APPENDIX A

Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission. Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net. To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	Leicestershire County Council
Clinical Commissioning Groups	East Leicestershire and Rutland CCG
	West Leicestershire 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 Council
Dates agreed at Health and Well-Being Board:	**13/02/2014 and 01/04/14**
Date submitted:	**14/02/2014 and 04/04/14**
Minimum required value of ITF pooled budget: 2014/15	**£2.012m**
2015/16	**£38.343m**
Total agreed value of pooled budget: 2014/15	**£18.251m**
2015/16	**£38.481m**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	
By	Dr Dave Briggs
Position	Managing Director, East Leicestershire and Rutland CCG
Date	02/04/14
Signed on behalf of the Clinical Commissioning Group	
By	Toby Sanders
Position	Managing Director, West Leicestershire CCG
Date	02/04/14

Signed on behalf of the Council	
By	John Sinnott
Position	Chief Executive, Leicestershire County Council
Date	02/04/14

Signed on behalf of the Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Cllr Ernie White, Chair, Leicestershire Health and Wellbeing Board
Date	02/04/14

c) Service provider engagement
Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

The leaders of the Leicester, Leicestershire and Rutland (LLR) health and care economy have recently developed an overarching vision setting out the changes needed in the local health and care system over the next five years.

This work involves all partners including providers and will culminate in publishing a five year strategy by June 2014.

The five year strategy will set out how partners will:

- Address rising demand
- Reduce pressure on acute care
- Provide more integrated and coordinated support in community settings
- Prevent unnecessary hospital admissions
- Offer more effective hospital discharge
- Reconfigure services to support the improved pathways of care

The programme of work to deliver the vision is already underway with all local providers, commissioners and many other stakeholders actively involved.

Leicestershire's Better Care Fund Plan (BCF) forms an important component of the LLR five year strategy.

The development of the Leicestershire BCF has been led by Leicestershire's Health and Wellbeing Board in the context of the LLR-wide strategy and the Joint Health and Wellbeing Strategy for Leicestershire.

In terms of provider engagement the Leicestershire BCF has been developed in conjunction with University Hospitals of Leicester (UHL), District Councils including housing providers, the social care providers at Leicestershire County Council, and Leicestershire Partnership Trust (LPT), all of whom are represented at the Health and Wellbeing Board.

The Leicestershire BCF plan demonstrates that partners have jointly agreed:

- A number of immediate priorities to transform the health and care system in the Leicestershire's communities over the next two years
- How the funds available will be used to support these changes
- The rate of improvement we aim to achieve against the six metrics within the BCF plan
- The impact on the activity and financial assumptions for providers as a result of these changes. This has been demonstrated by factoring these assumptions into the QIPP plans of CCGs and providers, and into the contract negotiations with providers.

The two year Leicestershire BCF plan comprises a combination of existing and new developments all of which will be progressed jointly between commissioners and providers across the whole system of health and care locally.

The Plan will:

- Consolidate, integrate and extend community based care for local people, to avoid unnecessary admissions to hospital and improve integrated care across all care settings
- Deliver some important new developments, such as the introduction of 24/7 integrated community services with a two hour response time, a new approach to prevention in Leicestershire's communities, and new care pathways for the care of frail older people

Multi Agency Workshops Involving Providers

Since the draft BCF submission on 14th February two significant elements of additional work have been completed, with the full involvement of providers. These are as follows:

- **Multi Agency Risk Workshop** – this session involved reviewing the draft BCF risk analysis, developing principles for the pooled budget and discussing the issues and workplan for the development of a section 75 agreement.

- **Multi Agency Impact Analysis workshop** – this session involved reviewing the proposals within the BCF in terms of their evidence base and benefits analysis, confirming and challenging the assumptions, understanding the metrics in more depth, the individual and collective contribution of schemes to one or more of the metrics, the trajectory of improvement anticipated.

Recommendations arising from both workshops have been used in finalising the BCF submission documents for 4th April.

Individual meetings and briefings with providers have also taken place during the period to develop the draft BCF Plan submission so that the overall BCF plan and its impact across the system is widely understood and the products are co-produced.

Governance Arrangements and Provider Involvement

The Terms of Reference for Leicestershire's Health and Wellbeing Board have been refreshed so that representatives from UHL and LPT became members of the Board with effect from February 2014.

UHL and LPT were therefore directly involved in the Health and Wellbeing Board's discussions and decision to approve the draft and final submissions of the BCF at the HWB meeting on 13th February and 1st April, as full members of the Board.

Introduction of the Multi-agency Integration Executive

From March 2014 a new Integration Executive has been created to oversee the programme of work to integrate health and care services in Leicestershire including providing strategic oversight and assurance to delivery of the BCF plan.

The representatives on the Integration Executive include providers such as UHL, LPT and the East Midlands Ambulance Service (EMAS).

The Integration Executive will meet monthly and report to the Health and Wellbeing Board.

From April 2014 an operational level group to oversee the day to day delivery of the components of the BCF will also be in place. This will be Chaired by the Director of Health and Care Integration, and will also have provider representation.

d) Patient, service user and public engagement
Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

In December 2013 at a Leicestershire Health and Wellbeing board development session, all partners agreed to adopt the National Voices principles and definitions for integration, reflecting the engagement with, and feedback from the public, that was achieved nationally during their development.

Patient, service user and public engagement in the development of the BCF Plan has involved a number of channels and there has been close, ongoing involvement of Local Healthwatch (LHW) in shaping and influencing the BCF Plan for Leicestershire throughout.

Summary of engagement to date:

- NHS Call to Action events
- The Council's consultation with the public about its future budgetary plans
- LHW public consultation to shape priorities for their 2014/15 workplan. The respondents to this consultation cited improving integration across health and care services as their top priority (66% of respondents).
- A launch event for the LLR five year strategy was held in January 2014.
- In order to engage further on the specific BCF plan proposals we also held a stakeholder event with the support of Local Healthwatch on 24th February. The purpose was to seek feedback on the progress to date with the Joint Health and Wellbeing Strategy and the emerging proposals in our BCF plan. **Appendix 1** to this template summarises the feedback from this event which has informed the final submission.

Future engagement plans

- The development of the LLR five year strategy for health and care transformation will involve a coordinated engagement plan with the public over coming months.
- The Leicestershire Health and Wellbeing Board in conjunction with LHW will develop a range of channels and mechanisms for engaging on the specific changes affecting health and care services in the county of Leicestershire.
- The Leicestershire Health and Wellbeing Board complies with the Public Sector Equality Duty and will ensure it gives 'due regard' in its decision making to the outcomes from public consultations and associated Equalities and Human Rights Impact Assessment.
- An early output to support our emerging communication and engagement plan is the development of the "BCF plan on a page" shown at **Appendix 2** to this submission – this is an easy read visual aid to the components of the BCF plan.

e) Related documentation
Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Synopsis and links
Joint Strategic Needs Assessment	http://website/healthwellbeingboard.htm
Joint Health and Wellbeing Strategy	http://website/healthwellbeingboard.htm
ELRCCG Operating Plan	Links will be shown here when documents are finalised
WLCCG Operating Plan	
LLR Five Year Strategy Vision and Goals	
LCC MTFS	

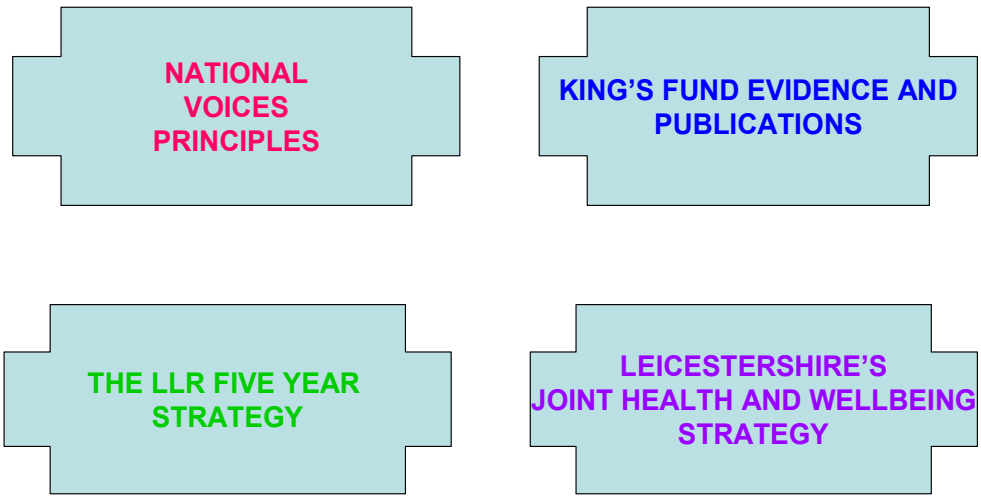
2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

The Leicestershire vision for transforming health and care is framed by four main strategic elements:-



The following sections describe each strategic element.

NATIONAL VOICES PRINCIPLES FOR INTEGRATED CARE

http://www.nationalvoices.org.uk/principles-integrated-care
http://www.england.nhs.uk/wp-content/uploads/2013/05/nv-narrative-cc.pdf

In December 2013 the Leicestershire Health and Wellbeing (HWB) Board held a development session to consider collective commissioning intentions for 2014/15 in the context of the national policy developments for integration and the BCF plans.

At this session partners considered the principles and narrative for integrated care developed by National Voices who were seeking wide support for the principles from commissioners and other stakeholders. As a result, Leicestershire HWB Board agreed to:

- Adopt the principles – see box below
- Ensure the principles underpin our approach to integration including the development of the BCF Plan

- I tell my story once
- I am always kept informed of what the next steps will be
- I always know who is coordinating my care
- I have one first point of contact
- I can see my health and care records at any time
- I know how much money is available to me for care and support and can determine how this is used.

The King's Fund	KING'S FUND EVIDENCE AND PUBLICATIONS

The work of The King's Fund has informed our vision for integration and the development of the BCF Plan in two key ways:

1. The core elements of integrated care
2. The evidence base for integrated care interventions

The Core Elements of Integrated Care

In line with The King's Fund recent report "***Making our health and care systems fit for an ageing population"***, http://www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population partners in Leicestershire have a clear view of the core elements of integrated care that should be in place to provide the optimum system of health and care - as illustrated in this diagram, taken from The King's Fund Report

Leicestershire partners agree that if care and support is designed and structured more effectively to meet the needs of the ageing population, it will also be planned and delivered more effectively for many other parts of the population, such as those under 65 who need support following surgery or illness, those who have a long term condition, or are at risk of developing a long term condition in later life.

Understanding and Applying the Evidence for Integrated Care

The BCF evidence summary provided by The King's Fund
http://www.kingsfund.org.uk/publications/making-best-use-better-care-fund
has been used to consider the anticipated impact of the interventions and care pathway changes proposed in the Leicestershire BCF and to test our ability to improve our performance against the six metrics in the BCF plan. An initial impact assessment was completed in March 2014 and further work on this has been factored into the programme plan for the Integration Executive in Q1 of 2014/15.

Better care together

A Partnership of Leicester, Leicestershire & Rutland Health

THE LLR FIVE YEAR STRATEGY

The LLR vision is:

To maximise value for the citizens of Leicester, Leicestershire and Rutland (LLR) by improving health and wellbeing outcomes that matter to them, their families and carers in a way that enhances the quality of care at the same time as reducing cost across the public sector to within allocated resources by restructuring the provision of safe, high quality services into the most efficient and effective settings.

The LLR Five Year Strategy sets out:

- The overall direction for the models of health, care and support services that will need to apply in five years time across the whole health and care system operating in LLR
- The steps needed to realise that vision; and
- A roadmap to better outcomes for our citizens.

Delivering the LLR Strategy

The LLR strategy must be delivered in an integrated way, so that we together:

- Enhance the quality of care, at the same time as reducing cost across the public sector, to within allocated resources
- Manage demand and restructure the provision of safe, high quality, services into the most efficient and effective settings

Therefore:

- Each of the Joint Health and Wellbeing Strategies of the three Health and Wellbeing Boards in LLR will be informed by the LLR strategy and roadmap, tailored to the needs of their specific populations.

- Each of the operating plans of the respective NHS organisations and Local Authorities will reflect the roadmap for improving health and care in LLR, so that locally everyone will deliver on the important changes for which they are individually and jointly responsible.

