Date: THURSDAY, 9 OCTOBER 2014

Time: 10:00 am

Location: THE COUNCIL CHAMBER - FIRST FLOOR, TOWN HALL, TOWN HALL SQUARE, LEICESTER

# HEALTH AND WELLBEING BOARD

## Councillors:

Councillor Rory Palmer, Deputy City Mayor (Chair)

Councillor Vi Dempster, Assistant City Mayor

Councillor Rita Patel, Assistant City Mayor

Councillor Manjula Sood MBE, Assistant City Mayor

## City Council Officers:

Deb Watson, Strategic Director Adult Social Care and Health

Andy Keeling, Chief Operating Officer

Elaine McHale, Interim Strategic Director Children's Services

Tracie Rees, Director Care Services and Commissioning, Adult Social Care

## NHS Representatives:

Professor. Azhar Farooqi, Co-Chair, Leicester City Clinical Commissioning Group

Dr Simon Freeman, Managing Director, Leicester City Clinical Commissioning Group

Dr Avi Prasad, Co-Chair, Leicester City Clinical Commissioning Group

David Sharp, Director, (Leicestershire and Lincolnshire Area) NHS England

## Healthwatch / Other Representatives:

Karen Chouhan, Chair, Healthwatch Leicester

Chief Superintendent, Rob Nixon, Leicester City Basic Command Unit Commander, Leicestershire Police

2 Vacancies

Members of the Board are summoned to attend the above meeting to consider the items of business listed overleaf.

Members of the public and the press are welcome to attend.

G. J. Carey

For Monitoring Officer

City Mayor healthwatch Leicester Leicestershire Police Protecting our communities NHS Leicester City Clinical Commissioning Group NHS Commissioning Board

# Information for members of the public

**Attending meetings and access to information**

You have the right to attend formal meetings such as full Council, committee meetings, City Mayor & Executive Public Briefing and Scrutiny Commissions and see copies of agendas and minutes. On occasion however, meetings may, for reasons set out in law, need to consider some items in private.

Dates of meetings and copies of public agendas and minutes are available on the Council's website at www.cabinet.leicester.gov.uk, from the Council's Customer Service Centre or by contacting us using the details below.

**Making meetings accessible to all**

Wheelchair access – Public meeting rooms at the Town Hall are accessible to wheelchair users. Wheelchair access to the Town Hall is from Horsefair Street (Press the buzzer on the left hand side of the door to be let in to the building, then take the lift to the ground floor and go straight ahead to the main reception).

Braille/audio tape/translation - If you require this please contact the Democratic Support Officer (production times will depend upon equipment/facility availability).

Induction loops - There are induction loop facilities in Town Hall meeting rooms. Please speak to reception staff at the Town Hall or the Democratic Support Officer at the meeting if you wish to use this facility or contact us using the details below.

Filming and Recording the Meeting - The Council is committed to transparency and supports efforts to record and share reports of proceedings of public meetings through a variety of means, including social media. In accordance with government regulations and the Council's policy, persons and press attending any meeting of the Council open to the public (except Licensing Sub Committees and where the public have been formally excluded) are allowed to record and/or report all or part of that meeting. Details of the Council's policy are available at www.leicester.gov.uk or from Democratic Support.

If you intend to film or make an audio recording of a meeting you are asked to notify the relevant Democratic Support Officer in advance of the meeting to ensure that participants can be notified in advance and consideration given to practicalities such as allocating appropriate space in the public gallery etc.

The aim of the Regulations and of the Council's policy is to encourage public interest and engagement so in recording or reporting on proceedings members of the public are asked:

- ✓ to respect the right of others to view and hear debates without interruption;
- ✓ to ensure that the sound on any device is fully muted and intrusive lighting avoided;
- ✓ where filming, to only focus on those people actively participating in the meeting;
- ✓ where filming, to (via the Chair of the meeting) ensure that those present are aware that they may be filmed and respect any requests to not be filmed.

**Further information**

If you have any queries about any of the above or the business to be discussed, please contact Graham Carey**, Democratic Support on (0116) 454 6356 or email** **graham.carey@leicester.gov.uk** or call in at City Hall, 115 Charles Street, Leicester, LE1 1FZ.

For Press Enquiries - please phone the **Communications Unit on 454 4151**

# PUBLIC SESSION

# AGENDA

**NOTE:**

**This meeting will be webcast live at the following link:-**

**http://www.leicester.public-i.tv**

**An archive copy of the webcast will normally be available on the Council's website within 48 hours of the meeting taking place at the following link:-**

**http://www.leicester.public-i.tv/core/portal/webcasts**

**1. APOLOGIES FOR ABSENCE**

**2. DECLARATIONS OF INTEREST**

Members are asked to declare any interests they may have in the business to be discussed at the meeting.

**3. MINUTES OF THE PREVIOUS MEETING** **Appendix A Page 1**

The Minutes of the previous meeting of the Board held on 3 July 2014 are attached and the Board is asked to confirm them as a correct record.

**4. THE CHALLENGES FACING PRIMARY CARE IN LEICESTER CITY** **Appendix B Page 17**

Leicester City Clinical Commissioning Group (CCG) to submit a report on the challenges in primary care in the City and what is being done to respond to these challenges. Dr Simon Freeman, Managing Director, Leicester City CCG and David Sharp, Director, Leicestershire and Lincolnshire Area, NHS England will present the report at the meeting.

**5. BETTER CARE TOGETHER JOINT LEICESTER, LEICESTERSHIRE AND RUTLAND FIVE YEAR STRATEGY - UPDATE** **Appendix C Page 27**

Geoff Rowbotham, Interim Programme Director Better Care Together, to submit a report providing an update on the progress of the Better Care Together Strategy.

**6. JOINT HEALTH AND WELLBEING STRATEGY -** **Appendix D Page 35**

a) Dr Simon Freeman, Managing Director, Leicester City Clinical Commissioning Group, to submit the six monthly update report on the progress of the Joint

Health and Wellbeing Strategy.

b) Andrew L Smith, Director Planning, Transportation & Economic Development, Leicester City Council, to report on how the Directorate are working to support the Joint Health and Wellbeing Strategy.

**7. CAMHS REVIEW** **Appendix E Page 87**

West Leicestershire Clinical Commissioning Group to submit a report providing an update on the Children and Adolescent Mental Health Service Review (CAMHS). Leon Charikar CAMHS Commissioning Manager Leicester, Leicestershire and Rutland will attend the meeting to present the report.

**8. LEICESTER PHARMACEUTICAL NEEDS ASSESSMENT** **Appendix F Page 99**

Rod Moore, Divisional Director Public Health, Leicester City Council to provide a verbal update on the progress of the development of Leicester's Pharmaceutical Needs Assessment (PNA). A copy of the consultation document on the Draft PNA which runs from 29 September 2014 to 28 November 2014 is attached for information.

**9. BETTER CARE FUND** **Appendix G Page 119**

To receive and note the Better Care Fund submission.

**10. QUESTIONS FROM MEMBERS OF THE PUBLIC**

The Chair to invite questions from members of the public.

**11. DATES OF FUTURE MEETINGS**

To note that future meetings of the Board will be held on the following dates:-

Thursday 11 December 2014
Thursday 5 February 2015
Thursday 26 March 2015
Thursday 25 June 2015
Thursday 3 September 2015
Thursday 29 October 2015
Thursday 10 December 2015
Thursday 4 February 2015
Thursday 7 April 2016

( Note: - Meetings of the Board are likely to be held in City Hall from December onwards.)

**12. ANY OTHER URGENT BUSINESS**

# Appendix A

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 3 JULY 2014 at 10.00am

**Present:**

| | | |
|---|---|---|
| Councillor Rory Palmer (part of the meeting) | – | Deputy City Mayor, Leicester City Council |
| Karen Chouhan | – | Chair Healthwatch Leicester |
| Councillor Vi Dempster | – | Assistant City Mayor, Children's Young People and Schools, Leicester City Council |
| Professor Azhar Farooqi | – | Co-Chair, Leicester City Clinical Commissioning Group |
| Dr Simon Freeman | – | Managing Director Leicester City Clinical Commissioning Group |
| Andy Keeling | – | Chief Operating Officer, Leicester City Council |
| Elaine McHale | – | Interim Strategic Director, Children's Services |
| Chief Superintendent Rob Nixon | – | Leicester City Basic Command Unit Commander, Leicestershire Police |
| Councillor Rita Patel (Chair for the Meeting) | – | Assistant City Mayor, Adult Social Care |
| Dr Avi Prasad | – | Co-Chair, Leicester City Clinical Commissioning Group |
| Tracie Rees | – | Director of Care Services and Commissioning, Adult Social Care, Leicester City Council |
| Councillor Manjula Sood | – | Assistant City Mayor (Community Involvement), Leicester City Council |
| Deb Watson | – | Strategic Director Adult Social Care and Health, Leicester City Council |

**Invited attendees**

| | | |
|---|---|---|
| Councillor Michael Cooke | - | Chair Leicester City Council Health and Wellbeing Scrutiny Commission |

**In attendance**

| | | |
|---|---|---|
| Graham Carey | – | Democratic Services, Leicester City Council |
| Sue Cavill | – | Head of Customer Communications and Engagement - Greater East Midlands Commissioning Support Unit |
| | - | |

* * *  * *  * * *

## 1. APOLOGIES FOR ABSENCE

Apologies for absence were received from Councillor Palmer, who had been delayed, and from Councillor Sood. Apologies were also received from Chief Superintendent Rob Nixon, Leicestershire Police.

## 2. CHAIR OF THE MEETING

Councillor Patel announced that Councillor Palmer was unable to attend and had asked her to Chair the meeting in his absence.

Councillor Patel in the Chair.

## 3. DECLARATIONS OF INTEREST

Members were asked to declare any interests they may have in the business to be discussed at the meeting. No such declarations were made.

## 4. MEMBERSHIP OF THE BOARD

RESOLVED:

1) That the membership of the Board as amended at the Annual Council meeting on 29 May 2014 to increase the number of members in each group to 4 be noted as follows:-

**Councillors**

Chair of the Board – Councillor Palmer - Deputy City Mayor
Councillor Dempster - Assistant City Mayor (Children, Young People and Schools)
Councillor Patel - Assistant City Mayor (Adult Social Care)
Councillor Sood MBE - Assistant City Mayor (Community Involvement, Partnerships and Equalities)

**City Council Officers**

Deb Watson – Strategic Director, Adult Social Care and Health
Andy Keeling – Chief Operating Officer
Elaine McHale – Interim Strategic Director, Children's Services
Tracie Rees, Director, Care Services and Commissioning, Adult Social Care

**NHS Representatives**

Professor Azhar Farooqi, Co-Chair, Leicester City Clinical Commissioning Group
Dr Simon Freeman, Managing Director, Leicester City Clinical Commissioning Group
Dr Avi Prasad, Co-Chair, Leicester City Clinical Commissioning Group

David Sharp, Director, (Leicestershire and Lincolnshire Area) NHS England

**Healthwatch and Other Representatives**

Karen Chouhan, Chair, Healthwatch Leicester
Chief Superintendent Rob Nixon, Leicester City Basic Command Unit Commander, Leicestershire Police
2 vacancies

2) That it be noted that the Board's Terms of Reference were amended by the Council to reflect this change in membership and also that the Board will meet 6 times a year in future and that all other Terms of Reference remained the same as before.

## 5. MINUTES OF THE PREVIOUS MEETINGS

RESOLVED:

That the Minutes of the previous meetings of the Board held on 3 April 2014 at 9.30 am and 11.30 am be confirmed as a correct record.

## 6. DIRECTOR OF PUBLIC HEALTH - ANNUAL REPORT

The Strategic Director, Adult Social Care and Health presented her Annual Report as the Director of Public Health. A presentation on the report was also made at the meeting, a copy of which is attached to these minutes.

In presenting the report the following comments were made in addition to those listed in the presentation:-

- Although there was a statutory requirement to produce a report there was no guidance on what should be included in the report. However it was customary to include an assessment of the health of population and to make recommendations about things that could be done to improve the health of population.

- One of the report's purposes was also to inform the City Council, Health and Wellbeing Board, Clinical Commissioning Group, NHS England, Public Health England and other partners about the health of the resident population and to identify key areas where improvements could be made that would benefit the health of the population. The plan also provides information on health needs overall which informs the planning and the commissioning process within all partner organisations.

- The report also sat alongside the Joint Strategic Needs Assessment which had enabled the Board to produce its Joint Health and Wellbeing Strategy 'Closing the Gap'.

- The report also helps to provide a record of the health of the population which allows a comparison to be made over a period of time and with other places, both locally and nationally.

- The striking differences for Leicester from these comparisons were:-

    - Leicester was ranked 25th most deprived area out of 326 local authorities in England, it was noted that deprivation probably had the greatest single impact upon the health of the population.

    - Deprivation was also linked to lifestyle factors and material conditions that can affect the health of people, e.g people living in cold damp conditions have a greater risk of heart problems etc.

    - The population of Leicester has a very rich diversity. There are 18 different ethnic groups in the City with populations of 1,000 or more identified in the 2011 census. (37% Asian/Asian British, 6% Black/Black British, 46% White and 4% Other White groups from Poland and other EU succession countries).

    - Different ethnic backgrounds have different predispositions to health conditions. Lifestyle factors are deeply embedded in the lives of people from different cultures and can impact upon health either to increase the risk of, or be a protective factor against, particular health conditions.

    - Leicester's population is relatively young in nature. 34.5% of households have dependent children (29% nationally) and 20% of the population in Leicester are aged 20 – 29 years old compared to 14% nationally.

    - There are also significant socio-economic challenges in Leicester. 29% of adults have no educational qualification and 35% of 16-74 year olds were economically inactive compared to 30% nationally.

    - All these factors had a high impact upon health and health needs.

- The top three causes of deaths in the Leicester population under 75 years old were cancer, cardio-vascular disease and respiratory diseases. Although the highest cause of deaths in Leicester was cancer, the rate of deaths was comparable to the national death rate in the population. The two biggest impacts upon health in Leicester which made the most difference to life expectancy in Leicester compared to elsewhere were cardio-vascular disease (e.g. heart attacks and strokes) and respiratory diseases.

- Life expectancy at birth (which is derived from mortality rates) are used as an overall summary measure as it reflects all factors which have influenced a person's health during their lifetime.

- There were also differences in health conditions between different groups. For example, there are high rates of diabetes and cardio vascular disease in the South Asian and Black population compared to the white population. By contrast there are high rates of respiratory diseases in the white population resulting mainly from the higher prevalence of smoking among deprived white communities.

The average life expectancy for people in Leicester compared to the national averages had been widening for a number of years leading up to 2010. However there were some encouraging indications that the gap had been reducing over the last four years, and whilst it was too early to identify it as a trend, there had been numerous partnership efforts in the last four years to improve the health of the population and it was hoped that these had contributed to a cumulative positive effect upon the general health of the population.

The main lifestyle issues affecting the local population were:-

a) Whilst the majority of adults were non-or low risk drinkers, there were higher rates of alcohol related conditions and harm and higher rates of hospital admissions in Leicester compared to the East Midlands. However, young people were less likely to report ever having an alcoholic drink - 20% of 11-15 year olds in Leicester compared to the national rate of 42%.

b) Smoking was the greatest single cause of preventable premature deaths and over 20% of adults in Leicester smoke. On average 0.5% of 11 year olds smoked which rose to 11% for 15 years olds. Public Health staff work closely with schools using creative engagement techniques to avoid young people becoming 'replacement smokers' in future years.

c) The levels of overweight and obesity is increasing in the population. Whilst the rates for adults were similar to national rates, there were significantly higher rates of obesity for children aged 4-5 and 10-11 years old. Efforts needed to be concentrated around these groups.

d) Diagnosis for acute sexually transmitted infections (STIs) were above the regional and national averages and Leicester was the 6$^{th}$ highest prevalence area for HIV outside of London. This was an area for concern and needed work in the future to reduce these rates.

e) Rates of teenage pregnancy had dropped since 1998 and the rate in 2011 was 30.7% per 1,000 15-17 year old girls which is almost a 50% fall since 1998.

f) Oral health for children at age 5 years old having decayed, missing and filled teeth was the worst in England and a strategy had been put in

place to promote oral health in pre-school children.

It was also noted that 23% of the total burden of ill health in UK was attributable to mental health diseases and illness. In Leicester this equated to 10-15% of children and young people having a recognised mental health problem and 36,000 people of working age had a common mental health condition such as depression or anxiety. Approximately 8,000 of people over 65 years old suffer from depression and 3,000 have dementia. There were a number of recommendations in the strategy in relation to mental health, particularly that all partners should promote the use of the Five Ways to Wellbeing with staff as well as those who use services.

The report also showed that the long term conditions affecting the population aged 65 years and above were predominately diabetes, depression, dementia, CHD, strokes, bronchitis and emphysema and all these conditions were expected to continue to rise over time.

Other health factors mentioned in the report were:-

a) The rates of tuberculosis in Leicester were the highest in the East Midlands and higher than England but the rates was consistently falling.

b) There had been good uptake of childhood vaccinations in recent years and this was important to maintain. It was noted that there had been some deterioration in the up-take in 2013/14 compared with the previous year.

c) Cervical screening rates have also been declining locally and nationally and up-take of smear test remained significantly lower in Leicester than the national average.

d) Bowel cancer screening rates are lower in Leicester than elsewhere and twice as many tests in Leicester had a positive result, suggesting the need to significantly improve up-take of this screening test.

Leicester had one of the highest up-takes of NHS Health Checks in the Country with approximately 72% of those eligible between the ages of 40 and 74 years old having received an NHS Check by the end of 2013/14. It was noted that this had been a significant partnership effort over recent years and that Leicester City CCG had worked hard to ensure that GP practices deliver the checks. 20% of those receiving the checks needed further treatment for previously undiagnosed conditions. 4,900 people were now being treated to prevent more serious conditions or existing conditions from deteriorating. Work on prevention of illness and stopping conditions deteriorating was an essential element of the Better Care Fund Plan.

In conclusion, the Strategic Director acknowledged the time and hard work of public health staff who had produced the detailed analysis presented in the report and thanked the Divisional Director Public Health for leading this work.

Following a general discussion and questions on the report, the following comments and observations were noted:-

a) It would be desirable for data on all health inequalities to be broken down to the same level of statistical analysis for all protected characteristics, as it would enable a more targeted approach to be taken to develop strategies to tackle health inequalities related to protected characteristics. However, it was noted that this was not always possible as some health data was collected nationally and other data was collected locally without accompanying information about each person's ethnicity, sexuality or religion etc.

b) Where local data on protected characteristics was not available, national data was often extrapolated as an indicator provided it was felt that the local position was not considered to be largely different from the national picture.

c) The Director of Public Health's Annual Report provided a snapshot in time of the health of the population. The Public Health Team also undertook individual work on joint specific needs assessments on specific issues and/or groups where it was felt that particular groups were vulnerable.

d) The report's findings were also intended to be used to refine and improve existing strategies and to assist with the development of new strategies and their implementation.

e) Everyone that commissioned services for the population should consider the findings in the Annual Report to identify where there were higher or different needs in parts of the community and take these into account in order to target the limited resources available in the health economy to address them. Deprivation is a key issue.

f) It was noted that the CCG had been carrying out low level analysis to test a number of hypotheses to see if suggested health inequalities were a determinant of health outcomes. It was difficult to get sufficient data to provide a definitive answer.

g) An analysis of the take up of NHS Health Checks showed that there was no apparent differential in the take up of health checks by different ethnic groups or in different areas of the City.

h) The CCG also felt that testing a hypothesis at a low level could provide useful indications of whether health inequalities were amenable to health interventions or subject to wider determinants of health.

i) There should be a greater use of health equality audits by commissioners of services, both in relation to the protected characteristics and in relation to deprivation.

j) If all stakeholders undertook detailed health equality audits on 1 or 2 services each year it would to build a picture over time of ethnicity and other factors affecting health in the City.

k) Further work needed to be undertaken on understanding why the change in the reduction between the national and local life expectancy rates had occurred. Both deprivation and ethnicity had implications for the health of the population. Alcohol related illnesses and diabetes affected different parts of communities and there was a need to focus services where they would have the greatest impact.

l) Many of the recommendations were aimed at the strategic or system level and a number of the recommendations resonated closely with the 'Closing The Gap' strategic aims and priorities. The Board already received six monthly updates on the progress with this strategy so this would also indicate to some extent whether the recommendations were being taken up and acted upon by health partners.

m) Progress against the recommendations in the Annual Report would also feature in next year's Annual Report.

n) In addition to data provided by the Office of National Statistics and health episode statistics, there was also qualitative data held by all stakeholders and more could be done to have a stronger and collective understanding of the issues by sharing the information each stakeholder held.

o) All stakeholders should respond in brief to the Director of Public Health's Annual Report and the recommendations to outline what action they intended to take as a result or whether there were any elements they disagreed with.

RESOLVED:

1) That the Director of Public Health's Annual Report 2013/14 be received.

2) That all partner organisations and other stakeholders be commended to consider the recommendations and respond in brief to them to outline what action they intended to take as a result or whether there were any elements they disagreed with.

3) That Healthwatch's offer to suggest areas of questioning to help with developing Health Equality Audits be welcomed.

4) That the Director of Public Health be thanked for producing and extremely informative, user friendly and accessible report.

## 7. PHARMACEUTICAL NEEDS ASSESSMENT

The Divisional Director of Public Health submitted a report outlining the preparation of the Pharmaceutical Needs Assessment (PNA) for Leicester which the Board was required to publish by March 2015.

It was noted that the Board's statutory responsibility to prepare and publish the PNA was being overseen by the Leicester Joint Integrated Commissioning Board through the Leicester, Leicestershire and Rutland Pharmaceutical Needs Assessment Project Team. The terms of reference for the Project Team were submitted as part of the report.

The purpose of the PNA was to identify the pharmaceutical services currently available and to assess the need for pharmaceutical services in the future. The PNA was a statutory document used by NHS England to agree changes to the commissioning of local pharmaceutical services.

The PNA was currently going through a period of local public consultation until 14 July 2014. There would then be a period of statutory consultation for 60 days starting in September 2014 and the list of statutory consultees was listed in the report. The consultation process would also be open to the public and, whilst the consultation would be available through the Council's website, printed copies of the PNA and the consultation process would also be distributed.

RESOLVED:-

That the report be noted and that further reports be received on the progress of the PNA prior to the final PNA being submitted to the Board for approval in March 2015.

## 8. LLR HEALTH AND SOCIAL CARE 5 YEAR STRATEGY DIRECTIONAL PLAN FOR BETTER CARE TOGETHER PROGRAMME

The Programme Director for Leicester, Leicestershire and Rutland Five Year Strategy submitted a report on the Directional Plan for the Better Care Together Programme. A copy of the summary report and the Better Care Together 5 Year Strategic Plan 2014-2019 had previously been circulated to Members of the Board.

The Board received a presentation 'A blueprint for Health and Social Care in LLR 2014-19 – Phase 2 – Discussion and Review Phase' a copy of which is attached to these minutes.

