy by seeking to only assess a patient's long term needs once they have recovered from their acute illness or hospital episode.

As a result, pathways two and three offer a period of NHS funded reablement (home based and residential care based) for up to six weeks which includes case management and therapy assessment alongside enabling carers. The aim is to increase the number of people who remain in their own homes, and reduce the complexity of a long term care package. By offering discharge to assess, it supports the aim of reducing the number of people who are assessed in the acute trust for Continuing Healthcare funding. These assessments are now completed whilst the person is nearing the end of their reablement period.

4.2.3 Trusted Assessor

The concept of trusted assessor is to ensure the patient is assessed for their ongoing needs once, and that the assessment is 'trusted' by the receiving community service. For LLR, this principle is in place for pathways two and three.

The hospital discharge team at UHL and nominated team members in the community hospitals complete the assessment document which then negates the need for the referring service lead to visit the patient in hospital to re-assess their needs before accepting the patient.

Currently the document is paper based but there is an established program of work to support an electronic version.

Trusted assessment does not currently apply to long term stays in residential and nursing care homes. A piece of work is planned which addresses how care homes and hospitals will work together on this basis.

4.2.4 End of Life (EOL) and Fast Track Cases

In 2017, the EOL strategy team is planning to test a new approach whereby existing services are deployed via a coordinated hub (e.g. all services can be accessed via a single point of contact, and the services decide which skill set is most needed to support the patient). The aim is to avoid a 'prescribed' approach to end of life care which often does not meet the patient's needs and overburdens services.

The approach supports 'discharge to assess' and trusted assessment as there is a case management function to ensure the patient's ongoing needs are supported once they reach their intended destination (home, hospice etc.).

4.2.5 LLR System Oversight of Discharge Flow and DTOC Performance

The LLR health and care system's performance in relation to delayed transfers of care and the implementation of the pathways noted above is led by the LLR A&E Delivery Board, supported by a Discharge Working Group.

The LLR Recovery Action Plan contains the local action plan targeted to improving hospital discharge performance.

The two high impact actions from the RAP in relation to improving hospital discharge in LLR are:

- Increase capacity in Pathways two and three to support discharge including discharge to assess
- Improve interface with CHC approval and brokerage

UHL have implemented a new "Red 2 Green" system across all wards which has been designed to focus on internal flow in support of more effective hospital discharge.
Once a patient is medically fit for discharge there should be a series of rapid and coordinated activities across the hospital to ensure this happens at pace.

For example, ensuring senior clinical decisions take place early in the day, prompt access to medications for discharge, ensuring the discharge to assess approach is taken, with proactive and responsive support from hospital based social care teams and discharge inreach services.

The LLR Urgent Care Recovery Action Plan is reviewed fortnightly by the A&E Delivery Board, with daily/weekly operational escalation procedures in place across all agencies to deal with system surges and capacity problems. These arrangements have been strengthened as usual over the winter period including regular daily teleconferences to manage specific discharge cases, pressures and blockages.

In recent weeks the A&E Delivery Board has been able to monitor new data arising from the Red 2 Green approach, collectively tackling the key themes and issues arising from this analysis, with the underlying operational issues being fully surfaced and addressed.

4.2.6 Home First Programme

In terms of transformation, and the implementation of medium term, sustainable solutions in LLR, since January 2017 a new Home First Programme Board has been established as a key workstream of the LLR STP.

Scoping and baseline analysis is currently in progress but a draft PID is already in place. The focus of this work will be to:

- Oversee the implementation of the Home First strategy, including working effectively with the Integrated Teams Board, A&E Delivery Board and Integration Boards;
- Continue the service redesign needed to fully embed the new discharge pathways
- Further review the existing referral processes and systems operating across organisations such as for CHC and discharge to assess
- Ensure that reablement and rehabilitation capacity is organised to provide the most effective and efficient hospital discharge arrangements

- Ensure that reablement outcomes focus on returning people to maximum functionality, avoiding readmissions and keep people in their usual place of residence for as long as possible. Agreeing the future model of community support in line with the Home First strategy;
- Determine/refine the future capacity requirements needed for hospital beds, linked to STP planning assumptions and contribute to the bed reductions outlined in the STP
- Ensure that local people are effectively engaged in Home First and developing a communications and engagement plan to support the strategy;
- Ensure that the implications of Home First on carers are well addressed
- Lead a collaborative approach to developing and managing the market for domiciliary care and care homes across health and social care in order to deliver Home First.

The Home First Workstream will consider both step down and step up services within its remit and will work closely with the existing Discharge Steering Group in delivering its objectives.

In support of the LLR A&E Delivery Board and the new Home First Workstream an independent ECIP review has recently been conducted to provide further insights into the current discharge pathways and systems across LLR.

This review considers the current services operating between hospital and community settings and the partnership working arrangements and referrals processes between health and social care partners to facilitate hospital discharge, and makes recommendations about where further improvements can be made with reference to best practice.

The outputs of this review are expected to be available in late February to inform next steps. These will be adopted by the Home First Workstream and A&E Delivery Board and where applicable reflected in the RAP and Home First PID/workplan. *(This para will be updated with the key recommendations, once the report is finalised and approved, and before the BCF submission is sent to NHSE)*

4.3 BCF 3 Integrated Housing Support

During 2016/17 we developed a business case for our new integrated housing service across Leicestershire, called Lightbulb.

The service brings together a range of previously fragmented housing support services provided by district councils, the county council and other providers into one integrated and consistent offer across the local population. The service will operate on a hub and spoke model with locality based spokes in each District Council. The housing offer will therefore support integrated locality health and care teams.

We have tested a number of parts of this service over the past 18 months using a transformation grant from DCLG.

The business case demonstrates the effectiveness of the proposed model which includes introducing a new housing coordinator role who will provide one point of contact for supporting customers to access major and minor adaptations, affordable warmth, hospital discharge support, home safety, home maintenance etc.

A new housing MOT offers a holistic assessment of need and seeks to provide earlier intervention targeted to health and wellbeing e.g. falls prevention within the home environment.

Within the Lightbulb service model are specific staffing resources for supporting hospital discharge. Staff are based at Leicester Royal Infirmary and the Bradgate Unit, working closely with discharge teams to support patients with a range of housing solutions such as homelessness, rent/tenancy issues, furniture packs, cleaning and clearing patients homes have become cluttered or unsuitable e.g. due to hoarding, moving furniture to accommodate a change in the person's mobility/reduce risks of falls, expediting adaptations, and tackling heating problems.

Key benefits from the Lightbulb housing service include streamlining processes with fewer handoffs and delays, the opportunity to provide on average 3 housing interventions to vulnerable people (based on the findings from our housing MOT pilot), integrating housing support into locality based health and care teams, significant reductions in delayed transfers of care due to housing related issues, as demonstrated by the work of the discharge housing support staff over the past year.

Subject to approval of the business case by partners in Q3/4 of 2016/17, the service is intended to be rolled out between April and October 2017.

The Lightbulb business case can be found at this weblink
http://politics.leics.gov.uk/ieListDocuments.aspx?CId=135&MId=4607&Ver=4 (item 499)

4.4 BCF 4 Integrated Domiciliary Care - Help to Live at Home

During 2016/17 a new domiciliary care service, called Help to Live at Home was commissioned jointly by the County CCGs and Leicestershire County Council.

The procurement secured nine new providers for the Leicestershire area covering 18 "geographical lots aligned to the CCG boundaries. The service has been commissioned to deliver improved reablement and provide the opportunity for local home care providers to be integrated with other parts of the health and care system in their locality.

The new service went live on 7th November. However, just prior to the launch, one of the new providers exited the process, which led to the council enacting a contingency plan across West Leicestershire, where three lots geographical lots were affected by this situation.