The emerging LLR five year strategy is readily aligned to Leicestershire's current Joint Health and Wellbeing Strategy and BCF plan, due to the emphasis across the system on reducing avoidable admission to hospital, with the redesign of alternative pathways and prevention outside of hospital settings.

In Leicestershire we now have the benefit of much stronger connections and strategic alignment into this larger unit of planning, and it is becoming clearer how our local Joint Health and Wellbeing Strategy and BCF plan will contribute to the overall shift of activity from acute to community settings which is planned at scale across LLR, over the five year period.

LEICESTERSHIRE'S JOINT HEALTH AND WELLBEING STRATEGY

Overall Goal:	**To Be Achieved By:**
"Add quality and years to life" http://www.leics.gov.uk/leicestershire_health_wellbeing_strategy.doc	• **Improving health throughout people's lives,** • **Reducing health inequalities** • **Focusing on the needs of the local population.**

To deliver Leicestershire's Joint Health and Wellbeing Strategy the following four priorities have been identified,

Getting it right from childhood

Managing the shift to early intervention and prevention

Supporting the ageing population

Improving mental health and wellbeing

The strategy also has cross-cutting theme as follows:

- Tackling the wider determinants of health by influencing other Boards

Overall, the successful delivery of our Joint Health and Wellbeing Strategy, and the LLR five year strategy are dependent upon the ability of partners in Leicestershire to focus on shifting activity from acute to community settings and achieve greater integration of care for local citizens.

The key to success in Leicestershire is the local translation of the LLR strategy and road map into the most effective practical changes that will transform the way care is delivered, and that the leaders of the health and care economy drive change on the ground towards shared outcomes. The BCF is therefore a real opportunity to demonstrate how we can target local resources to achieve greater integration, transform services and make measurable impact on the outcomes that matter most for local people.

Leicestershire's Vision for Integrated Health and care	**We will create a strong, sustainable, person-centred and integrated health and care system which:** • **Meets future demands** • **Supports the LLR five year strategy** • **Improves outcomes for the local population**

What changes will we deliver through the BCF Plan and what will local services and support look and feel like in the future as a result

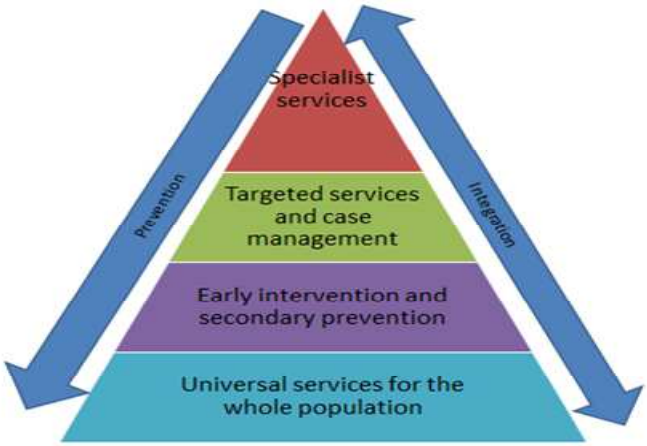
People rarely need support from a single service as they age, or if they are vulnerable through ill health, disability, injury or social exclusion/isolation. They have told us that they find it difficult to navigate between services and feel that there are many barriers in the way as they move between health, social care and other statutory services.

These barriers are simply not understandable or acceptable to the population we serve. A key feature of this plan is to address this, and support people and communities much more effectively so that when people are in need of information, support or services to maintain or improve their health and wellbeing, local partners will:

- Deliver this support in a co-ordinated way across agencies
- Provide this support as early as possible, anticipating future needs, as well as dealing with immediate needs in the most appropriate setting.

Ultimately our BCF plan aims to provide a very clear articulation of the menu of services, information and support available to the public, and make this menu more understandable and accessible, particularly in community settings.

The Leicestershire BCF plan is based on improving how citizens access information, support and services and how these are designed across the stepped pyramid of care illustrated in this diagram.



There will be clear integrated service offers at each layer of the pyramid, operating across organisational boundaries, with a view to coordinating care for individuals, carers and families. We will design service offers that maintain people at the lowest possible level of the pyramid according to their needs, so that progression up the pyramid is avoided/delayed wherever possible and admission to specialist services is only undertaken when absolutely necessary.

Over the next two years we will work towards achieving an integrated health and care system through:

- Providing focused leadership to integration across organisational boundaries.
- Building on existing priorities and current work, where we can see measurable impact.
- Aligning our plans across the system of health and care.
- Streamlining and focusing our efforts on tackling a smaller number of areas.
- Identifying those citizens at greatest risk and supporting them to maintain or regain their independence which will reduce their reliance on more costly interventions.
- Adopting a whole system approach to pathway re-design (patient journey) ensuring integration of planning, commissioning and delivery is considered where appropriate.
- Improving the customer experience through driving up quality and performance.
- Delivering efficiencies through developing more effective and streamlined practices and processes.
- Integrating care records and using more integrated technology to support joint care plans.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

The implementation of the Better Care Fund marks an important milestone in the relationship between local partners.

It presents a huge opportunity to make lasting and fundamental changes to the way we work together, for the benefit of local people and the public purse.

The aim of the BCF plan is to deliver important improvements to the way we collectively offer care and support to local citizens. To do this, we are making stepped changes to both the composition and capacity of local, integrated, community based services so that avoidable pressure on hospital care is reduced. Our BCF Plan contains four themes as shown below:

Unified Prevention Offer for Leicestershire's Communities	Integrated, Proactive Care for those with Long Term Conditions
Bring together prevention services in Leicestershire's communities into one consistent offer, including housing expertise and support to carers Provide better coordination in communities of this offer so that local people have easy access to information, help and advice.	Scale up the support already offered by primary and community care services for patients with long term conditions/the frail order – including through: • The introduction of case management for the over 75s • Changes to how records and data are shared between agencies and with patients so that ongoing care is planned more effectively and changes in needs/care plans can be anticipated and addressed earlier.

Integrated Urgent Response	Hospital Discharge and Reablement
Introduce an integrated two hour community services response, to avoid unnecessary hospital admissions for those who need urgent assistance Introduce seven day working in GP practice which integrates effectively with community based health and care services, both in and out of hours Implement an integrated service for frail older people	Make significant improvements in the timeliness and effectiveness of discharge pathways from hospital, especially for frail older people. Consolidate, integrate and extend a number of Leicestershire's existing community based services into one 24/7 service operating across health and social care, with a single point of access - to focus on maintaining independence in the community for as long as possible

Measuring the impact of the BCF Plan

Since the original BCF submission on 14th February 2014 a detailed impact analysis has been undertaken of the components of the BCF plan per the (five) national and (one) local metrics, against which delivery of the BCF plan will be assessed.

The impact assessment was the subject of a multiagency workshop to confirm and challenge the plan, held on 12th March 2014.

<u>As a result of implementing our BCF plan we expect to see:</u>

	A reduction in hospital bed days due to discharge being delayed
	A reduction in avoidable hospital admissions
	To Be Confirmed
	More support in the community including preventing falls
	More people receiving help to recover at home
	Less people going into nursing and residential care

The following sections explain the definition of each metric, and the rate of improvement we are aiming for in each case, over the two year period.

National Metric (1)	Definition	Trajectory of improvement
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	This is a nationally defined metric measuring delivery of the outcome to reduce inappropriate admissions of older people to residential care.	The proposed trajectory is for a reduction from 762.73 permanent admissions per 100,000 population per year to 718.74 (or 5.77%) by 31st March 2015

National Metric (2)	Definition	Trajectory of improvement
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	This is a nationally defined metric measuring delivery of the outcome to increase the effectiveness of reablement and rehabilitation services whilst ensuring that the number of service users offered the service does not decrease. The aim is therefore to increase the percentage of service users still at home 91 days after discharge	The proposed trajectory is for an increase from 78.22% of service users still at home 91 days after discharge to 82.19% (or 5.08%) by 31st March 2015.

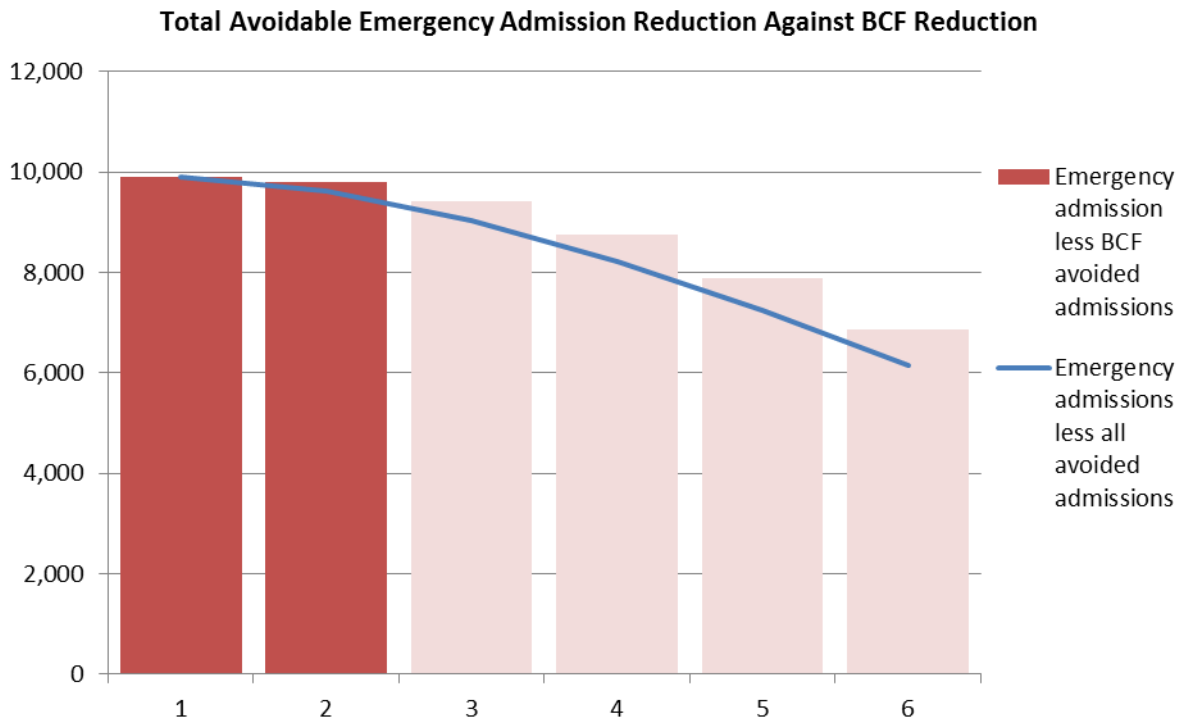
National Metric (3)	Definition	Trajectory of improvement
Delayed transfers of care from hospital per 100,000 population (average per month)	This is a nationally defined metric measuring delivery of the outcome of effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults. The aim is therefore to reduce the rate of delayed bed days per 100,000 population.	The proposed trajectory is for a decrease from a baseline of 292.71 delayed bed days per 100,000 per month to 288.18 (1.55%) by 31st December 2014 followed by a further reduction to 287.67 (0.18%) by 30th June 2015.

National Metric (4)	Definition	Trajectory of improvement
Avoidable emergency admissions	This is a nationally defined metric measuring delivery of the outcome to reduce avoidable emergency admissions which can be influenced by effective collaboration across the health and care system. This is a composite measure of: Unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages) Unplanned hospitalisation for asthma, diabetes and epilepsy in children Emergency admissions for acute conditions that should not usually require hospital admission (all ages) Emergency admissions for children with lower respiratory tract infections	The proposed trajectory is for a decrease from a baseline of 124.12 emergency admissions per 100,000 per month to 121.69 (1.96%) by 30th September 2014 and then remaining the same at 121.69 until 31st March 2015.

Avoidable Emergency Admissions – supplementary information

The two CCGs in Leicestershire have set out a combined trajectory to reduce avoidable emergency admissions by 15% by 2018/19. Only a proportion of this trajectory is to be achieved by the schemes in the BCF, with a selection of other parts of CCG commissioning plans impacting on the remainder of the trajectory.