During the presentation it was noted that:-

a) The strategy was produced by a partnership of commissioners, providers, local authorities and Healthwatch.

b) It was the biggest ever health and social care review locally.

c) Whilst the review was being conducted against a backdrop of a financially challenged health economy, it was not purely a financially driven plan.

d) The values and principles which underpinned the Plan together with its strategic aims and objectives were listed in the presentation.

e) The Better Care Together programme was based around a 'left shift' in the settings and models of care moving care from the acute sector of hospital health care into the primary and community care services sector. However this shift would not take place until the primary and community services necessary to support and achieve this new care model were in place.

f) The Improvement Interventions for outcomes in 5 years' time for the 8 pathways of Urgent Care, Frail Older People, Long Term Conditions, Planned Care, Maternity and Neonates, Children Young People and families, Mental Health and Learning Disabilities were set out in detail in the presentation.

g) The current phase of 'Discussion and Review' would end in September 2014. During this period further discussions would be held with partners and there would be further community and patient engagement during the summer. Detailed options for change and a final strategy for approval would be presented for approval in September 2014.

h) Phase 3 – 'Implementation and Consultation' would start in September and where formal public consultation was required, this would not take place until after the elections in May 2015.

Following questions from the public it was stated that:-

a) The plan was evidence based and all the evidence used to underpin the plan had been published in its appendices. The directional plan was by its nature a high level plan and further more detailed business cases would be developed in the future. Any evidence to support those would also be made available.

b) A Risk Register was currently being developed and would be submitted to the Better Care Together Board in due course. The risk register was being prepared on the best practice guidance of the Office of Government Commerce and they had also been asked to provide an independent assessment of the governance and risk management elements of the programme.

c) Although the Better Care Together Board did not currently meet in public this was being re-assessed as to whether it should in future.

d) There had been extensive public involvement and engagement in the development of the programme which had involved public patient

involvement groups and Healthwatch. Further discussions were being held with these partnership groups to determine the appropriate method and level of consultation which would satisfy the patient involvement groups, Healthwatch and Local Authority Scrutiny requirements.

e) The final plan will be submitted to the various provider and CCG Boards as well as all the Healthwatch, Health and Wellbeing Boards and Scrutiny Committees.

f) Only those parts of the programme that do not require consultation will be implemented initially. There would need to be a major consultation exercise on the proposal; to reconfigure the acute hospital service provision from 3 sites to 2 sites. It was not know yet whether this would be a single consultation process or a number of consultations on each part of the scheme.

g) Although the programme identified a reduction in capacity of 400 beds from the system, this should not necessarily be seen as a cause for concern. Approximately half these beds could be reduced through improved productivity of acute hospital services. Currently UHL did not undertake enough day case surgery operations as they did not have the dedicated facilities. Consequently this increased the need for inpatient beds. Investment was being provided to build dedicated facilities to allow this pressure to be removed. These better clinical processes should account for half the proposed reduction in the number of beds. The remainder of the reduction in beds would be achieved through the transfer of patients out of acute hospital care into community hospital or home based care as appropriate. This was particularly relevant to the radical changes proposed for the care of elderly and frail patients to reduce their admissions to hospital unless it was essential for them to be there, by providing more intervention and support services in the community and at primary care level.

h) Leicestershire Partnership Trust (LPT) confirmed that they would continue to support 250 community beds across the county but under the proposals there was likely to be an increase in the number of acute or sub-acute patients being admitted to them. It was critical that integrated social care services were in place to support this proposed shift in care and that the level of investment was sufficient to support this. The investment needed to work alongside the proposals to reduce admissions and to manage long term conditions differently in order to create the right flows through the system as a whole. There were significant risks in delivering this element and all parts needed to be delivered efficiently to achieve the desired outcomes.

i) The Board had a role in holding the whole system to account in delivering the Plan. Social care services needed to be fully integrated into the Plan to ensure that people at risk were identified and intervention was provided at an early stage to prevent pressure on more acute services.

At 11.33am, Councillor Palmer entered the meeting and with his agreement Councillor Patel continued to Chair the meeting.

Councillor Palmer commented that:-

a) It was imperative to secure the confidence of the public, patients and stakeholders and to demonstrate that everyone involved in the process was committed to making the process open and transparent and that decisions were made through the effective use of all available public forums.

b) A great deal of effort and work had gone into getting the plan to this stage and the roles of Philip Parkinson as Chair of the Board and that of the Interim Programme Director should be acknowledged.

c) The scale and magnitude of the plan required that high quality decisions were taken.

d) It was crucial for public confidence that the delivery of the plan was seen to be credible.

e) The Council would also be discussing the respective roles of the Health and Wellbeing Board and the Health and Wellbeing Scrutiny Commission in relation to the plan. It was likely that the Board would oversee the strategic elements of the programme and the Commission would scrutinise the details of individual parts of the programme.

f) The plan looked at an array of acute services but it was evident that it did not make any specific reference to the children's cardiac heart services. The plan should be an important vehicle to reflect the aspiration to retain this facility in Leicester.

In response, the Chief Executive of University Hospitals of Leicester NHS Trust stated that the plan contained a reference to investing in the children's services which was complementary to the LLR Plan. There were however, some complicated issues that still needed to be resolved and an operational appraisal was currently being undertaken to consider these. Children's services were currently split between Glenfield Hospital and Leicester Royal Infirmary. It was not feasible to move children's congenital heart surgery away from the adult heart surgery facilities and equally the paediatric services could not move from the Royal Infirmary as it needed to support the A&E services there. Furthermore the new Emergency Floor scheme would have a specific Children's A&E facility within it. Although there was no obvious solution to providing all children's service in one place, the Trust was still committed to providing a full range of children's services.

During general discussion members of the Board also made the following

observations:-

a) The primary care sector needed to be developed further if it was to provide more care in the community, particularly in relation to GP services.

b) Capacity and resources represented two of the largest risks in delivering the plan. The primary care sector have been considering a number of national and local policy issues to understand what the new system should look like. The Local Medical Committee was holding a solutions day the following week to map out the options for a re-configured primary care sector so that it was fit for purpose to meet the new challenges.

c) Dr Prasad commented that 90% of NHS activity took place in the GP sector of primary care and it was important to get the reconfiguration of services right as it could have a huge impact on the Better Care Together Plan. Investment in the primary care sector had reduced from 10% to 8% in recent years. There was shortage of GPs in Leicester as it was not an attractive place to work. There would shortly be a cohort of GPs retiring and recruitment was already difficult.

d) Professor Farooqi also referred to the reduced numbers of students on training programmes and many newly qualified doctors opting to work overseas.

f) It was recognised that part of the programme relied on making the most of GPs expertise and that patients needed to be directed to the right person to deliver their care such as practice nurses, pharmacists, health care assistants and other health practitioners. However this was not easy to achieve as many patients wanted to see a GP and often complained if they were directed to other health professionals, even if other health professionals could provide the appropriate level of care for the patient.

g) There needed to be a modal shift away from the patient being a consumer within the health service to recognising that they are part of a mutual society, otherwise commissioners, providers of services and patients would all suffer the consequences. Embedding this ethos in everyone would not be without its challenges. Until this cultural change took place, the public understood what other options were available to them and had the confidence to use them, then there was a huge risk to the plan succeeding.

h) The Director (Leicestershire and Lincolnshire Area) NHS England commented that recruitment issues of GPs were common across the East Midlands area, and competing for limited numbers of GPs was not necessarily the focus to solve the issues involved. Given the future aging population it was likely that the number of consultations with GPs would increase and the length of consultations would increase as the

severity of the conditions increased. The time was now right to rethink the model of primary care delivery, particularly in relation to small independent GP surgeries and to look to groups or federations of surgeries to provide the support that would be required in the future. It was suggested that the Board should re-visit this issue at a future meeting to discuss the primary care strategy that was necessary to underpin this issue.

i) It was recognised that the challenges facing the health economy required steps such as the Better Care Together initiative to be taken because maintaining the status quo was worse. Any critique of the proposals should be focussed on challenging how well the changes can be delivered and not on challenging whether the changes are required or possible.

j) There was now an opportunity to deliver things differently and better than they have been delivered before to reduce the burdens on the acute NHS services. This included more preventative measures to stop people becoming ill and to prevent existing health conditions from deteriorating.

In conclusion it was noted that comments on the proposals could be made through the Better Care Together website, through Healthwatch or direct to the Interim Programme Director.

The Interim Programme Director also undertook to discuss with Healthwatch the best way to meet the challenge of communicating the proposals and consultations with those sectors of the community that don't have access to the internet or do not speak English as a first language.

RESOLVED:-

1) The report, presentation and the proposals for developing and approving the final Better Care Together Strategy be noted.

2) That the Board receive further progress reports on the development of the Better Care Together Strategy prior to its formal approval.

3) That the City Council reconciles the differing roles of the Health and Wellbeing Board and the Health and Wellbeing Scrutiny Commission in the future consideration of the Better Care Together Strategy and its implementation.

## 9. ANNOUNCEMENTS

The Strategic Director for Adult Social Care and Health reported that the Care Act had now received Royal Assent and would be implemented from April 2015. This would introduce significant changes to the delivery of social care and would increase the costs of social care considerably. The consultation on

the draft regulations under the Act was currently being undertaken. The draft regulations were available on the Department of Health website.

## 10. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Divisional Director of Public Health undertook to respond to a question from a member of the public on the number of people from Hindu, Sikh and Muslim communities that were suffering from mental health conditions.

## 11. DATES OF FUTURE MEETINGS

NOTED:

that future meetings of the Board will be held on the following dates:-

Thursday 9 October 2014
Thursday 11 December 2014
Thursday 5 February 2015
Thursday 26 March 2015
Thursday 25 June 2015
Thursday 3 September 2015
Thursday 29 October 2015
Thursday 10 December 2015
Thursday 4 February 2016
Thursday 7 April 2016

All meetings will start at 10.00am unless stated otherwise on the agenda for the meeting.

It was also NOTED that the next meeting of the Board on 9 October will be held in the Tea Room, 1st Floor Town Hall. Future meetings will be held in City Hall, 115 Charles Street as soon as the meeting rooms become available for public use.

## 12. CLOSE OF MEETING

The Chair declared the meeting closed at 12.15 pm.

Appendix B

**LEICESTER CITY HEALTH AND WELLBEING BOARD**
**9 OCTOBER 2014**

| | |
|---|---|
| **Subject:** | The Challenges facing Primary Care in Leicester City |
| **Presented to the Health and Wellbeing Board by:** | Professor Azhar Farooqi (CCG Chair), Dr David Sharp (AT Director), Ms Sue Lock (CCG Chief Operating Officer) |
| **Author:** | Sue Lock (CCG Chief Operating Officer) and Lesley Harrison (Head of Primary Medical Care, AT) |


**EXECUTIVE SUMMARY:**
National and local polices identify the potential for efficiency savings and improved quality delivered by expanded out-of-hospital services. Primary medical care services must have sufficient capacity and capability to take up such a role.

This paper identifies the major challenges facing primary care, from both a patient and a practice perspective and gives a summary of the planned solutions to address those challenges.

Tackling GP recruitment is the highest short-term priority and a resolution using non-recurrent funding is proposed. This is a GP recruitment incentive scheme. The criteria and details of the process are currently being worked up but it is proposed that the Health and Wellbeing Board plays a role in approving applications from practices.


**RECOMMENDATIONS:**

The Health and Wellbeing Board is requested to:

1. Consider the analysis of the challenges facing primary medical care in the City
2. Agree the short-term priority is GP recruitment
3. Approve the principle of the proposed GP recruitment scheme, including approval of payments via the Health and Wellbeing Board.

## CHALLENGES FACING PRIMARY MEDICAL CARE IN LEICESTER CITY

### Introduction

National Context

1. *"Everyone Counts: Planning for Patients 2014/15 to 2018/19" (December 2013)* sets the overall medium term planning framework for the NHS and describes what the NHS must deliver to patients nationally. The NHS 'Call to Action' asks all NHS providers and commissioners to respond to the significant challenges facing the NHS in delivering health and care policy into the future, including:

    - An ageing society
    - The rise of long-term conditions
    - Rising public and patient expectations
    - Increasing costs of providing care
    - Limited productivity
    - Pressure of constrained public resources that the NHS (and social care) face
    - Variation in quality of care across the health system.

LLR Context

2. The financial picture that is seen nationally is reflected in the local health economy, perhaps with even clearer focus. There is an accepted need to deliver greater local efficiencies and a recognised potential to achieve that by the development of integrated out-of-hospital services, increased in-hospital efficiencies and a stronger focus on disease prevention. The case for change at an LLR level is summarised in the diagram below:-

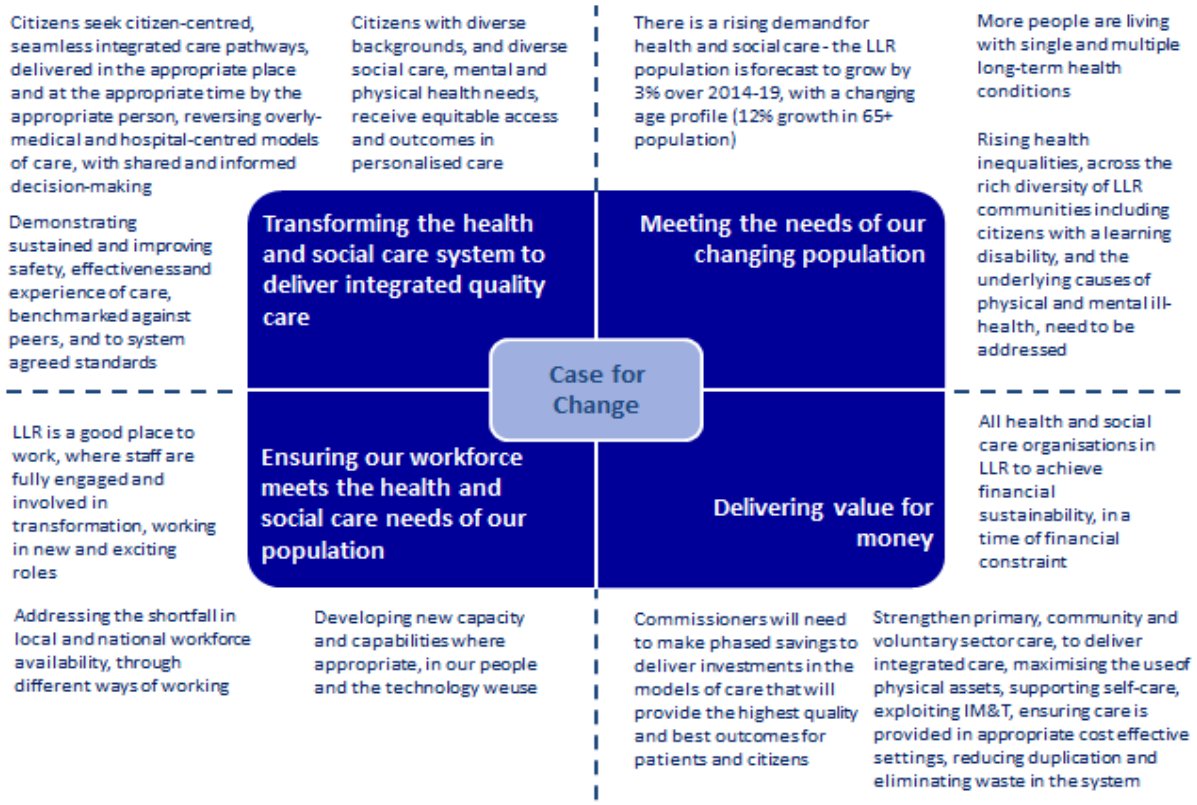



**Figure 1. The case for change in Leicester, Leicestershire and Rutland**

Leicester City Context

3. The national direction of travel, as outlined in "Everyone Counts" fits the vision of Leicester City's Health and Wellbeing Board and their strategy "Closing the Gap".

4. Our vision for a healthier population goes much further than just ensuring people get the right care from individual services. We want to create a holistic service delivery mechanism so that every Leicester citizen benefits from a positive experience and better quality of care. We will do this through focussing on three priority areas, delivering one integrated model of care:

    i) Prevention, early detection and improvement of health-related quality of life
    ii) Reducing the time spent in hospital avoidably
    iii) Enabling independence following hospital care

5. A strong, fit-for-purpose primary medical care service is a pre-requisite if we are to address the national requirements and to achieve our local ambitions in closing the health inequality gap for the people of Leicester City.

## PROFILE OF PRIMARY MEDICAL CARE IN LEICESTER CITY – 2014

6. Leicester City's *resident* population is estimated at 331,606 whilst the *registered* population is approximately 378,000 i.e. the City is a "net importer" of patients from the County. Those 378,000 patients are cared for by a total of 62 GP practices (as at September 2014.)

7. At the present time (September 2014), ten GP practices in Leicester are single-handed; the remaining 52 practices have multiple GP partners or are ocntracts held by alternative providers (for example corporate bodies).

8. In terms of population, 13% of patients are treated by single-handed GPs in Leicester compared to approximately 9% nationally. Analysis shows that as a result, the average practice list size in Leicester is below that seen nationally.

| | |
|---|---|
| Average list size (Leicester City CCG) | 5,920 |
| National average list size | 6,487 |

**Table 1. Average GP practice list sizes**

Looking at the deprivation levels and health need assessments by ward, there are four distinct areas or Health Need Neighbourhoods which we propose maka a logical footprint for planning and service delivery. Although their names have not been finalised, for the current time we can refer to them as North, South, Central and North East.

| Health Need Neighbourhood | Ave Pop'n per practice June 14 | 75+ Pop'n | % 75+ Pop'n | Total GPs (WTE) | *Ave List Size per WTE GP* |
|---|---|---|---|---|---|
| 1 North | 5973 | 4954 | 5.6% | 44.6 | *2058* |
| 2 South | 6056 | 3130 | 4.5% | 44.3 | *1888* |
| 3 Central | 6093 | 6113 | 4.5% | 74.7 | *1875* |
| 4 North & East | 6205 | 5709 | 8.0% | 44.6 | *1876* |
| **TOTAL** | **6077** | **19906** | **5.4%** | **208.2** | ***1922*** |

**Table 2 Profile of the four City Health Need Neighbourhoods**

9. The CCG currently has 14 training practices. This is important as training practices can play an important role in supporting new GPs and encouraging them to stay in the area once they are qualified.

10. With regard to contract type, there are:-

- General medical services (GMS) – 35 Practices
- Personal medical services (PMS) – 16 Practices
- Alternative provider medical services (APMS) – 11 Practices.

11. Until fairly recently, practices were almost exclusively run on a GP partner basis, with occasional use of locums to cover study, sickness or holiday absence. More recently, there has been a significant growth in locum and salaried GPs, with fewer being attracted to the partnership model. The latest information indicates that Leicester now has a GP workforce made up of almost equal thirds of partners, salaried GP and locums. The graph and table below highlights the number of GP partners that are likely to retire in the next 5 to 10 years – 60 out of a total of 121 partners are 50 or over, which is almost 50%. The current structure of practice-based primary care provision is likely to undergo severe instability if new partners cannot be attracted into the system to take their place. Effective recruitment and retention is key to maintaining the City's local primary medical care services.

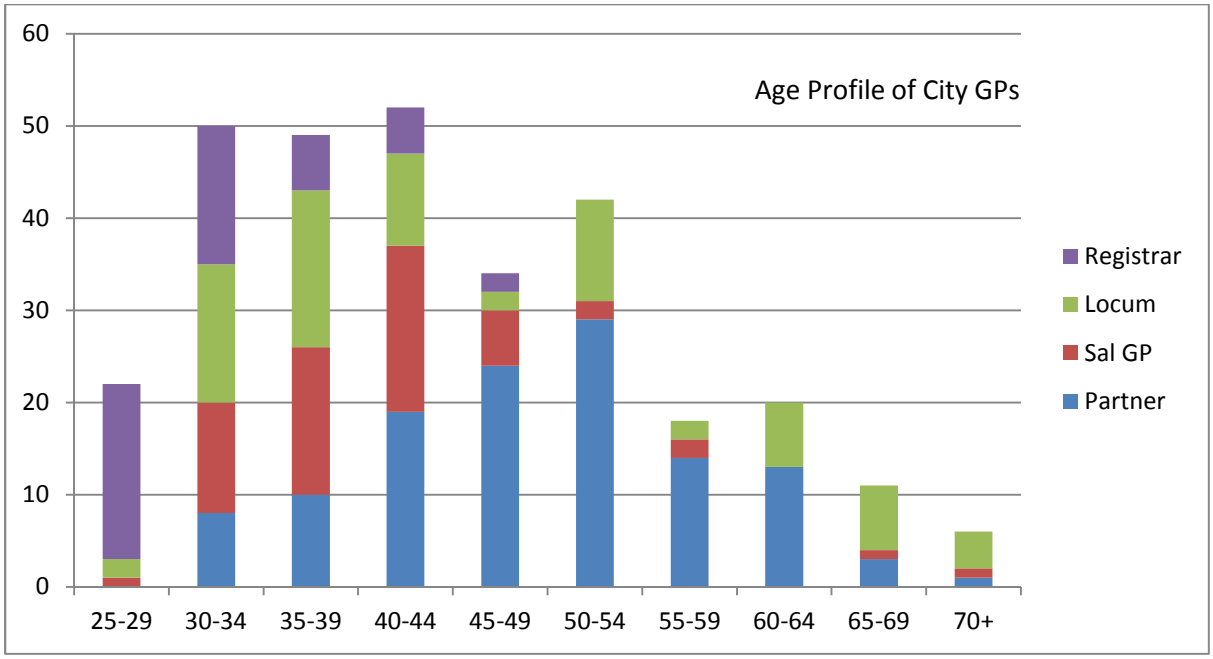



**Figure 2 Age Profile and GP type, by age band**

| Age | Partner | Sal GP | Locum | Registrar | No |
|---|---|---|---|---|---|
| 25-29 | 0 | 1 | 2 | 19 | 22 |
| 30-34 | 8 | 12 | 15 | 15 | 50 |
| 35-39 | 10 | 16 | 17 | 6 | 49 |
| 40-44 | 19 | 18 | 10 | 5 | 52 |
| 45-49 | 24 | 6 | 2 | 2 | 34 |
| 50-54 | 29 | 2 | 11 | 0 | 42 |
| 55-59 | 14 | 2 | 2 | 0 | 18 |
| 60-64 | 13 | | 7 | 0 | 20 |
| 65-69 | 3 | 1 | 7 | 0 | 11 |
| 70+ | 1 | 1 | 4 | 0 | 6 |
| **TOTAL** | **121** | **59** | **77** | **47** | **304** |

**Table 3 GP age profile by type**

## CHALLENGES FACING PRIMARY CARE IN LEICESTER CITY

12. Since the "Call to Action" in November 2013, the CCG has embarked on a series of engagement activities with the public, patients, member practices and wider stakeholders to understand what the challenges and issues are perceived to be and to gather information on what an improved primary care system might look like. With regard to patients, we have worked with representatives from practices' Patient Participation groups, gathered information from listening events with the public, from community and faith leaders, membership feedback, from HealthWatch, national patient surveys and from comments and complaints.