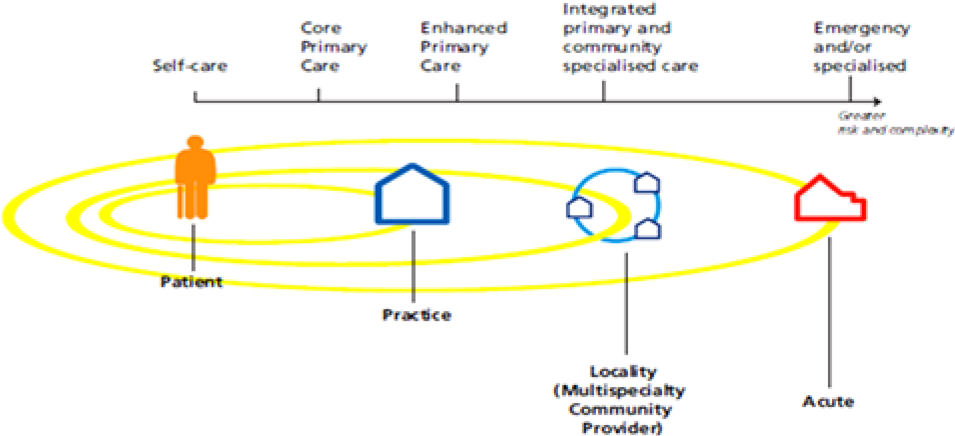
These lots are currently being covered by other local providers on an interim basis, and a re-procurement is underway with a view to selecting provider(s) for the remaining three lots by March 2017.

A back office joint commissioning function is in place to support the delivery of HTLAH and resources supporting the back office form part of the Leicestershire BCF financial plan.

Further work is being undertaken in Q4 of 2016/17 to stabilise provision, maximise capacity and monitor ongoing quality assurance requirements with the new providers.

4.5 BCF 5 - Integrated Locality Teams

Per the diagram below, our model of integrated health and care 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.



- Multidisciplinary teams and integrated services that are configured on a locality basis and wrap-around clusters of GP practices.
- Community based alternatives for urgent care.
- Ensuring those being discharged from hospital are received safely back into local community services.
- Shifting demand into non-medical support where appropriate by providing a broad and consistent range of social and preventative services.

Between November 2016 and April 2017 preparatory work has been undertaken at pace to implement integrated locality teams in LLR - in summary this has involved:

- Setting up a multi-agency Programme Board as one of the key workstreams of the STP - with joint SROs across health and care, and joint clinical leads across primary and secondary care.
- Development of a PID.
- Identification of 11 locality leadership teams across LLR comprised of designated senior professionals from primary care, CCGs, social care and community nursing teams.
- Undertaking a readiness self-assessment across all 11 locality teams.
- Assessing and adapting the learning from MSCP Vanguard sites including in particular Hampshire and Sunderland, to inform the local model.
- Via risk stratification, defining the cohorts in scope for integrated locality teams to focus on.

- Providing data analysis packets by locality and a self-serve guide to promote the ongoing use of this analysis.
- Defining the model of case management, care coordination, and how multidisciplinary working should develop in LLR with effect from April 2016.
- Defining the key evidence based interventions that should be applied to the patient cohorts to improve case management, care coordination and reduce acute/urgent care spend.
- Developing a framework for evaluating the impact of integrated locality teams.
- Developing a governance and accountability framework for integrated locality teams
- Sourcing leadership development for integrated locality teams (with a leadership programme commencing in February 2017).
- Using a range of the above outputs to create a "manual" for integrated locality teams for LLR to help structure their operational work, and capture learning and impact in the early stages of implementation.
- A number of initial test beds will be identified across the 11 integrated locality teams with a view to testing interventions within the specific cohorts, with effect from April 2017.

4.6 BCF 6 Integrated Urgent Care

During 2016/17 LLR partners have been working towards a new model of integrated urgent care in line with the NHS England Five Year Forward View, through our participation across LLR in the national Urgent Care Vanguard programme. This work has culminated in a procurement for a new model of service for April 2017 onwards which has the following key design principles:

- Responsive, accessible person-centred services as close to home as possible.
- Services will wrap care around the individual, promoting self-care and independence, enhancing recovery and reablement, through integrated health and social care services that are innovative and promote care in the right setting at the right time.
- Urgent care services in LLR will be consistently available 24 hours per day, 7 days a week in community and hospital settings.
- Clinical triage and navigation is a central part of the new integrated urgent care offer, reducing demand on ambulances and acute emergency services.

The following diagram identifies the components of our integrated urgent care system.

LLR Clinical Navigation

(Incorporating 111 clinical triage, OOH telephone advice, EMAS CATS, professioal advice line incl Consultant Connect and SPA)

Service piloted across LLR from October 2016 - hosted by DHU. Procurement in mid 2017.

The main changes to urgent care which will be delivered by the new service model are:

- The creation of a clinical navigation service, providing telephone advice, assessment and onward referral for people calling NHS 111 and 999.
- The clinicians working in the service will have access to patients' primary care records and care plans, where relevant, and will be able to directly book patients into primary and community urgent care services.
- The service will include warm transfer callers to specialist advice for mental health, medication and dental issues.
- Future plans for the navigation hub include bringing it together with a professional advice line and integration with a single point of access for social care.
- Extended access to primary care across LLR – so that patients can access primary care services 8am to a minimum of 8pm every day of the week.
- Urgent Care Centres will offer a range of diagnostic tests and medical expertise for people with more complex or urgent needs, and we will strengthen community based ambulatory care pathways which can avoid admission without the need to referral to acute hospital.
- An integrated streaming and urgent care service at the front door of Leicester Royal Infirmary Emergency Department, staffed by senior GPs working within the rebuilt Emergency Department.
- A 24/7 urgent care home visiting service across LLR, including out of hours home visiting and an acute visiting service for people with complex needs or living in care homes.

The Leicestershire Better Care Fund supports delivery of this new model of service by providing investment associated with the following components of the new urgent care model.

List of BCF urgent care schemes for 2017/18 which support the new model of urgent care from April 2017.

The CCG operating plans for 2017/18 indicate that the total number of emergency admissions commissioned for 2017/18 as 63,123 admissions, (comprising 34,779 for WLCCG and 28,344 for East Leicestershire and Rutland CCG.

The total number of emergency admissions commissioned reflects the impact assumed from the new urgent care system in totality, including the contribution from each BCF funded component.

The individual contribution assumed for each of the BCF funded schemes is shown below. The table shows the baseline activity assumed per scheme from 2016/17 and any additional activity required of the schemes over and above this level of achievement for 2017/18.

Insert table – awaiting final data

While these schemes will be reported monthly via the Integration Executive (and quarterly via NHSE governance routes), local performance management and assurance for the delivery of the urgent care system as a whole is via the LLR A&E Delivery Board.

4.7 BCF 7 - Integrated Points of Access

The Integrated Points of Access programme is an important enabler to the delivery of our urgent care system and to multidisciplinary community based teams working in localities. The service will provide integrated call handling across community based health and care services on a 24/7 basis.

Following production of a business case approved in the early part of 2016, LLR partners are currently in phase one of this development.

The Integrated Points of Access programme is working with seven existing call centres across health and care which coordinate community based services. These vary in size, scope and purpose, operate with differing models and performance requirements and are providing services from different locations within a range of NHS and LA organisations.

The business case demonstrated the benefits of enhancing the model of care by moving to a more consistent call handling approach across these services, and integrating them for example into a consolidated management structure, using the same technology and potentially operating from a consolidated estate.

Phase one of the work ends in June 2017, which involves each existing call centre adopting the new model of service, delivering initial operational benefits from this change. A gateway review then follows before partners determine if further integration across the services should be taken forward with the benefit of an estate and technology appraisal to inform next steps.

The design of the service is concerned with improved call handling and improved technology, for example having text messaging alerts and updates between professionals engaged in case management and care coordination in the community, freeing up valuable professional time in chasing the progress of activities across different parts of the system. As such this is a key enabler to integrated locality teams and is also a critical part of the LLR infrastructure sitting beneath the new clinical navigation service.

