LEICESTERSHIRE'S BETTER CARE FUND PLAN 2019/20

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Appendix A

INTRODUCTION

The Leicestershire BCF Plan 2017-19 has proved effective in delivering service transformation by:

- Leading the implementation of a new integrated service offers, spanning health, care and housing
- Maximising the impact of BCF funding, in particular supporting new models of integrated care in the community
- Maximising the impact of IBCF funding, in particular to improve hospital discharge and sustain adult social care
- Achieving the target for all four of BCF metrics in 2018/19
- Leading ground-breaking work in data integration, via the new LLR Business Intelligence Strategy.

The Leicestershire BCF Plan and pooled budget for 2019/20 remains a key enabler to the transformation of health and care within the County, and across the wider health and care economy of Leicester, Leicestershire and Rutland.

2019/20 marks the final year of the current national BCF Policy framework and a transitional year in terms of adopting the new NHS 10 Year Plan, and the policy requirements of the anticipated Adult Social Care Green Paper and NHS Green Paper on Prevention.

Leicestershire's BCF Plan for 2019/20 is broadly a continuation of the 2017-19 plan and is summarised in the following slides. It should be read in conjunction with:

- The BCF Plan on a Page - http://www.healthandcareleicestershire.co.uk/wp-content/uploads/2018/10/BCF-Plan-on-a-page-2017-19-rev.102018.pdf
- The narrative predecessor BCF Plan 2017-19
- http://www.healthandcareleicestershire.co.uk/download/Leicestershire-BCF-Plan-2017-19.pdf
- The BCF 2019/20 Expenditure Plan (Appendix A)

LLR's vision, goals and principles

The aim of the BCT partnership is to improve the provision of health care in Leicester, Leicestershire and Rutland by bringing together NHS organisations and other partners, including local authorities and the voluntary and community sector closer together to deliver a better services and to do so more efficiently. The following diagrams explain our vision, principles and goals for a sustainable, affordable system that is fit for purpose. The vision, goals and principles has been developed by the clinical leadership group and have been agreed by all our partners.

Our goals

Keep more people well and out of hospital through better public health and prevention of illness, early detection and management of disease, support for patients at home and in their community.

Care in a crisis from NHS 111 to 999, urgent care to the emergency department, including an urgent and emergency response for people experiencing mental health episodes.

More care closer to home from the management of long term conditions to planned procedures and follow-ups

High quality specialist care to support patients in their homes, community facilities and hospitals to get the best possible outcomes.

LLR's Integrated Care System: Workstreams and Delivery Tiers

Integrated Care System Development
led by the System Leadership Team

Enablers	Transformation Programmes
Workforce	Planned Care
Digital - IM&T and BI	Cancer
Finance and Contracting	Urgent Care
Communications and Engagement	Integrated Community Services
Clinical leadership	Primary Care
	Mental Health
	Learning Disabilities
	Childrens, maternity &neonates
	Prevention and health inequalities

Level	Population Size	Purpose
Neighborhood (Health Needs Neighborhood and Localities)	30,000 to 50,000	• Deliver high quality primary care • Proactive care via integrated locality teams for defined populations and cohorts • Asset based community development to support health, wellbeing and prevention
Place (Leicester City, Leicestershire County and Rutland	37,000 to 610,00	• Based on upper tier authority boundaries • Delivery of specialised based integrated community services, including social care • Delivery of reablement, rehabilitation and recovery services • Prevention services at scale
Systems (Leicester, Leicestershire and Rutland)	1,000,000+	• System strategy, planning and implementation • Work across the system on specialist areas such as cancer, mental health and urgent care • Make best use of all our combined assets including staff and buildings • Manage performance and system finances • Establish a system framework for prevention

Our vision for Health and Care Integration in Leicestershire (Place)

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

BCF Plan Themes 2019/20

- Unified Prevention Offer - (place and neighbourhood) for example First Contact Plus, Falls Prevention, Lightbulb Housing Services
- Integrated Community Services –for example integrated reablement , integrated teams
- Improving Hospital Discharge - high impact changes, core integrated discharge services
- Sustaining Adult Social Care – for example demand management, workforce development, Care Act, assistive technology
- Integrated Commissioning – for example Dementia, CHC, LD, Personal Budgets
- Urgent Care – for example acute home visiting service
- Data Integration - for example data warehousing integration tool
- Disabled Facilities Grants (ring fenced to District Councils for major home adaptations)