The overall trajectory to reduce avoidable emergency admissions over the five year period is illustrated in the graph below in (one colour) with the BCF contributing elements shown in (another colour)



In 2014/15 a 3% combined reduction in emergency admissions is based on the impact that can be achieved via a full year effect through the following interventions:

- Implementation of Intensive Community Support (Virtual Beds)
  - 48 beds for ELRCCG and 48 beds for WLCCG.
  - WLCCG beds in place from April 2013
  - Phased implementation of ELRCCG beds commenced in October 2013, with all 48 virtual beds fully operational from December 2013.
- Implementation of CRS (Social Care Crisis Response Service) – phased implementation from September 2013
- Proactive Care WLCCG – Risk Stratification and case management approach to LTC patients within a primary care setting
- Integrated Care Model ELRCCG – Risk Stratification and case management approach of patients identified at medium risk using the risk stratification model - the model was fully rolled out across from January 2014
- Children's community nursing pilot – commenced late 2013.
- COPD Scheme
- CVD Scheme
- Single Front Door (A&E)

Through the BCF plan we have set out how we plan to expand on the existing platform of integrated community services in Leicestershire e.g. by the introduction of the integrated two hour urgent response, and developing a business case to improve the integrated care of frail older people.

The impact of these further interventions, will allow for increasing levels of ambition with a stretch applied to the trajectory from 2015/16 onwards.

National Metric (5)	Definition	Trajectory of Improvement
 **Patient / service user experience**	TBC This will be a nationally defined metric however, at the time of writing this paper the guidance confirming the definition of the metric has not be released. The outcome will be to demonstrate local population/health data, patient/service user and carer feedback has been collated and used to improve patient experience. To provide assurance that there is a co-design approach to service design, delivery and monitoring, putting patients in control and ensuring parity of esteem.	**TBC**

Local Metric (6)	Definition	Trajectory of Improvement
 **Injuries due to falls in people aged 65 and over**	This is a locally defined metric measuring delivery of the outcome to reduce emergency admissions due to falls in people aged 65 and over	The proposed trajectory is for a decrease from a baseline of 168.20 emergency admissions per 100,000 per month to 162.17 (3.58%) by 31st March 2015 followed by a slight increase to 162.21 (0.02%) by 30th September 2015. *This metric is being reviewed following the proposal to introduce an additional falls prevention scheme within the BCF in association with East Midlands Ambulance Service. The evidence from other areas suggests the trajectory can be significantly improved with the introduction of this service and this trajectory will be re-modelled in Q1 2014/15 accordingly.*

In addition to the six metrics above, the BCF Plan will also drive the following improvements in terms of length of stay:

- A reduction in the number of people whose length of stay is 15 days or greater.
- A reduction in the time between a patient being assessed as medically fit for discharge and the time that they are discharged.

Further work will be completed in relation to the overall impact on length of stay in the BCF as part of the work to develop a business case for an integrated service for frail older people.

The work completed on impact analysis for the BCF to date has also indicated that further work is needed to validate/develop performance indicators for each component of the BCF so that the contribution of individual interventions in the BCF against the six top line metrics can be evidenced more effectively. This work has been factored into the BCF programme plan.

Appendix 3 shows a more detailed breakdown against each of the metrics in support of this submission. This includes a table which illustrates which BCF component schemes we consider will have the greatest impact on each of the six metrics.

What measures of health gain will you apply to your population?
The measures of health gain will be those linked directly to the outcomes within our LLR-wide strategy and the Joint Health and Wellbeing Strategy for Leicestershire which map across as shown in the table below. These are associated primarily with delivering improved outcomes for those with specific LTCs and frail older people, the impact on their associated mortality rates, and measures of quality of life such as maintaining independence, and the impact on health inequalities. Results will be achieved by significant improvements in prevention, proactive care, and care coordination for the local population, by developing a fully integrated health and care system by 2018.

LLR Wide Strategy Priorities ***(Provisional)***	**Leicestershire's Joint Health and Wellbeing Strategy Priorities**	**BCF Themes**
Respiratory Disease	Supporting the ageing population Managing the shift to prevention and early intervention Getting it right from childhood	Unified prevention offer LTCs Integrated urgent response Hospital discharge and reablement
CVD	Supporting the ageing population Managing the shift to prevention and early intervention Getting it right from childhood	Unified prevention offer LTCs Integrated urgent response Hospital discharge and reablement
Cancer	Supporting the ageing population Managing the shift to prevention and early intervention Getting it right from childhood	Unified prevention offer LTCs Integrated urgent response Hospital discharge and reablement
Mental Health & Substance Misuse	Improving mental health and wellbeing Managing the shift to prevention and early intervention Getting it right from childhood	Unified prevention offer Hospital discharge and reablement
Dementia	Supporting the ageing population Improving mental health and wellbeing Managing the shift to prevention and early intervention	Unified prevention offer LTCs Integrated urgent response Hospital discharge and reablement

The delivery of the outcomes in our Joint Health and Wellbeing Strategy, and the LLR-wide strategy, are also supported by the significant investment in primary prevention through services commissioned by Public Health (e.g. smoking cessation, obesity and physical activity programme).

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery (see below)
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care *(see pages 3, 34-36 and pages 43-44).*

A Unified Prevention Offer for Leicestershire's Communities

Intervening early can have a major impact on the health of individuals and prevent or reduce the need for more costly care later on.

In Leicestershire, prevention is a key strand of our Health and Wellbeing strategy, and our delivery model per the care pyramid. It is also an area where we believe collaboration is key to achieving successful outcomes and a greater quality of life for the citizens in Leicestershire.

We have considered evidence from other communities (e.g. Derby), where prevention is more targeted, consolidated and cost effective, through for example, Local Area Coordination, and we can see opportunities to achieve these benefits in Leicestershire.

By investing in the bottom tier of the care pyramid as a priority we are also providing the necessary infrastructure for other elements of the BCF plan to function effectively.

What do we want to achieve?

We want people and communities to:

- Be able to access a range of support early, through social and community networks
- Be empowered to take control of their health and wellbeing
- Live healthier and independent lives
- Maintain their independence within their community for longer.

By 2018 we aim to have a comprehensive offer for community based prevention for the citizens of Leicestershire, funded by bringing together all the resources available to Local Councils and the NHS.

By investing in prevention we expect to see a reduction in the number of people accessing services in crisis or inappropriately and when people have a need for a health or care intervention that they can quickly return to their optimum independence within a supportive community.

We already have local examples of where this has proved successful including support to Carers, Supporting Leicestershire Families, First Contact and Housing related support for older people.

However in order to feel confident that we are reaching more vulnerable people in time to make a difference - both to them as individuals and their impact on the health and care system - we need to consolidate our efforts and raise our ambition.

We are already investing part of the current social care allocation in a menu of prevention services. It is important that we continue to fund some of these services whilst we plan for a new model. These include the existing services to carers, extra care housing for older people and timebanking.

Last year we worked with the Chartered Institute for Housing and our District Councils Housing colleagues to look at what housing has to offer around promoting and supporting positive health and wellbeing.

This has led to a number of opportunities for further work around Disabled Facilities Grant (DFG), aids and equipment, and home improvement, which have been incorporated into the overall BCF prevention plan.

How will the Unified Prevention component of the BCF Plan deliver improvements and what are the initial milestones
(Please refer also to the high level programme plan at **Appendix 4**)

The initial part of the BCF prevention plan will involve:

1. **Extending the existing carers health and wellbeing support programme** across all GP practices in the county

2. **Scoping the new unified prevention offer (leading to an outline business case)** including:
    - Understand all the prevention services and resources currently available from all partners
    - Examine the evidence in terms of proven interventions elsewhere, such as Local Area Coordination
    - Examine how we can achieve greater integration of the prevention offer for those who present at the emergency department, or in crisis, so that where applicable citizens can be diverted to appropriate community based support, linking with the other priorities and care pathways in the BCF plan.
    - Examine how greater integration of housing support can be achieved in our prevention offer (see 4.1.3 below)
    - Agreeing how the model needs to change and become a unified offer

Our programme plan shows we intend to have completed the outline scope and outline business case by Q1 2014/15

3. **Implementation plan will follow** - to include:

- Testing the concept and model of Local Area Coordination in Leicestershire. This will introduce a new model of support for vulnerable people which focuses on identifying and supporting those who need help before they hit crisis, and working towards building an inclusive resilient community around them.

- We aim to test the model to support vulnerable people, those with Long Term Conditions, and to meet the differing needs of those in rural and urban areas.

- Assessing the contributions that stakeholders will make to the BCF budget for 2015/16

- Launching the new prevention offer/model

- If proved effective, implementation will include rolling out Local Area Coordination to the remaining areas. This will be a phased implementation which will allow the model to be evaluated, and lessons learned to be incorporated in the roll out.

Unified Prevention Offer: Integrating Housing

Housing professionals and our Health and Wellbeing Board recognise the potential that housing services have to deliver better health and social care outcomes. Everyone is fully engaged in shaping and delivering different ways of working in Leicestershire to achieve this, including a range of housing providers who have been actively engaged in our work to date.

In 2013, we worked with the Chartered Institute of Housing to identify the "Housing Offer to Health." As a result, Leicestershire's approach to prevention will include implementing an integrated offer of housing support targeted to improve health and wellbeing in our communities.

Using our current First Contact scheme and the proposed Local Area Coordination approach described above, we can reduce demand on other services such as GPs and hospital care by effectively signposting to practical housing advice and interventions across multiple agencies, using one referral form. This will pick up important interventions such as Keeping Warm and Well at Home, and providing a range of practical support to older and vulnerable people.

Our aim is to reduce emergency admissions and prevent delayed hospital discharge through primary prevention focused on housing support. Our BCF plan for Integrating Housing as a key part of prevention therefore focuses on two main areas as illustrated in the table below:

A consistent housing improvement offer across Leicestershire	This will provide practical support for both self funders and those eligible for statutory support so that aids, equipment, adaptations, handy person maintenance services and energy efficiency interventions are readily and rapidly available across all tenures, including via statutory assessments by occupational therapists and for those accessing DFGs. This will reduce the time taken to provide practical help to individual service users, reduce process costs for services paid for through the public purse and support vulnerable people to access the low level practical support that helps them remain independently at home. Existing funding streams which could be redirected to deliver this service, including the DFG funding, will be scoped in 2014/15, and the service developed through negotiations and business case proposals.
Housing as an Integral part of care planning - e.g. all planning and decisions around an individual's hospital discharge will include early consideration and action regarding appropriate and supportive housing options.	Housing will become much more clearly linked to all aspects of the BCF and its priority care pathways. Partners will work collaboratively to identify and deliver housing solutions to prevent delayed hospital discharge, support reablement, offer an urgent response to avoid admission, including via the emergency department, and to maintain the independence of those with Long Term Conditions for as long as possible. We will build health, social care and housing considerations into assessments of a customer's needs right from the start, in a way that recognises the potential of appropriate housing and housing based support in delivering independence and reducing whole system costs. The specific needs of those with mental health problems are also being considered with a number of local solutions being discussed across LLR. This is also a critical part of the housing offer, given the increased emphasis nationally on parity of mental health with physical health, and locally due to the trends in occupancy and delayed transfers of care experienced over the last two years for mental health patients.

Unified Prevention Summary Table

Leicestershire Better Care Fund Plan	*New or Existing*	*Investment 2014/15 £000's*	*Investment 2015/16 £000's*	*Metrics*	*Metric Symbols*
First Contact	Existing	159	162	4,5	
Carers Services	Existing	370	450	1,5	
Time Banking	Existing	72		5	
Advice and Information	Existing	4		5	
Carers Assessments (Care Bill Implications)	New		275	1,5	
Specialist support to people with Dementia & Carers	Existing	294	320	5	
Strengthening Autism Pathway	Existing	163	95		
Assistive Technology	Existing	984	995	1,5,6	
Assistive Technology – replacement equipment	Existing	1,444			
Local Area Co-ordination	New	240	600	4,5,6	
Housing Offer – Disabled Facilities Grants	New		1,739	1,5,6	
		3,730	**4,636**		
Protection of Services					
NHS – LD Short Breaks	Existing		844	5	
		3,730	**5,480**		

Key to metrics

1. Permanent admissions of older people (aged 65 and over) to residential and nursing homes, per 100,000 population.
2. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.
3. Delayed transfer of care from hospital per 100,000 population (average per month).
4. Avoidable emergency admissions (composite measure).
5. Patient/service user experience
6. Injuries due to falls in people aged 65 and over

Integrated, Proactive Care for those with Long Term Conditions

Both local Clinical Commissioning Groups have developed effective models of care to support people with long term conditions to maintain the maximum level of independence and self care that they can.