4.8 BCF 8 - Integrated Data

Leicestershire is seen as a national exemplar in data sharing due to the early adoption of the NHS number onto social care records (currently at 98%), the adoption of the PI care and health trak tool in 2015/16, and the application of this tool during 2016/17 to support arrange of transformation priorities including the emerging workstreams of the STP.

The implementation of PI Care and Health trak has provided valuable insights into the utilisation of health and care services across LLR and the impact of changes in care pathways. It has also been the catalyst for the creation of business intelligence network across LLR, and provided the data source/sets for the STP workforce analysis and the evaluation of BCF services through simulation modelling with Loughborough University.

The development of the summary care record solution for LLR is a critical enabler to the STP and Leicestershire Integration Programme.

The milestones in the digital roadmap which support this development are summarised below:

To be updated.

4.9 BCF 9 Integrated Commissioning

Section to be added - currently being drafted reflecting work in progress on

- *Joint approach to commissioning nursing and residential care placements*
- *Integrated Personal Budgets*

Brief Section summarising existing Section 75 agreements covering

- *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).*

And plans to develop an overarching s75 during 2017/18

4.10 BCF Plan Scheme Level Overview

A scheme level breakdown of the BCF plan which maps BCF components to the STP and the BCF National Metrics and BCF National Conditions is provided at Appendix 3.

Further scheme level financial detail is provided in the BCF spending plan at Appendix 4.

5 DELIVERY OF THE BETTER CARE FUND NATIONAL CONDITIONS AND METRICS

5.1 Assurance on the preparation and approval of the BCF Plan by the Leicestershire Health and Wellbeing Board

There has been extensive engagement across all partners in the preparation of the Leicestershire BCF as shown in Appendix 5.

The detailed work to refresh the BCF has been led by the Leicestershire Integration Executive per the scheme of delegation in place via the Health and Wellbeing Board Terms of Reference.

The Leicestershire Health and Wellbeing Board received a report and presentation on the progress with the BCF refresh at their meeting on 5, January 2017, and are being asked to receive the draft BCF submission for approval on 16 March 2017, in order that the Board is able to receive these materials prior to the pre-election period.

It is hoped the Board will be able to approve the draft BCF submission at this meeting, subject to the national BCF guidance being published ahead of this date. Should this not be available delegated approvals will be put in place so that the BCF submission can be finalised and the NHS England submission timescales can be achieved between formal Board meetings.

5.2 How the BCF Plan Maintains Protection of Adult Social Care

Within the 2016/17 BCF plan we agreed a number of investments where specific types of packages of care and other social care services were protected. In the 2016/17 BCF plan this totalled £17m of the £39m pooled budget.

The prioritisation and type of resource to be protected has been reviewed for 2017/18 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.

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

In the Leicester, Leicestershire and Rutland (LLR) local health and social care economy, a funding gap of £400m has been identified by 2020/21 if no action was taken on how current services are being delivered. This includes the current funding pressures faced by social care services, and the NHS together with anticipated increased demand and costs over the next five years.

The STP builds upon the Better Care Together (BCT) partnership programme and aims to address the way by which health and care services are delivered to meet the needs of the local people, while at the same time ensuring that the current financial pressures faced are effectively managed. The five year Strategic Plan sets out the most ambitious change for health and social care for LLR and was published in November 2016.

The five year plan has identified five key strands for change which taken together will help us to eliminate our combined financial gap by 2020/21 and contribute to closing the health and wellbeing and care and quality gaps

The five key strands include the development of:

- New models of care focused on prevention, and moderating demand growth, including place based integrated teams, a new model for primary care, effective and efficient planned care and an integrated urgent care offer.
- A reconfiguration of hospital based services, subject to consultation.
- Redesigned pathways to deliver improved outcomes for patients and residents.
- Operational efficiencies - to support financial sustainability.
- Getting the enablers right-including workforce; IM&T; estates; and health and social care commissioning integration.

As interventions are focussed towards prevention, avoided hospital admissions, a ‘home first’ model of care and greater integration across social care, community health care and primary care, it has been recognised that this will impact on demand for social care support, public health interventions and community services.

The full implications of the strategy for the County Council need to be identified and addressed in order to manage the increased pressure on resources and to allow for planning to meet this additional demand. To date there are no additional Council funds identified to resource this. However there is a commitment, by all partners, to ensure a system wide response to meeting changes in demand across the sector that may enable further funding transfers from the NHS to local authorities with social care responsibilities may be required.

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 £66m budget savings between 2017-21, of which £10m is earmarked to be saved from Adult Social Care. The Council recognises the need to protect adult social care and accordingly has allocated only 12% of required savings despite spending 38% of the Council budget in this area.

The Council's 2016/17 MTFS shows an increased financial allocation for growth totalling £13m in Adult Social Care for the next four years, representing a 4% growth in adult social care budgets whilst overall council spending will fall.
The funding proposed from the BCF will in part meet increasing demand and cost and continue to protect social care services alongside the council's own measures.

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 2017/18 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 20117/18.

The breakdown of adult social care protection shown in the table below corresponds with the detailed BCF spending plan at Appendix 4.

Please note: the table below shows the 2016/17 breakdown. The adult social care protected spend for 2017/18 has locally been agreed to be set at the same level, per the same components as in the 2016/17 table - however this is subject to confirmation against the national technical guidance when published, and any changes required as a result.

Column will be added to show 2017/18, per the note above

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	Demand growth in nursing placements equivalent to 750 bed weeks.				238
Increased demand for Community Based Social Care Services	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**

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.

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.	BCF2	805
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.	BCF9	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.	BCF2	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.	BCF2	45
		1,193
Two elements of the DH Local Reform and Community Voices Grant are 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	58
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)		

5.3 Financial Requirements including Confirmation of the Source of Funds for the Refreshed BCF Plan

Financial Context

The BCF refresh for 2017/18 and 2018/19 has involved a comprehensive review of the proposed spending plan for that period.

The BCF Operational Group and the Integration Finance and Performance Group have led the detailed work to evaluate the performance of the BCF plan in 2016/17 including assessing financial performance and risks and the outputs of this work have been reported via the Integration Executive, approved by the Integration Finance and Performance Group 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, seeking local agreements on the level of the risk pool, the impact of national BCF allocations including inflationary factors and DFG allocation requirements.

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 in a health and care economy which continues to face significant sustainability risks linked to the over use of acute care.

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

- That the planning process has been made over the medium term with partner contributions to the pool exceeding the minimum required BCF funding levels of £43m in 2017/18 and 2018/19 (£39.1m in 2016/17)
- Additional contributions above the required minimum BCF level of funding total include:

  - An additional CCG contribution of £2.6m due to the addition into the BCF plan from 2017/18 of the second phase of the Intensive Community Support service in Leicestershire. This over and above the BCF minimum contribution and the s75 agreement will be revised to reflect this
  - An additional LA contribution of £0.7m in 17/18 and £0.1m in 18/19 (£0.2m in 16/17).
- That the investment in adult social care protection within the fund will be *£17m.*
- That *£2.9m* in 2017/18 and 2018/19 (£1.7m in 2016/17) of the DFG allocation will be passported directly to Districts for DFG delivery, in line with grant conditions, and the remaining *£0.2m* funding will be allocated as part of a joint decision including housing authorities.
- That funding has been set aside to help progress the Government's intention that by 2020 health and social care will be integrated across England.
- A further financial refresh will take place in Q3-4 of 2017/18 to take account of ongoing commissioning developments linked to the STP, national policy requirements and any further savings/re-prioritisation needed to ensure a sustainable pooled budget in the medium term.
- The creation of a £1m risk pool from within the BCF during 2017/18 is in recognition of the need to achieve further savings and headroom so that the plan can become more sustainable in the medium term. This is due to the significant financial pressures affecting partners in 2017/18, and the fact that, unlike the previous 2 financial years, the BCF plan does not have the benefit of any other contingencies or reserves to draw on from 2017/18 onwards.
- Should the £1m risk pool not be able to be achieved from the service review/VFM activities outlined in the programme plan the risk will be shared between CCG core budgets and the BCF plan on a 50%/50% basis.
- This will be reflected in the s75 agreement.
- Improved Better Care Fund (iBCF) – per the announcements made in the 2015 CSR, Local Authorities were expected to benefit from improved BCF allocations from 2017/18 onwards, however the amount received per area depends on the ability of the council to raise funding from the social care precept. As a result, Leicestershire does not receive any additional iBCF funding in 2017/18, and reduced levels in later years. It is anticipated that £5.6m of iBCF additional funding will be available via Local Authority allocations in 2018/19.The county council included a 2% social care precept in 2016/17 and budget plans include proposals to introduce a maximum further 6% over the next three financial years.