13. To gain feedback from member practices, we have held discussions at Locality meetings, at Protected Learning Time (PLT) events, undertaken electronic surveys, taken feedback at professional forums (e.g. Practice Manager and Practice Nurse forums), at individual practice meetings and at Board Development sessions. The main themes that emerged are shown below:-

| **Patients** | **Practices** |
|---|---|
| Improve access | Excessive workload |
| Variable quality across practices | Insufficient resources |
| More personalised care | Severe recruitment and retention issues |
| Longer appointments | Premises constraints |
| Clearer communication | Population diversity |
| More patient information | Health burden and inequalities |
| | Patient expectations |

**Table 4. Patient and GP Practice feedback on issues facing primary care**

To a large extent, the challenges facing practices are causing the issues raised by patients.

What patients said

14. **Access** is poor. Patients told us that in many practices it is just too hard to make an appointment. They wanted fast access to appointments that are easy to make, particularly for children, those with long terms conditions and older people. Telephone systems should be able to cope with the volume of calls and there should be the choice of on-line booking. Those in most need should be given priority.

15. The **quality** of general practice should be improved. Patients noted that practices varied in the quality of service that they offered their patients and this variation was justifiably felt to be unacceptable.

16. **Personalised care** is not always available. Patients want to be treated by a GP who knows them, where this is appropriate (e.g. where patients have Long Term Conditions (LTCs)). If the complaint is straightforward e.g. a minor illness, many patients who expressed a view were not concerned about seeing their normal GP.

17. There is insufficient appointment **time.** Patients said they wanted their GP to have time to listen to them. The length of the appointment should be linked to the nature of the condition e.g. automatically have longer appointments for patients with more complex conditions, particularly mental health issues and those with multi-morbidities. Several mentioned their unhappiness at only being able to discuss a single condition at each appointment.

18. **Communication** and **Information** is sometimes poor. Several patients and carers requested clear, easily understood information in an appropriate format and language that helps them to take responsibility for their condition and to use NHS services wisely. This was felt to be particularly important for those who might be

new to the City and who came from a country where primary care was not provided. Training in communication skills for the whole primary healthcare team was suggested by several patients. There were several patients who did not understand what they had been told but felt unable to take up any more time in asking questions. They wanted to feel unrushed and be able to discuss their issues properly.

What practices said

19. The past two years have seen a rapidly growing **workload** with too little capacity to deal with it, leading to many clinicians feeling stressed and unable to take on any more work. There was an overwhelming message from the majority of practices that "something needs to change" – either less work or more resource, but certainly that the current model is not sustainable and has reached crisis point. With the planned transformation of services to an increased out-of hospital model of care, practices feel that demand needs to reduce or capacity increase, which requires more resource coming into primary care.
20. A lack of **resources**. The extra workload needs to bring resource with it to enable teams to be expanded and provide the extra capacity that is required. The funding of new services needs to recognise the real cost of delivery and offer a sense of financial stability to encourage practices to sign up to them and employ with confidence the extra staff required to support delivery.

21. Acute difficulties with **recruitment** and **retention**, particularly relating to the GP workforce. This is an immediate and urgent priority bearing in mind the age profile of the City GPs and the number likely to retire over the coming five to ten years. Younger doctors are showing a growing reluctance to become partners, with more of them enjoying a portfolio of different roles, one of which is as salaried or locum GPs. Numbers going through GP training are falling and for those that do complete training, they are anecdotally reported as not being attracted to working in the City. *Addressing recruitment and retention is the highest priority in the immediate term.*

22. **Premises** issues. Several practices have reported a lack of space to accommodate new services, a lack of funding available for refurbishment / expansion and general improvement. Some practices have also encountered issues in LIFT buildings, where they claim that the service costs are very high and there is often a lack of flexibility in discussions with the property company relating to extended opening hours or issues with accommodation.

23. These challenges come on top of those that are due to the complexities of the city population i.e. population **diversity**; levels of **deprivation**; variation in health **outcomes**, health **inequalities**; **disease** burden as well as growing public **expectations** of the service.

**PLANNED SOLUTIONS**

The CCG and AT are working together on a five year strategic plan to address primary care in the City, which will tackle the issues set out above. The strategic plan will be underpinned by an implementation plan covering the following main themes / areas:-

| Key Theme | Detail |
|---|---|
| 1. Service development plan | Review current service provision in light of local health need |
| 2. Demand and capacity modelling | Undertake modelling based upon analysis of future activity, new models of care and more prevention work. Compare with capacity modelling (workforce, skills, and premises) and identify gap. |
| 3. Develop workforce plan | Develop workforce plan based upon capacity and demand model and local service review. Identify numbers and any skill requirements. Explore the use of other primary care contractors in pathway and service reviews, for example Community Pharmacists and Optometrists and ensure these forecast numbers are included in the workforce plan. |
| 4. Recruitment | Develop immediate and longer term recruitment strategy to attract GPs and nurses to work in Leicester City. A short term resolution funded non-recurrently is being implemented in collaboration with the Area Team. This is a GP recruitment incentive scheme which will fund a practice to enable it to offer an additional cash incentive to their employment offer. The AT is currently working on criteria that will underpin the scheme. It is proposed that approval of incentive payments will be via the HWB. A link has also been established with Health Education East Midlands (HEEM) to improve Leicester City profile as a place to work |
| 5. Retention | Develop retention strategy which in particular supports trainee doctors, nurses and allied health professionals, encouraging them to stay in Leicester following qualification. |
| 6. Health Inequalities | Explore quantification of health inequalities benefits and relevant associated health outcomes measures |
| 7. Quality Contract | Develop and test quality contract based upon measurable achievement of health outcomes sensitive to local health need |

| Key Theme | Detail |
|---|---|
| 8. Premises | Update premises survey to enable accurate capacity planning |
| 9. Public engagement exercise | Undertake further public engagement exercise, particularly with regard to exploring the definition of appropriate access and new primary care models and feedback on the overall strategic plan. |
| 10. Communications plan | On-going plan, but in particular to focus upon<br>• Accessing services<br>• Increasing self-care<br>• Improving information availability for the public |
| 11. IM&T | Maximising the use and efficiencies offered by IM&T e.g. through access to patient records, on-line booking etc. |

**Table 5. Implementation plan themes**

There will be a comprehensive consultation exercise on the strategic plan over the coming months.

**LEICESTER CITY HEALTH AND WELLBEING BOARD**
**DATE**

| | |
|---|---|
| **Subject:** | Leicester, Leicestershire and Rutland Better Care Together Programme Update |
| **Presented to the Health and Wellbeing Board by:** | Mr Geoff Rowbotham<br>Interim Programme Director |
| **Author:** | Mr Geoff Rowbotham<br>Interim Programme Director |

**EXECUTIVE SUMMARY:**

The Better Care Together (BCT) Programme Board is responsible for the production of the 5 year strategic plan for the Leicester, Leicestershire and Rutland (LLR) health and social care system. The Programme Board includes local social care, health commissioners and providers, public and patient representatives. It is supported by a structure of clinical, patient, public, and political reference groups, and by enabling groups e.g. Estates, Workforce, Information Technology.

The BCT Programme is taking a phased approach to the production of the 5 year strategic plan: development (to June 2014); discussion and review (June to Sept 2014); and, implementation and formal consultation where required (Oct onwards). A draft plan, as part of the 'discussion and review stage' was made available to the public in June for comment. It has been received by Health and Well Being Boards and Health watch groups across Leicester, Leicestershire and Rutland. Comment is being incorporated within the draft plan through a 'You said, we did' section prior to it being proposed for formal approval alongside the supporting Programme Initiation Document (PID) and Strategic Outline Case (SOC)
During July –August 2014 the BCT programme has been focused on:-

i. LLR DRAFT 5 YEAR PLAN- 'DISCUSSION AND REVIEW' PHASE.
ii. LEADERSHIP AND GOVERNANCE OF THE BCT PROGRAMME.
iii. DEVELOPING, RESOURCING AND COMMENCING SERVICE RECONFIGURATION.

Considerable progress has been made during the past 8 weeks resulting in the programme being on schedule despite the challenging timescales it has set itself. The purpose of the paper is to provide a high level update on progress during this time and to highlight the key programme priorities for the next 3 months.

**RECOMMENDATIONS:**

The Health and Wellbeing Board is requested to:

Note the considerable progress made and key next steps

Better care together

A partnership of Leicester, Leicestershire & Rutland Health and Social Care

**LEICESTER, LEICSTERSHIRE and RUTLAND BETTER CARE TOGETHER**

**PROGRAMME UPDATE**

September 2014

**BACKGROUND**

The Better Care Together (BCT) Programme Board is responsible for the production of the 5 year strategic plan for the Leicester, Leicestershire and Rutland (LLR) health and social care system. The Programme Board includes local social care, health commissioners and providers, public and patient representatives. It is supported by a structure of clinical, patient, public, and political reference groups, and by enabling groups e.g. Estates, Workforce, Information Technology.

The BCT Programme is taking a phased approach to the production of the 5 year strategic plan: development (to June 2014); discussion and review (June to September 2014); and, implementation and formal consultation where required (October onwards).

A first draft of a 5 year strategic plan was submitted on behalf of the LLR unit of health and social care planning to NHS England (NHSE) on 4th April 2014. NHSE required LLR, as a 'unit of planning' to submit a further update of the 5 year strategic plan to NHS England on Friday 20th June 2014, that triangulates with local CCG, provider, Health and Well Being, Local Authority and Area Team plans. The BCT Board met this requirement and submitted a draft strategic plan on 20th June.

During July –August 2014 the BCT programme has been focused on:-

i. LLR DRAFT 5 YEAR PLAN- 'DISCUSSION AND REVIEW' PHASE.
ii. LEADERSHIP AND GOVERNANCE OF THE BCT PROGRAMME.
iii. DEVELOPING, RESOURCING AND COMMENCING SERVICE RECONFIGURATION.

Considerable progress has been made during the past 8 weeks resulting in the programme being on schedule despite the challenging timescales it has set itself. The purpose of the paper is to provide a high level update on progress during this time and to highlight the key programme priorities for the next 3 months.

**i. LLR DRAFT 5 YEAR PLAN- 'DISCUSSION AND REVIEW' PHASE July-Sept 2014**

The draft plan was publicly launched across LLR by the NHS and Social care partnership through a number of media events on Thursday 26th June. Following the successful launch it has been circulated to Partner Boards, Cabinet/Executives, key stakeholder and public groups for comment as well as being made available on the Better Care Together web site. www.bettercareleicester.nhs.uk/information-library/better-care-together-plan-2014.

Meetings have included:-

Public, Patient, Voluntary and Community sector events

Public and patient events have been held by Leicester, Leicestershire and Rutland Health watch committees and a summary of recommendations is being provided for inclusion in the refreshed draft 5 Year Strategic Plan being submitted to the BCT Partnership Board in October.

Voluntary Action Leicester (VAL) have organised and supported a number of engagement events as part of an agreed ongoing engagement process at which the plan has been reviewed.

Partner Organisation-NHS

Leicester City, West Leicestershire and East Leicestershire and Rutland Clinical Commissioning Groups have formally reviewed the draft plan.

Clinical review of the draft 5 Year Plan has been undertaken by the joint BCT Health and Social care Clinical Reference Group and externally by the East Midlands Clinical senate.

Partner Organisations-Local Authority

The Leicester, Leicestershire and Rutland Health and Well Being Boards and Local Authority cabinets and executive team have reviewed the plan. Heath and Overview and Scrutiny Committees have noted the plan.

National Bodies-NHS

The plan has been reviewed by NHS England, Trust Development Authority and the NHS Local Area team.

**Key next Steps**

-The feedback to date has been positive, constructive and supportive of the approach outlined within the plan. This feedback is being incorporated in a refreshed LLR 5 Year Strategic plan incorporating a section 'You said, we did' that is going to the Better Care Together Board on the 2nd October for approval.

- In addition to the 5 Year Plan the BCT Partnership Board as recognised within OGC best practice is developing 2 supporting key documents:

- A Programme Initiation Document (PID). This document defines the BCT programme and sets out the basis on which it is to be initiated, governed and delivered- September completion.
- The Strategic Outline Case (SOC). Provides the LLR system 'wrapper' for the individual LLR organisations business cases to ensure that the proposed preferred way forward represents value for money-October completion .

-Primary and Adult Social Care Strategic reviews have commenced to respond to the proposals within the 5 Year plan. The outline proposals will be incorporated within the 5 Year Plan refresh, PID and SOC - 1st Draft September.

-Following this the key strategic documents will be circulated to partner organisations Boards, Health and Well Being Boards and Health Watch Committees for formal approval- November 2014.

-Incorporated into the partner organisations operating plans 2015/16.

**ii. LEADERSHIP AND GOVERNANCE OF THE BCT PROGRAMME July- Sept 2014**

The BCT Partnership Board carried out a review which was supported by external consultants to establish the appropriate leadership and governance of the BCT programme. The key revisions to the existing structure agreed by the BCT Partnership Board were as follows:

Better Care Together Partnership Board

-The recruitment of a permanent independent Chair- Kaye Burnett commences October 2014.

-The appointment of Senior Responsible Officers to lead the programme-John Adler Chief Officer UHL and Toby Sanders MD West Leicestershire CCG appointed from August 2014.

-Streamlining and refocus of the Partnership Board –Membership reduced by 20%, Non-Executive/Lay membership added and agreement to hold public meetings bi monthly from January 2015-Approved July 2014.

-Establishment of a cross partnership BCT delivery group –Established August 2014

External Assurance

The benefits of embedding an ongoing external assurance process has been adopted by the LLR BCT Partnership Board to ensure we recognise good practice and are able to demonstrate good governance.

Clinical Assurance has been through the 2 reviews completed by the East Midlands Clinical Senate of the draft 5 Year Plan. A further review of the detailed clinical work stream proposals has been scheduled for February 2014.

National Assurance has been through the NHS England Planning and Delivering service changes for patients good practice guide December 2013. The initial 'strategic sense check' of the 5 Year programme was completed in August and the plan approved.

**Key next steps**

An independent OGC external gateway best practice review is being undertaken to assess the BCT programme governance- Nov 2014.

A further NHS England review will be carried out with a particular focus on approving the formal readiness and process for any areas requiring formal consultation post May 2015- Spring 2014.

-The establishment of a small permanent BCT cross partnership programme management office to develop and support across the LLR partner organisations an integrated implementation and governance process and report system performance-January 2015.

iii. **DEVELOPING, RESOURCING & COMMENCING SERVICE RECONFIGURATION Aug- onwards**

The 8 priority clinical work streams (Frail Older People, Long term Conditions, Mental Health, Urgent Care, Planned Care, Learning Disabilities, Maternity& Neonates and Children's services) and supporting enabling programmes ( Workforce, IM&T, Estates & Facilities, Communication & Engagement) identified within the 5 Year draft strategic plan implementation plans have commenced development through a workbook process. To support this work:

- A core team consisting of a Senior Reporting Officer, Workbook lead, Clinical lead (Primary & Acute) and Finance lead have been established from across the partnership organisations for each of the clinical work streams and enabling programmes.
- These are being supported by nominated leads from Public and Patient Groups, Communication and Public Health representatives.
- The Better Care Fund programmes are being aligned within the appropriate Better Care Together work streams.

A Communication and Engagement framework that recognises the need to tailor and differentiate our approach for key audiences and stakeholders i.e. Public and Patient engagement, Staff engagement and Partner Assurance through an ongoing engagement process is being developed jointly by the partner organisations Communication leads and the BCT Public and Patient Reference Group.

As part of this framework the Equality and Diversity leads have held a workshop to develop a shared approach to Equality, Diversity and Human rights.

This framework will build further on the ongoing need to ensure we continue to demonstrate assurance required against the four key tests for any major service change (ie strong public & patient support, patient choice, clinical evidence base and clinical commissioner support).

**Key next Steps**

-The review and approval of the clinical and enabling workbooks through the Clinical Reference Group and Better Care Partnership Board- October 2014.

-The resourcing and establishment of the approved implementation programmes- November 2014.

-The approval of the Communication and Engagement strategy framework to support the implementation and development of the formal engagement plan - October 2014.

-Following approval of the 5 Year Strategic Plan the process, programme and timescales to identify areas requiring formal consultation will be developed for approval and before any commencement planned for post May 2015.

G.W.Rowbotham

Interim Programme Director

Better Care Together

**LEICESTER CITY HEALTH AND WELLBEING BOARD**

**9th OCTOBER 2014**

| | |
|---|---|
| **Subject:** | **Update on the Progress of the Joint Health and Wellbeing Strategy** |
| **Presented to the Health and Wellbeing Board by:** | **Dr Simon Freeman** |
| **Author:** | **Adam Archer** |

**EXECUTIVE SUMMARY:**

This report presents information on progress in delivering the Joint Health and Wellbeing Strategy: 'Closing the Gap'. Responsibility for ensuring effective delivery of this strategy has been devolved to the Leicester City Joint Integrated Commissioning Board (JICB).

This is the third bi-annual progress report to the Health and Wellbeing Board. It serves two related purposes: providing assurance that actions identified in the strategy are being delivered and/or flagging up any potential risks to delivery; and, reporting on the performance indicators set out in Annex 2 of the strategy.

This is a high level monitoring report, it acknowledges that both the actions and performance indicators in the strategy are subject to separate monitoring and reporting through the governance arrangements of those partner organisations coming together through the Health and Wellbeing Board.

Progress can be seen in each priority area and there are positive performance trends for at least some of the measures tracking progress in every area. While improvements can be seen against specific measures, it is still very early to judge where the desired impact on the health and wellbeing of the city's residents is being made overall.

**RECOMMENDATIONS:**

The Health and Wellbeing Board is requested to:

(i) Note progress on the delivery of the Joint Health and Wellbeing Strategy;

(ii) Identify any areas of concern that require further reporting or remedial action from the JICB;

# Update on the Progress of the Joint Health and Wellbeing Strategy

Report on behalf of the Leicester City Joint Integrated Commissioning Board

## 1. Introduction

This report presents information on progress in delivering the Joint Health and Wellbeing Strategy: 'Closing the Gap'.

The strategy aims to reduce health inequalities, delivering against the five strategic priorities:

- Improving outcomes for children and young people
- Reducing premature mortality
- Supporting independence for older people, people with dementia, long term conditions and carers
- Improving mental health and emotional resilience
- Addressing the wider determinants of health through effective use of resources, partnership and community working

For each priority a number of focus areas are identified, and the strategy includes key performance indicators to measure progress. More data is now available to show progress, with direction of travel indications for 23 of the 25 measures now available.

## 2. Progress on implementing the actions in the Health and Wellbeing Strategy

The overall approach we have taken to monitoring progress against the actions set out on the strategy has been 'light touch' – in order to give a broad overview of progress, and in keeping with the high level and extensive scope of the strategy itself.

Each of the five strategic priorities of the strategy consists of a number of sub-sections. Strategic priorities 1 to 4 contain 15 sub sections, and we have asked contacts for those sub sections to provide a progress statement and RAG rating on each one. For Strategic Priority 5: Focus on the Wider Determinants of Health, there is just one statement for the priority as a whole, to reflect the more enabling and cross-cutting nature of this priority.

To ensure that delivery of the Strategy is given the required focus and drive the JICB have instigated a rolling programme of detailed assessments of progress across priority actions. The first such assessment, looking at alcohol related harm is included as appendix 1b of this report.

Overall, the RAG ratings that contact people gave to the 16 areas were:

| | | |
|---|---|---|
| **Red** | Action is at serious risk of not being delivered. | 0 |
| **Amber** | Some risk that actions may not be delivered but this risk will be managed. | 8 |
| **Green** | Good progress is being made and there are no significant problems. | 8 |

The 16 statements of progress, together with RAG ratings are set out at Appendix 1.

Some of the main achievements to support delivery of the outcomes include:

**Youth services:** A remodelled Youth Service is providing a more integrated youth offer including improved access to contraception and sexual health services.

**Healthy lifestyles for children:** The new child weight management service - FLiC (Family Lifestyle Clubs) commenced delivery on 1st April 2014, provided by Leicestershire Nutrition and Dietetics Service within LPT

**Physical activity and healthy weight:** The Healthy Lifestyles Hub is being rolled out across GP practices in the city, in conjunction with the CCG, by end March 2015 over half of GP practices will be referring into the hub and by October 2015 the hub will be city-wide.

**Diabetes:** A new Diabetes pathway has been introduced across the city which sees more patients managed in general practice rather than acute settings. "Walking Away from Diabetes" groups are now running in the city aiming using walking as a means of preventing type 2 diabetes.

**Carers:** Carers are receiving additional support and training. Training has been delivered to 300 more carers during last year. Voluntary sector providers have delivered an additional 360 carer's breaks.

**Mental Health**: A series of Mental Health Summits have been held in Leicester, raising awareness of mental illness and influencing local service commissioners. The Leicester City Mental Health Partnership Board has been established and will aim to improve mental health care, tackle stigma and reduce inequalities.

3. Monitoring the key performance indicators in the Health and Wellbeing Strategy

The majority of performance indicators in the strategy are outcome measures. They are designed to provide evidence that the actions identified in the strategy (and indeed the wider efforts of partners under the Board's "call to action") are having the desired impact, or not, as the case may be.

The indicators do not have specific targets, but rather reflect the ambition of the strategy to improve on the current positions for all our priorities.

The baseline position for each indicator is given at Appendix 2, alongside an indication of the direction of travel of performance relative to this baseline. Where possible, a separate indication is given showing direction of travel since the previous update report. More data is available than at the time of the previous update in April 2014. Overall the position remains broadly similar to that reported in April.

As highlighted above, many of these are outcome measures and will show improvement only after the successful completion of actions currently planned and/or being implemented. While improvements can be seen against some specific measures, it is still very early to judge whether the desired improvement "across the piece" is happening.

Measures showing particular improvement relative to the baseline in the Joint Health and Wellbeing Strategy include those monitoring:

**Health checks –** Numbers receiving checks continue to rise, latest outturn 25,886 and 3,536 patients subsequently have a management plan put in place.

**Care's receiving needs assessment -** Improving trend continues, with 28.4% being the latest outturn

**Reablement -** Older people supported to live at home following discharge from hospital 91.2% at home after 91 days in the last quarter.

For the first time in this report we have included benchmarking data, where it is available, to help us understand our performance and rate of improvement (or decline) in relation to other similar local authorities. Rather than use the CIPFA Nearest Neighbour Model for all measures (as previously proposed), we have used the most appropriate benchmarking group for each measure (e.g. National Foundation for Educational Research benchmarking group for children's and young people's measures).

Given the increased levels of data available for this third progress report, we have also been able to include trend analysis in graph form for most of our measures. This information is set out in appendix 2b.

A summary of the current position on the 25 indicators in the strategy is shown below. The full report on the indicators is set out in appendix 2 of this report.

## Direction of travel against baselines in the strategy

| | | |
|---|---|---|
|  | Performance has improved from the baseline in the strategy | 10 |
|  | Performance is similar to the baseline in the strategy | 7 |
|  | Performance has worsened from the baseline in the strategy | 5 |
|  | No data has been published since the baseline, or there are data quality issues | 3 |

**Appendix 1(a)**

# Implementing the actions in 'Closing the Gap: Leicester's Joint Health and Wellbeing Strategy 2013-16'

**Progress: September 2014**

## Strategic Priority 1: Improve outcomes for children and young people

| | |
|---|---|
| **Section** | **1.1 Reduce Infant Mortality** |
| **Contact(s)** | Jo Atkinson, Public Health Consultant, Leicester City Council |

Leicester's current rate of infant mortality (7/1000) is significantly higher than the national rate (4.3/ 1000), although similar to our comparator cities such as Wolverhampton, Birmingham and Nottingham. It is, however, of concern that rates of infant mortality have not reduced in the city over the past decade, but have remained relatively stable.