WHAT WILL THE BCF PLAN DELIVER/FUND IN 2019/20 - PREVENTION

- Leicestershire's social prescribing one stop shop **First Contact Plus** is well established, with GP and (new) self referral options, via both digital and telephone channels. It provides access to a range of interagency prevention support including **lifestyle services**.
- **Local Area Coordinators** (LCC funded) are based in Leicestershire's neighbourhoods providing a face to face service, working with caseloads of people who need additional support with social prescribing, and building community capacity targeted to improving health and wellbeing.
- Leicestershire's award winning **Lightbulb Housing Service**, provides a one stop shop for all aspects of neighbourhood housing support, including the hospital housing team **(HET).**
- **LLR's Falls Pathway** includes non conveyance alternatives, technology, therapy triage and postural stability classes, with key prevention components currently being tested.

The above components have been designed specifically to provide a consistent, easy to access prevention offer for the **Integrated Teams** working in Leicestershire's neighbourhoods and the populations they serve. In 2019 we will be consolidating the prevention offer further and measuring the impact in 2 ways:

- How systematically and effectively the prevention offer is delivered by our Integrated Teams, and the impact on case management and patient outcomes
- Insights gathered from our **Prevention at Scale** project which is assessing why patients seek GP appointments for non medical interventions, and how our prevention services could better meet their needs

WHAT WILL THE PLAN DELIVER/FUND IN 2019/20 – INTEGRATED TEAMS

Across Leicester, Leicestershire and Rutland we have implemented **Integrated Teams** in each neighbourhood, initially focusing on improved care coordination for patients who are frail, have high health care costs or 5 or more long term conditions.

In 2018/19 we are undertaking an evaluation of the 4 components of the integrated teams model via **a pilot in the Fosseway area of Hinckley and Bosworth**. In 2019/20 we will apply the learning from this to finalise implementation of the model across all Integrated Teams in Leicestershire.

With the introduction of **Primary Care Networks** in 2019/20 we will focus on the following priorities:

- Refining and embedding the approach to population health management (using the ACG risk stratification tool and other neighbourhood/locality level data sets per our BI strategy)
- **Ensuring each integrated team is supported by a care coordinator**
- Extending the types of patients the integrated teams case manage
- Extending the team/model to include other services such as community mental health
- **Assessing if the current social prescribing infrastructure in Leicestershire meets with the NHS plan requirements, and addressing any gaps.**

WHAT WILL THE PLAN DELIVER/FUND IN 2019/20 – INTEGRATED DISCHARGE

- In Q1 2019/20 we will deliver the final element of the national **High Impact Changes** framework (7 day services) so that we achieve "established" against all 8 domains and will continue to deliver a range of other improvements via the LLR multiagency discharge action plan
- In 2019/20 we will design and deliver **more effective medium term accommodation solutions for MH and LD patients**, as these are the remaining areas where we experience the most delayed bed days.
- In 2019/20 we have **committed approx £15m of the BCF/IBCF to maintaining our good DTOC performance** in line with the national target**.**
- The **Integrated Teams case management model** includes receiving daily data on simple discharges from hospital which are proactively contacted by the care coordinator. A check list is applied to troubleshoot any issues once home, helping individuals, families and carers with advice and coordination for any follow up needed including prevention support, help with medications etc.
- **The hospital housing discharge (HET) team** (funded non recurrently from the IBCF for 2019/20) will deliver expert housing support to discharge teams and their patients at the Bradgate Unit and UHL.

WHAT WILL THE PLAN DELIVER/FUND IN 2019/20
INTEGRATED COMMUNITY SERVICES

Reablement

- In 2018/19 we have developed and tested a **new integrated reablement offer including 24/7 crisis response** and in 2019/20 we will apply the learning and finalise the implementation. There will be a **combined point of access** for receiving referrals and for the operational delivery of integrated NHS and LA reablement services.
- In November 2019 we will extend the contracts of our **Help to Live at Home** domiciliary care providers, following the first 3 years of our integrated service, and plan for the next phase of developments.

Redesigning Other Community Services

- In 2018/19 across LLR a process has begun to **redesign community nursing, therapy and community hospital provision,** led by the NHS
- In 2019/20 engagement and consultation on the proposed model will take place and initial stages of the changes will be implemented
- The BCF plan for Leicestershire funds some existing services (for example Intensive Community Support beds) - so BCF funding will be re-aligned according to the new model
- There will be implications for how adult social care services are delivered in community settings and how these integrate further with the redesigned NHS services.