The table below confirms the source of funds to be applied to the BCF over the two year period. The BCF will be subject to refresh for 2018/19 to take account of refreshed guidance, any changes in the BCF policy and BCF allocations, and agreement will be sought across the partnership, including via the Health and Wellbeing Board by April 2018.

Better Care Fund Funding 2017/18 and 2018/19		
Funding Source	2017/18 £000	2018/19 £000
Minimum Contributions		
East Leicestershire & Rutland CCG*	15,832	16,129
West Leicestershire CCG*	20,843	21,239
Disabled Facilities Grants	3,067	3,067
	39,743	40,435
Additional Contributions		
Additional LA Contribution	716	53
Additional CCG Allocation (ICS scheme)	2,563	2,563
	3,279	2,616
Total BCF Funding	**43,022**	**43,051**
* Inclusive of Care Act Funding	1,388	

5.4 Leicestershire BCF Section 75

The (rolling) section 75 for the Leicestershire BCF was initially approved in 2015 and refreshed in line with the 2016/17 BCF plan schedules in June 2016.

This work was undertaken in partnership across the two CCGs and LA, and with the support of respective finance officers, corporate governance officers and legal advisers.

The BCF s75 was also updated in 2016/17 to reflect the inclusion of back office functions and reablement services associated with the new Help to Live at Home Service, which in itself has a related s75 document.

Work to refresh the BCF s75 for 2017/18 will be undertaken in April and June 2017 and the s75 will be approved via the existing governance routes of the CCG Boards, and by delegated authority from Leicestershire County Council’s Cabinet.

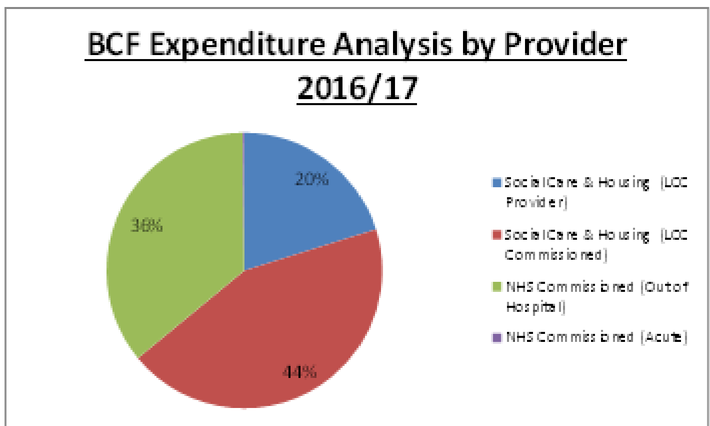
5.5 Investment in NHS Commissioned Out of Hospital Services

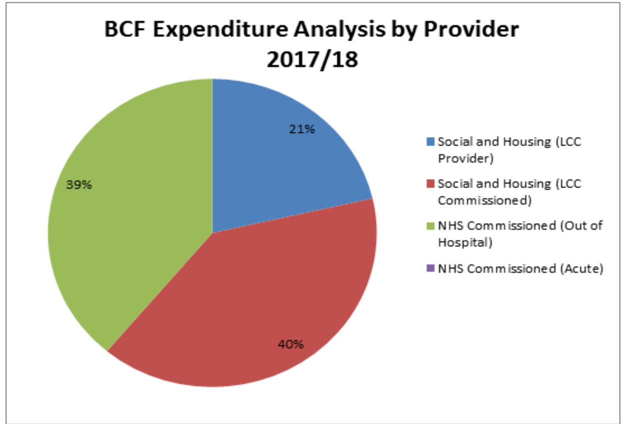
The detailed BCF spending plan at Appendix 4 demonstrates the breadth of the Leicestershire BCF plan in investing in NHS commissioned services out of hospital. This

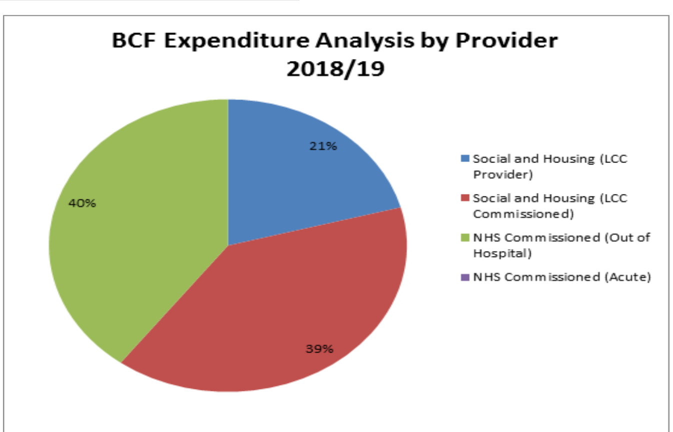
includes not only NHS community services and social care services but a range of prevention services such as first contact, housing support and local area coordination.

The proportion of the plan invested in these services is illustrated in the following tables and pie charts with comparison chart between 2016/17 and 2017/18:

Analysis of BCF Expenditure by Provider	2016/17	2017/18	2018/19
	£000	£000	£000
Social and Housing (LCC Provider)	7,942	9,206	8,950
Social and Housing (LCC Commissioned)	17,298	17,069	16,978
NHS Commissioned (Out of Hospital)	14,102	16,745	17,123
NHS Commissioned (Acute)	78	-	-
	39,419	43,020	43,051







Provisional themes table is to be further checked.

Analysis of BCF Expenditure by Theme	2016/17	2018/19	2018/19
	£000	£000	£000
Unified Prevention Offer	553	166	167
Home First	27,134	28,179	28,088
Integrated Housing Support	2,803	3,730	3,536
Integrated Domicilliary Care	992	1,694	1,694
Integrated Locality Theme	1,368	1,691	1,691
Integrated Urgent care	4,016	4,533	4,538
Integrated Commissioning	1,738	1,829	1,755
Enablers	815	545	548
Risk Pool, Contingency and Cost Improvement Target	-	656	1,035
	39,419	43,020	43,051

5.6 Disabled Facilities Grant Allocations

The Leicestershire BCF plan currently forecasts and commits to allocate *£2.85m* to Districts in the form of DFG allocations, subject to confirmation of the 2017/18 DFG allocations expected to be confirmed nationally by March 2017.

Due to the financial gap in DFG funding in the 2016/17 financial plan, caused by the late removal of the social care capital grant nationally, Leicestershire County Council has provided £600k of additional funds into the BCF to mitigate this pressure.

The allocation by District is shown in lines 32-38 of the BCF spending plan (Appendix 4). Preparations for the refresh of the BCF plan included working with District Councils to examine DFG forecasting information so that a more realistic projection of spend could be developed. Districts will move to invoicing quarterly for DFG activity based on actual DFG spend with effect from April 2017.

Although current forecasting information assumes the majority of the *£2.85m* will be required, should any allocation remain uncommitted/or be forecast to be uncommitted, each District will agree how this is to be used in the context of the BCF policy, e.g. in support of strategic priorities which integrate of health, wellbeing and housing, for the benefit of their local residents.

5.7 Better Care Fund Metrics

The following tables set out each BCF metric, our performance in 2016/17, our proposed trajectory for the 2 year period of this BCF plan and a summary of the rationale for the level of performance we are aiming for.