This involves risk stratification and care planning, with primary and community based support planned around the patient, carer and family.

Care plans “step up” care when needed to support through period of crisis or increased need and “step down” care when the person stabilises or needs decrease.

Further integration of pathways, data, records, technology and, where appropriate, services, are the key to improving our local service offer to patients with Long Term Conditions

In order to transform primary care services and respond to the challenge of case management of patients over 75s, the CCGs are further developing their plans to enable primary care to proactively manage patients with multiple morbidities and those that are at the end of their lives. This includes the local plans for extending primary care services across the seven day period.

Releasing time for primary care to undertake a co-ordinated multidisciplinary approach to patient care is a key enabler to improved system management of patients that are complex and have multiple health and social care issues.

Leicestershire CCGs are also working with local authorities and other health partners to establish effective systems to deliver personal health budgets to individuals eligible through the NHS Continuing Health Care (CHC) process, with a view to the extension of this approach to those with LTCs in line with national policy implementation timescales.

An LLR steering group has been established to plan and develop policies and procedures for implementation for on-going management of personal health budgets. Membership includes health and social care representatives.

National timeline:

- April 2014 - those in receipt of CHC have the right to ask for a personal health budget
- October 2014 - those in receipt of CHC have the right to have a personal health budget
- October 2015 - those with long term conditions will be able to have a personal health budget (further guidance pending).

By putting in place:

- A more accessible, unified prevention offer
- Enhanced, multidisciplinary integrated care on a 24/7 basis
- Integrated crisis response within two hours
- Case management for those over 75 by GPs
- Greater integration of data and care records, centred on the NHS number
- Greater use of telecare and telehealth
- An implementation plan for personal health budgets

We can continue to enhance the whole system of care for patients with Long Term Conditions in Leicestershire to maximise independence and choice, and avoid unnecessary acute care episodes on a 24/7 basis.

Summary Table: Long Term Conditions

Better Care Fund Schemes	*New or Existing*	*2014/15 £000's*	*2015/16 £000's*	*Metrics*	*Metric Symbols*
Proactive Care (West Leicestershire)	Existing	540	540	4,5,6	
Integrated Model for Long Term Conditions (East Leicestershire)	Existing	460	460	4,5,6	
Pathway to Housing	Existing	72		5	
Memory Plus Service	Existing	10		1	
Improving Quality in Care Homes	Existing	487	501	4,5,	
IT Enablers – data sharing, care plans, telehealth & telecare	New		650	5	
		1,569	**2,151**		
Protection of Services					
Social Care – Nursing care packages	Existing	2,995	3,361	4	
Social Care – Sustainable community services	Existing	1,466	1,876	1,4	
Social Care – Increasing demographic pressures	Existing & New	1,741	4,584	4	
Social Care – protection of community care packages	Existing		3,852	1,4	
		7,771	**15,824**		

Key to metrics

1. Permanent admissions of older people (aged 65 and over) to residential and nursing homes, per 100,000 population.
2. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.
3. Delayed transfer of care from hospital per 100,000 population (average per month).
4. Avoidable emergency admissions (composite measure).
5. Patient/service user experience
6. Injuries due to falls in people aged 65 and over

Integrated Urgent Response

Our Ambitions for Improving Integrated Community Care

A key priority of the Integrated Commissioning Board and its partners has been to prevent unnecessary time spent in acute settings. Using the existing social care allocations and working with local community providers to change models of care, Leicestershire County Council, East Leicestershire and Rutland CCG and West Leicestershire CCG have made some good initial progress to integrate local community based services across the health and care system, with the emphasis on:

- Admission avoidance
- Effective reablement, e.g. following illness or injury
- Proactive and integrated management of patients with long term conditions

Initial progress has consisted of strengthening the range of interventions that are jointly offered to support the urgent care system by preventing unnecessary admission, and agreeing a shared approach to discharge which ensures that the individual gets the right support to facilitate their recovery.

Developments in 2013/14 have included:-

- Community based teams across Leicestershire and Rutland being configured around clusters of GP practices,
- More options for care in the community, including the introduction of intensive community nursing support in the home
- The addition of night care to the intensive community support service
- The addition of therapy and Community Psychiatric Nurse support to discharge pathways
- A social care crisis response service, with a two hour response time.

There is now greater clarity and ambition about how further integration could be achieved and a pressing need to redesign services on an LLR wide basis so we can sustain the health and care system in line with the LLR strategy.

The Leicestershire BCF plan initially will focus on two main components of work:

1. Harmonise a number of still separate, historical services operating across health and the local authority into an integrated package for the future

and;

2. Address some important remaining gaps in service which are negatively affecting the urgent care system, in particular the ability of health and care partners in the community to respond as one, rapidly, on a 24/7 basis**.**

We recognise there are still gaps in delivering the optimum pathways of care locally and we urgently need to consider additional opportunities to stretch our ambitions to impact on the metrics at pace and scale and improve outcomes further.

Evidence shows that for older people, if a length of stay in an acute trust can be achieved which is less than 16 days, mortality reduces and the ongoing costs of managing their care reduces, since their chances of regaining their previous functional baseline improves.

However, when older patients become unwell they often need investigations and medical supervision as well as intensive nursing support for a short period of time. They are not acutely ill in the traditional sense of what hospitals are designed for, but often end up there because there are very limited options currently that can offer diagnostics, medical supervision and intensive nursing support other than urgent care in an acute hospital.

At times the length of stay can be affected by the need for additional diagnostics and treatment which could be achieved outside of hospital, hence the term “Discharge to Assess” rather than be kept unnecessarily as an inpatient.

Within the LLR-wide strategy all partners are keen to develop better options for those discharged from acute settings and those who need investigation and treatment but for whom admission could be avoided.

In response to this, in 2014/15 we will undertake further scoping work, in particular to consider

- How the rapid diagnosis and treatment of frail older people can be improved in community settings
- What the options could be for this
- The relative impact and affordability of these options

This work will be in the context of acute sector activity assumptions/expenditure over the next five years per the LLR-wide strategy, and the stepped changes needed to reduce the costs of acute care.

One of the options we would wish to test is whether further consolidation of services into a rapid assessment and treatment service for frail/complex older people would be feasible and cost effective. If so, this potentially could offer outpatient and short stay options (e.g. up to 72 hours) which are not readily available in our current models of care.

In the meantime we will press ahead with two important developments which put in place firmer foundations and prepare the way for our future ambitions.

Partners agree there are a number of important benefits that can be achieved by creating an integrated service which can respond in a crisis which include:

- Provide a more responsive, needs led service, managed through a single co-ordination point, operating on a 24/7 basis
- Create a team of sufficient size and scale to respond to urgent need within two hours

The BCF plan therefore incorporates the investment needed to move to a two hour response time across both health and social care components of the service.

This will be achieved in the context of designing this service offer within a consolidated group of other community based services - all of which are to be delivered on a 24/7 basis in the future, as detailed above.

This will entail the development of a (joint) single point of access across health and care services and will need to be underpinned by the enabling work related to data integration and information technology to support care planning across the system.

This work will also be supported by the extension of primary care services across seven day working and the further integration of community and primary care services in support of patients with LTCs and frail older people.

Summary Table Integrated Urgent Response

Better Care Fund Schemes	***New or Existing***	***2014/15 £000's***	***2015/16 £000's***	***Metrics***	***Metric Symbols***
Integrated Crisis Response Service (Health & Social Care)	Expanding	1,039	2,000	4,3,1,5,2	
Health & Social Care Older Frail Service	New	1,000	2,000	4,5	
Ambulance Falls Prevention	New	50	100	6,4,5	
Expanded Role of Primary Medical Care	New	300	750	4	
		2,389	**4,850**		

Key to metrics

1. Permanent admissions of older people (aged 65 and over) to residential and nursing homes, per 100,000 population.
2. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services.
3. Delayed transfer of care from hospital per 100,000 population (average per month).
4. Avoidable emergency admissions (composite measure).
5. Patient/service user experience
6. Injuries due to falls in people aged 65 and over

Hospital Discharge and Reablement

Length of stay and Hospital Discharge

Over the last year there has been significant investment in a number of joint initiatives across the County such as strengthening hospital discharge through in reach, which has proved to be very effective.

The BCF plan builds on this progress, focusing the system as a whole on avoiding admissions and tackling an upward trend in lengths of stay, in particular those above 11 days where we have experienced a 19% increase in the last financial year across Leicester, Leicestershire and Rutland.

A number of existing initiatives are taking place within the acute setting to streamline discharge arrangements and these will carry on, along with continued investment through the BCF (per the existing social care allocations) for hospital to home and the new bridging service, along with assertive in reach, and the work LLR-wide on improving the range of discharge solutions and support available for mental health patients.

Implementing the Minimum Safe Data Set - (for patient transfer between health & social care)

During 2013/14 clinical, therapeutic and social care partners worked together to agree a minimum data set to enable the safe transfer of patients between care settings. Across LLR agreement has been reached to implement the tool currently being used electronically by South Warwickshire Foundation Trust. This has delivered a three day reduction in processing time for discharging older adults, and has smoothed transitions generally across health and social care boundaries.

During 2014/15 we will deploy this tool in UHL and consider its use in other settings to ensure that people get the best opportunity to have their risks of transfer assessed with the greatest equality across the system.

An additional benefit of the tool is that it contains a risk algorithm that allows clinicians to select another service option if there is insufficient capacity in the identified service, or if they feel that the particular circumstances of the patient warrant a different service offer. This will provide additional intelligence for commissioners when considering future service models.

Consolidation of 24/7 Community Based Health and Care Services

The intent to integrate community services further, forms an essential part of the plan to avoid admission and support effective discharge and reablement.

The existing services that would be subject to consolidation are:

- Intermediate care
- Single point of access
- Intensive community support (including night cover)
- Reablement (Health)
- Reablement (Social Care).

As a result of these changes the two hour rapid response will be created and a number of other benefits will also be realised as follows:

- There will be improvements for patients, carers and families in their experience of care, including care planning and coordination.
- There will be process efficiencies in referral times and choices – by providing the acute trust with a single discharge service.
- There will be process efficiencies in referral times and choices – by providing GP's, social care and community health services with a single service to avoid unnecessary acute admissions.
- We will be able to release savings as part of the overall LLR cost efficiencies.
- There will be savings in duplications between teams and inter-team referrals.
- There will be workforce improvements and broader skills training within the integrated team.
- There will be improvements to the coordination of care and the ability to provide more flexible care to suit the changing risks and needs of individuals.
- There will be improvements to records and data sharing for the integrated team.

An initial outline of this work is shown below
(See also the high level programme plan at **Appendix 4**)

- April 2014 - deploy night cover for the intensive community support service
- April - June 2014 create a single specification for all services that have traditionally comprised "step up and step down care" with work force development requirements and a trajectory for implementing the new specification
- Focus on cost effectiveness - some of the individual component parts of the service offer have a high unit cost. Through 2014/15 we will be working with public health to evaluate the benefits of the model both qualitatively and quantitatively to ensure that we are able to consider the interventions that add the most value and produce the most benefits for people through the specification period.
- July 2014 onwards agree the workforce development plan, implementation timescales and approach to contract variations with providers
- September 2014 evaluate the benefits of the night care component, and the existing crisis response service from social care
- 2015/16 – Integrate the new specification into core community services

Underlying these activities will be a full programme of work around workforce engagement/development, to ensure that people are clear about their roles and relative contributions to the delivery of the new service specification, with a skills profiling activity and training programme to maximise the early benefits of deployment.