WHAT WILL THE PLAN DELIVER/FUND IN 2019/20 – SUSTAINING ADULT SOCIAL CARE

The IBCF is a non recurrent grant to LAs targeted to sustaining adult social care and supporting hospital discharge.

A Green Paper on Adult Social Care in expected in 2019/20 which will set out future funding arrangements for Adult Social Care. As the IBCF is non recurrent, a transition plan is in place for 2019/20 for all remaining IBCF elements of the plan.

Aside from the Hospital Discharge investments already covered in this presentation, IBCF funding is supporting for example :

- **Workforce development**, such as intensive recruitment and retention support for the social care provider market
- **Maintaining capacity** /deferring savings requirements in the HART service (LCC's reablement service)
- The continuation of the **discharge response team (DRT) within UHL**
- **Enhanced carer support** per the LLR carers strategy
- Additional **enablers for Transforming Care** (LD)
- Mitigating a range of **inflationary , demand, and legislative pressures** on social care, for example demographic demand and national living wage

WHAT WILL THE PLAN DELIVER/FUND IN 2019/20 – DIGITAL TRANSFORMATION AND DATA INTEGRATION

- The Leicestershire BCF plan is testing new **Assistive Technology** in the home during 2019/20 – with a view to upgrading from traditional pendant and pull cord alarms to using the "internet of things" – e.g. sensors and smart phone/home technology which can then be used for multiple purposes by consumers and connect them to a range of integrated health and care services.

- The implementation of the **LLR Falls Pathway** includes testing 3 technologies as part of an EMAHSN evaluation programme – these will:
  - Assess a person's risk of falling
  - Track individual patients and the falls interventions they have received to measure the impact of falls assessment and interventions.

- Per the LLR BI Strategy, the implementation of the **new data integration warehousing tool** (a product being designed with Mids and Lancs CSU) will take place in 2019/20, supported by the BCF funding.

- All of the above are being planned and delivered in the context of the **LLR Digital Roadmap**, which will evolve further in 2019/20 in light of the additional digital commitments in the NHS Long Term Plan.

WHAT WILL THE PLAN/FUND DELIVER IN 2019/20 – INTEGRATED COMMISSIONING

Priorities for integrated commissioning at Place level in 2019/20 have been agreed as follows:

- **Organisational Development for Integrated Commissioning** – workshop Q1 2019 to set the outcomes framework, culture and goals across the work programme/partnership
- Develop our local approach/offer for **Integrated Personal Budgets**
- +1 contract extension of the existing **Help to Live at Home** provider contracts, and determine the **commissioning plan for Domiciliary Care for 2020 onwards**
- **Post diagnostic community and inreach dementia services**
- Plan for commissioning requirements arising from the **Community Services Redesign**
- **Review the health and social care protocol** and **commission a revised training offer** from 2020
- Work plan in relation to **Learning Disabilities at Place level** (in support of the LLR Transforming Care Programme)
- Implement further actions in relation to **CHC processes and funding arrangements** between agencies