A range of initiatives/ services are in place and being further developed to tackle the risk factors for infant mortality. The infant feeding strategy is being revised and due to be completed by early 2015, the key aim of which is to improve breastfeeding rates. In November 2013 we achieved Stage 2 of the UNICEF Baby Friendly Initiative and in February 2015 will be assessed for stage 3, the final stage. An action plan has been developed and is monitored by the infant feeding board to ensure that providers are prepared for stage 3. A peer support programme targeted at areas of the city with the lowest breastfeeding rates is currently being commissioned, which will be operational by early 2015.

A maternal obesity service is now operating across the city, all women with a BMI of over 35 at booking receive a phone call from a dietician and advice and motivational support is provided. Women are also offered place on a 6 week programme running in 4 venues across the city involving advice and support from both a midwife and dietician along with a physical activity session e.g. aquanatal or pilates. A refocus on encouraging women to book early for antenatal care is taking place as although an increase in the proportion booking before 12 weeks was demonstrated earlier in the year, this proportion has recently reduced again.

Due to the importance of the issue and the fact that infant mortality rates have not reduced over the past 10 years, it is proposed that a group be brought together to determine whether more focus needs to be given to infant mortality. Discussion will take place regarding whether there is anything more that the local authority, health and other agencies should be doing to impact on this more significantly and whether an infant mortality strategy should be developed locally.

| | |
|---|---|
| **RATING Amber** | Some risk that actions may not be delivered but this risk will be managed. |

| Section | 1.2 Reduce Teenage Pregnancy |
|---|---|
| Contact(s) | Jasmine Murphy, Consultant in Public Health, Leicester City Council |
| | Liz Rodrigo, Public Health Principal, Leicester City Council |
| | David Thrussell, Head of Young Peoples Service, Leicester City Council |

Teenage pregnancy is monitored on the rate of conceptions per 1,000 females aged 15 to 17. In Leicester, this has risen to 32.9 per 1,000 girls in 2012 from 30.0 per 1,000 girls in 2011. Although there has been a 2.9 increase in the rate of teenage pregnancy for Leicester between 2011 and 2012, it should be noted that this rise is not statistically significant. Furthermore, there has been a 49.1% decrease in teenage pregnancy locally from the 1998 baseline.

**Access to contraception**
The new integrated sexual health service commenced on 1st January 2014. The service has reviewed its young people's provision and has extended delivery. A new city centre accommodation is still required for a dedicated young people's sexual health service following the planned relocation of the Connexions Information, Advice and Guidance Service and appropriate alternative city centre premises need to be identified.

Community Based Public Health Services for Young People covering emergency hormonal contraception, chlamydia screening and long-acting reversible contraception is currently being re-procured. Additionally, a new C-Card (Condom Card) scheme for young people is also being piloted by the integrated sexual health service. C-Card schemes are confidential community based services which provide free condoms, sexual health advice and support to young people. The scheme aims aim to make condoms more accessible to young people, whilst providing them with support and information about sexual health and how to use them correctly. By bringing C-Card schemes to young people, they aim to encourage good longer-term sexual health awareness and behaviour and better use of further services.

Children's Services have completed their transformation programme that has secured better integration with locality early help services. This has transformed services ensuring that the child's voice is central to service delivery; whilst leading to improvements in the quality of practice and ultimately outcomes for children, young people and families. A key intended outcome is to ensure that services are delivered at the right time and place to children and young people through an integrated early help offer to prevent escalation into more complex statutory services. The remodelled Youth Service is also providing a more integrated youth offer including improved access to contraception and sexual health services. Workforce training for both city council and commissioned youth service providers includes targeting vulnerable young people including those at risk of underage conception or poor health outcomes.

Phase 2 of the THINK Family Programme will support additional targeting of young people and families at risk of poor health outcomes including both mental and physical health. This will build upon the success of the current programme focussed on improving school attendance, ETE engagement, and reduction in crime and anti-social behaviour.

**Relationship & Sex Education (RSE)**
A revised RSE Strategy is required for the City.

| RATING Amber | Some risk that actions may not be delivered but this risk will be managed. |
|---|---|

| Section | 1.3 Improve readiness for school at age five |
|---|---|
| Contact(s) | Julia Pilsbury, Early Help Targeted Services, Leicester City Council |

**Action 1: Improving data systems to enable us to identify children at risk of achieving poor outcomes and who have delayed development at an early age, enabling us to target learning support to those who need it most.**

Early Help Targeted services continue to develop the use of e-start to register families and analysis attendance data. We have also developed a list of children vulnerable to poor outcomes i.e. Children in Need, Children subject to Child Protection Plans, children subject to a CAF, or where a member of the family has a CAF or is part of the Think Family work, also siblings of children who fell into the lowest 20% for the LA. Children's Centres then use this data working with colleagues in the field to identify those families not accessing services and/or there is concern. The Children's Centre then target these families for activities and invite and/or home visit. Children's Centres are also using DWP data to target those families identified as eligible for two year nursery education and inform and support attendance.

As of August 2014 health are now sharing data which will enable Children's Centres to cross reference information and support the identification referred to above.
Children's Centre Teachers continue to access data net in order to pick up trends and identify children at risk of poorer outcomes at Foundation Stage, enabling them to target work with individual children and families and make contact through schools who have a greater proportion of children falling into the bottom 20%. Children's Centre staff continue to provide individual support to children and promote and enable parents to get involved in their child's learning. Learning plans are developed and progress is tracked to evidence the impact of targeted support towards improving outcomes.

**Action 2: Improving our partnership working to improve the quality, quantity and take up of family orientated preventative health and wellbeing initiatives for children living in our most deprived areas.**

The integrated model of services delivered through Children's Centres (located in the most deprived areas of the city) continues to support the following: LCC and Health services working closely together through formal liaison meetings and day to day working to identify families that may benefit from specific interventions aimed at improving learning and health outcomes. This enables Children's Centres to include local information to data thus providing more informed data. The two year old development check continue to be carried out jointly by Health Visitors and Children's Centre staff, enabling issues to be identified earlier and actions planned to address emerging learning or health concerns. The majority of Children's Centre staff are trained in baby friendly breast feeding that enables them to promote the benefits of breast feeding and skin to skin contact. Some staff are also trained in healthy eating initiatives which enables them to provide informed information for parents' and some groups activity which promotes this. They work with midwifery to promote breast feeding and early learning activities during ante natal groups. They work with other health partners to develop and target preventative health and wellbeing initiatives to families, focusing on areas such as reducing obesity, improving health and reducing infant mortality through supporting breast feeding, reducing smoking in pregnancy, and promoting good oral hygiene. Children's Centre teachers' work with local schools to identify and support transition to school and ongoing support for children previously identified as vulnerable to poor outcomes.

| | |
|---|---|
| Children's Centres work with the library service to promote library use, all Children's Centres have the galaxy system installed so that they can issue books form the centres and to deliver stay and play type activity in libraries and the Governments' Book Start initiative. | |
| **RATING Amber** | Some risk that actions may not be delivered but this risk will be managed. |

| | |
|---|---|
| **Section** | **1.4 Promote healthy weight and lifestyles in children and young people** |
| **Contact(s)** | Jo Atkinson, Consultant in Public Health, Leicester City Council<br>Steph Dunkley, Public Health Principal, Leicester City Council |

The city has significantly high rates of childhood obesity in the city in both reception year and year 6 compared to the national rates.

A healthy weight needs assessment has been completed and the Healthy Weight Strategy is being revised but due to capacity issues has been delayed and will be finalised early/mid 2015.

The Food Routes programme continues to run in primary schools encouraging a whole school approach to healthy eating, including cooking skills courses for children and their families. The service is being re-commissioned on a larger scale to also include secondary schools and the development of food growing skills. The new service will commence on 1st April 2015

A healthy eating initiative in children's centres and other early years settings including community-based "Cook and Eat" programmes is being commissioned currently. The service will commence delivery in early 2015.

Investment is being made in the delivery and co-ordination of physical activity interventions in primary schools, delivery will start in late 2014.

The new child weight management service - FLiC (Family Lifestyle Clubs) commenced delivery on 1st April 2014, provided by Leicestershire Nutrition and Dietetics Service within LPT

| | |
|---|---|
| **RATING Amber** | Some risk that actions may not be delivered but this risk will be managed. |

## Strategic Priority 2: Reduce premature mortality

| Section | 2.1 Reduce smoking and tobacco use |
|---|---|
| Contact(s) | Rod Moore, Public Health, Leicester City Council |

The full year results for 2013/14 show that the smoking cessation service in Leicester achieved 98.6% of its expected 4 week quitters in a year that was marked by changes in smoker's behaviour due to the further impact of e-cigarettes.

The service continues to be among the best at attracting smokers to the service and helping them to quit. The number of people setting a quit date per 100,000 population aged 16+has declined over the past 5 years, this pattern is mirrored at national and regional level, however, the number of people setting a quit date in Leicester still remains above national and regional levels and Leicester has the 3rd highest number of people setting a quit date (per 100,000 population 16+) in comparison to its ONS comparators in 2013/14. Leicester is also performing well in terms of quitters - the percentage successfully quitting in 2013/14 (57%) is 4 percentage points higher compared to 2012/13 (53% and Leicester has the highest number of people successfully quitting smoking (per 100,000 population) in comparison to its ONS comparators in 2013/14. 72.4% of all quits were validated by CO monitoring (which measures the level of carbon monoxide in the bloodstream), significantly higher than the average for England (70.1%) and for the East Midlands (59.7%) and 4th among comparator authorities but significantly higher than the average for those authorities (65%).

The challenging conditions continue and in q1 of 2014/15 the service has reported that it is 36% below target for the quarter and campaigns are planned for the autumn/winter, including Stoptober as part of recovery plan. Work has also continued to promote and support smoking cessation with communities, hospitals, primary care, maternity services and other settings. The CCG has funded some additional work in strengthening smoking cessation efforts in UHL. The service continues to make smoking cessation available to younger smokers. The Step Right Out Campaign to reduce exposure to second hand smoke in homes and cars continues and is part of a number of promotional campaigns planned for the autumn and winter.

| RATING Amber | Some risk that actions may not be delivered but this risk will be managed. |
|---|---|

| Section | 2.2 Increase physical activity and healthy weight |
|---|---|
| Contact(s) | Jo Atkinson, Consultant in Public Health, Leicester City Council<br>Steph Dunkley, Public Health Principal, Leicester City Council |

The Healthy Lifestyles Hub is being rolled out across GP practices in the city, in conjunction with the CCG, by end March 2015 over half of GP practices will be referring into the hub and by October 2015 the hub will be city-wide. The health trainer service (one to one lifestyle advice) continues to operate in the most disadvantaged areas of the city and is performing well against targets. The combined hub and health trainer service is currently being re-procured with the new service starting on 1st April 2015.

Adult weight management services continue to be provided across the city, particularly targeting those areas and groups with the highest level of need. Consultation on weight

| |
|---|
| management services took place during May/ June 2014 and the results fed into the re-procurement. New adult weight management services will start to deliver from 1st April 2015.<br><br>"Walking Away from Diabetes" groups are now running in the city aiming using walking as a means of preventing type 2 diabetes. This scheme will be expanded during 2015 with a focus on increasing the number of referrals into the programme particularly from GPs.<br><br>The Active Lifestyle Scheme continues to see a high level of demand and now has a waiting list. The service is currently being reviewed and re-designed and the new service will launch in early 2015 giving people a wider range of physical activity opportunities to access.<br><br>The healthy weight needs assessment has been completed, however, the revised Healthy Weight Strategy has been delayed due to capacity issues but will be finalised by mid-2015. A detailed action plan will also be developed. Consultation events will take place during 2015 in order to engage with key stakeholders. The strategic healthy weight group will be re-launched in late 2014 and will have a key role in leading on the development and implementation of the strategy and action plan during 2015. |

| | |
|---|---|
| **RATING Amber** | Some risk that actions may not be delivered but this risk will be managed. |

| | |
|---|---|
| **Section** | **2.3 Reduce Harmful Alcohol Consumption** |
| **Contact(s)** | Julie O'Boyle, Consultant in Public Health<br>Chief Inspector Donna Tobin-Davies, Leicestershire Police<br>Karly Thompson, Divisional Director East Midlands Ambulance Service<br>Paul Hebborn, Leicestershire Fire and Rescue Service<br>Justine Denton, Leicester City Council Trading Standards<br>Mike Broster, Head of Licensing Leicester City Council<br>Rachna Vyas, Head of Strategy and Planning, Leicester City CCG |
| *This priority action was subject to a more detailed assessment by the Joint Integrated Commissioning Board at its meeting in August 2014. The report presented to that meeting is attached as appendix 1b of this report.* | |
| **RATING Green** | Good progress is being made and there are no significant problems. |

| | |
|---|---|
| **Section** | **2.4 Improve the identification and clinical management of cardiovascular disease, respiratory disease and cancer** |
| **Contact(s)** | Sarah Prema, Leicester City Clinical Commissioning Group (CCG) |
| One of the key clinical workstreams for the Better Care Together Programme is Long Term Conditions, including CVD, respiratory disease and cancer.<br><br>Between April and August 2014, 6213 NHS health checks have been completed. No actual target has been set for this year, with practices being asked to target all remaining eligible patients on their lists. Of the 6213 patients, 556 have had conditions detected and a management plan put in place. This compares with the performance for 2013/14, | |

| |
|---|
| with 31,725 patients receiving health checks, and 3536 patients subsequently having a management plan put in place.<br><br>New Diabetes pathway has been introduced across the city which sees more patients managed in general practice, rather than in acute hospital settings.<br><br>Lifestyle referral hub has been established, which gives health professionals a one stop-shop for patients who need lifestyle interventions such as exercise and diet advice.<br><br>Telehealth and health coaching is supporting 70 patients to manage their conditions better and reduce emergency admissions to hospital.<br><br>Evaluation of a COPD case finding project which ran from November 2013 to April 2014 is currently under way to determine future commissioning intentions.<br><br>A pilot service for potential smoking quitters is currently underway in the acute hospital and run by the local Smoking Cessation Service.<br><br>Practices are using risk stratification tools to identify those patients most at risk and undertaking the appropriate interventions to support patients to better manage their condition and stay as independent as possible for as long as possible. This may include medicines review; care planning; and referral onto appropriate services. |

| | |
|---|---|
| **RATING Green** | Good progress is being made and there are no significant problems. |

### Strategic Priority 3: Support independence

| | |
|---|---|
| **Section** | **3.1 People with long term conditions** |
| **Contact(s)** | Sarah Prema, Leicester City Clinical Commissioning Group |
| See 2.4 above | |
| **RATING Green** | Good progress is being made and there are no significant problems. |

| | |
|---|---|
| **Section** | **3.2 Older People** |
| **Contact(s)** | Bev White, Leicester City Council |
| Work continues to develop reablement and enablement pathways which will support older people to maintain or regain their independence.<br><br>LCC is very involved in a Big Lottery bid with VCS partner organisation Vista which will bring almost £5m of investment into Leicester form April 2015. This investment will tackle loneliness and isolation amongst those communities particularly at risk in Leicester. This workstream is known as Leicester Ageing Together.<br><br>Locally, the Royal Voluntary Service has been successful in bidding to a national investment fund through the Cabinet Office to support older people in hospital to return home safely at the earliest possible opportunity. The scheme offers a range of practical solutions such as home safety checks, provision of food, transport and can go onto to | |

support the person with on-going good neighbour type relationships.

The Assistant City Mayor with responsibility for Adult Social Care and Health, Cllr Rita Patel, has set up an Adult Social Care Commission which will receive evidence from older people and key stakeholders about the services that they receive which impact positively or negatively upon their health and well-being. The Commission will report in late 2015.

A Strategy for Older People which will take a holistic approach to the coordination and delivery of culturally appropriate high quality services across health, social care, housing and other relevant organisations is being scoped. This will also consider how we can increase the participation of older people in neighbourhoods to increase social inclusion and general wellbeing. The scope of the Strategy will dovetail with the Adult Social Care Commission.

| | |
|---|---|
| **RATING Green** | Good progress is being made and there are no significant problems. |

| | |
|---|---|
| **Section** | **3.3 People with Dementia** |
| **Contacts** | Bev White Leicester City Council<br>Alison Brooks LCCCG |

The work on the local Better Care Together Strategy has highlighted Dementia as one of its priority areas and a summary of achievements of the LLR Strategy is being put together as part of a local strategy for delivering the Better Care Together Dementia workstream.

The priority areas are:

1. Develop Dementia care Coordinators
2. Support Integration of skills and services
3. Universal care planning
4. Increase capacity to deliver psychiatric care
5. Increase support for carers
6. Increase awareness of services available
7. Deliver high quality care in care homes
8. Increase awareness of dementia and care pathways amongst the public
9. Align currently available resources to localities

The outputs set out in the Joint LLR Dementia Strategy continue to be implemented:

- A memory assessment pathway has been developed and a shared care protocol is being finalised
- An integrated crisis response service has been developed and its success is being monitored
- A suite of information for carers, people with dementia, GP's and professionals has been developed and is about to be published
- The implementation of carers' assessments is a priority in the carer's strategy
- Work continues to ensure that re-ablement and intermediate care pathways are appropriate for people with dementia and facilitate early discharge back into the community.
- The provision of appropriate, high quality support services and assistive

technology continue to be rolled out

- Awareness of dementia and the availability of services within specific communities continues to be promoted via Memory Cafes and Dementia Friends sessions
- Dementia champions have been recruited, trained and a network developed to ensure that the care delivered in hospitals is of the highest quality; a similar programme for residential and nursing homes is in development.

| | |
|---|---|
| **RATING Green** | Good progress is being made and there are no significant problems. |

| | |
|---|---|
| **Section** | **3.4 Carers** |
| **Contacts** | Mercy Lett-Charnock, Leicester City Council |

The number of carers assessments is increasing year on year with 1,972 having been completed in 2013/14.

Carers personal budgets are being widely promoted in order to enable carers to access personalised support that meets their needs. Uptake is increasing and additional funding has been allocated to support this.

Five voluntary sector providers were awarded monies by the City Council to deliver additional carers breaks and support. It is anticipated approximately 360 additional breaks will be delivered during the year.

A carer training programme has been developed within the City Council which has delivered training to an additional 300 carers during the last year, to help them undertake their role. In response to specific carer requests training has been delivered on welfare rights in English and Gujarati, the Personal Independence Payment (PIP) and Looking after someone with Mental Ill health amongst others.

Thirty additional front line staff members have received carer assessment training during the year to help increase the number of assessments done as well as improving understanding of carer issues.

An event for Carers Week organised in Town Hall Square was well supported by partners and well attended by the public. The event aimed to increase the number of carers identified and highlight the support available to them.

| | |
|---|---|
| **RATING Green** | Good progress is being made and there are no significant problems. |

## Strategic Priority 4: Improve mental health and emotional resilience

| Section | 4.1 Promote the emotional wellbeing of children and young people |
|---|---|
| Contacts | Jasmine Murphy, Consultant Public Health, Leicester City Council |
| | Mark Wheatley, Public Health Principal, Leicester City Council |

The Public Health approach continues to focus on strengthening emotional wellbeing in schools and working with specialist services to ensure that there is mental health care provision for children and families in need. All services involved in the support of children are expected to promote mental wellbeing for children, pertinent to the level of care offered; from signposting through to specialist care.

With regard to local authority led services Children and Family Centres and Early Help services will support children and families in terms of managing behaviour, child development and building self-esteem.

More broadly there is a need to ensure that universal and specialist services are more joined up, with better use of available resources including Health visitors, School Nurses, GPs, Educational Psychologists, schools, community paediatricians as well as specialist services. Public Health is currently working with the Educational Psychology Department to develop an emotional wellbeing and support programme for children which is likely to include information about self-harm, bullying, social media and physical activity.

The CCG is the commissioner of specialist Child and Adolescent Mental Health Services (CAMHS), such as the Children and Families Support Team, primary mental health services, the Leicester City Child Behaviour Intervention Initiative and is currently developing children's IAPT services.

CAMHS has a Tiered approach, so that children and young people should be able to gain timely access to the services that they require. There are additional specialist services for issues such as Attention Deficit-Hyperactivity Disorder, Eating Problems and Autism.

| RATING Amber | Some risk that actions may not be delivered but this risk will be managed. |
|---|---|

| Section | 4.2 Address common mental health problems in adults and mitigate the risks of mental health problems in groups who are particularly vulnerable. |
|---|---|
| Contacts | Yasmin Surti, Lead commissioner Mental Health, Leicester City Council |
| | Julie O'Boyle, Consultant in Public Health, Leicester City Council |
| | Mark Wheatley, Public Health Principal, Leicester City Council |

Public Health has raised awareness of the importance of protecting wellbeing to all Heads of Service at Leicester City Council; supporting the improvement of the mental health and wellbeing of councillors and our own staff and workplaces so that they are able to engage and listen to people about what they need for better mental health.

We have worked to reduce inequalities in mental health in the community by delivering a Joint Specific Needs Assessment on mental health in Leicester and by working with local NHS organisations to Improve Access to Psychological Therapy to all disadvantaged communities. Open Mind IAPT delivers psychological therapies where they are needed,

in collaboration with local voluntary sector organisations, such as Adhar, Trade and the LGBT centre, to address the stigma of mental health problems in different communities.

Adult Social Care and Public Health have supported a series of Mental Health Summits in Leicester, raising awareness of mental illness and influencing local service commissioners to integrate health and social care. The Leicester City Mental Health Partnership Board emerged from these summits and is chaired by Councillor Rita Patel. This is a forum in which individual service users and carers, local voluntary and community groups and statutory organisations meet to work together to reduce inequalities in mental health in our community, improve mental health care and tackle the stigma associated with mental illness.

In the last year more than 200 people across the community, and City Council staff have attended Suicide Awareness and Partnership Training. We have encouraged positive mental health in our schools and colleges, with Educational Psychologists producing anti-bullying guidance and working with commissioners to take account of the effects of mental health and mental illness across the life course.

There have been important local initiatives, such as the Triage Car, in which the Police and Leicestershire Partnership Trust collaborate to provide alternative care and support for someone with a mental health problem. In addition, there is a national Crisis Care Concordat which sets out the expected response of mental health services when a person has been taken to a place of safety. Partners are currently working up plans on how expectations within the concordat will be delivered. This local 'crisis declaration' is expected to be launched in early October 2014.

A key element of the work across LLR under the 5 year Better Care Together Strategy is to develop parity of esteem between mental and physical health problems. People with mental illness are more at risk of premature mortality than the population generally. The programme has identified the need to increased resilience in the population, provide earlier and more effective intervention, integrated local care delivery and proactive timely response to crisis, and to maintain demand for secondary care services. It has been agreed that LA, NHS and 3rd sector partners will work together and contribute to the development of a more effective network. Three work streams to develop and redesign interventions have been identified: prevention, including children; strengthening primary care; and, the acute mental health pathway.