	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.		
2016/17 Performance	**Trajectory for 2017/18 and 2018/19**	**Target setting methodology and rationale**
621.80, based on Apr-Jan data	630.60 and 630.60	These targets have been set in agreement with the Adults and Communities Directorate at Leicestershire County Council based on the forecast end of year position for 2016/17 based on the Apr-Dec data. More challenging targets were not set because the new Help to Live at Home domiciliary care scheme has yet to achieve stability, and the evidence from the JSNA shows that the number of people aged 85+ is set to grow at a greater rate than the rest of the population from 2016 onwards.

	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.		
2016/17 Performance	**Trajectory for 2017/18 and 2018/19**	**Target setting methodology and rationale**
88.0%	89.0%, 89.0%	A small improvement in performance has been used to set the target. 89.0% would put Leicestershire in the top quartile nationally based on 2015/16 performance. These targets have been set in agreement with the Adults and Communities

		Directorate at Leicestershire County Council.

	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.		
2016/17 Performance	**Trajectory for 2017/18 and 2018/19**	**Target setting methodology and rationale**
287.04, 357.19 and 382.17 days delayed per 100,000 population aged 18+ per month for quarters 1-3 respectively	2017/18 • Q1 – 289.91 • Q2 – 355.94 • Q3 – 378.92 • Q4 – 474.71 2018/19 • Q1 – 285.67 • Q2 – 292.17 • Q3 – 275.81 • Q4 – 376.31	In terms of total days delayed in 2017/18 a 0.5% reduction on 2016/17 performance has been applied, allowing for population increase. However, that reduction has been phased across the year with 1% deterioration in performance in the number of days in Q1. For the final three quarters of 2017/18, 0.35% (Q2), 0.85% (Q3) and 1.3% (Q4) improvements in performance have been applied. The 2018/19 targets are based on aligning us closer to the performance shown by Derbyshire and Nottinghamshire, our real and statistical neighbours. Although Leicestershire benchmarks well nationally, we are still ambitious to reduce our delayed transfers of care.

<table>
<tr><td> </td><td colspan="2">Non-Elective Admissions (General & Acute)</td></tr>
<tr><td colspan="3">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.</td></tr>
<tr><th>2016/17 Performance</th><th>Trajectory for 2017/18 and 2018/19</th><th>Target setting methodology and rationale</th></tr>
<tr><td>753.75 admissions per 100,000 population per month</td><td>768.87 and 768.04 admissions per 100,000 population per month – based on CCG operating plans</td><td>In 2016/17 the target of avoiding 1,517 admissions was set, based on alignment with CCG operating plans. This number of avoided admissions was achieved by the end of September and by the end of December, 2,138 admissions had been avoided by BCF funded schemes.

CCG Operating Plan 2017/18 indicates the county CCG's will commission 63,123 emergency admissions. This represents an increase in the number of emergency admissions when compared with the 2016/17 contract (58,896).

The following is an initial breakdown of admissions to be avoided by schemes detailed in operating plan (for the two Leicestershire CCG's):

UEC = 662
Cardiorespiratory QIPP = 41
Stroke neuro rehab = 58
Total = 760

Admissions to be avoided by other BCF schemes:

ICS = further work in progress
ICRS-EoL = further work in progress
eFRAT = further work in progress</td></tr>
</table>

	Improved Patient Experience	
Selected metric for BCF Plan from national menu: - taken from GP Patient Survey: "In the last 6 months, have you had enough support from local services or organisations to help manage long-term health condition(s)? Please think about all organisations and services, not just health." The metric measures the number of patients giving a response of "Yes, definitely" or "Yes, to some extent" to the above question in the GP Patient Survey in comparison to the total number of responses to the question.		
2016/17 Performance	**Trajectory for 2017/18 and 2018/19**	**Assessment of impact of BCF on achieving the performance**
Data released July 2017	64.9% and 66.2%	Data is now released only annually each July. 2016/17 data 2015/16 performance was 63.6% released in July 2016. This is better than the England average for this period of 63.1%. The targets are for data due to be released in July 2018 and July 2019.

	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.		
2016/17 Performance	**Trajectory for 2017/18 and 2018/19**	**Assessment of impact of BCF on achieving the performance**
1,401.24 per 100,000 population aged 65+	1,191.05, 1,120.71	The targets for 2017/18 and 2018/19 are based on the predicted 2016/17 rate of 1,401.24 admissions per 100,000 population aged 65+ and the recently approved falls pathway improvement business case which will be implemented from April 2017. This should reduce falls admissions by 15% in year 1 and 20% in year 2. 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.

6 PROGRAMME PLAN

Our Programme Plan has been refreshed in light of the work undertaken to review the BCF plan for 2017/18. A high level summary is given below (the more detailed Gantt chart is available at Appendix 6).

The BCF refresh identified a number of specific commissioning actions and activities including service reviews and ongoing VFM assessment will take place in 2017/18. These are highlighted in red for ease of reference.

	Q1	Q2	Q3	Q4
Programme Management				
Sign-off section 75 agreement				
Monitor and report BCF performance and finance process				
Agree communications and engagement plan for 2017/18				
Annual review of BCF Equalities Human Rights Impact Assessment (EHRIA)				
Develop and agree evaluation plan for integration programme				
BCF Schemes				
Unified Prevention Offer				
Develop/agree social prescribing model for Leicestershire				
Information sharing agreement across Unified Prevention Board partners				
Map all areas of STP for prevention				
Undertake review of First Contact Plus service				
Integrated Locality Teams (STP workstream)				
Confirmation of case management model across LLR				
Review Integrated Care/Proactive Care models and redesign LLR approach				
Mobilisation of new falls pathway across LLR				
Develop and implement phase 3 eFRAT (Falls Risk Assessment Tool)				
Further development of falls prevention programme				
Pilot new pathway for end of life (including 24/7 service)				
Scope and mobilise cardiorespiratory service				
LLR Dementia Workstream				
Launch new jointly procured post diagnostic support & community in-reach service for people affected by dementia				
Housing				
Develop a proposed business model for medium term approach for Assistive Technology across Leicestershire				
Implement phase 1 (early roll-out in 1 District) of Lightbulb Programme				
Full roll-out of Lightbulb Programme across Leicestershire				
Refresh Disabled Facilities Grants quarterly forecasting for 2018/19				
Home First (STP Workstream)				
Baseline review of all current reablement spend, activity & outcomes				
Further milestones to be confirmed post baseline review				
Develop a new joint health & care LLR Carers strategy for 2017-20				
Explore recommendations to revise training approach for Health and Social Care Protocol				
Confirm commissioning intentions for Health & Social Care Protocol for April 2018 onwards				
Develop medium & longer term approach for integrated discharge services				

	Q1	Q2	Q3	Q4
Review overall mental health pathway as part of Home First work				
Urgent Care Model (STP workstream)				
Implement new urgent care services				
Review the social care Crisis Response Service				
BCT LD Short Breaks				
Review the LD Short Breaks service for 2018/19				
Integrated Commissioning				
Scope joint commissioning of placements / fee reviews				
Review of integration and quality review teams				
Help to Live at Home – mobilisation of new contracts				
Integrated Points of Access				
Standardisation phase for existing customer centres				
Conduct gateway review				
Agree progress to phase 2 (implementation stage)				
Integrated Data				
Agree commissioning plan for the PI Care and Health tool (or equivalent) from April 2018 onwards (developed in overall context of STP BI Strategy)				