BCF National Metrics – Draft Targets 19/20*

Reminder of the Four Metrics

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

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

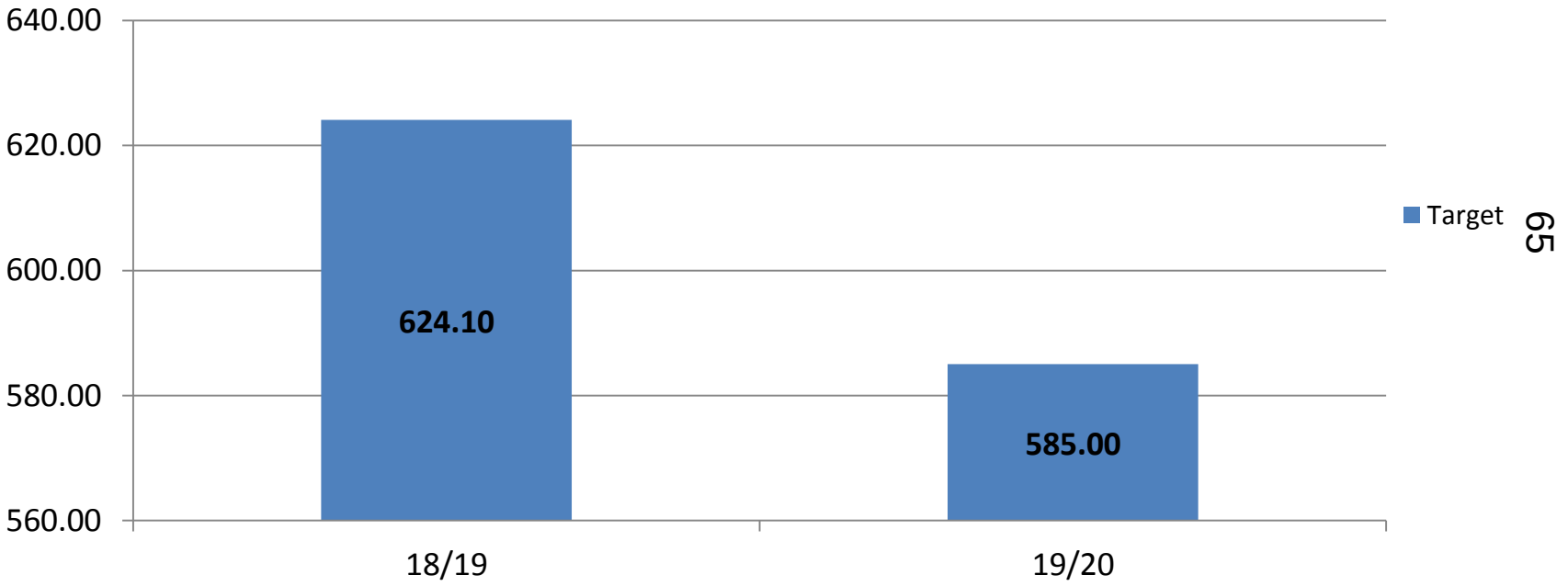
3. **Metric 3:** Delayed transfers of care from hospital per 100,000 population

4. **Metric 4:** Total non-elective admissions into hospital (general and acute), per 100,000 population

**BCF guidance not yet published for 2019/10*

Metric 1 – Admissions to residential/nursing homes

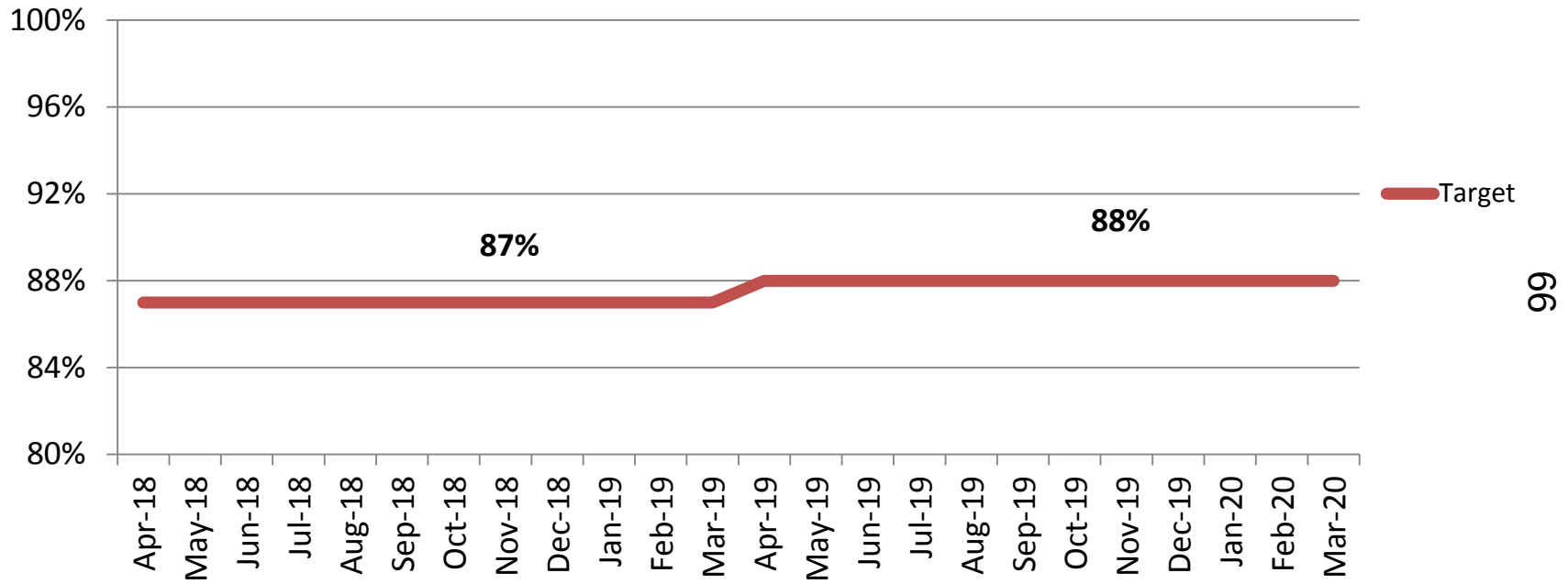
- **Target – per 100,000 population, per year**