Commissioners are scoping the potential for other developments, such as a crisis house, as a way of improving mental health crisis care. And in addition to the Better Care Together strategy we will also be refreshing the Joint Health and Social Care Leicester City MH strategy in the next few months in order to ensure the needs of our diverse communities are properly considered in planning and service development.

| | |
|---|---|
| **RATING Green** | Good progress is being made and there are no significant problems. |

| | |
|---|---|
| **Section** | **4.3 Support people with severe and enduring mental health needs** |
| **Contacts** | Sarah Prema, Leicester City Clinical Commissioning Group |

- A review of the crisis pathway for mental health services is currently underway and there has been early implementation of services to support patients who are experiencing deterioration in their mental health. This includes the development

| | |
|---|---|
| of a crisis house which is due to be operational in January 2015.<br>• The Better Care Together programme has mental health as one of its priority workstreams and is in the process of developing proposals to improve services across all tiers of provision.<br>• Additional IAPT provision has been put in place which focuses on older people.<br>• A pilot scheme has been approved to increase awareness of mental health issues and the services available to support people amongst faith leaders in the city. | |
| **RATING Green** | Good progress is being made and there are no significant problems |

### Strategic Priority 5: Focus on the wider determinants of health

| **Contacts** | Sue Cavill, Public Health, Leicester City Council |
|---|---|
| The Deputy City Mayor is leading work on further plans to help improve community engagement in implementing the strategy and assessing the equality impacts of decisions.<br><br>From October onwards, Health and Wellbeing Board meetings will include updates from council departments about how they are contributing to the aims of the Health and Wellbeing Strategy in terms of the wider determinants of health.<br><br>At a recent Health and Wellbeing Board development session it was also agreed that individual Board members would also act as champions for each Health and Wellbeing Strategy priority, and they will help to take this forward. | |
| **RATING Amber** | Some risk that actions may not be delivered but this risk will be managed. |

**Appendix 1(b)**

# Joint Integrated Commissioning Board
**21st August 2014**

| | |
|---|---|
| **Title of report:** | Reducing Harmful Alcohol Use<br>A review of a priority in the Closing the Gap Strategy |
| **Author:** | Sally Vallance, Joint Integrated Commissioning Board Lead Officer<br>Julie O'Boyle, Consultant in Public Health |
| **Presenter:** | Sally Vallance and Julie O'Boyle |

**Purpose of report:**

To provide an update on the prevalence of harmful alcohol use in Leicester, the strategy in place to address the issue and progress against the action plan.

This paper forms the first of a set of reviews of work occurring to support the delivery of priorities within the 'Closing the Gap Strategy' and provides an opportunity for JICB to review activity and plans, to assess progress and to take action if necessary to drive improvement.

**Key points to note:**

Leicester's strategy covering this work is the Leicester Alcohol Harm Reduction Strategy 2012 to 2017. It is overseen by the Safer Leicester Partnership and developed by the Leicester Alcohol Harm Reduction Delivery Group (a sub-group of the SLP).

Leicester has significantly higher rates of alcohol specific deaths for men than regional and national figures and has significantly higher rates of alcohol related hospital admissions.

An action plan addressing the key priorities in the strategy has been developed and is frequently updated. The current strategy being overseen by the Alcohol Harm Reduction Delivery Group is in place until 2017. The current action plan is attached as appendix A.

**Actions required by JICB members:**

1. JICB are asked to note the current strategy in place covering this work.
2. JICB are asked to consider whether the current action plan is likely to bring about the impact required and intended through the Closing the Gap Strategy. If not, the JICB are asked to propose revisions to these or to request further work.
3. JICB are asked to continue support given to LAHRDG through officer attendance and through attendance at the October summit.

**What do we know about harmful alcohol use in Leicester?**

1.1 There are some broad headlines about alcohol use in Leicester that help to provide an overview of the issue:

- Leicester has significantly higher levels of alcohol specific deaths for men in comparison to national and regional levels with men in Leicester twice as likely to die from an alcohol specific condition, such as liver disease, than the England or East Midland average.
- Alcohol related hospital admissions in Leicester are significantly high (above national and regional) although they are starting to fall
- Alcohol related crime in Leicester is higher than national and regional although this is on a downward trend
- Leicester has high levels of abstinence from drinking. The fact that hospital admissions are death rates for the City are still high would suggest that those that do drink do so at particularly harmful levels.
- A Total Place review for Leicester and Leicestershire carried out in 2010 put an estimate of the 'true' public service cost of alcohol in the region of £89m taking both health and crime costs into account.

1.2 The Director of Public Health Annual Report 2013/14 provides a summary of the latest data and trends in relation to alcohol consumption, links to this can be found at the end of this report.

**Why do we think harmful alcohol use is an issue in Leicester (i.e. what are the causes?)**

1.3 There are a range of issues leading to people drinking in the first place and then, for some, leading to this becoming harmful. Reasons can include:

- Cultural issues which can be wide ranging from the culture of student populations and common links to drinking (fresher's week etc.) to a culture of drinking as part of family and social contact. There can also be cultural and religious reasons for abstaining from drinking.
- Means of 'coping' with complex issues e.g. MH, drug use, homelessness, experience of abuse and other traumatic events
- Experimental use of alcohol as part of growing up
- Availability and affordability of alcohol, more so than other substances and widespread throughout the country
- Dependency where 'regular' drinking can start for many of the reasons stated above but can then lead to a dependency and harmful levels of drinking
- Late engagement with treatment services which can lead to increased harm to the individual as a result

**What services are commissioned in Leicester to address this?**

1.4 A range of services are commissioned including:

- Public Health (PH) campaigns to prevent harmful alcohol use in the population overall, commissioned by PH

- Brief interventions (a structured talk with a primary care practitioner such as a GP, paid for through the PH budget) in primary care where high levels of alcohol consumption are identified
- Alcohol liaison nurse services working with patients admitted to hospital or attending A&E with alcohol related health issues. This service delivers brief and extended interventions, refers into specialist services and supports patients undergoing unplanned detox. Commissioned by public health LCC.
- Alcohol engagement workers, working in GP surgeries to deliver brief interventions and provide advice and awareness relating to alcohol, commissioned by LCCCG
- Alcohol treatment services including community based services, community detox services, in-patient services and residential rehabilitation commissioned through PH and ASC
- Specialist end to end criminal justice based treatment services spanning low level ASB arrest and through sentencing both within the community and custodial provision commissioned through PH and ASC.

**What strategies are in place to co-ordinate this work?**

1.5 The main strategy underpinning work in this area is the Leicester City Alcohol Harm Reduction Strategy. The strategy was approved by the Safer Leicester Partnership (SLP) in 2013 and runs to 2017. The strategy builds on knowledge of needs and harm resulting from alcohol use, as captured in the 2012 JSpNA on alcohol use. It is the second Alcohol Harm Reduction Strategy to be produced in the City. The strategy contains a set of actions which are designed to bring about positive impact on the five priority themes namely:

- Promoting a culture of responsible drinking
- Protection of children young people and families from alcohol related harm
- Improved Health and Wellbeing through early identification and recovery focussed treatment
- Promoting responsible selling of alcohol
- Reducing alcohol related crime, disorder and anti-social behaviour

1.6 The strategy was developed by the Leicester Alcohol Harm Reduction Delivery Group (LAHRDG) on behalf of SLP and it is the LAHRDG that monitors progress against the actions and the impact on performance indicators linked to this work. The SLP then receives regular summaries of progress.

**What actions have been agreed?**

1.7 Appendix A contains the latest version of the action plan for reducing harmful alcohol use which was first published as part of the Alcohol Harm Reduction Strategy. This document is reviewed and added to as an on-going piece of work through the LAHRDG.

1.8 A reducing harmful alcohol use summit is planned for October, bringing together a range of key agencies to look at the pattern of harmful alcohol use in Leicester, the key issues faced in the City and to discuss ways forward in tackling the problem.

**How is success measured?**

1.9 There are limited measures of harmful alcohol use available and so the extent of this problem remains difficult to assess. Broadly speaking, there are measures available (with risks associated) for:

- hospital admissions due to specific alcohol related conditions (over a year's lag in data availability)
- alcohol specific and linked mortality (over a year's lag in data availability)
- alcohol related crime
- numbers of people receiving brief interventions in primary care (with varying levels of take-up and application within settings)
- numbers engaging with alcohol liaison nurse team linked to secondary care
- numbers attending treatment for alcohol dependency
- successful completions of treatment for alcohol dependency

1.10 There are not generally reliable measures available for levels of alcohol consumption in the population overall. This means that it is difficult to measure any increase or decrease in the issue other than assessing the number of cases that are already causing a health or criminal problem.

**What are the barriers to progress?**

1.11 Work in this area is complex with a range of agencies and services either commissioned to deal with the issue or finding themselves impacted upon as a result of harmful consumption. Commissioning arrangements are also complex with PH & ASC, the CCG, NHS England and the Police all holding significant roles. Whilst there are great opportunities for joint commissioning that come with this, the complexity of co-ordinating a common approach remains a struggle. This co-ordination comes largely through the LAHRDG and the drug and alcohol strategic commissioning group and it is therefore key to ensure that partners continue to engage in these groups.

**What can JICB do to support progress against this priority?**

1.12 JICB support is requested in the form of continued engagement from relevant officers with the LAHRDG and the drug and alcohol strategic commissioning group. Attendance and engagement from JICB members at the October summit is also appreciated.

**How is the strategy and work delivered ensuring the effective deployment of resources?**

1.13 The strategy helps to co-ordinate a multi-agency approach to this complex issue. Harmful alcohol use can affect all age groups, can sit as a sole issue or form part of a complex mix of problems faced by individuals, families and communities. By working together to deliver this strategy, it helps to ensure a joined up and therefore more effective focus for agencies and their workforce.

**What work is taking place in communities to support the delivery of this priority?**

1.14 A variety of community based work is taking place, co-ordinated through the latest action plan attached as appendix A. Examples of community based work can be found within the plan.

**Further information**

1.15 The Director of Public Health Annual Report 2013/14 containing the latest data for the City on harmful alcohol use can be found at http://www.cabinet.leicester.gov.uk/mgConvert2PDF.aspx?ID=64402. The Governments alcohol strategy 2012 is available at https://www.gov.uk/government/publications/alcohol-strategy

APPENDIX A Leicester City Alcohol Harm Reduction Strategy Action Plan

| Priority Area: Promote a Culture of Responsible Drinking | | | |
|---|---|---|---|
| **Recommendation** | **Action** | **Lead** | **Comment / Update** |
| Challenge the normalisation of a heavy drinking culture | Targeted culturally appropriate effective campaigns based on social marketing principles<br>1. Social Marketing insight South Asian Drinkers<br>2. targeted campaign aimed at young men engaged with local football leagues<br>3. Student focused initiatives | <br>Public Health<br>Paul Conneally<br>DMU | <br>Bid currently being pulled together Priti Raichura leading<br>Bid submitted |
| Raise general awareness of alcohol units, safer drinking levels and the impact of excessive alcohol | Localisation of national campaigns and initiatives<br>1. AAW<br>2. Drink Driving Campaign<br>3. Dry January<br>4. campaign linked to world cup consider joint campaign with DV delivery group | <br>LCC Comms/Public Health<br>Police<br>Public Health<br>Public Health | <br>WB 17th November 2014<br>December 2014<br>January 2015 |
| Strengthen relationships with stakeholders to ensure consistent and coherent alcohol advice and harm reduction messages | Set up a providers forum<br>Front line Street Drinking forum<br>Tier 1 providers forum | Drug and alcohol commissioners<br>Tim Blewitt<br>CCG | Tier 2 and 3 provider's forum has been established and has had two meetings. An event is planned to coincide with national recovery week in September 2014<br>The forum has been re-established and is meeting on a monthly basis.<br>This is in the process of being established |

| Priority Area: Protect Children Young People and Families from Alcohol Related Harm | | | |
|---|---|---|---|
| **Recommendation** | **Action** | **Lead** | **Comment/update** |
| Improve our understanding of the prevalence of alcohol misuse amongst children and young people in Leicester; including how much they are drinking, what they are drinking, where they are drinking and where they are obtaining their alcohol. | Undertake a project to investigate attitudes of CYP to alcohol<br><br>Consider commissioning Health and Wellbeing Survey | Public Health (Caroline McClusky)<br><br>Public Health (Rod Moore) | Initial scoping paper completed. Work to be taken forward when new registrar comes into post in August 2014<br><br>Approval received from exec to go ahead. Specification being drawn up |
| Work in partnership with colleagues in education, youth services and the youth offending services, to provide comprehensive alcohol awareness education | PHSE is well developed in local schools and includes content relating to alcohol<br><br>alcohol awareness education is embedded in Healthy Schools programme (and any successor to this) | Public Health/Jasmine Murphy | Paper re successor to Healthy Schools has been produced |
| Develop effective alcohol harm reduction messages specifically targeted at under 18's | Social marketing insight project | Public Health | |
| Work with specialist services (think Family) to ensure appropriate support and interventions for parents and children affected by alcohol are in place and accessible | | | |
| Ensure that the children and young people's workforce are trained to deliver alcohol identification and brief advice (IBA), recognise signs of hidden harms of alcohol, and refer where appropriate, to relevant services. | Develop a suitable programme and apply to LETB for funding to run course<br><br>Support for children and young people affected by alcohol misuse, and referral where appropriate , is embedded in the school nursing service specification | Paul Conneally/Julie O'Boyle<br><br>Public Health (Jasmine Murphy) | |
| We will review the current service framework and identify the most effective model for young people's substance misuse services in time for new contracts in July 2014 | Develop New model for services<br><br>Commission New Services | Substance misuse commissioners | New services procured and contract awarded to life line. Contract starts July 1st 2014 |

| Recommendation | Action | Lead | Comment / Update |
|---|---|---|---|
| Increase the identification of young people with alcohol related issues, and the availability of brief and more intensive interventions with positive outcomes, | Set targets within contracts<br>Appropriate service specifications in place | Substance misuse commissioners | Specifications completed. New contracts in place |
| Make appropriate use of all available powers and legal interventions to address illegal selling of alcohol to children and young people including proxy selling. | Advice visits Trading Standards<br><br>Test Purchases/enforcement Police | Trading Standards<br><br>Police | 100 advice visits re age restricted sales and challenge 21 due to be undertaken<br><br>Test purchases being undertaken by police |
| Work with local universities and colleges to deliver awareness campaigns promoting safer drinking messages targeted at students | Broker closer working relationships between university welfare staff, partners and providers to deliver a comprehensive alcohol awareness campaign | Universities and providers | University Rep attends AHDRG<br><br>Alcohol awareness campaigns have been delivered at University of Leicester and DMU<br>Fire service engaged in events at universities<br><br>Student engagement at DMU and peer mentors trained |
| Tackle the link between alcohol and sexual risk taking behaviour by providing brief alcohol advice in sexual health services | Include alcohol brief advice within new integrated sexual health services<br><br>Develop suitable training course for these staff and apply to LETB for funding | Public Health (Liz Rodrigo)<br><br>Public Health and Inclusion Healthcare | New services launched 1st Jan 2014 alcohol IBA included in specification<br><br>Bid in development |

| Priority Area: Improve Health and Wellbeing through Education, Prevention and Effective Recovery Focused Treatment | | | |
|---|---|---|---|
| **Recommendation** | **Action** | **Lead** | **Comment/update** |
| Provide information and resources for individuals, to enable them to understand the role of alcohol in their lives so they can develop skills to change behaviours | Liaise with managers in publicly accessible areas to display alcohol awareness literature. E.g<br>GP surgeries<br>Libraries<br>Leisure centres<br>Cinemas | Public health/comms (Priti Raichura) | |
| Continue to commission and upscale the provision of screening and brief intervention training for a range of front line staff including primary care staff, dentists, pharmacists, community health and social care staff, housing and welfare staff, criminal justice teams, university and college staff etc. | Evaluate current IBA training<br><br>Commission service specific training<br><br>Roll out IBA training to student peer mentors at universities | Public Health/Priti Raichura | Evaluation paper to lead member briefing June 2014 |
| Reduce unplanned alcohol related emergency department attendance and hospital admissions by increasing capacity for early interventions in primary care settings. | Alcohol Liaison workers UHL re-commissioned<br><br>Alcohol engagement initiative re-commissioned | Public Health<br><br>CCG | Evaluation of service underway. Process for re-commissioning approved. Re-commissioning will commence October 2014 with new services in place by April 2015<br><br>Underway |
| Implement, monitor and performance manage the new substance misuse service specification to ensure compliance with all relevant clinical guidelines and best practice. | Contract and performance management processes. | Substance misuse commissioning board | Contracts in place and being monitored. |
| Work with primary care and providers across the whole treatment pathway to ensure that service users experience a seamless transition across and between services | Review pathways to ensure seamless transition | CCG/Lead Commissioners | Jeremy Bennett to convene meeting to take this forward |
| Increase the number of people accessing appropriate and effective recovery focussed alcohol treatment | Monitor treatment data | Substance misuse commissioning board | Contracts in place and being monitored |

| Recommendation | Action | Lead | Comment / Update |
|---|---|---|---|
| Increase the proportion of clients exiting services who have successfully completed treatment (i.e. no longer require structured alcohol treatment). | Monitor treatment data | Substance misuse commissioning board | Contracts in place and being monitored |
| Ensure commissioned services support recovery and address the wider factors that reinforce dependency, including housing and social care needs, family support, domestic violence etc. | Monitor treatment data | Substance misuse commissioning board | Contracts in place and being monitored |
| Reduce alcohol related hospital admissions and reduce the number of alcohol related deaths | LAPE Profile | PH England | April 2014 new data released. |
| undertake a review of tier four (inpatient detoxification and rehabilitation) provision across the city to identify the most appropriate model to meet the needs of our population | Health Needs assessment<br><br>Re-procure services | PH/ David Pearce<br><br>SM commissioners | Needs assessment complete<br><br>Re-procurement underway |
| Host a local network for front-line alcohol and related professionals to raise awareness of the range of services within the city and to promote and share best practice | Set up and host local alcohol network | SM commissioners | Network in place |
| Review provision to ensure that the needs of service users with a dual diagnosis (alcohol and mental health issues) are appropriately catered for | | Public Health/SM commissioners | |

| Priority Area: Promote Responsible Selling of Alcohol | | | |
|---|---|---|---|
| **Recommendation** | **Action** | **Lead** | **Comment/update** |
| We shall raise public awareness of the benefits of using licensed premises that have signed up to such schemes. | | Licensing | Best Bar none scheme not running this year due to lack of capacity. Lack of capacity is also impacting on ability to undertake any promotional work |
| Responsible authorities will ensure that licensed premises have a ready access to information and advice about their legal responsibilities and of best practice in the sale of alcohol. | | Licensing | ongoing |
| Responsible authorities will make appropriate representations regarding applications for licenses to sell alcohol, to ensure premises are suitably located, operated and controlled. | | Responsible authorities | Police and local authority engaged in this. need to have more overt input from public health |
| We shall promote the Challenge 21 age verification scheme. | Advice visits | Trading standards | 100 advice visits planned for 2014/15 |
| We shall maintain a focus on underage drinking in licensed premises and on sales in off-licences to ensure that young people do not obtain alcohol illegally. | Test purchases | Police | Test purchases underway |
| We shall focus enforcement action on licensed premises that adopt irresponsible drinks promotions that encourage people to drink more than they might ordinarily do or in a manner that carries a risk to people's health. | Licensing visits | Licensing/Police | |
| We shall work with HM Revenue & Customs to tackle the supply of illicit, smuggled and counterfeit alcohol, the low price of which presents a significant risk of excessive consumption. | | | |
| Enforcement authorities will ensure that their activities will be intelligence-led and based upon improved information collection and sharing by responsible authorities and local communities. | | | |
| We shall make appropriate use of all the available powers and legal interventions to address any illegal or irresponsible sales of alcohol by licensed premises, in particular the use of Licensing Act review powers. | | | |

| Priority Area: Reduce Alcohol Related Crime, Disorder and Anti-social Behaviour | | | |
|---|---|---|---|
| **Recommendation** | **Action** | **Lead** | **Comment/update** |
| Monitor the new provisions within the integrated criminal justice substance misuse service for offenders to assess effectiveness of the pathway out of criminal justice and into community treatment. | | SM Commissioning board | |
| Maintain and take forward a co-ordinated approach to ensure an effective response to the street drinking issue in Leicester City Centre. | Apply to PCC for funding to pilot an extended alcohol outreach project<br><br>Pilot extended outreach project<br><br>Continue outreach provision<br><br>Repeat project in summer months<br><br>Produce an educational leaflet targeting less entrenched street drinkers<br><br>Extension of anchor centre opening hours<br><br>Promote anchor centre | PH<br><br>Laura Devlin (Homelessness outreach)<br><br>Public Health<br><br>Homeless outreach team<br><br>PH/Homeless outreach/Anchor centre<br><br>Commissioners/inclusion healthcare<br><br>Street drinking forum/inclusion health care/ partners | Funding approved September 13<br><br>Project commenced Nov 13<br>Project completed and report submitted<br><br>Further funding (£35k) secured from PCC. New worker in post |
| Continue to monitor and evaluate the effectiveness of the restrictive conditions of selling high alcohol content beers and lagers within specified areas of the city centre | Consider a voluntary city wide ban on selling super strength beers lager and ciders | SLP | |

| | | | |
|---|---|---|---|
| Work with partners including police, health and the voluntary sector to map incidence of alcohol fuelled violent crime including domestic and sexual violence. | Expand current data sharing between police and A&E to include data relating to street drinking | A&E data group and street drinking management group | |
| Continue to work with licensing and others to ensure alcohol harm is reduced through effective use of licensing powers. | City wide DPPO | SLP | Public consultation re DPPO underway |
| Support initiatives to increase positive perceptions of Leicester City's night time economy through initiatives such as Purple Flag Accreditation. | Apply for purple flag accreditation | NTE delivery group/City centre director | |
| Widen and Increase engagement and membership to City Watch. | Increase the % of establishments engaging with the city watch initiative | Night Time Economy Strategic Group | On going<br>Improved communication amongst the night time economy |
| Promote and train venues and security companies to use the City Watch radio more routinely. | Audit of use of city watch radio<br>Incorporate radio training in door supervisors course | Night Time Economy Strategic Group | More effective communication in night time economy |
| continue to manage alcohol related disorder in our town centre through high visibility policing | | Police | |
| Investigate the feasibility of a city wide DPPO to reduce the impact of antisocial behaviour linked to irresponsible drinking in public spaces | | Community Safety | Paper has gone to exec public consultation underway |