Summary Table: Discharge and Reablement

Better Care Fund Schemes	*New or Existing*	*2014/15 £000's*	*2015/16 £000's*	*Metrics*	*Metrics Symbols*
HART Reablement	Existing	432	432	2,3,5	
Intermediate Care Team	Existing	580	580	2,3,4,5	
Integrated Residential Reablement	Existing	556	556	2,3,5	
Hospital to Home	Existing	72	72	2,3,5	
HART Scheduling System	Existing	95	130		
Patient Transfer Minimum Data Set	New	90		5	
Bridging Service	New	500	750	1,2,3,5	
Strengthening Mental Health Discharge Provision	Existing	255	261	3,5	
		2,580	**2,781**		
Protection of Services					
NHS – Step Down	Existing		529	3,5	
NHS – Intensive Community Service	Existing		1,821	3,4,5	
NHS – Assertive In Reach	Existing	569	569	3,5	
NHS – Reablement	Existing		4,132	3,5	
Social Care – Residential Care Respite	Existing	743	743	4	
Social Care – Cost pressures linked to new models of working	Existing & new	220	1,640		
		4,112	**12,215**		

c) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Section needs cross checking/aligning to final outcome of UHL contract negotiations

The implications for the acute sector in 2014/15 involve £4.648m of non elective activity being removed from the acute sector contract on the basis that this activity will be avoided by delivering the schemes in the draft BCF, with impact on the metrics detailed on page 14-19.

This equates to £2.217m of activity for East Leicestershire and Rutland CCG and £2.431m of activity for West Leicestershire CCGs.

These assumptions have been reflected in the QIPP plan currently being agreed between CCGs and the local acute Trust as part of the 2014/15 contract negotiations, and are therefore subject to change for the final submission on 4th April.

It should be noted that the QIPP non-elective assumptions for CCGs and the acute trust comprise a number of activities only some of which are directly linked to schemes in the BCF.

As part of the approach to risk sharing and risk management of the pooled budget through which the BCF Plan will be delivered and governed, a figure of £1.3m has been identified to mitigate the risk of schemes failing to deliver and any consequence on acute sector activity.

The individual elements of the BCF, their impact on acute activity, the QIPP plans between CCGs and the acute trust and the impact of the plan on the metrics have been subject to an impact assessment through a multi-agency workshop, the outputs of which have been shared with the Integration Executive on 25th March and the Health and Wellbeing Board on the 1st April.

d) Governance
Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

LLR-Wide Strategic Programme

The LLR strategic programme is governed by local health and care system leaders through a Programme Board which has the following terms of reference:

- To ensure the production of a five year LLR Health & Social Care Strategy in line with NHSE/LGA guidance
- To ensure that the strategy is co-produced and owned and fit for purpose for execution by LAs, CCGs and HWBBs
- To ensure that the strategy has been subject to patient engagement and involvement
- To ensure that the BCF Plans and five year LLR strategy are properly integrated
- To agree the future governance structure as a vehicle for implementation of the Strategy from June 2014 onwards

The composition of the programme board is as follows:

- CHAIR: Independent
- 3 x LLR HWBB Chairs
- 3 x CCG Accountable Officers
- 3 x CCG Chairs
- UHL Chief Executive
- UHL Medical Director
- LPT Chief Executive
- LPT Medical Director
- 3 x Directors of Adult Social Care
- NHS England
- Healthwatch

The programme was launched on 29th January 2014, following work to refresh and refine the vision, workstreams and governance of the Better Care Together (BCT) programme operating in LLR.

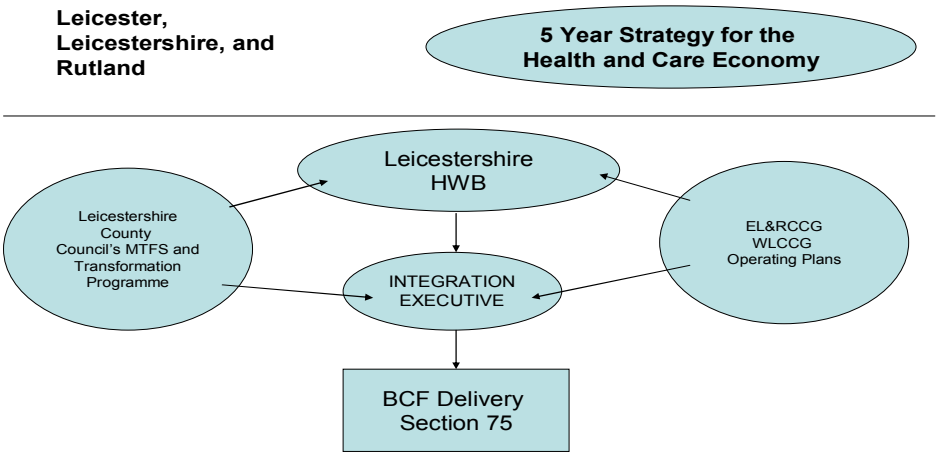
The BCT Programme has a joint shared vision for all partners. 'To maximise value for the citizens of LLR by improving health and wellbeing outcomes that matter to them, their families and carers in a way that enhances the quality of care at the same time as reducing cost across the public sector to within allocated resources by restructuring the provision of safe, high quality services into the most efficient and effective settings'

All partners have acknowledged that the BCT Programme is the preferred vehicle in delivering the changes needed to address the long term needs in both health and social care of the citizens of LLR.

Three key features of the refreshed BCT Programme are:

- To ensure much stronger alignment and integration between the LLR wide programme and the respective strategies of local Health and Wellbeing Boards
- The adoption of Health and Wellbeing Board Chairs into the membership and leadership of the programme
- Embedding of the BCF plans in the workstream arrangements as key enablers to integrated working across the five year strategy by transforming how care is delivered, in particular outside of hospital settings.

The following diagrams illustrate the relationship between the LLR-wide tier of the strategy and the local governance arrangements for the Leicestershire Health and Wellbeing Board including the role of the Integration Executive in overseeing the delivery of the BCF and the section 75 agreement for the pooled budget.



Refreshing the JHWBS and the Health and Wellbeing Board Terms of Reference

On 24 February 2014 the Leicestershire Health and Wellbeing Board's stakeholder event will reflect on progress to date in delivering our Joint Health and Wellbeing Strategy (JHWBS).

Although we anticipate maintaining our current JHWBS priorities, based on the JSNA evidence, we will be building on the "how" of delivery with respect to the work now in progress across the LLR wide programme and the development of the BCF plan.

We anticipate Leicestershire's JHWBS, workplan and governance arrangements will be updated during 2014/15 to take account of the LLR wide strategy and the introduction of BCF plan.

At their meeting on 13th February 2014 (http://politics.leics.gov.uk/ieListDocuments.aspx?CId=1038&MId=4072&Ver=4) the Leicestershire Health and Wellbeing Board refreshed their terms of reference including the following key areas of change:

- Providers joining the Board
- Taking into account the Board's new responsibilities with respect to the BCF
- Reflecting the relationship with the LLR wide five year strategy and associated governance arrangements

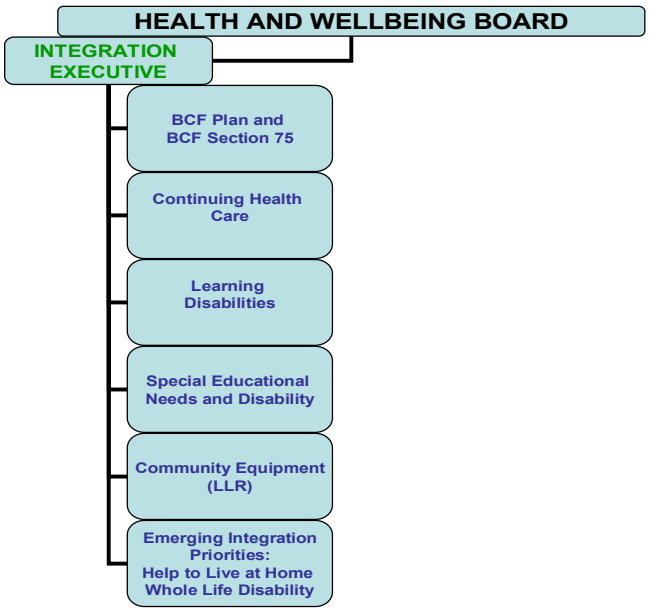
At the 13th March meeting of the Leicestershire Health and Wellbeing Board (http://politics.leics.gov.uk/ieListDocuments.aspx?CId=1038&MId=3981&Ver=4), the Board approved the creation of a new sub group, the Integration Executive, to support the Health and Wellbeing Board in:

- Steering the delivery of the BCF
- Governing the pooled budget
- Extending our ambitions for local integration/transformation beyond the current scope of the BCF
- Further crystallise the local alignment of the BCF to the priorities within the JHWBS and the LLR wide programme.

The terms of reference can be found at (http://website/leics_health_wellbeing_board_tor-2.pdf)

Proposed structure of work to be overseen by the Integration Executive (provisional)

The Integration Executive will meet monthly with membership to include CCGs, LA, District Councils, Local Health Watch and the two large local NHS providers.



Integration Programme Plan - 2014/15

There is now an established programme for the LLR five year strategy.

Integration forms one of the main strands of Leicestershire County Council's transformation programme and has a high priority corporately.

In Leicestershire NHS partners, the council and a range of other partners have already developed an integration work plan over the past two financial years led by a sub group of the HWB Board, called the Integrated Commissioning Board, using the existing social care allocations.

Leicestershire's BCF plan demonstrates how we have taken the learning from our progress to date, refined our vision and set out an incremental plan to create a joined up health and care system by 2018.

There are several areas of the plan which require further proof of concept by undertaking further preparatory work, business case development and evaluation in 2014/15, before wider implementation, either within Leicestershire itself, or as part of the LLR-wide strategy

The BCF plan shows how our approach can be scaled up over the next two years on a countywide basis, using the extended pool of resources which will become available through the BCF and the further work ahead to achieve this.

A high level programme plan has been developed which brings together all the main elements of joint work across the health and care system has been developed, which will be governed by the Integration Executive. This is attached at **Appendix 4.**

The information gathered during the impact analysis in February and March 2014 has involved taking a baseline position for each element of the integration programme including the BCF related elements. We have looked at the status of current progress, governance evidence of delivery, and assessed key milestones for 2014/15, and the current project resources allocated to each element of the programme from all parts of the system of health and care.

In addition there are some centralised resources to support delivery of the Integration Programme which include

- a Director of Health and Care Integration (0.8wte) - a shared leadership role operating across the NHS and local government in Leicestershire
- a full time business analyst allocated from Leicestershire County Council's Change Unit
- a full time programme administrator from adult social care
- 0.5 wte finance support from within Leicestershire County Council.

The Integration programme plan consists of the four different themes that are in the BCF plan along with five additional areas of ongoing joint work. The BCF themes are :

- Unified prevention offer for communities in Leicestershire
- Integrated, Proactive Care for those with long term conditions
- Integrated urgent response
- Hospital discharge and reablement

The other five elements proposed to be included into the overall integration programme:

- Special Educational Needs and Disabilities (SEN&D)
- Help to Live at Home
- Whole Life Disabilities
- Continuing Health Care (CHC)
- Integrated Community Equipment

An Operational Group, which includes membership from all the different areas within the integration programme, has been set up to oversee coordination and delivery. This will meet fortnightly and will report directly to the Integration Executive.

Key Milestones of the Integration Programme Plan

The key milestones for quarter one (2014/15) for the plan are detailed below.

Theme	Task	Delivery Date	Implementation
Unified prevention offer	Develop the local area coordination business case	June 2014	Q3 – 2014/15
Urgent response	Develop the older frailty service business case	June 2014	Q3 – 2014/15
CHC	Commissioning support model analysis	June 2014	Q3 – 2014/15
CHC	CCGs to confirm approach to GEM contract and commissioning support models	June 2014	Q2 – 2014/15
Help to live at home	Complete the design stage of the model	June 2014	Early implementation Q2 – 2015/16
Community equipment	Consolidate the community equipment team/service (hosted in the City)		April 2015

Programme Mgt - with linkage to LLR 5 Year Strategy	Develop a communications plan for the programme	June 2014	Implement early activities from May 2014 onwards
Programme Mgt - with linkage to LLR 5 Year Strategy	Develop a joint implementation plan for data sharing and adopting the NHS number	June 2014	By 2016/17 Phasing to be confirmed
Programme Mgt with linkage to LLR 5 Year	Develop a seven day working implementation plan (BCF dependent elements)	June 2014	Implementation phasing to be confirmed
Programme Mgt	Assess Care Bill Analysis and care bill implementation plan ref BCF dependencies	June 2014	Milestones per LA implementation plan
Programme Mgt	Develop and approve the section 75 pooled budget agreement	By February 2015	April 2015

Programme Plan Next Steps

Further work will be undertaken with the operational group to develop the detail beneath the high level programme plan including the findings from the impact analysis which shows the current project (people) resources allocated to the schemes in the BCF and wider integration programme.