7 INTEGRATION PROGRAMME RESOURCES

7.1 Team Structure Chart

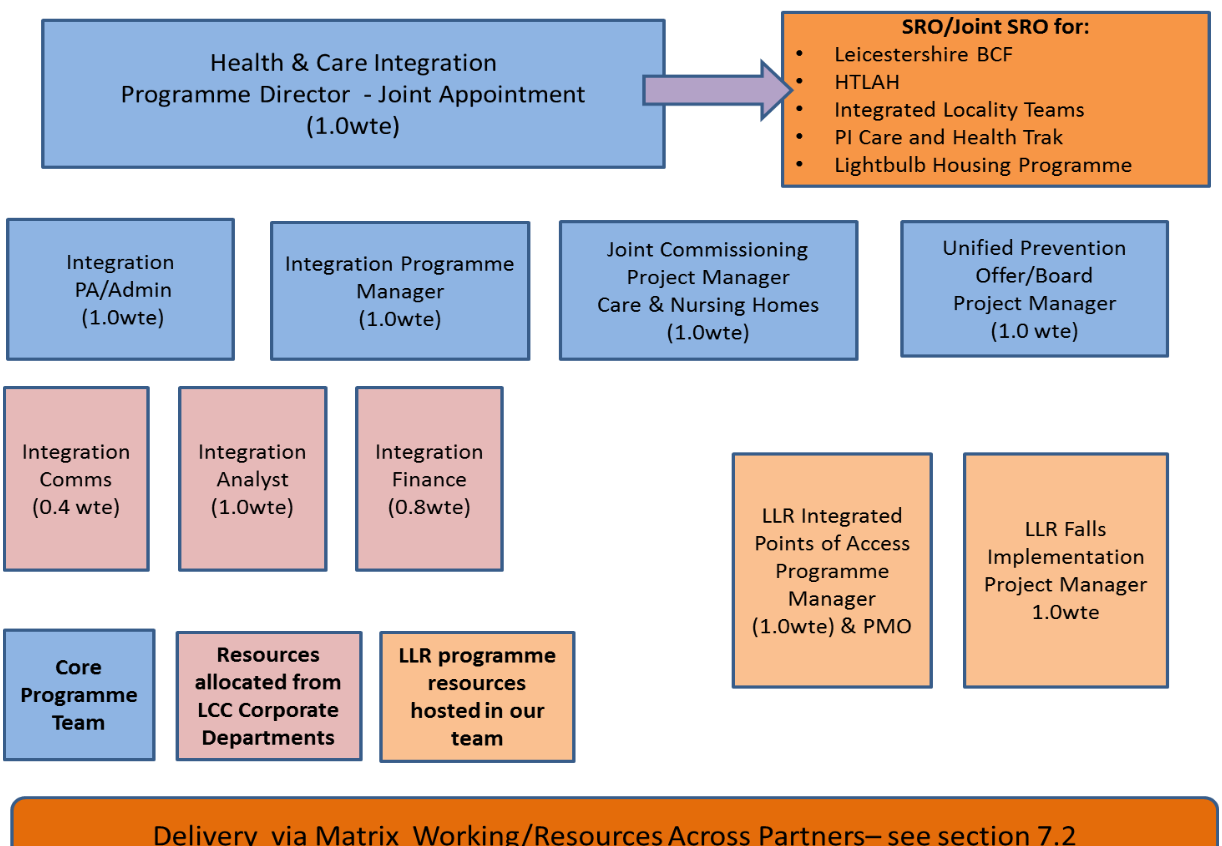
The diagram below shows the core integration team staff structure chart and associated level of resource in place to deliver the Leicestershire Integration Programme and BCF.

Roles shaded in blue and pink (per the key) are core to the team, including resources commissioned from LCC's corporate departments.

The joint commissioning project manager role is currently assigned to the care and nursing homes workstream and is operationally hosted in ELRCCG.

These have been included in the BCF programme management costs in the BCF spending plan at Appendix 4.

The LLR roles/programme resources are hosted in the team but the source of funds is outside of the BCF, linked to LLR STP infrastructure.



7.2 Matrix Management for Programme Delivery across the Partnership

The majority of the BCF is delivered through matrix working with partners, and project/delivery leads come from a wide range of partner organisations, including on an LLR wide basis

The programme plan at Appendix 6 shows the distribution of the work across, including the managerial lead and governance route for each element of the workplan.

The Integration Operational Group, which meets monthly, coordinates delivery and inputs across all agencies in order to achieve the programme milestones. Further information about the role of this group and the governance of the programme overall can be found in section 10.

There are a number of key roles and relationships in the matrix management system which ensures we deliver the totality of our programme:

- CCG Integration Leads (x two)
- Urgent Care PMO
- STP PMO
- Leicestershire County Council Transformation Unit
- Adult Social Care Assistant Directors/Transformation Leads
- STP PMO
- District Council Leads for Health and Housing

8 PROGRAMME EVALUATION & MEASURING IMPACT

8.1 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 the BCF policy framework and technical guidance for 2017/18.

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, via the Integration performance dashboard and programme highlight report.

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, e.g. the evaluation of Local Area Coordination and the SIMTEGR8 programme (see section 8.2).

g) During the BCF refresh for 2017/18 we conducted a number of in depth reviews of existing BCF funded services to examine their overall efficacy and VFM. The findings were scrutinised by the Integration Operational Group and Integration Executive and informed specific commissioning and decommissioning decisions for the 2017/18 – 2018/19 BCF plan.

8.2 SIMTEGR8

During 2016/17, we conducted a second phase of our integration evaluation and research study (SIMTEGR8) in conjunction with Loughborough University, SIMUL8 Corporation and Leicestershire Healthwatch. Building on the methodology developed in 2016/17 where we evaluated 4 emergency admissions avoidance services, a further four BCF services in 2016/17. Findings are being disseminated regionally and nationally during 2017/18. Further information can be found here http://www.healthandcareleicestershire.co.uk/health-and-care-integration/monitoring-and-evaluation/

9 RISK REGISTER AND RISK MANAGEMENT

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 7.

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 issues and risks on a monthly basis. The Key Risks relating to the BCF refresh as at March 2017 are summarised below. These are can characterised as a combination of:

1. Overall LLR system level risks (service, financial and transformational), per the LLR STP.

2. Specific risks affecting the Leicestershire BCF plan/pooled budget, (arising from both the LLR system level risks and the national policy position for the BCF).

   a. Impact of the 2017/18 financial position across the health and care economy – risk that partners are forced to address immediate urgent care system pressures vs investing in medium term solutions.
   b. Lack of financial headroom within the Leicestershire BCF plan, including lack of reserves and contingencies from 2017/18 onwards.
   c. Increased significant risks in CCG financial plans from 2017/18 onwards.
   d. The national BCF guidance has not yet been published at the time of drafting this narrative. There are 3 key areas of risk that need further clarification via this guidance:
      i. Whether a risk pool is required for emergency admissions performance. (Initial feedback is that BCF guidance is likely to state this is required only if the BCF is expected to deliver a reduction in emergency admissions beyond CCG operating plan assumptions).
      ii. Whether any increase in LA allocations into the BCF will be announced/available, based on the previous 2015 CSR announcements and intentions. If so, these would be linked to either DFG or Adult Social Care budgets.
      iii. Any DFG allocations pressures into the Leicestershire BCF arising from the LA allocations/BCF technical guidance (expected in late February 2017).
   e. Reliance on the delivery of further in year savings from service review and redesign across a number of BCF service lines in order to deliver a more sustainable medium term financial plan.

   f. A number of these BCF service lines are subject to work lead by STP workstreams during 2017/18, with key milestones and quantifiable impact in some areas still to be confirmed.
   g. Ongoing urgent care pressures, including a deterioration in DTOC performance in 2016/17.

10 PROGRAMME GOVERNANCE

Since February 2014 the Leicestershire Integration Programme has been governed by the Leicestershire Health and Wellbeing Board, with a scheme of delegation in place to the Leicestershire Integration Executive, the group which provides day to day oversight of the delivery of the Integration Programme and associated pooled budgets, and which meets on a monthly basis.

Leicestershire Integration Executive

- Chaired by a clinical lead from the CCG (rotating approx. every 18 months) the Leicestershire Integration Executive is a very productive, delivery focused group which has consistently benefited from excellent engagement at Director level across health and care organisations. The Integration Executive includes representation from the County Council, District Councils and Healthwatch, plus all local NHS organisations, both commissioners and providers.
- This group is the overarching governance group responsible for the delivery of the whole integration programme in Leicestershire on behalf of the Health and Wellbeing Board. The group sets the vision for integration, oversees the delivery and evaluation of the BCF in totality, sets strategic priorities across workstreams and ensures alignment with LLR-wide programmes of work within the STP. Members of this group are also SROs for key deliverables within the LLR STP/ Leicestershire Integration Programme.