**Appendix 2(a)**

| ‘Closing the Gap’: Leicester’s Health and Wellbeing Strategy – 2013/16 Indicators | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Improve outcomes for children and young people** | | | | | | | |
| **Indicator**<br>(For information on activity in support of each measure please see these sections of Appendix 1) | Reporting frequency | **Baseline as published in strategy** | **Latest data as at September 2014** | Direction of travel vs last report | **Direction of travel vs Baseline** | Benchmark group | Rank within the group |
| Readiness for school at age 5<br>(Section 1.3) | Annual | 11/12 – 64% | **12/13 – 27.7%** |  |  | NFER | 11/11 |
| Breastfeeding at 6-8 weeks<br>(Section 1.1) | Quarterly | 11/12 – 54.9% | 12/13 – 55.1%<br>**13/14 - 56.7%** |  |  | NFER | (Not ranked – data quality issues) |
| Smoking in pregnancy<br>(Section 2.1) | Quarterly | 11/12 – 12.7% | 12/13 - 14.2%<br>**13/14 – 13.1%** |  |  | ONS | 7/11 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Conception rate in under 18 year old girls (per 1000)<br><br>Section 1.2 | Annual | 2011 – 30.0 | 2012 - 32.9 |  |  | NFER | 5/11 |
| Reduce obesity in children under 11 (bring down levels of overweight and obesity to 2000 levels, by 2020)<br><br>(Section 1.4) | Annual | Reception:<br>10/11 – 10.6% | Reception:<br>11/12 – 11.1%<br>12/13 – 10.4% |  |  | NFER | 5/11 |
| | Annual | Year 6:<br>10/11 – 20.6% | Year 6:<br>11/12- 20.5%<br>12/13- 21.1% |  |  | NFER | 6/11 |



| Reduce premature mortality | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Indicator**<br><br>(For information on activity in support of this measure please see these sections of Appendix 1) | Reporting frequency | **Baseline** | **Latest data as at September 2014** | Direction of travel vs last report | **Direction of travel vs Baseline** | Benchmark group | Rank within the group |
| Number of people having NHS Checks<br><br>(Section 2.4) | Quarterly (cumulative) | 11/12 – 8,238 | 12/13 – 24,048<br>**13/14 -25,886**<br><br>**Q1 14/15 - 3517** |  |  | This measure is unsuitable for ranking, however a benchmarkable proxy measure is included in appendix 2b | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Smoking cessation: 4 week quit rates<br><br>(Section 2.1) | Quarterly | 11/12 – 2,806 (1,153 per 100,000 adult pop.) | 12/13 – 2,763<br>**13/14 – 2,551** |  |  | ONS | 3/7 |
| Reduce smoking prevalence<br><br>(Section 2.1) | No regular pattern (Next Survey 2014) | 2010 – 26% (Lifestyle survey)<br>10/11 – 23.4% (Household survey) | Lifestyle survey to be undertaken during autumn/winter 2014 |  |  | N/A | N/A |
| Adults participating in recommended levels of physical activity<br><br>(Section 2.2) | Annual | Oct 10/Oct 11 – 27.8% | Apr 12/Apr 13 – 31.7%<br><br>**Apr 13 / Apr 14 – 31.1%** |  |  | ONS | 3/7 |
| Alcohol-related harm<br><br>Please see appendix 2c for technical note<br><br>(Section 2.3) | Annual | 11/12 – 6,283 (1,992 per 100,000 pop.)<br><br>11/12 (narrow definition)<br>**719.1** | 12/13 – 6,404 (2,038 per 100,000 pop.) Original definition<br><br>2012/13 (narrow definition)<br>**717.2** |  |  | ONS | 3/7 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Uptake of bowel cancer screening in men and women<br><br>(Sections 2.4 & 3.1) | Annual | 11/12 – 43% | 12/13 – 46.6% |  |  | To follow | |
| Coverage of cervical screening in women<br><br>(Sections 2.4 & 3.1) | Annual | 11/12 – 74.7% | 12/13 - 73.9% |  |  | ONS | 7/10 |
| Diabetes: management of blood sugar levels<br><br>(Sections 2.4 & 3.1) | Annual | 11/12 – 62% | 12/13 - 61.8% |  |  | ONS | 7/10 |
| CHD: management of blood pressure<br><br>(Section 2.4) | Annual | 11/12 – 88.3% | 12/13 - 89.1% |  |  | ONS | 6/10 |
| COPD: Flu vaccination<br><br>(Section 2.4) | Annual | 11/12 – 92.3% | 12/13 - 91.5% |  |  | ONS | 5/10 |

| Support independence | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Indicator**<br><br>**(For information on activity in support of this measure please see these sections of Appendix 1)** | Reporting frequency | **Baseline** | **Latest data as at September 2014** | Direction of travel vs last report | **Direction of travel vs Baseline** | Benchmark Group | Rank within the group |
| People with Long Term Conditions in control of their condition<br><br>Please see Appendix 2c for technical note<br><br>(Section 3.1) | Annual | 11/12 – 60.8%<br>*Revised baseline* | 12/13 – 61.3%<br>**13/14 – 62%** |  |  | ONS | 7/10 |
| Carers receiving needs assessment or review and a specific carers service or advice and information<br><br>(Section 3.4) | Quarterly (cumulative) | 11/12 – 18.8% | 12/13 – 26.5%<br>**13/14 - 28.40%**<br>**Q1 14/15 7.1%** |  |  | CIPFA | 13/16 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Proportion of older people (65 and over) who are still at home 91 days after discharge from hospital into reablement /rehabilitation services<br><br>(Section 3.2) | Quarterly | 11/12 – 77.2% | 12/13 – 83.8%<br>**13/14 – 86.9%**<br><br>**14/15 Q1 – 91.2%** |  |  | CIPFA | 8/16 |
| Older people, aged 65 and over, admitted on a permanent basis in the year to residential or nursing care per 100,000 population<br><br>(Section 3.2) | Quarterly (cumulative) | 11/12 – 763.20 - revised Feb 2014 | 12/13 – 735.27<br>**13/14 - 764.4**<br><br>**14/15 Q1 - 197.8** |  |  | CIPFA | 10/16 |
| Dementia - Effectiveness of post-diagnosis care in sustaining independence and improving quality of life<br><br>Please see Appendix 2c for technical note<br><br>Section 3.3 | N/A | N/A | No Data |  |  | N/A | N/A |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Carer-reported quality of life<br><br>Section 3.4 | Biennial (Next survey 14/15) | 9/10 – 8.7 | 12/13 – 7.1 |  |  | CIPFA | 15/16 |
| The proportion of carers who report that they have been included or consulted in discussion about the person they care for.<br><br>Section 3.4 | Biennial (Next survey 14/15) | 9/10 – 70% | 12/13 – 63.5% |  |  | CIPFA | 16/16 |



| **Improve mental health and emotional resilience** | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Indicator**<br><br>**(For information on activity in support of this measure please see these sections of Appendix 1)** | Reporting frequency | **Baseline** | **Latest data as at September 2014** | Direction of travel vs last report | **Direction of travel vs Baseline** | Benchmark Group | Rank within the group |
| Self-reported well-being - people with a high anxiety score<br><br>(Section 4.2) | Annual | 11/12 – 41.99% | 12/13 – 41.2% |  |  | ONS | 6/7 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Proportion of adults in contact with secondary mental health services living independently with or without support<br><br>Please see Appendix 2c for technical note<br><br>(Section 4.3) | Quarterly | 11/12 – 68.1% | 12/13 – 32.2%<br>**13/14 - 34.1%**<br><br>**14/15 Q1 – 41.8%** |  |  | CIPFA | 12/16 |

## Appendix 2(b)

### Performance Trends and Benchmarking

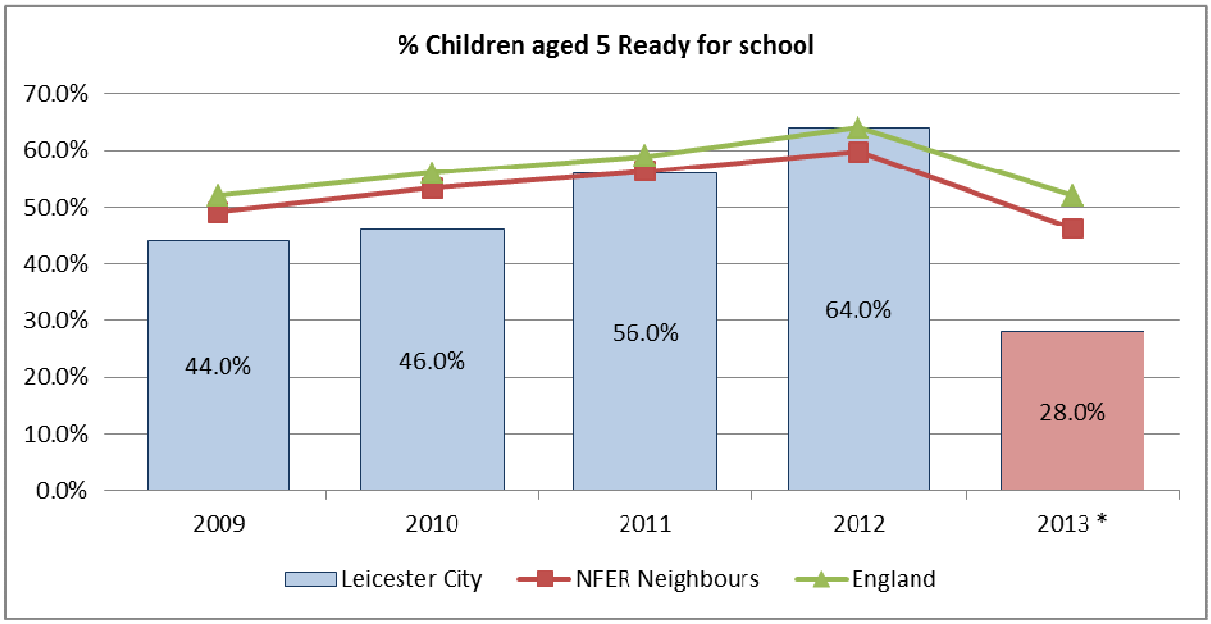
**Key for Graphs**

**NFER Neighbours** = National Foundation for Educational Research Statistical Neighbour Group
**ONS** = Office for National Statistics Neighbour Group
**CIPFA** = Chartered Institute for Public Finance and Accountancy Statistical Neighbour Group

| | |
|---|---|
| Historical data from before the baseline point | Data published from strategy baseline onwards |

**<u>Priority 1: Improve outcomes for children and young people</u>**

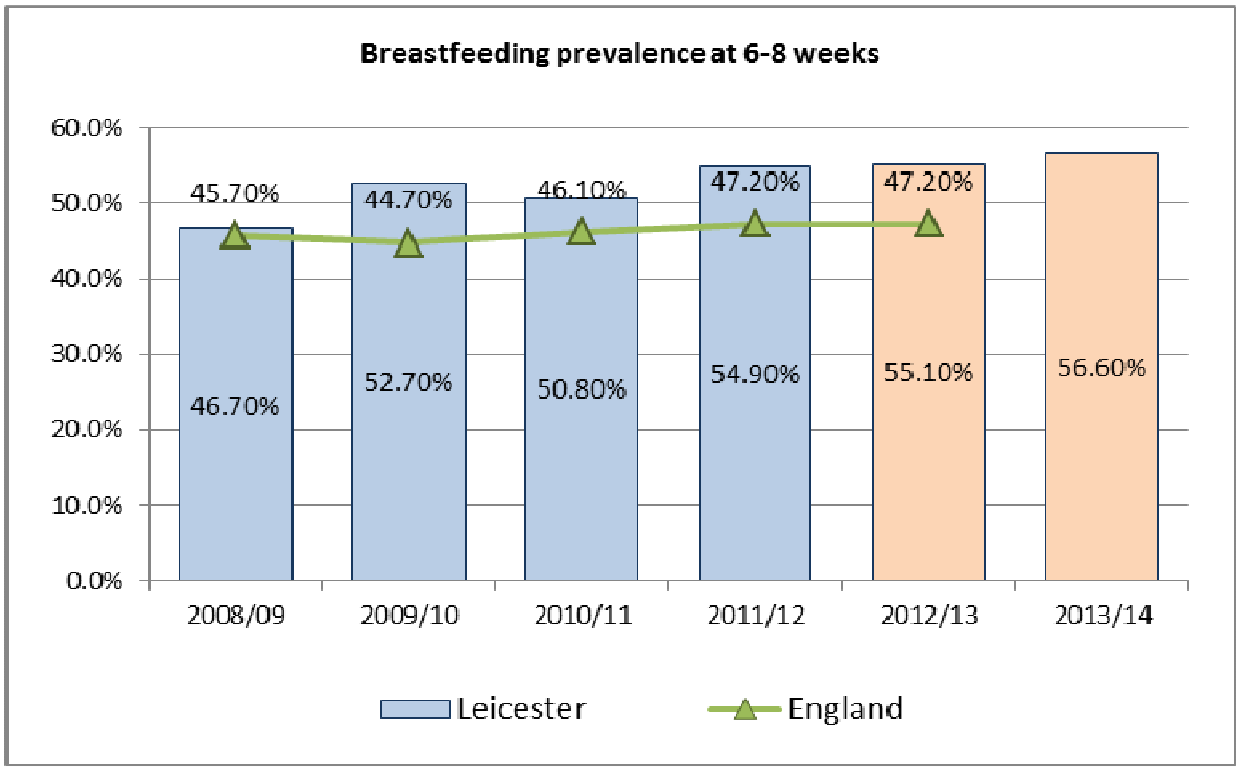
**Readiness for school at age 5**




High is good

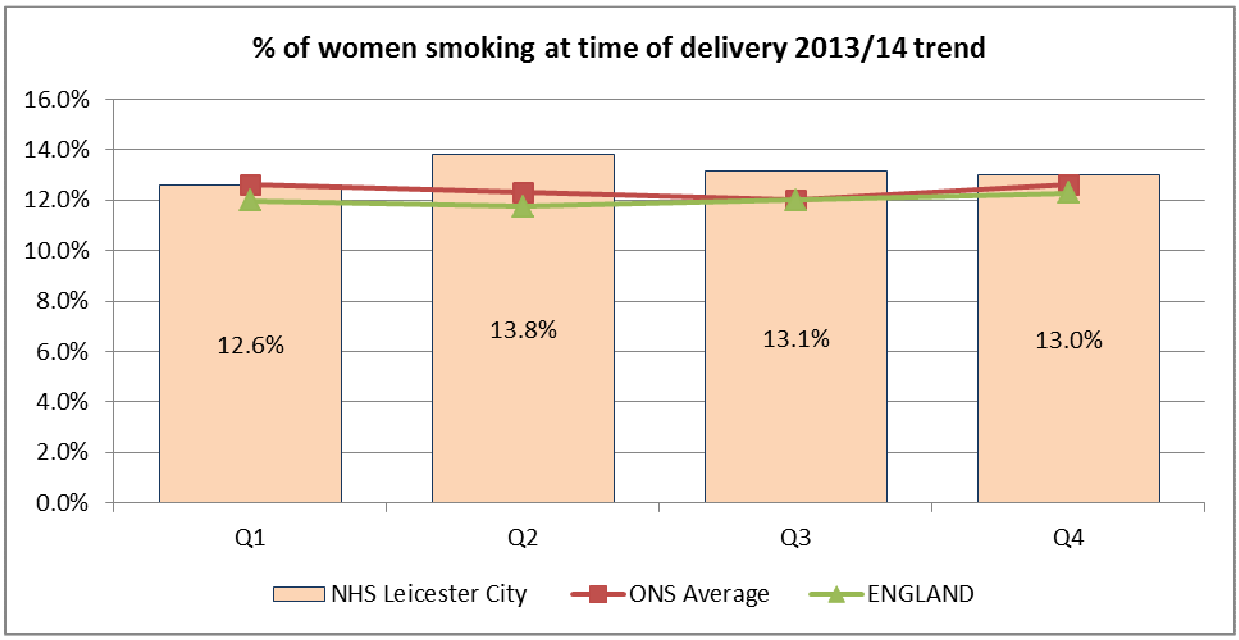
* N.B. trend graph shows historical trend for the old measure of "Achieving a good level of development at Early Years Foundation Stage for 2009-2012, 2013 was the first year of results for the new Foundation Stage Profile.