Governance Arrangements for the BCF Pooled Budget

The new Integration Executive will govern the delivery of the BCF and the pooled budget reporting to the Health and Wellbeing Board. Ahead of the Integration Executive's first meeting in March, a multi-agency risk management workshop was held on 18th February to:

a) Review the draft risk assessment that submitted with the draft BCF on 14th February

b) Develop principles and scenarios for the risk sharing agreement for the BCF section 75 and pooled budget

c) Discuss the CIPFA guidance on section 75 development and consider the factors affecting the preparation of a section 75 agreement for the BCF in Leicestershire

Attendees included CCGs, providers and LA representatives including finance leads.

A summary of the outputs is given in the table below with a status report where relevant.

Risk Workshop Outputs

Action/Comment	Status
A number of amendments/updates and additional risks will be added to the BCF risk analysis using feedback from this meeting	Edits have been made and reflected in the risk assessment in the final submission
There will be some additional briefing/stakeholder sessions with LPT and UHL teams, to extend the stakeholder engagement to date	Additional briefings arranged
The Section 75 agreement will need to include explanatory narrative about the definition of protection	Noted
Interim Memorandum/Agreement to be drafted for the 2014/15 period pending full section 75 agreement for 2015/16.	Draft agreement to be prepared for approval at the April Integration Executive Meeting
Impact analysis work prior to final submission with provider input	Completed with provider input.
There is a need to develop and articulate collective benefits across the pathways of care/interventions within the BCF and gain greater understanding of impact and risks across partners	Will be picked up as part of the further work (identified in the programme plan) on impact analysis in Q1 2014/15
Risk assessment and risk sharing protocol needs setting in the context of the deficit position of UHL, which is likely to be the situation over the full two year BCF period	Noted
Contingency discussion at the March meeting of the integration executive - need to include information about levels of contingency in other parts of financial planning for LA and NHS partners for comparison purposes, need also to look beyond 2015/16	Actioned via Integration Executive
Principles for the Pooled budget – draft to be produced using the initial list considered at the meeting with cross referencing to other examples such as the LD pooled budget, the alliance contract for planned care and local shared services arrangements.	Draft produced and approved by Integration Executive in March
A dedicated accountant role to be established for financial management of the BCF, funded from the pool, flexible on who hosts this role for employment purposes.	This requirement has been factored into the resource plan for the integration programme from 1st April onwards.

It was noted that the lead time for developing a section 75 agreement is usually 6months+ and will require the appropriate legal advice.	The programme plan identifies a strand of work specifically for the development of the section 75 and supporting risk sharing agreement.
A number of scenarios were discussed which will be developed for the risk sharing agreement.	The scenarios are reflected later in this section
A number of financial matters were highlighted (such as treatment of VAT/inflation etc) which will be discussed/developed by finance leads in the work to draft the section 75 agreement.	Factored into programme plan
The CIPFA guide	Digest/share with other colleagues as appropriate.

Risk Sharing Agreement, Scenarios, and Section 75 Next Steps

Following approval of the risk sharing principles in March, a memorandum of understanding will be drafted for the April meeting of the Integration Executive. This will set out the risk sharing approach and confirm the level of contingency for the plan (£1.3.m), show the main milestones, the operational team across agencies who will prepare the draft, and an estimate of legal costs.

The participants at the risk workshop agreed the initial MOU/risk sharing agreement should specifically cover the following scenarios:

a. Actions to be taken in the event that the trajectory of improvement for avoidable emergency admissions is not achieved
b. Situations that are exempt (outside of the BCF plan control) – e.g. impact of a major incident
c. BCF plan components prove measurably effective, but the rate of acute demand outstrips the impact of the BCF, which still leads to over performance on the acute contract
d. BCF components prove more effective than anticipated in driving care into the community, leading to higher than planned levels of demand on reablement or home care packages
e. Timetable for assurance on the outputs of the financial modelling work associated with the impact of the Care Bill

In assessing the level of contingency within the pooled budget required the Integration Executive initially considered the potential impact of scenarios a) and c) and modelled the potential financial consequences.

The details of these two scenarios are shown at **Appendix 5** to this plan.

Summary of Governance Milestones/Other Activities to Approve the BCF Plan Submission

A timetable for local approval of the draft and final BCF submissions was developed to include various actions needed to ensure NHS and LA partners are fully briefed and can approve the submission of the plan, culminating in joint sign off at a public meeting of the Health and Wellbeing Board in February for the draft submission, and in April for the final submission.

Summary leading to the approval of the draft submission

29th January	LLR-wide (better care together) Strategy launch	To bring over 140 leaders together from across the health and care economy to shape the vision and objectives for the next five years and the transformation needed for a sustainable system in the future.
23rd January and 3rd February	BCF Multiagency Project Meetings	To seek assurance from partners to the direction of travel, refine the content of the submission, agree financial assumptions including social care protection, troubleshoot remaining issues.
4th February	Cabinet	Report to set out the background to the BCF, a brief outline of discussions to date with partners and timetable for decisions. Delegation to Health and Wellbeing Board (pending revision of HWBB terms of reference)
4th February	Briefing with UHL Strategy Board	Review scope of plan, impact of acute sector activity and financial assumptions, metrics – seek feedback
5th February	Submission of papers for CCG Boards and HWB Board	Covering Sheet Part 1 Template Part 2 Template BCF Plan Narrative Document
10th February	Members Briefing	Briefing for key members Cabinet Lead Members and Chairmen and Spokesmen of: • Children and Families • Adult Social Care • Health
11th February	WLCCG Board Meeting ELRCCG Board Meeting	Approval of draft submission
13th February	H&WB Board Meeting	Approval of draft BCF submission Refresh of HWB TORs**
24th February	HWB Board Stakeholder meeting	Seek feedback from a wide range of stakeholders including the public about the refresh the Joint Health and Wellbeing Strategy in the context of the BCF
24th February	BCF briefing meeting on with LPT Executive Team	Review scope of draft plan, activity, financial assumptions, metrics, the developments affecting community services 2014/15–2015/16 – seek further feedback
18th February	Risk Workshop	Risk assessment, and principles and scenarios for the pooled budget

Programme of Work undertaken to Finalise the BCF Submission March –April 2014

- Impact assessment across all elements of the BCF plan
  - Including on 12th March AM a multi agency impact assessment workshop
- Review of metrics per regional assurance feedback and impact assessment
- Apply other feedback from regional assurance
- Apply updated BCF guidance issued on 12th March
- Develop BCF "plan on a page"
- Update BCF plan templates for final submission
- Develop programme plan and milestones for the BCF plan over a two year period
- Finalise principles and a memorandum of understanding for the 2014/15 pooled budget
- Meetings with LLR five year strategy programme director – strategic alignment
- Cross check for strategic alignment where applicable (e.g. LLR context and provider impact) with BCF leads for Leicester City and Rutland
- Update Risk Assessment

Governance Milestones March – April 2014

11th March
- East Midlands Health and Wellbeing Programme Leadership Group meeting in Kegworth - will receive outputs of the BCF regional assurance process
- CCG Board Meetings –update paper on BCF - assurance on work in progress to finalise the BCF plan

12th March
- AM – Multi agency impact assessment workshop
- PM – Health Overview and Scrutiny Committee Leicestershire County Council - BCF Update

13th March
- 2pm (Regular) HWB Board Meeting: Agenda includes set up of the Integration Executive, update on progress with the finalisation of the BCF plan, report on outputs of the JHWBS/BCF stakeholder engagement event held on 24th February, and feedback from the East Midlands BCF assurance review.

19th March
- Position Statement at Leicestershire County Council's Council Meeting (Mr. White CC)

24th March
- BCF covering report to be issued for HWB Board meeting on 1st April

25th March
- 5pm Inaugural meeting of the Integration Executive

26th March
- BCF final draft documents to be issued for HWB Board on 1st April

1 April
- 2pm Leicestershire County Council Cabinet Meeting – Report on the BCF submission, ahead of HWB Board meeting
- 5pm-6pm Extraordinary Meeting of the Leicestershire HWB Board to discuss and approve the BCF submission, subject to any final amendments needed.

4th April
- Submit BCF final plan to NHS England.

8th April
- CCG Board Meetings: opportunity for further BCF update which could include:
  - Formal receipt of final BCF submission
  - Feedback from Integration Executive/HWB Board
  - Discussion ref BCF programme plan/governance arrangements for 2014/15.

11th April
- 11am – All Member Briefing at Leicestershire County Council – BCF Update

***Updated HWBB terms of reference will also be addressed as part of the next review of the County Council's Constitution during the summer of 2014.*

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services. Please explain how local social care services will be protected within your plans.

We have agreed a number of investments from the BCF (mapped to each BCF theme) where specific types of packages of care/services are being protected to support hospital discharge and admission avoidance.

The prioritisation and type of resource to be protected has been 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 pressures still to be addressed.

While the protection identified within the BCF plan does not resolve all aspects of this pressure, 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 the frail older 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 GP practices.

The key points and table below show the analysis undertaken in the context of the MTFS, and the packages/activity type and investment levels that have been agreed in order to protect Adult Social Care in support of the BCF plan.

Leicestershire County Council is required to make a total of £110m budget savings between 2014-18 representing 30% of its total budget. The Council recognises the need to protect the most vulnerable citizens and accordingly has allocated some resource for demographic growth pressures over the next four years. The Council is sourcing a higher proportion of savings from non Adult Social Care Council services to mitigate some of the service reductions that would need to be made otherwise.

The Council's 2014/15 Medium Term Financial Strategy shows a proposed increased budget totalling £21.3m for Adult Social Care with £9.2m towards meeting increased demographic pressures by 2015/16.

The balance of projected unfunded additional demographic pressures is proposed to be funded from the BCF with £1.7m in 2014/15 and £4.6m from 2015/16.

The additional funding proposed from the BCF will meet increasing levels of demographic growth and continue to protect essential social care services as outlined below.

The impact of the social care protected interventions as detailed in the table below is subject to further analysis in February and March.

Service Protected	Health and ASC Benefit	BCF Contribution 2014-15	BCF Contribution 2015-16	BCF Theme
Nursing Care Home Packages	Ongoing provision of c300 nursing care placements enabling these high dependency service users to stay out of the acute sector.	2,995	3,361	Integrated proactive care for LTC
Sustaining community based services with increased pricing and increased average size of packages of homecare	Existing price and increased dependency in domiciliary care and other community based services enabling more people to stay or return to their homes.	1,466	1,876	Integrated proactive care for LTC
Residential reablement respite	Ongoing provision of Residential reablement respite care for c20 service users per week	743	743	Improving Hospital Discharge and Reablement
Increasing demographic pressures	Provision of care packages to meet above budgeted increasing demographic pressures for 18-64 years mental, physical and learning disabilities plus increasing people with dementia and more complex needs. Additional to the £21m being funded by the LA over four years.	1,741	4,584	Integrated proactive care for LTC
Maintaining Social Care pathway	Maintain capacity in social care pathway (i.e. social workers) to support new integrated model of working.	220	1,640	Improving Hospital Discharge and Reablement
Maintain care packages	Maintain support levels for existing service users. This will avoid a 20% average reduction in all long term support packages		3,852	Integrated proactive care for LTC
Total Value of Protected Services		**7,165**	**16,056**	

Implications of the Care Bill

The Care Bill will be implemented in stages between 2014 and 2016.

Amongst the key changes are national eligibility criteria, new responsibilities for Information and Advice, increased rights and access to services for carers, and Adult Social Care funding reforms.

It is likely that these changes will have a significant impact on publicly funded Adult Social Care, and therefore, increase the financial pressure on the Council.

At this stage it is too early to make a full assessment about the scale of this impact.

Since the draft BCF was submitted, Local Authorities have received confirmation of their specific allocation from a national investment of £135m for the implementation of the Care Bill. This forms one of the elements of the overall BCF financial envelope for each Authority and its partners. The Leicestershire allocation is circa £1.3m.