There are 3 other key groups in place which support delivery of the Integration Programme :

Integration Operational Group

- Chaired by the Director of Health and Care Integration, this group comprises senior managers responsible for delivery of the various components of integration across the programme, with representatives from all partners on the Integration Executive.
- The group which meets quarterly is responsible for overall detailed coordination of the Integration/BCF programme plan, including business case development, investment and disinvestment proposals, project management, programme/project level budget management, scheme level trajectories, metrics, KPIs and evaluation, digesting national policy and best practice, staffing resources into key elements of the programme, troubleshooting across the programme partnership, communications and engagement plans/materials, governance planners and reporting into respective partner organisations, refreshing the annual BCF plan/submission and ensuring the quarterly reporting to NHSE is prepared, approved and submitted.

Integration Finance and Performance Group

- Chaired by a CCG Director of Finance, this group comprises director/senior manager level commissioning and finance leads from the LA and two County CCGs.

- The group is primarily responsible for oversight of the pooled budgets supporting the integration programme, including setting strategy for contingencies and risk pools, and the overall financial management and performance of the section 75 for the BCF.

- During 2016/17 the TORs have been updated to include oversight of other section 75 agreements and pooled budgets which support the Integration Programme including Help to Live at Home, Learning Disabilities and Community Equipment. The group is tasked with overall prioritisation of investments and making final recommendations on the BCF financial plan/pooled annually, as well as refreshing the BCF s75, and ensuring the appropriate governance approvals for the s75 via LCC Cabinet, CCG Boards and the Health and Wellbeing Board.

Unified Prevention Board

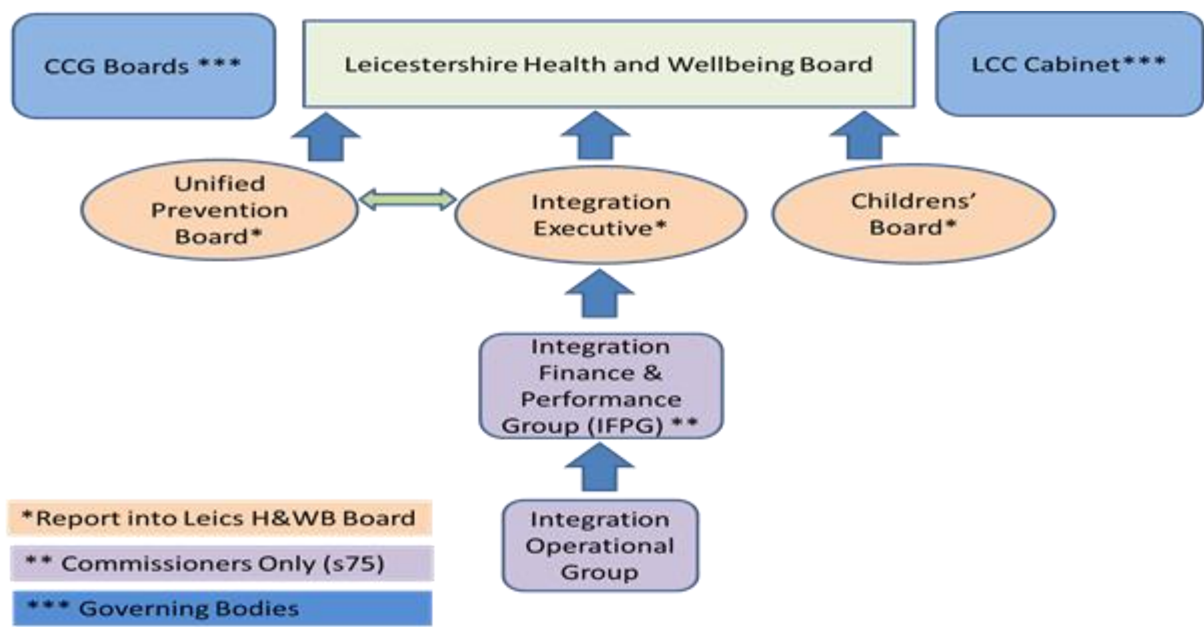
- Chaired by the Director of Public Health and the District Council Chief Executive from Blaby, this group meets monthly and comprises senior managers from all health and care partners as well as the voluntary sector, fire and police.

- The group has been tasked with a baseline review of existing services, designing the model for a unified prevention offer for Leicestershire's communities/localities for the future, and recommending the forward commissioning strategy. During 2016/17 the group has been assessing the most appropriate model/mechanisms for social prescribing in support of the unified prevention offer. This group reports directly to Leicestershire's Health and Wellbeing Board given the importance of this work in relation to both Leicestershire's Joint Health and Wellbeing Strategy and LLR STP prevention workstream.

The Leicestershire Integration Programme has maintained good visibility, communication and engagement across partner organisations with regular all member briefings, reports to executive teams of NHS Trusts, CCG Board meetings, scrutiny committees, Cabinet and the District Councils, (for example via District Council Health and Wellbeing forums, the Housing and Health Members Advisory group, the Lightbulb Programme Board and District Council Chief Executives meetings).

Governance approvals for the Integration Programme can be complex but the governance planner and programme plan ensure activities are well coordinated and that individual organisations are engaged in the development, assurance and approval of plans with clear records of decisions and delegated authority where applicable.

The diagram below shows the current governance arrangements for the Integration programme and how the Integration Executive reports into the Leicestershire Health and Wellbeing Board.



The Integration Programme has participated in two internal audits to test the delivery and governance mechanisms associated with the programme including the BCF specifically, both of which have returned high levels of assurance. CCG and LA internal and external auditors are also closely involved in testing the financial arrangements and financial governance operating between the three commissioners who lead the s75 BCF.

While the above arrangements have served us well to date, with the introduction of the LLR STP, it is timely to review our local arrangements, especially as the new STP workstreams will bring together integration deliverables across the 3 LA footprints and we would wish to avoid duplication of effort and governance arrangements where possible.

STP Governance

The following LLR –wide workstreams will now involve oversight of deliverables that are closely linked to the 3 BCF plans in LLR

- Integrated Locality Teams
- Home First
- Urgent Care
- Integrated Points of Access
- Prevention
- Implementation of the LLR Digital Roadmap