**Breastfeeding at 6-8 weeks**



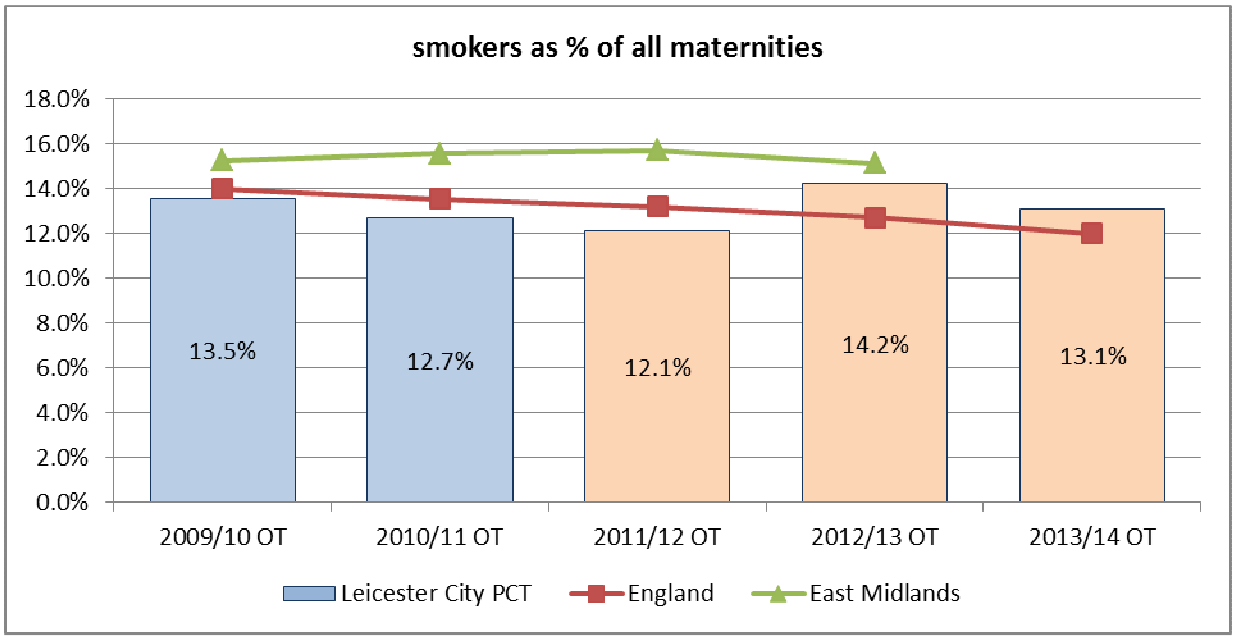

High is good

**Smoking in pregnancy - Latest trend**



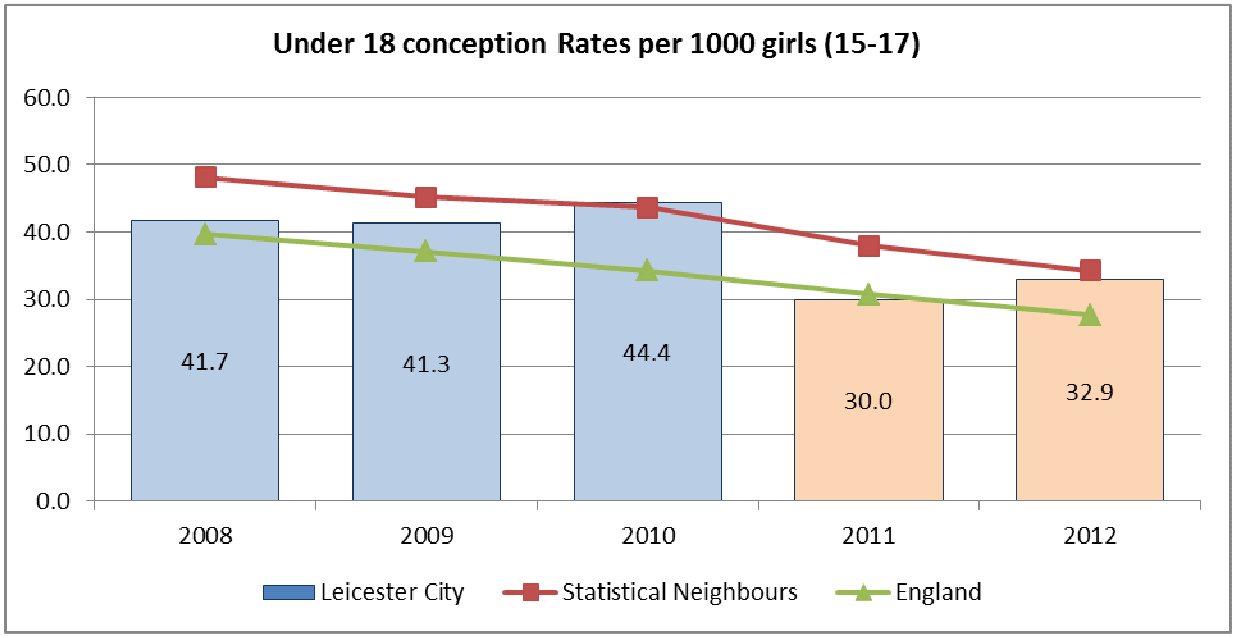

Low is good

**Smoking in pregnancy - Long term trend**



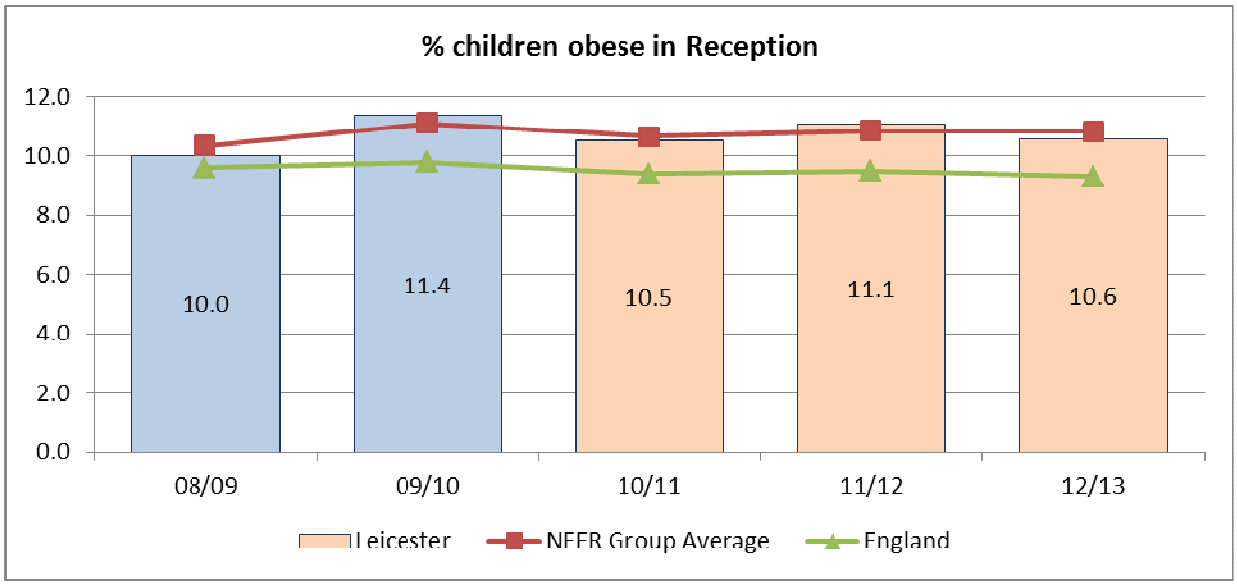

Low is good

**Under 18 conception Rates per 1000 girls (15-17)**



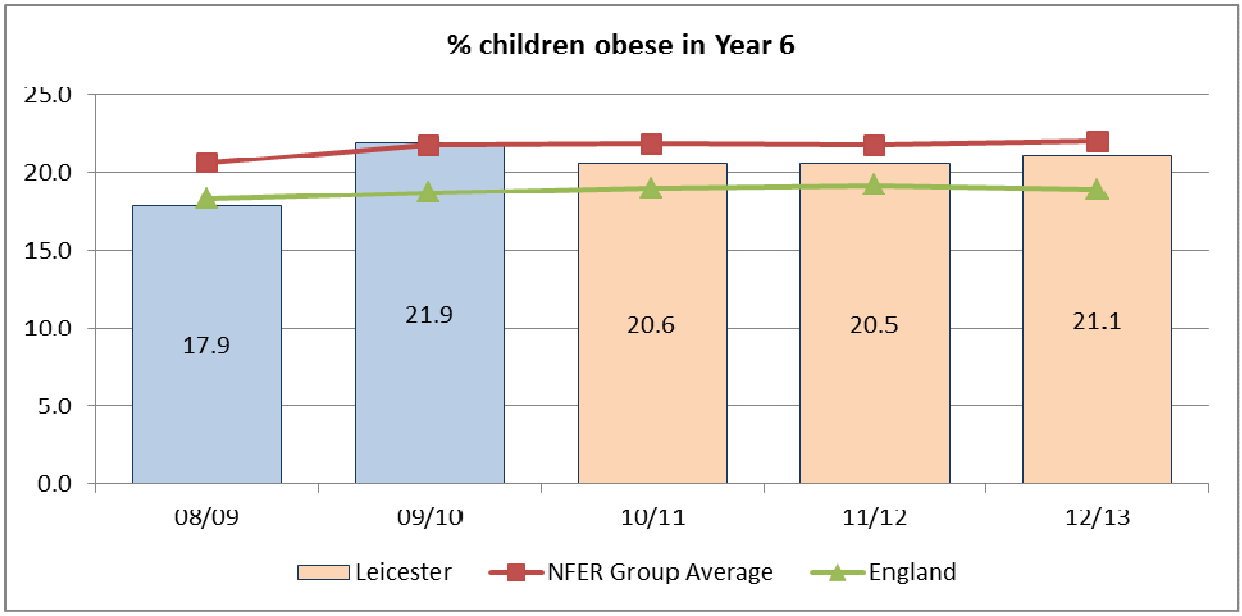

Low is good

**% children obese in Reception**




Low is good

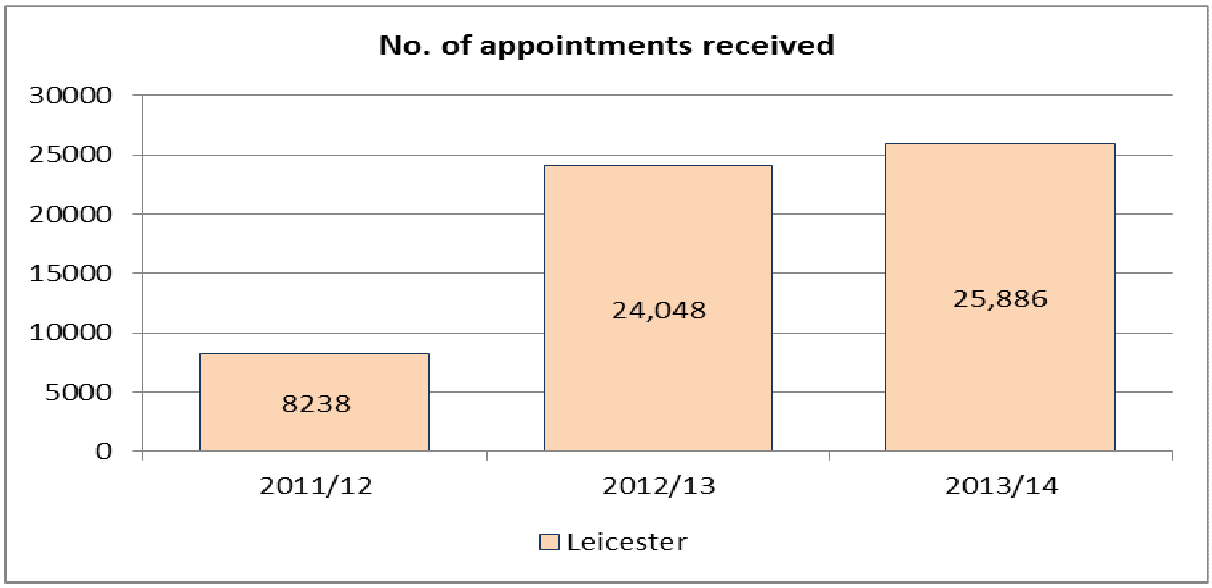
**% children obese in Year 6**




Low is good

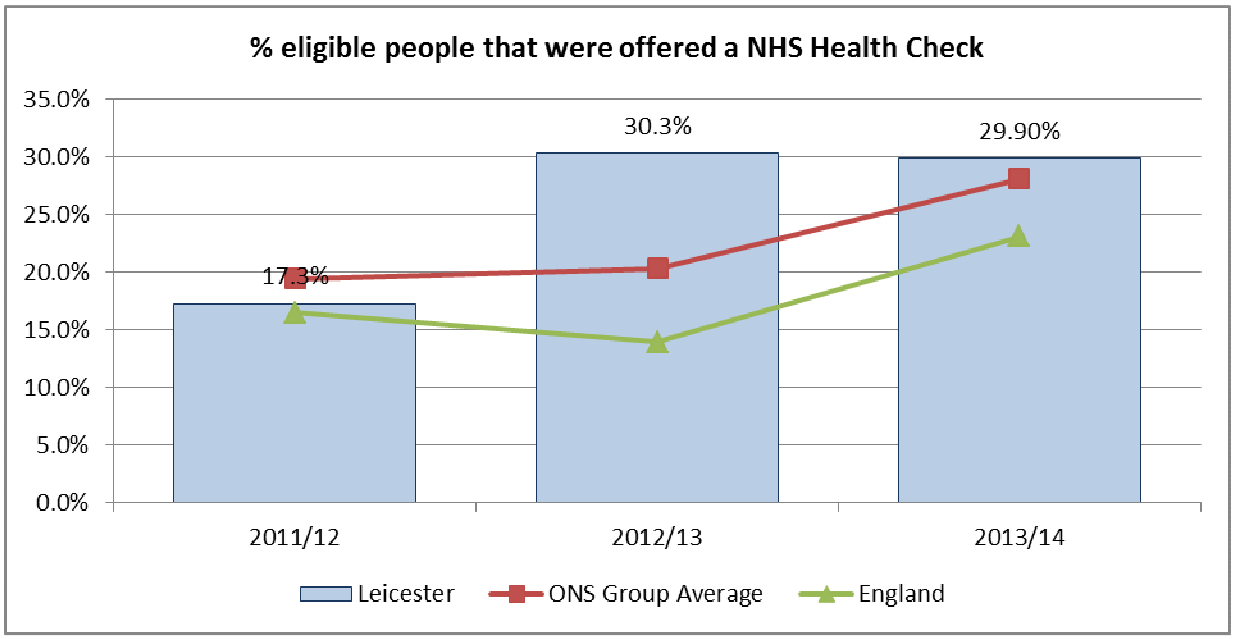
## Priority 2: Reduce premature mortality

### Number of people having NHS Checks



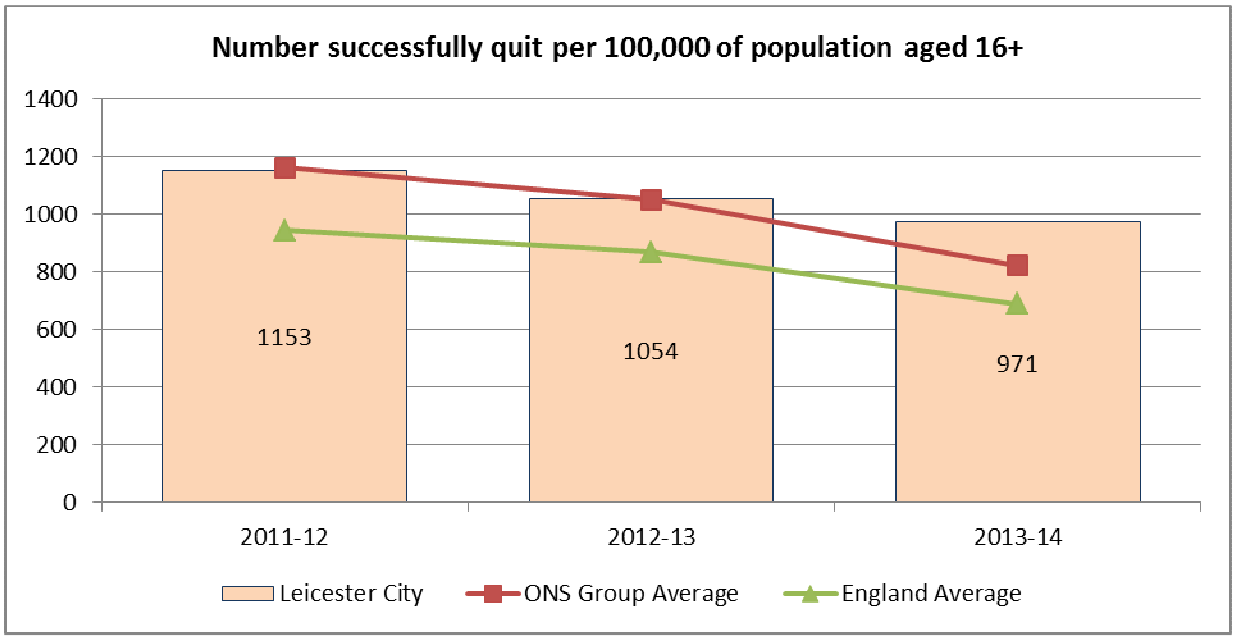

High is good

### Proxy measure: % eligible people that were offered a NHS Health Check (used because it enables meaningful comparisons between different sized areas)



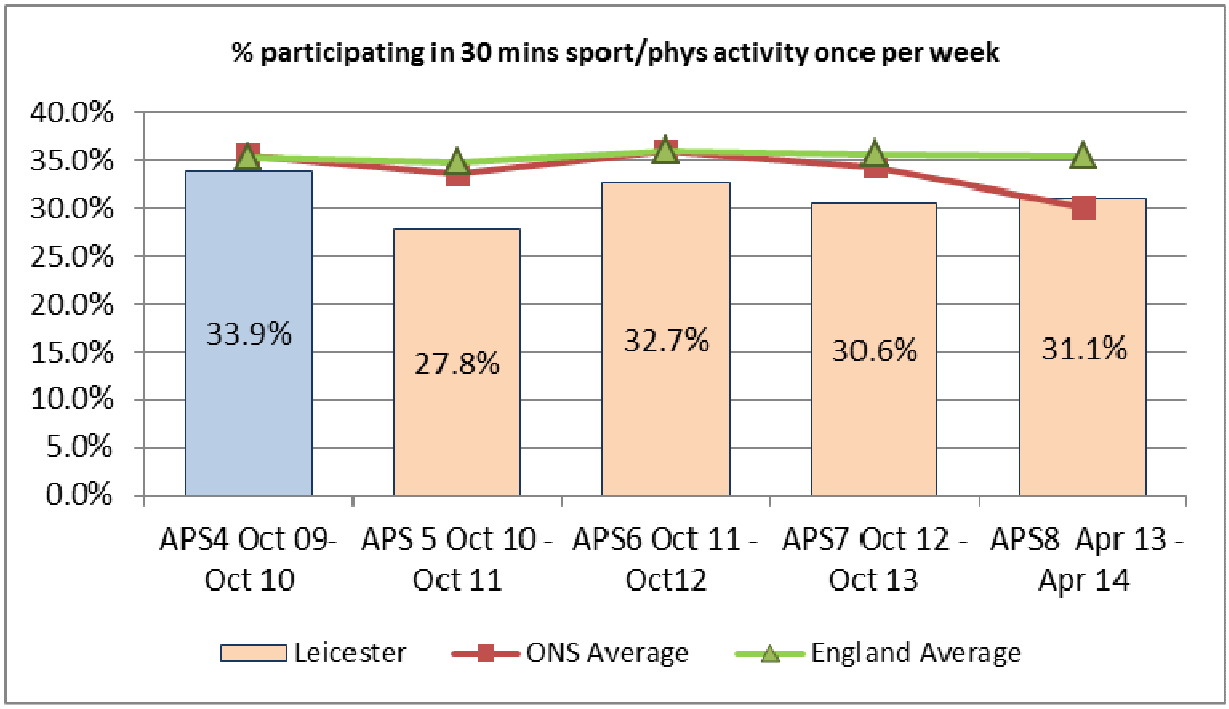

High is good

**Number successfully quit (self-report) per 100,000 of population aged 16 and over**



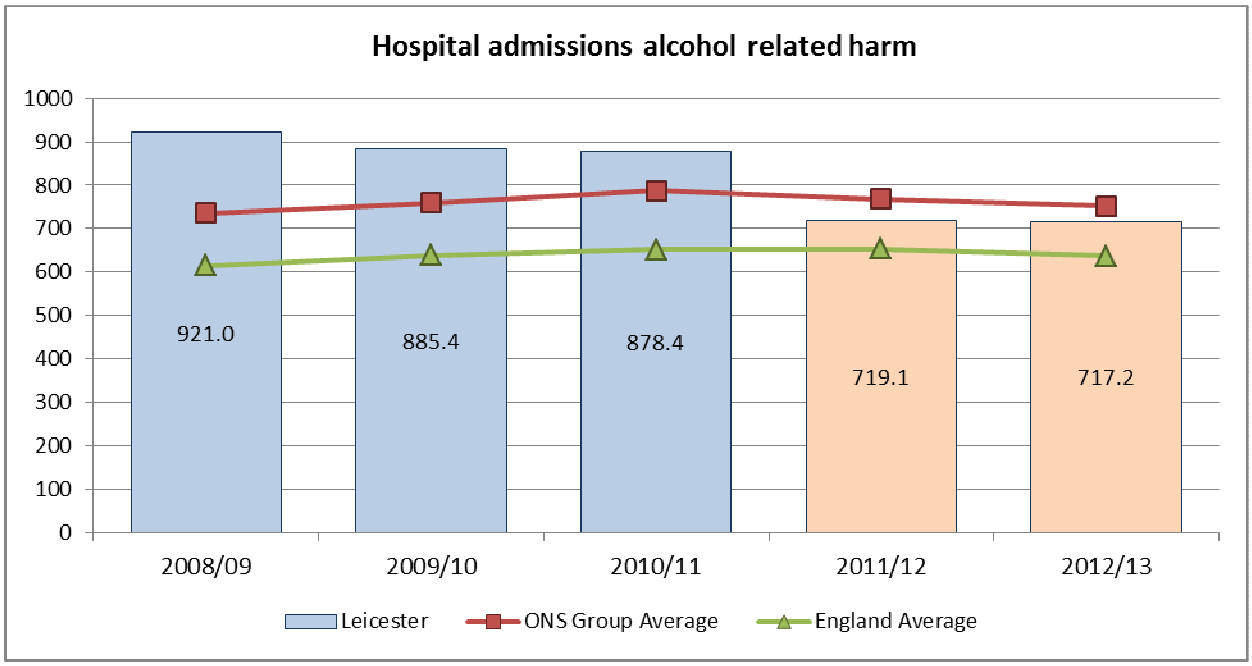

High is good

**% participating in 30 minutes of sport/physical activity per week**




High is good

**Hospital admissions for alcohol related harm, new narrow definition measure**

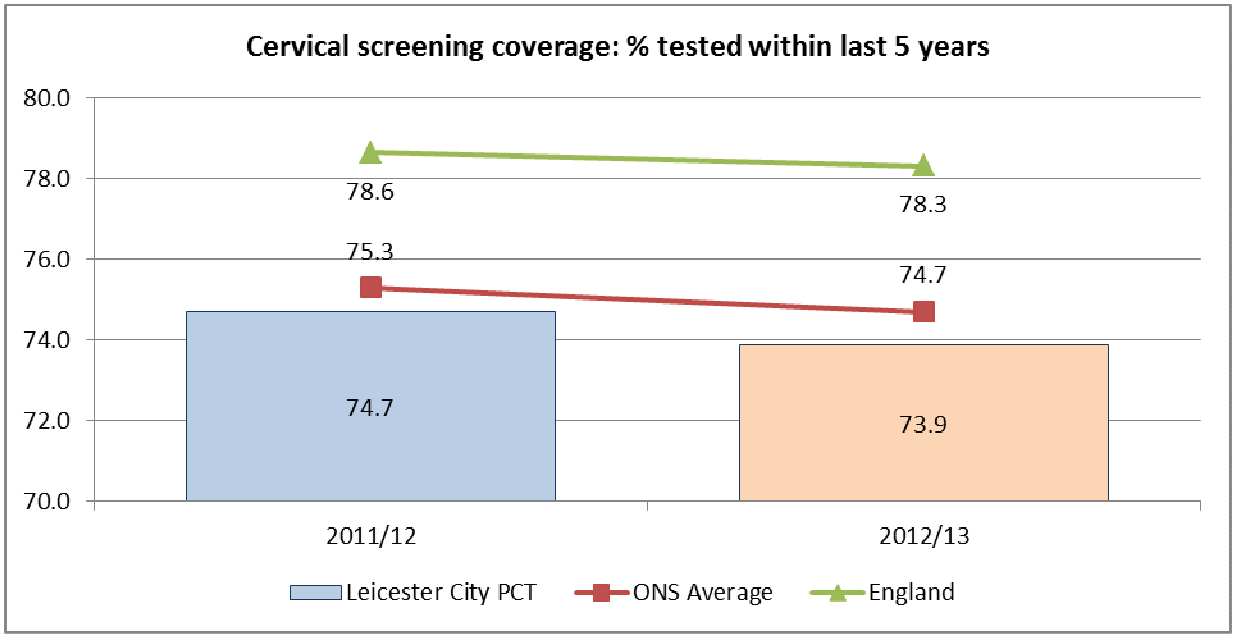



Low is good

**Reducing smoking prevalence:**

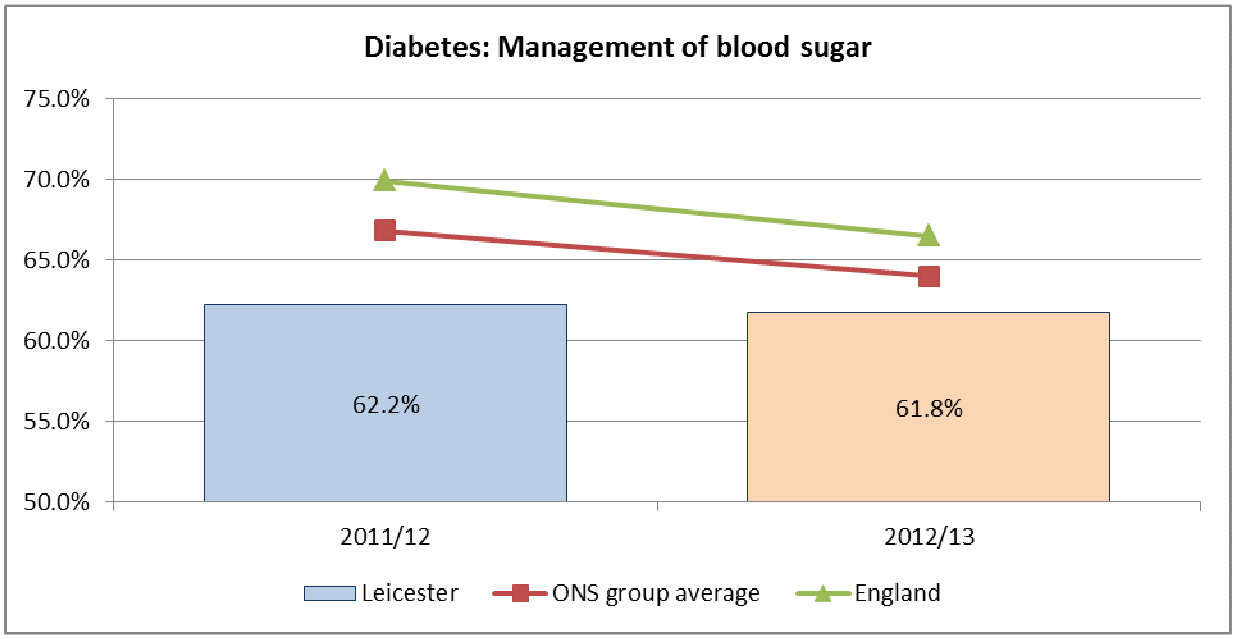
No benchmarking possible. There is no regular pattern for this measure, survey to be undertaken in Autumn/winter 2014

**Cervical screening coverage**



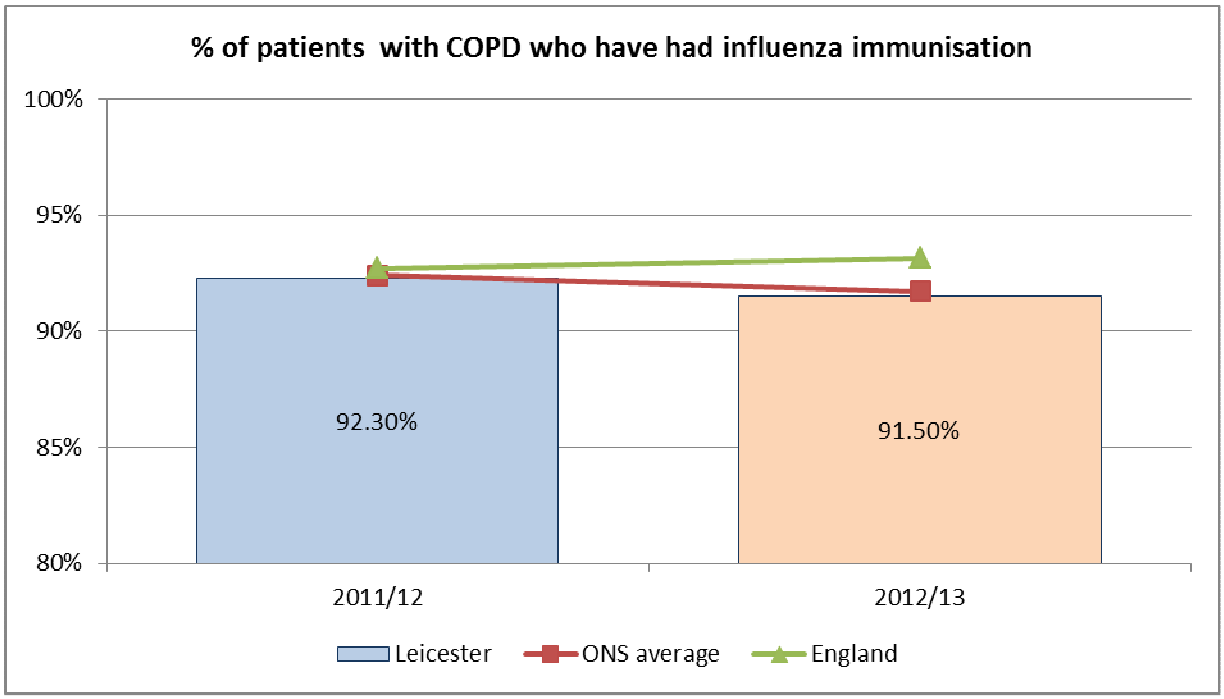

High is good

**Diabetes: The percentage of patients with diabetes in whom the last IFCC-HbA1c is 59 mmol/mol in the preceding 15 months.**