FY18/19: **624.10** (target)
FY19/20: **585.00** (target)
Variance: -**39.1**

Metric 2 – Reablement

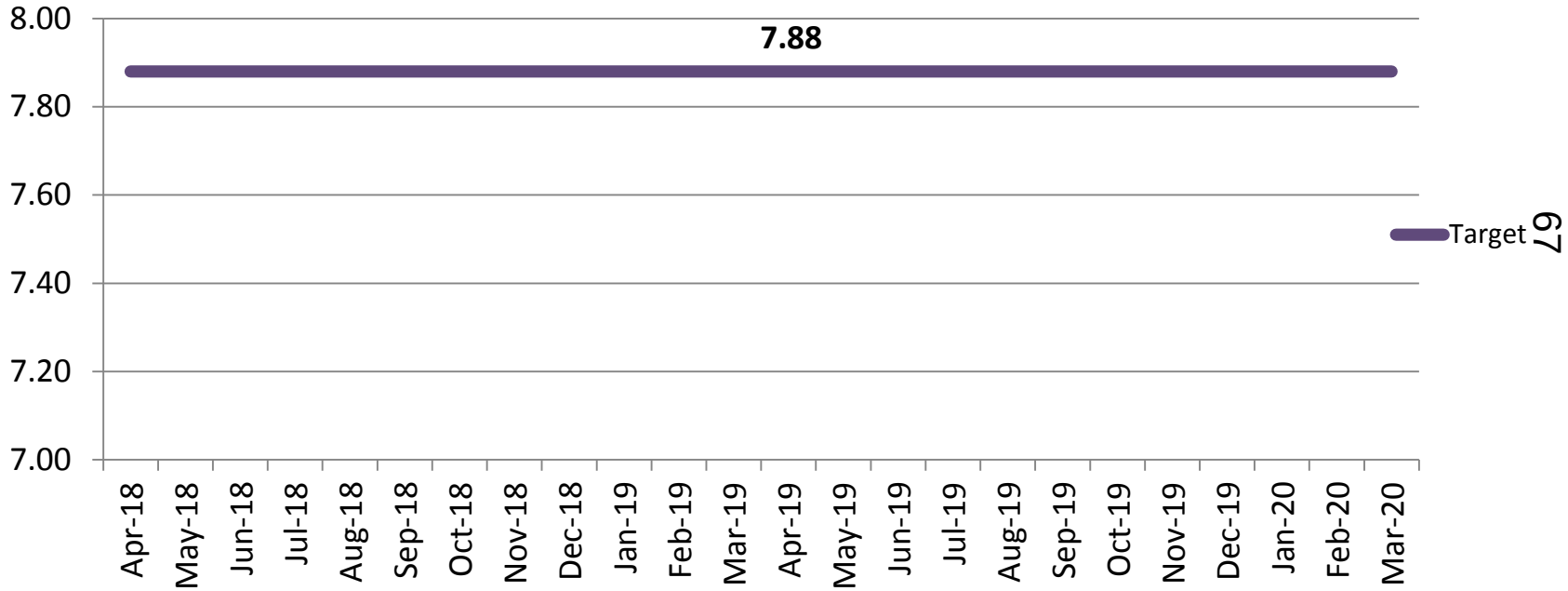
- **Target – % per month/year**



FY18/19: **87%** (target)
FY19/20: **88%** (target – locally set)
Variance: +**1%**