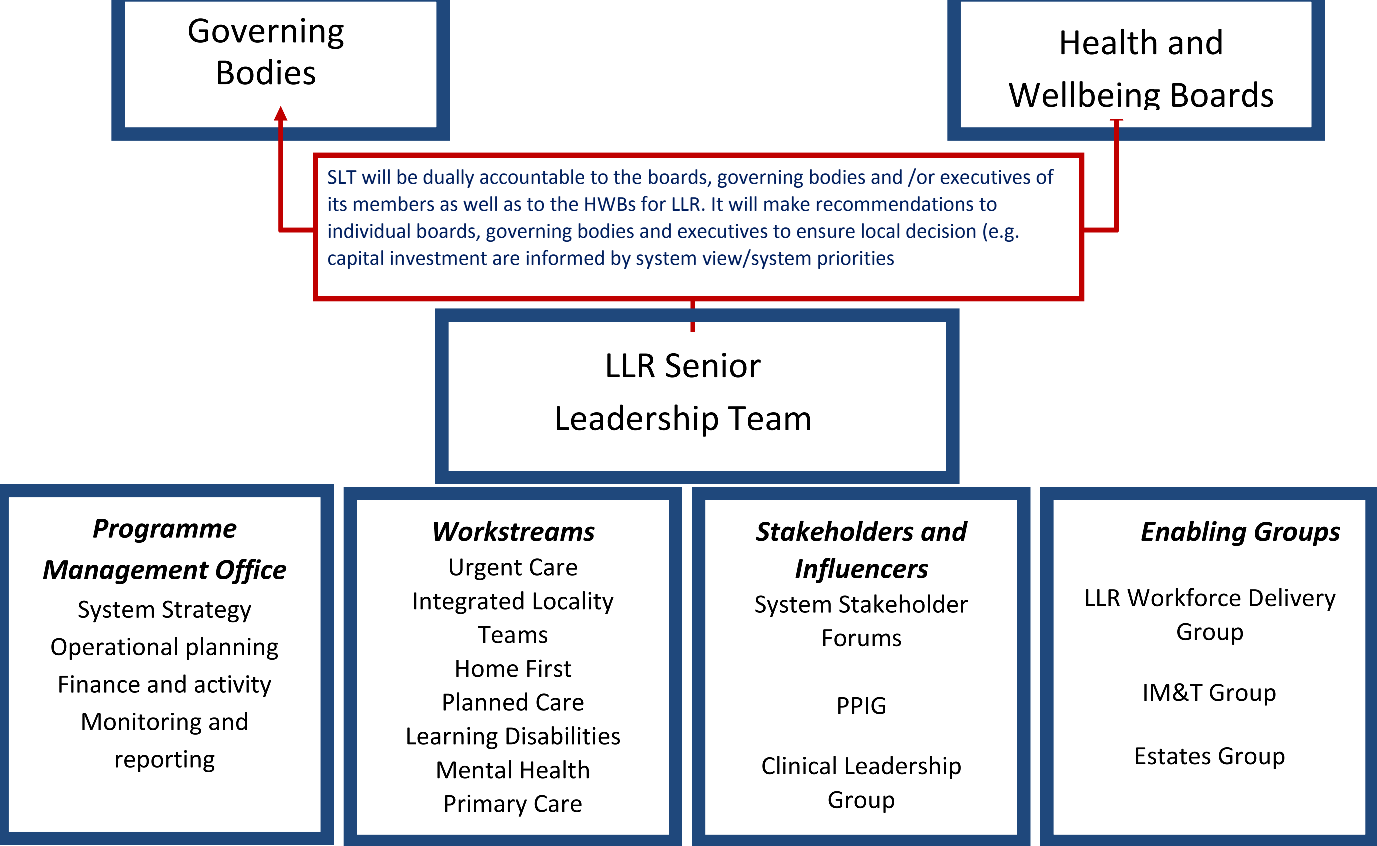
The progress of integration across health and care will therefore increasingly be delivered and measured on an LLR wide basis, with the BCF plans and pooled budgets as a key enabler to delivering improved models of care in LLR.

However the development, approval, submission, and quarterly monitoring of local BCF plans, including their national conditions, metrics and budgets is still anticipated to continue via NHSE on the basis of each LA footprint for the next two financial years, expect perhaps in the case of those areas who "graduate" from the BCF.

National guidance about graduation from the BCF is expected shortly. In the meantime locally we will refresh our governance structures in 2017/18 so that we place emphasis on the STP workstreams where applicable for the delivery of BCF components, as well as keeping in place a lean local structure to govern assurance and reporting for each Health and Wellbeing Board area. Following a leadership development session across LLR in February 2017, the Senior Leadership Team for the STP is already engaged in considering how these matters should be addressed.

In addition to the issues noted above, it has been agreed that each Health and Wellbeing Board in LLR should take a lead oversight role in one or more of the STP workstreams. For Leicestershire this will be Integrated Locality Teams and Community Hospitals reconfiguration. Local governance arrangements and TORs for the Health and Wellbeing Board are already being updated to reflect this and a paper setting out the Board's role and actions in this regard was presented at the January 2017 Health and Wellbeing Board meeting – see this weblink: http://politics.leics.gov.uk/documents/s125463/Outputs%20from%20Development%20Session.pdf

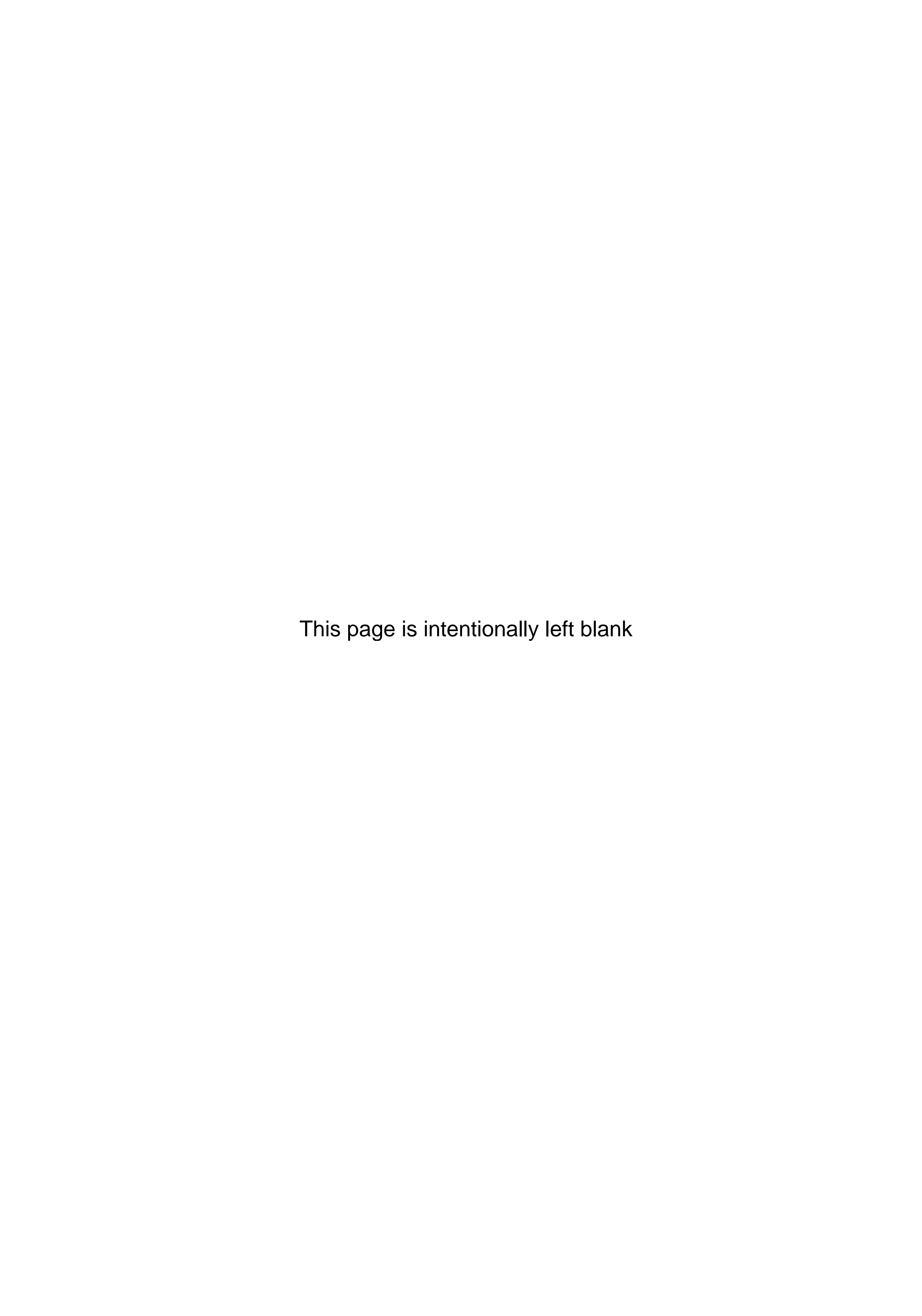
A diagram showing the governance arrangements for the LLR STP is given below.



11 EQUALITY AND HUMAN RIGHTS IMPACT ASSESSMENT

Developments within the BCF Plan are subject to an equality impact assessment and the evidence base supporting the BCF Plan has been tested with respect to Leicestershire Joint Strategic Needs Assessment. An equalities and human rights impact assessment has been undertaken which is provided at - http://ow.ly/1sgC309cJUu .

This document is undergoing annual review by Leicestershire County Council's (Adults and Communities Department) Equalities Group on 14 March 2017 and any revisions arising from this will be reflected in the final BCF Plan submission to NHS England.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