There will be further allocations of resources directly to Local Authorities in 2015/16 to pay for implementation of the non-financial reform elements of the Bill and in 2016/17 to fund the financial reforms. There is a risk that these allocations will not fully fund the actual costs.

Further analysis is needed to assess specific implications against the requirements of the Bill and to assist with this national modelling tool has been developed. This tool is being piloted in a number of Local Authority's and over time will be used to assess the potential impact of the Care Bill with respect to their population.

The development and application of the tool is iterative, and at the time of this submission further refinements to the modelling tool are anticipated. There is also a national consultation in progress about eligibility criteria.

The BCF submission has already identified an indicative £300k for additional carer assessments based on current estimates but this could be subject to change and represents only one aspect of the Bill's requirements.

Risks in relation to the introduction of the Care Bill have been reflected in the risk register, and all assumptions and risks will be updated as further analysis becomes available, with regular updates to the Integration Executive

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

Following the publication of NHS England's clinical standards for seven day working, all Acute Trusts in the East Midlands are undertaking a baseline assessment by June 2014 against the ten elements of the clinical standards.

This will include an overview of how other elements of the health and care system that intersect with acute providers on a seven day basis are being configured to support seven day working, for example for Leicestershire the intensive crisis response service which will offer a combined health and social care response to avoid admissions where urgent held is needed in the community.

In terms of primary care developments in support of seven day working, the Leicestershire Health and Wellbeing Board received a report in March 2014 from NHS England covering the emerging strategy of NHS England/Operating plan.

This report and the Board's discussions included how primary care strategy is developing nationally and how this will be translated into Leicestershire and Lincolnshire, with respect to our Area Team.

The Health and Wellbeing Board discussed the parameters of the core contract for GPs and the additional services currently being commissioned by both NHS England and CCGs in order to extend the primary care service offer to local patients beyond the core contract. The minutes capturing the Health and Wellbeing Board's discussions on this topic and the action agreed can be found here (http://politics.leics.gov.uk/ieListDocuments.aspx?CId=1038&MId=3981&Ver=4)

In the meantime, £1m has been identified within the BCF plan to extend the role of primary care further in relation to seven day working and case management of the over 75s. This is a starting point which will be reviewed as the local primary care strategy becomes further developed.

Further discussions are planned between NHS England and local CCGs to consider the application of these funds in the context of the current levels/pattern of commissioning between the two commissioning organisations and to co-produce future milestones for extending primary which will also need to interface with out of hours GP provision, social care services and the acute sector developments noted above..

Several components of the BCF relate specifically to making a significant shift in delivering 24/7 integrated community based support for Leicestershire's communities. The draft BCF plan shows how we will develop from our foundations and then rapidly create further integration across acute, community and GP settings of care, starting with these developments:

- The introduction of an integrated single point of access across health and care services 24/7
- The introduction of a two hour integrated response service for urgent health and care support in the community
- The introduction of case management of the over 75s
- The introduction of a new Bridging Service to make further improvements to hospital discharge, including at weekends.
- The extension of primary care services across seven day working and the further integration of community and primary care services in support of patients with LTCs and frail older people.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

The NHS locally already uses the NHS number as a primary identifier.

Adult social care are not currently in a position to do this, although the systems we utilise have provision for holding the NHS number and this is populated where a number is known. – see next steps below.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

As part of our plans for integration and use of minimum patient transfer dataset over 2014/15 & 2015/16, our ambition is to fully implement the use of the NHS number as the primary identifier by 2016/17.

A high level interagency agreement has been produced setting out the principles for data sharing. This work will be progressed further in the context of the LLR five year strategy.

All three BCF plans within the LLR strategy will be coordinating their "ask" of the data/IT LLR workstream to ensure the milestones and dependencies across the system are captured and the pace of this work is accelerated in support of BCF delivery.

This is particularly important in terms of overall effectiveness of, and dependencies related to, the BCF plans that relate to an integrated single point of access 24/7, the two hour urgent response in the community, discharge planning, case management for the over 75s, seven day working and LTC joint care plans.

In the meantime, operationally, both Leicester City Council and Leicestershire County Council are in the process of implementing a new Adult Social Care information system called IAS. This has built in functionality to record the NHS number as an identifier.

Local and national discussions are in progress, including via the Department of Health to consider how IAS functionality should be developed and exploited in support of the integration agenda.

IAS also has provider portal which allows, for example domiciliary care providers, to access the IAS system to upload core data on the activity they have performed.

The programme plan for the Integration Executive includes a milestone to develop an multiagency implementation plan by June 2014 to set out the steps needed to achieve data sharing and adoption of the NHS number in Leicestershire.

This work will include:

- How data and care records can be shared more effectively between IAS and the systems of other commissioners and providers in Leicestershire's health and care system and the respective milestones across operating systems in order to achieve this.
- The information governance requirements.
- The cultural and organisational differences affecting the progression of this work.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK)

We are committed to adopting systems that are based upon Open APIs and Open Standards (i.e. secure email standards, interoperability standards (ITK).

Both the new Adult Social Care and home care rostering products being introduced by Leicestershire County Council have a range of open API's and XML schemas to utilise web services and re-use of interfacing code.

NHS systems used locally such as HISS (PAS); ICE, EMIS, Maracis/RiO are supportive of Open APIs and Open Standards. The main exception is the nationally contracted TPP SystmOne product.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

We are committed to ensuring that the appropriate Information Governance (IG) Controls will be in place.

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

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

The majority of NHS systems are covered by the national NHS Registration Authority Chip and Pin access system which provides position based access control.

In addition to the above elements Leicestershire County Council will be hosting a national centre for excellence in data sharing which will bring a number of additional benefits to the BCF programme and the Council's overall transformation programme. In particular it will facilitate the opportunities to learn from national best practice in information sharing, and provide capacity to support the local programme.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Both CCGs have implemented risk stratification tools with case management for at risk populations as part of their programme of support for:

- Older frail patients
- Those with LTCs
- Those at risk of developing LTCs/frailty.

West Leicestershire CCG

In WLCCG 49 of the 50 practices have implemented risk stratification which collates and analyses a combination of acute and primary care data through clinical systems The exception is the Loughborough University practice, who has a student based population. In WLCCG there are ten clinical coordinators who are the case managers for those categorised at risk using the risk stratification tool. Since April 2013, 409 patients have been reviewed and admitted to virtual wards where case management is delivered accessing social care resource. These patients receive joint assessment, interventions and care plans per their assessed needs. Through the introduction of the BCF plan there will be a much greater integration of social care risk factors and interventions into case management, including housing support, which has proved to be an increasingly important element, hence the development of the housing offer to health. The BCF plan seeks to align the existing and improving inputs of primary care teams, community nursing teams and social care into fully integrated teams clustered around GP practices, with case management also being introduced as standard for the over 75s. Over the course of the BCF plan period the intention is to develop a new model of care for frail older people from the existing/ extending components.

<u>Supporting information WLCCG Risk Stratification</u>

In terms of the categorisation of at risk patients:

Patients who are frail will have one or more of 12 diagnoses, such as falls, dementia, urinary or faecal incontinence or malnutrition.

The Likelihood of Admission refers to a patient's chance of being electively or non-electively admitted in the next 12 months.

A score of five represents a 50% or greater chance of being admitted. A score of four represents a 40-49% chance of being admitted. Three equals 30-39% and so on.

Relative to the whole population, patients in groups four and five have a high likelihood of being hospitalised.

Resource Utilisation Band (RUB) These bandings (1-5) show groups of patients with increasing likelihood of being in the top 5% costliest group next year.

The risk factors are currently comprised of the following elements:

- The likelihood of any patient being in the top five per cent highest cost group of patients next year.
- Patients most likely to be admitted in the next 12 months.

- Prescription given associated with the named condition.
- Read Diagnosis Code / Primary Code / Secondary Care code present.
- Both RX and ICD are present.
- Treatment - the patient has a prescription associated with that condition and has attended OPD or ED for that condition, but no diagnostic code was found in the primary care record for that condition.

East Leicestershire and Rutland CCG
East Leicestershire and Rutland CCG utilises the Adjusted Clinical Groups (ACG) risk stratification tool to identify patients at risk of future avoidable hospital admissions. The CCG and Local Authorities Integrated Care service, uses this risk stratification tool within a joint process to assess patients at risk, coordinate identified interventions to reduce/manage this risk and allocate a lead professional where appropriate.

There are ten integrated health and social care coordinators who are the care coordinators for those patients identified at risk using the risk stratification tool and whom have opted into the service. These patients receive joint assessment, interventions and care plans per their assessed needs. Through the introduction of the BCF plan there will be a much greater integration of social care risk factors and interventions into case management, including housing support, which has proved to be an increasingly important element, hence the development of the housing offer to health.

4) RISKS
Please provide details of the most important risks and your plans to mitigate them.

This should include risks associated with the impact on NHS service providers.

We provided an initial risk analysis for the draft submission. This was refined following:-

- The risk workshop at the end of February
- Further testing and modelling in relation to the activity and financial assumptions, and the impact on the metrics during February and March.

Risks to Plan Preparation and approval

Description	Likelihood	Risk rating before Mitigation	Potential Impact	Mitigation	Risk Rating following mitigation
Lack of agreement to one or more components of the plan	M	H	• Draft and final plans are not secure between partners,	• Iterations of draft plan with CCG MDs and LA, regular project team meetings to refine content/assumptions. • Build in sufficient confirm and challenge time. • Multiagency workshop on risk assessment and pooled budget 18/02/14 • Multiagency workshop on impact assessment 12/03/14 • Review by Integration Executive prior to final submission. • Seek early agreement to adult social care protection levels – see below	L
Lack of agreement to the levels of social care protection in the plan	M	M	• Draft and final plans are not secure between partners, • Regional/national assurance sign off is compromised due to not meeting a key national condition	• Ensure elements for adult social care protection map clearly to the themes and metrics in the BCF. • Determine level of granularity needed and discuss with CCGs • Prepare breakdown of social care protection allocation to meet BCF guidance and stakeholder requirements • Prepare briefing materials for CCG Board discussions in January/February. • Check feedback from regional/national assurance for any concerns about the submitted levels, if applicable.	L

Description	Likelihood	Risk rating before Mitigation	Potential Impact	Mitigation	Risk Rating following mitigation
Lack of agreement to the metrics and trajectories for the plan	H	H	• Draft and final plans are not secure between partners. • Regional/national assurance sign off is compromised, • Providers and other stakeholders have low confidence in plans	• Initial cut of data for metrics and trajectories prepared by CCGs/CSU/LA. • Quality assurance review of metrics undertaken using NHSE feedback. • Detailed review per metric at the impact assessment workshop in March with provider representation • Review of recommendations arising from the workshop by Integration Executive and HWB Board prior to submission of final BCF.	L Except for avoidable emergency admissions (M)
Lack of agreement to scale of ambition within the plan	M	H	• Draft and final plans are not secure between partners. • Lack of confidence that the health and care system can transform. • Impact on CCG/provider contract negotiations.	• Iterations of draft plan with CCG MDs and LA, regular project team meetings to refine content/assumptions. • Build in sufficient confirm and challenge time including provider input • Multi agency Workshop on impact assessment 12/03/14 • Clear rationale for trajectory for reducing avoidable emergency admissions over a five year period. • Review by Integration Executive prior to final submission. • Alignment to final outcome of contract negotiations by 31/03/14	M

Description	Likelihood	Risk rating before Mitigation	Potential Impact	Mitigation	Risk Rating following mitigation
Plan not assured regionally/nationally by NHSE/Local Govt	L	M	• Additional regional intervention is needed. • Reputation of BCF plan and HWB Board partnership are compromised • Lack of confidence in local delivery.	• Apply national guidance including all updates when published • Apply the technical guidance for metrics • Stress test the metrics before final submission • Provide clear rationale for any local variations from metrics technical guidance • Local awareness of self assessment parameters for regional assurance • Review other examples of BCF draft plans for good practice. • Establish contact with national BCF lead • Assimilate feedback from regional assurance before final submission	L
BCF impact assessment challenges one or more element of the plan	M	H	• Plan components need further prioritisation • Alternative proposals may need to be introduced • Financial assumptions may need adjustment	• Impact assessment workshop to review impact of proposals to metrics, and consider KPIs beneath the main metrics to seek further assurance on delivery/impact. • Recommendations on any deletions/additions for BCF schemes (and/or the balance of investment between schemes) to be received by the Integration Executive and HWB Board prior to final submission. • Regular milestone reviews of the BCF by the Integration Executive	M