Metric 3 – Delayed Transfers of Care

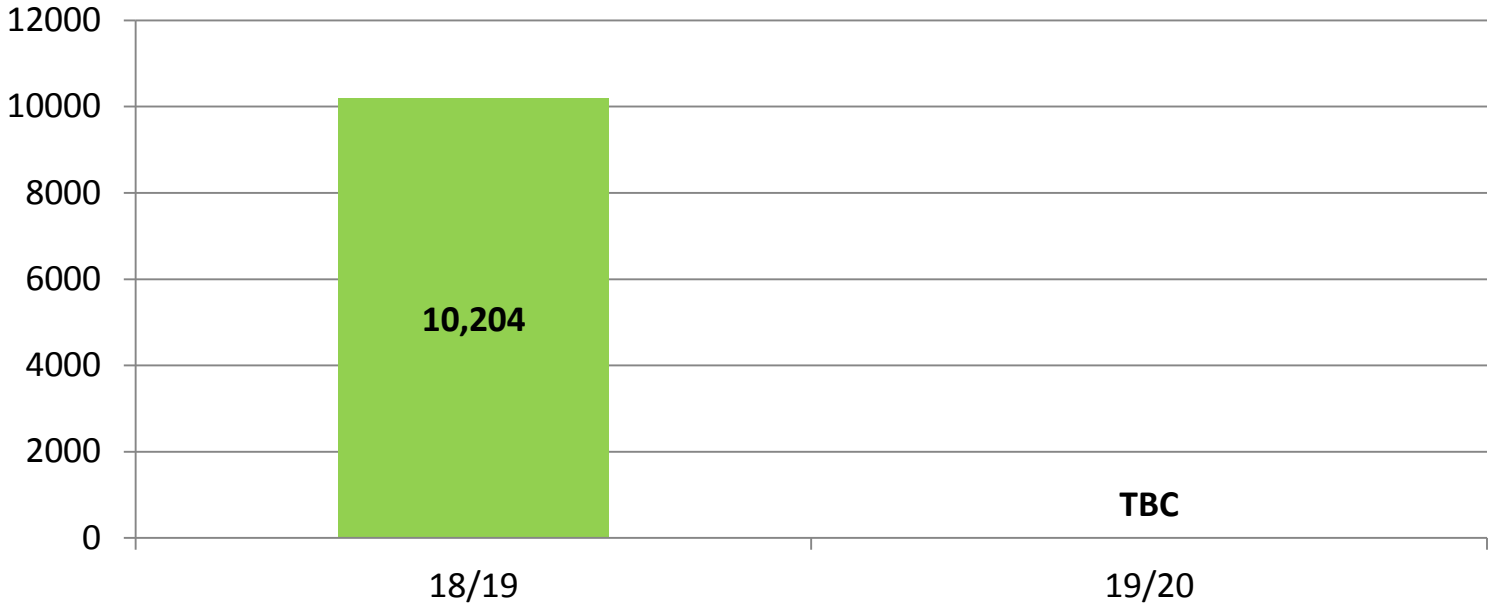
- **Target – per 100,000 population, per month/year**



FY18/19: **7.88** (target)
FY19/20: **7.88** (draft target - proposed locally - e.g. maintain DTOC performance – actual is subject to national confirmation by NHSE - pending
Variance: TBC

Metric 4 – Non-Elective Admissions

- **Target – per 100,000 population, per year**



FY18/19: **10,204** (target)
FY19/20: **TBC** (issued nationally by NHSE – pending)
Variance: **TBC**

BCF Plan Pooled Budget: Source of Funds

	2018/19 £m	2019/20 £m
CCG Minimum Allocation	37.4	*38.0
IBCF - Autumn 2015 review	5.6	11.4
IBCF (additional ASC allocation) - Spring 2017 Budget	6.8	3.4
IBCF (Winter Pressures) - Autumn Budget 2018	**Nil	2.4
Disabled Facilities Grant	3.6	***3.9
Total BCF Plan	**53.4**	**59.1**

* Based on indicative uplift of 1.79% on 2018/19 allocation

** The Council received a £2.4m allocation of winter pressures funding in 2018/19 but this was not part of the IBCF.

***Estimated allocation ,based on 2018/19, increased per national allocation announcements

BCF Expenditure Plan
Movement between 2018/19 and 2019/20

	WLCCG £'000	ELRCCG £'000	Total £'000
Inflation – LCC Commissioned Services	57	44	101
Inflation – CCG Commissioned Services	142	93	235
First Contact Plus (reduced requirement)	-7	-6	-12
Primary Care Coordinators (reducing current investment & retaining 1x Band 6 post)	-189	-169	-358
ELRCCG QIPP Scheme – 20 ICS beds reduction	-	-600	-600
Help to Live at Home – Step Up Reablement	-195	-148	-344
Help to Live at Home – Step Down Reablement	-96	-73	-169
Integrated approach to residential and nursing care home provision – scheme ended	-7	-9	-15
GP input into Waterside Extra Care Facility	-50	-	-50
Urgent Care Centres – increased BCF contribution	-	390	390
Removal of CCG Contingency	-500	-500	-1,000
Removal of 2018/19 cost improvement target	434	139	573
Realignment of future LCC investment & reduction for care coordination	-141	-68	-210
WLCCG Care Coordination	210	-	210