Description	Likelihood	Risk rating before Mitigation	Potential Impact	Mitigation	Risk Rating following mitigation
Risk Sharing arrangements for pooled budget not agreed	H	M	• Partners are not clear on their level of risk in undertaking the plan, • Individual board/committees of organisations unable to approve plan • Impact on CCG/provider contract negotiations	• Workshop held in February to develop the principles and scenarios for the pooled budget. • Outputs received by the Integration Executive in March • Assurance via the HWB board meeting on 1st April.	M
Insufficient alignment with LLR five year Strategy	M	M	• Mismatch between strategic objectives, • Duplication of effort, • Unclear impact for providers, • Regional/national assurance sign off is compromised	• LLR Strategy launch on 29th January to confirm direction of travel, workstreams and governance. • LLR strategy workstreams and governance refreshed February/March • Meetings held with LLR programme director in early March to ensure alignment of BCF to emerging strategic objectives of the LLR programme. • TORs for integration executive (new - March) and TORs for HWB Board (updated - February) have both ensured alignment of governance arrangements	L
Insufficient alignment with BCF plans in Leicester City and Rutland (where applicable)	M	M	• Unclear impact for providers, • Inconsistency of submissions in LLR context. • Regional/national assurance sign off is compromised	• Review/cross check across key elements of City and Rutland Plans as part of local assurance before final submission – in particular for LLR context and aggregated provider impact.	L

Description	Likelihood	Risk rating before Mitigation	Potential Impact	Mitigation	Risk Rating following mitigation
Lack of visibility/engagement across wider stakeholders including the public and VCS	H	M	• Stakeholders disengaged, • Lack of public understanding and support for the plans • VCS unclear as to how they can contribute to and support the plan.	• Close involvement of LHW in plan preparation. • Wider stakeholder engagement meeting held 24th February. • Forward engagement plan under discussion in context of comms/engagement plan for the LLR-wide programme. • BCF "plan on a page" being developed to support external comms • Easy read symbols and diagrams applied to final BCF submission • More targeted VCS engagement planned for Q1 of 2014/15	M
Wider stakeholders including the public and VCS challenge proposed changes	H	H	• Formal challenge through judicial review process delays implementation of change • Reputational impact • Financial costs of legal action and delays	• Ensure stakeholder engagement and consultation follows recent Council guidance approved in January 2014 on Consultation Principles, Equalities and Human Rights Assessments and Legal Implications of Service Change. • Ensure 'due regard' given in decision making by Health and Wellbeing Board	M
Providers not able to support initial draft	H	H	• Draft and final plans are not secure between partners • Reputation of BCF plan and HWB Board partnership are compromised • Lack of confidence in local delivery • Impact on CCG/provider contract negotiations • Regional/national assurance sign off is compromised.	• Individual briefings with providers • Engagement of providers in preparation of proposals/project team meetings and workshops • Providers as members of the HWB Board and Integration Executive • Additional briefings/engagement/ comms cascade into wider teams within UHL and LPT	M

Risks to Plan Delivery

Description	Likelihood	Risk before mitigation	Potential Impact	Mitigation	Risk after mitigation
Lack of clarity/pace on LLR five year strategy affects pace of BCF delivery	M	H	• Mismatch between strategic objectives, • Duplication of effort, • Unclear impact for providers across LLR • Dependencies are not clearly articulated • Risks between programmes are not transparent or well mitigated • Mismatch in accountability between programmes • BCF delivery stalls due to an unforeseen delay due to LLR dependencies	• Health and Wellbeing Board & BCF directly linked to LLR Programme Board • Close working between BCF lead and LLR programme lead • Risk analysis for BCF to be shared proactively with the LLR programme director • LLR programme structure incorporates clear BCF workstreams for each council • LLR dependencies affecting sequencing and pace to be assessed and factored into the programme plan • Refresh risk analysis with programme plan detail in Q1 2014/15	M
Lack of LLR integrated workforce plans	H	H	• Unable to plan effectively for local workforce requirements including the necessary workforce development and training in the medium term. • Workforce planning between LA and NHS partners remains disjointed and workforce related investment and benefits realisation not aligned. • LLR's "ask" of academic and other training partners is piecemeal/confused.	• To be progressed via the LLR Programme Board with mitigating actions translated into BCF programme plan • Seek clarity on the TORs and workplan of the LLR workforce subgroup. • Seek assurance that the LLR workforce subgroup has taken into account the specific workforce requirements within the BCF plan, with reporting into the Integration Executive.	H

Description	Likelihood	Risk before mitigation	Potential Impact	Mitigation	Risk after mitigation
Insufficient capacity or expertise to deliver the BCF (programme resource)	M	M	• Unable to execute plan to milestones • Compromise delivery of metrics • Lack of confidence that programme will deliver	• Programme plan and impact assessment has identified resource and expertise required with associated risks/mitigation	M
Delays/slippage on delivery of components of the plan	H	H	• Unable to execute plan to milestones • Compromise delivery of metrics • Lack of confidence that programme will deliver	• High level and detailed programme plans to be developed • Expenditure realistically profiled to plan • Contingency agreement per the pooled budget • Governance via Integration Executive	M
Poor evidence base/analysis for proof of concept/business case development	H		• Poor decision making affecting commissioning decisions • Poor selection of schemes to metrics • Lack of assurance on plan delivery	• Secure analyst resource. • Clinical/subject matter experts engaged in evidence base analysis (including public health) • Multiagency impact assessment workshop and product details evidence base. • Confirm and challenge via Integration Executive • Data quality review on scheme related KPIs supporting metrics in Q1 2014/15 • Scope development of intelligence hub as enabler within BCF plan.	M

Description	Likelihood	Risk before mitigation	Potential Impact	Mitigation	Risk after mitigation
Plan does not deliver against metrics e.g. The BCF plan does not deliver sufficiently to allow CCGs to release the planned level of funding across the two financial years. The impact of the BCF plan does not result in providers being able to extract the required levels of capacity from the system	H	H	• Unable to execute plan to milestones • Compromise delivery of metrics • Pressure on the acute system • Additional system costs • Reputational damage to HWB partners • Lack of public confidence in using alternatives to hospital. • Over performance on CCG acute contracts. • QIPP plans cannot be delivered in the acute sector. • Fixed costs and overheads cannot be reduced in line with planned activity reductions in the acute sector. • Impact on future contract negotiations and sustainability across the health and care economy.	• Further analysis on the impact of BCF schemes prior to final submission. • Metrics and trajectories subject to quality assurance in February/March • Evidence base to be linked more clearly to trajectory assumptions • Impact assessment workshop to stress test the metrics with provider involvement • Realistic stretch projections over the five year period on key metrics such as avoidable emergency admissions • Clear line of sight from BCF plan to acute contract activity and financial assumptions • Aggregated BCF plan impact clear across LLR • Detailed programme plan • Expenditure realistically profiled to plan. • Reporting on BCF delivery through Integration Executive • Scenario specifically addressed in risk sharing agreement • Contingency fund in pooled budget	H (until further evidenced at end of Yr 1)
Commissioning decisions/arrangements do not support integration	M	M	• Plan is not enacted in support of integrated care priorities	• Health and Wellbeing Board through Integration Executive to govern how integrated commissioning plans are enacted	L

Description	Likelihood	Risk before mitigation	Potential Impact	Mitigation	Risk after mitigation
Lack of contingency/effective alternative schemes if plan is failing	H	M	• Unable to reach trajectory of performance • Loss of confidence in local health and care system • Reputational damage	• Programme plan to include scoping effective alternatives/extensions of BCF schemes beyond 2015/16, including feasibility of mobilisation • Integration Executive to promote culture of innovation	M
Lack of effective communication about the BCF and how this supports/ fits with other plans	H	H	• Confusion about local plans, stakeholders disengaged, lack of support for plans	• Communications support to programme plan, joint messages to be agreed/enacted in conjunction with LLR-wide comms and engagement plan.	M
Dispute on risk sharing agreement	H	M	• Inability to maintain BCF funding plans beyond 2014/15 • Partnership unable to be sustained.	• Risk sharing agreement progressed February/March including via multi agency workshop • Pooled budget principles developed • Risk sharing arrangements for the pooled budget to cover dispute scenarios and methods of resolution • Contingency fund to be confirmed and challenged by Integration Executive following impact assessment workshop	M

Description	Likelihood	Risk before mitigation	Potential Impact	Mitigation	Risk after mitigation
Challenged Health Economy - External advisers External Advisers (for LLR 5 year plan) challenge/redirect local strategy including BCF assumptions leading to reprioritisation of BCF	M/H?	H	• Changes to BCF plan before impact of current schemes can be realised. • Potential impact on metrics delivery. • Lack of confidence in BCF plan. • Increased national/regional scrutiny and upward reporting. • Resources diverted to steering new course, rather than delivery. • Potential for escalating tensions between commissioners/providers/ other stakeholders. • Potential for change of personnel/leading to instability within the health and care system. • Impact of remedial work detracts from BCF delivery	• LLR Pre work on five year strategy • BCF refresh in Autumn 2014/15 to sense check position post publication of five year strategy. • Contingency plan if BCF is stalled/ reconfigured from 2016/17 onwards with comms plan to support this scenario. • Integration Executive contingency plan on resource allocation (people) if further work needed.	M
Challenged Health Economy –deficit (acute provider)	H	H	• System is in deficit for whole BCF period. • BCF funding is compromised. • System leadership could be subject to further change/ instability • Impact of remedial work detracts from BCF delivery	• Ensure BCF delivery to planned milestones • Seek stretch on metrics from 2015/16 onwards where possible • Consider additional/replacement schemes if can go further faster within available resources.	H

Description	Likelihood	Risk before mitigation	Potential Impact	Mitigation	Risk after mitigation
BCF delivery costs greater than estimated	H	M	• Affordability of plan is jeopardised • Unable to deliver milestones/trajectory • Loss of confidence in the plan • Lack of financial control	• Further scoping and business case analysis in support of programme elements. • Phasing assumptions tested via programme plan. • Expenditure to plan kept under close review by integration executive with mitigation plan for re-prioritisation. • Dedicated finance lead for pooled budget	M
Costs of implementing the care bill not yet quantifiable and may not be fully funded	H	H	• MTFS of council placed under additional pressure • Additional savings needed in ASC • Potential impact on acute NHS	• Work plan within council to scope and implement Care Bill to inform BCF plan • Address the implications of national guidance and allocations letters about Care Bill funding as these are published. • Active involvement in the national modelling tool design and outputs. • Phased approach to financial planning with respect to Care Bill implementation • Briefings via the Integration Executive as implementation progresses, to include outcome of national and local work on eligibility. • Risk analysis to be regularly reviewed	M
Demand outstrips social care protection assumptions	M	M	• MTFS of council placed under additional pressure • Additional savings needed in ASC • Potential impact on acute NHS • Recurrent BCF plan in dispute	• Data tracking via ASC to inform BCF plan performance. • Risk sharing agreement to specifically cover this scenario • Regular BCF programme milestone reviews/risk reviews	L

Description	Likelihood	Risk before mitigation	Potential Impact	Mitigation	Risk after mitigation
Lack of opportunity to bring in additional schemes/innovate/flex the plan within the two year period.	H	M	• Missed opportunities for improving integrated care as additional evidence becomes available. • Culture of the programme is not conducive to mature debate. • Lack of openness to ideas from other settings/locations	• Regular BCF programme milestone reviews • Provider innovation to be encouraged via Integration Executive.	L
Environmental/Policy Change (e.g. election/ fundamental change to BCF/integration policy affecting NHS and/or LA partners)	M	M	• BCF approach is scrapped or expanded nationally. • Metrics/performance regime changes • Organisational integration becomes more of a policy imperative than service/care pathway integration (organisational integration not currently part of our BCF proposals) • Pace of delivery compromised due to change of direction	• Integration Executive and HWB Board to provide strategic local leadership to ensure improving integrate care remains central to five year objectives with linkage to LLR-wide strategy. • Integration Executive and HWB Board to consider an MOU to cover future proofing medium term commitments within the boundaries of the existing mechanisms for joint working across health and local govt.	L

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