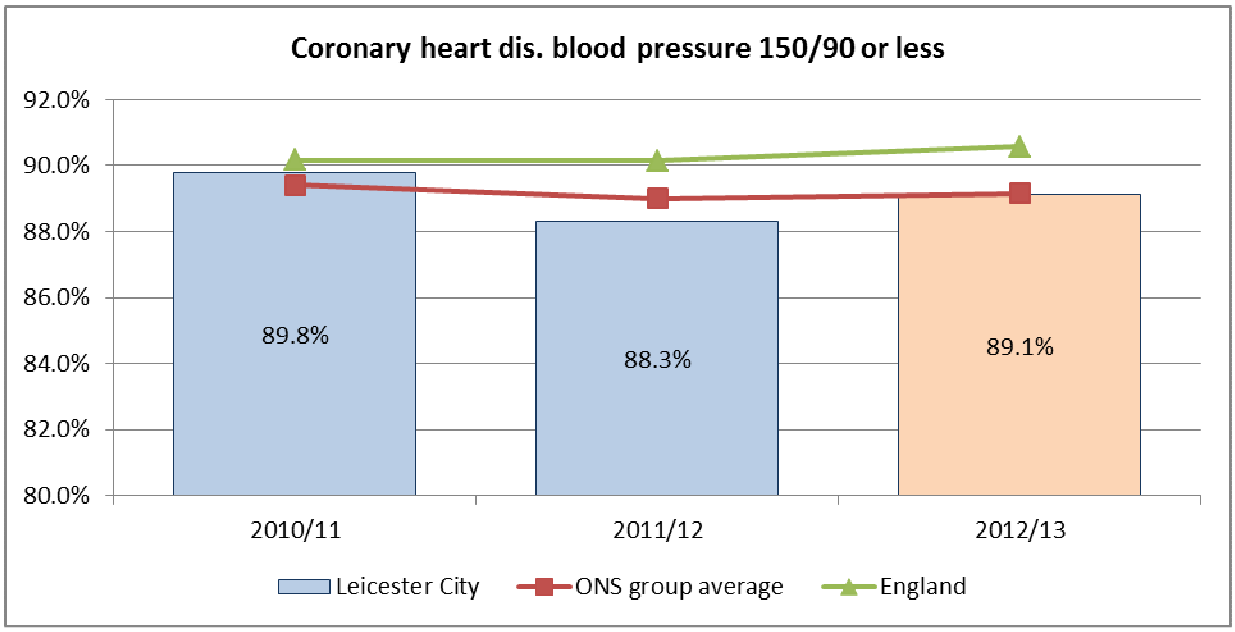

High is good

**Chronic Obstructive Pulmonary Disease: percentage of patients with COPD who have had influenza immunisation**




High is good

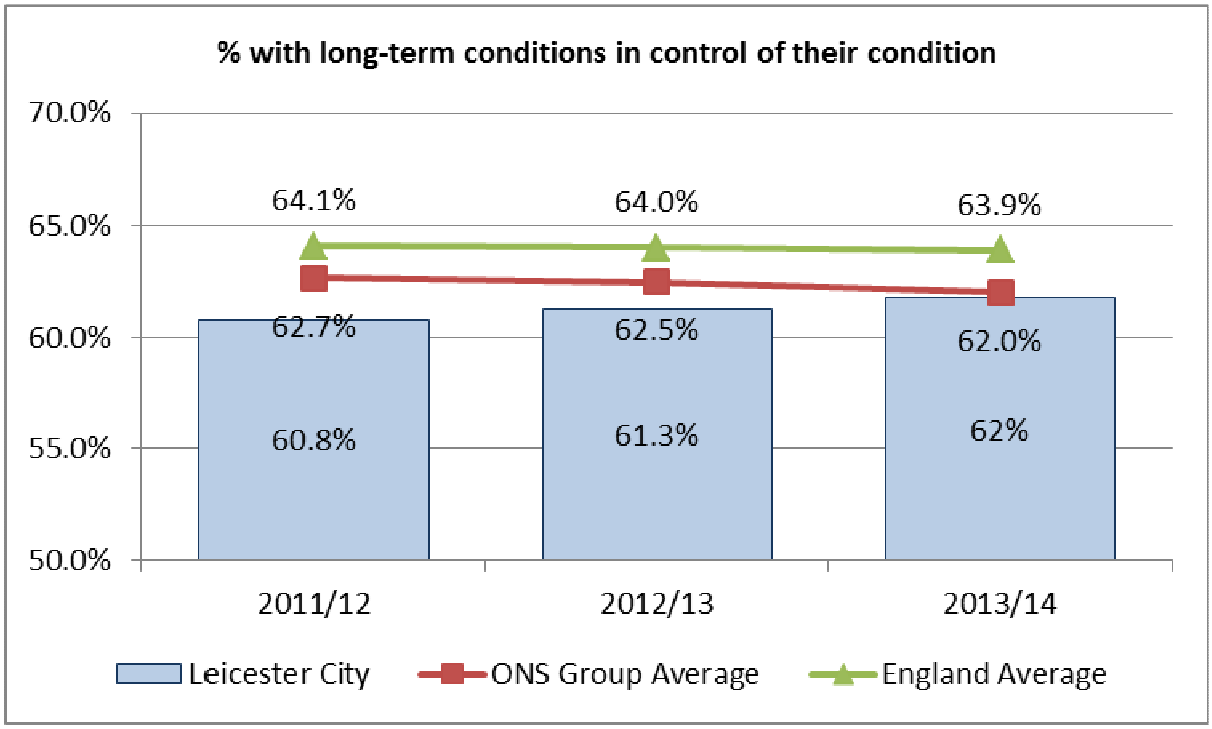
**Coronary Heart Disease:** The percentage of patients with coronary heart disease in whom the last blood pressure reading (measured in the preceding 15 months) is 150/90 or less




High is good

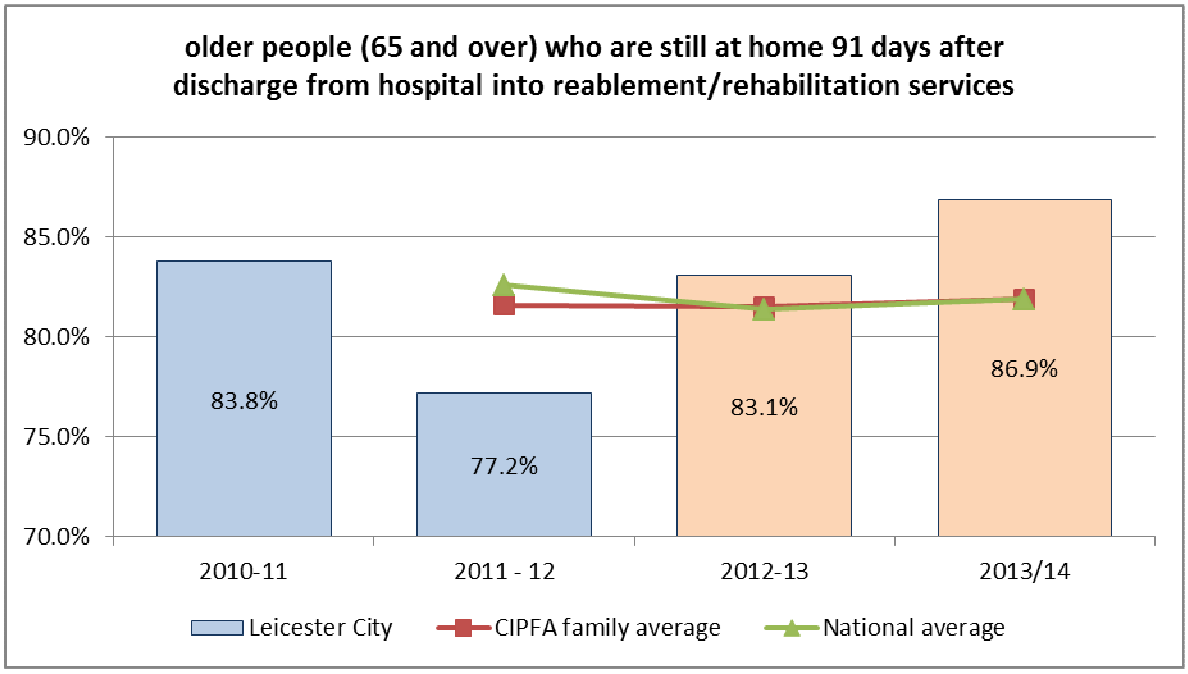
## Priority 3: Promoting Independence

**Long term conditions: People with Long Term Conditions in control of their condition**



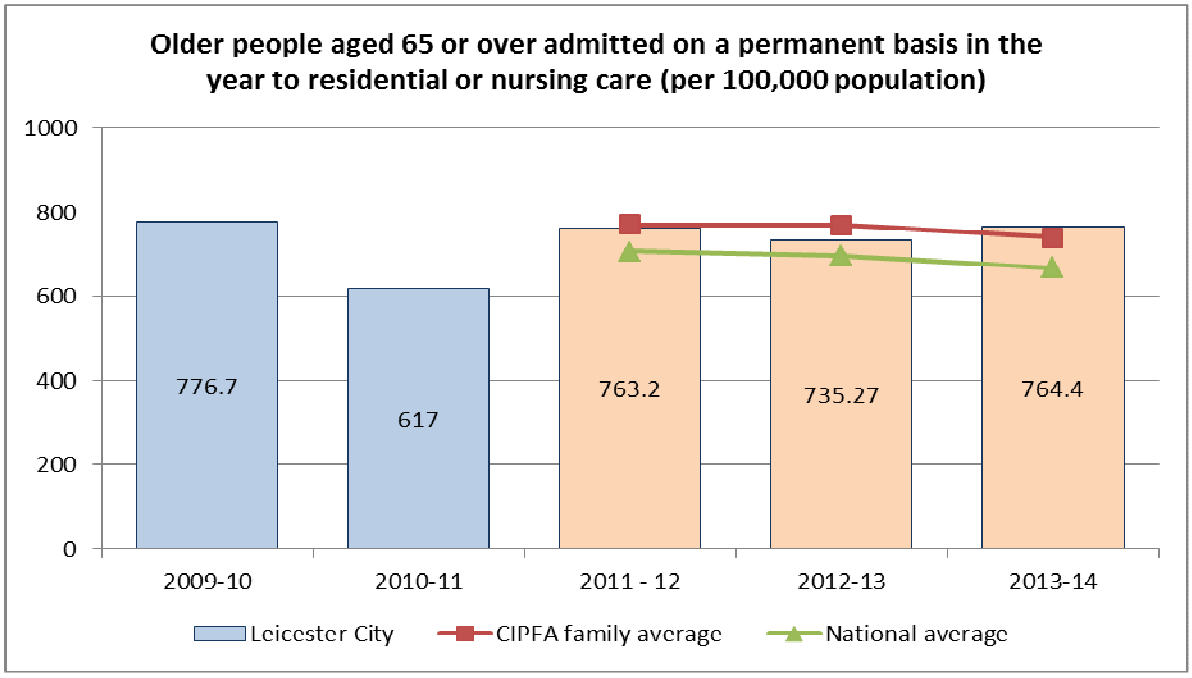

High is good

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




High is good

**Older people aged 65 or over admitted on a permanent basis in the year to residential or nursing care (per 100,000 population)**

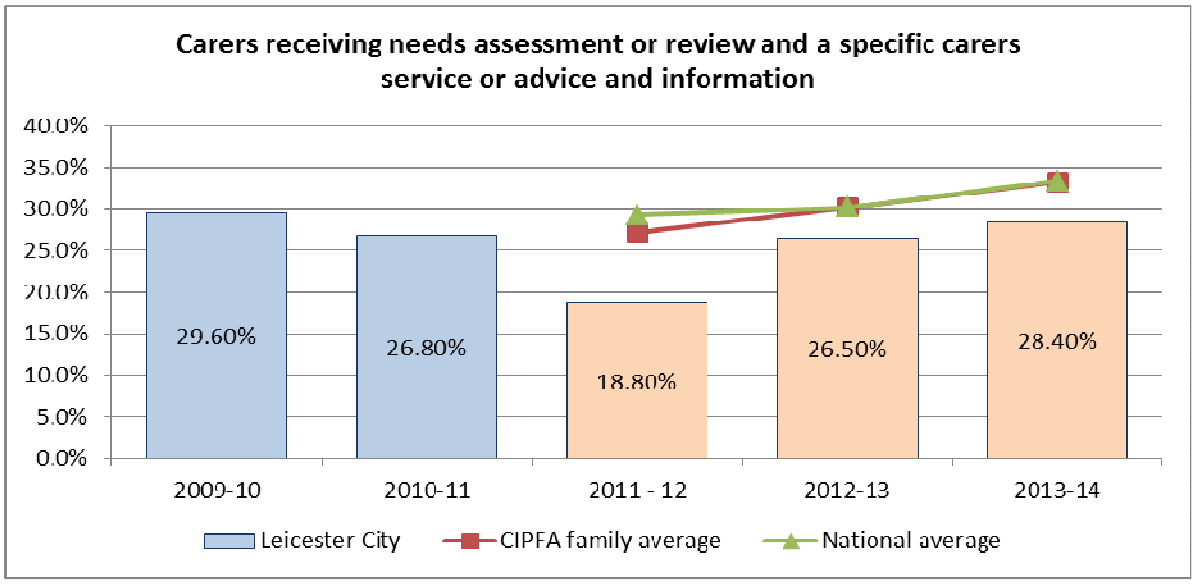



Low is good

**Dementia effectiveness – post dementia care:**

This measure has yet to have any data produced

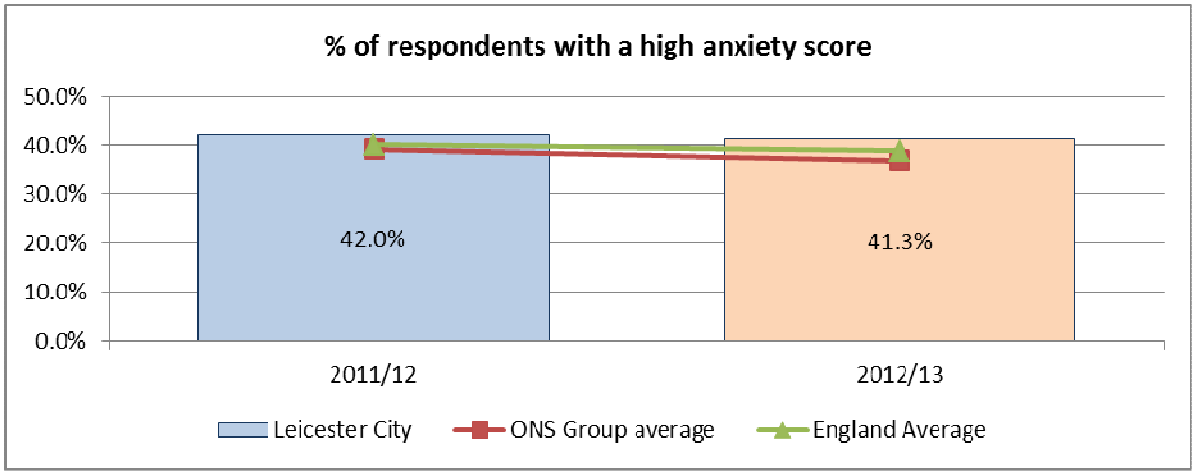
**Carers receiving needs assessment or review and a specific carers service or advice/info**




High is good

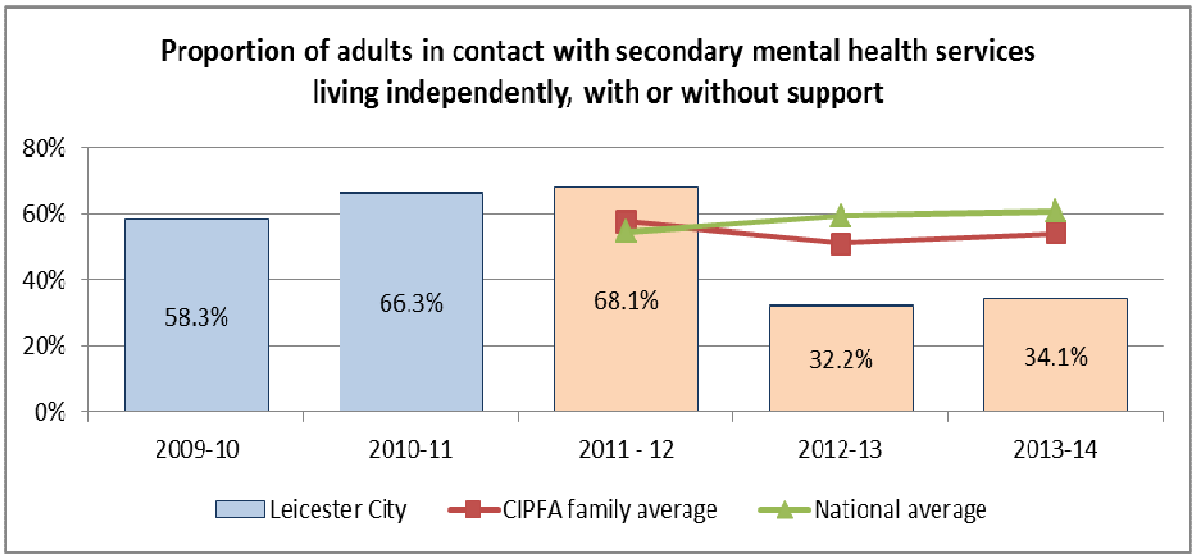
**<u>Priority 4: Improve mental health and emotional resilience</u>**

**Self-reported wellbeing: % of respondents with a high anxiety score:**




Low is good

**Adults in contact with secondary mental health services living independently**




High is good

## Appendix 2(c)

## Technical Notes

**Production of progress statements for Appendix 1:**

To produce each statement, a contact person was identified for each of the areas. That person was asked to liaise with key colleagues to:

- refer to the text of the Joint Health and Wellbeing Strategy for their sub-section;
- report on progress with taking forward the actions in that section, as at September 2013, particularly referring to the bullet points listed under *What we plan to do*;
- make the progress statement short and succinct;
- focus particularly on any key achievements in the context of the strategy or any areas that are on significantly at risk of not being delivered (ie red rated); and
- provide a RAG rating for progress on work in that sub-section.

**Reporting frequency for Appendix 2 indictors:**

Of the 25 indicators, 2 are reported biennially, 13 annually, 8 quarterly, 1 has no fixed reporting pattern and 1 is a placeholder (not yet being collected).For the biennial and no fixed pattern indicators, there has been no data published since the adoption of the strategy.

**Data quality issues and other technical notes on performance indicators**

| Indicator | Notes |
|---|---|
| Alcohol related harm | The definition of the alcohol-related hospital admissions measure has changed. The narrow definition indicator has been adopted for this report, roughly equating to alcohol specific admissions.<br><br>This is not directly comparable with the previous NI39 data as there have been changes to the health conditions and fractions following new epidemiological evidence. |
| People with Long Term Conditions in control of their condition | Data is based on weighted survey results from GP Access Survey. Data quality issues have been resolved, the original baseline was incorrect and has subsequently been amended |
| Dementia - Effectiveness of post-diagnosis care in sustaining independence and improving quality of life | This measure was originally it was planned to be introduced from 14/15 onwards, however, it remains a placeholder in the 14/15 ASCOF framework. The complimentary measure in the NHS Outcome Framework has an estimated implementation date of 2016/17. |
| Proportion of adults in contact with secondary mental health services living | Data quality issues with this indicator persist, as such we are not confident to make a judgement on direction of travel |

| Indicator | Notes |
|---|---|
| independently with or without support | |

**Benchmarking:**

This report includes benchmarking against relevant comparator authorities, where possible. The comparator groups used to benchmark different measures are shown below.

| **Chartered Institute of Public Finance and Accountancy (CIPFA) Nearest Neighbours Model** | **National Foundation for Educational Research (NFER) benchmarking group** | **Office for National Statistics (ONS) benchmarking group** |
|---|---|---|
| Luton<br>Wolverhampton<br>Nottingham<br>Coventry<br>Sandwell<br>Bradford<br>Peterborough<br>Blackburn with Darwen<br>Kingston upon Hull<br>Derby<br>Middlesbrough<br>Liverpool<br>Oldham<br>Newcastle upon Tyne<br>Slough<br>**Leicester** | Wolverhampton<br>Hounslow<br>Sandwell<br>Blackburn with Darwen<br>Slough<br>Coventry<br>Hillingdon<br>Walsall<br>Birmingham<br>Southampton<br>**Leicester** | **Manchester**<br>NHS Central Manchester CCG<br>NHS South Manchester CCG<br>NHS North Manchester CCG<br>**Barking And Dagenham**<br>NHS Barking And Dagenham CCG<br>**Nottingham**<br>NHS Nottingham City CCG<br>**Birmingham**<br>NHS Birmingham Crosscity CCG<br>NHS Birmingham South And Central CCG<br>**Sandwell**<br>NHS Sandwell And West Birmingham CCG<br>**Wolverhampton**<br>NHS Wolverhampton CCG<br>**Leicester**<br>NHS Leicester City CCG |

**LEICESTER CITY HEALTH AND WELLBEING BOARD**

**9th October 2014**

| | |
|---|---|
| **Subject:** | CAMHS Review – Emotional Health and Wellbeing of Children and Young People |
| **Presented to the Health and Wellbeing Board by:** | Leon Charikar |
| **Author:** | Leon Charikar |

**EXECUTIVE SUMMARY:**

This report addresses work across Leicester City, Leicestershire County and Rutland County to produce a joint multi-agency strategic approach to improving the emotional and mental health of children and young people. This strategy is based on four strands:

- Promotion of good emotional health through universal services
- Co-ordinated and integrated early and targeted support services
- Clear care pathways to and from specialist clinical services for children with mental health or developmental disorders

- Joint strategic direction and leadership to ensure strong co-ordination and joint working across organisations

The report also provides an update on the review of the Child and Adolescent Outpatient Mental Health Services provided by Leicestershire Partnership Trust.

**RECOMMENDATIONS:**

The Health and Wellbeing Board is requested to:

Note and Comment on this report.

## 1 INTRODUCTION

*"By promoting good mental health and intervening early, particularly in the crucial childhood and teenage years, we can help to prevent mental illness from developing and mitigate its effects when it does."*

*No Health Without Mental Health: A cross-government strategy (2011)*

Effective and high quality health, social care and educational services can protect children and their families from the impact of mental illness and emotional distress. Such services are also a valuable mid to long term investment in promoting resilience and preventing more extensive mental health care needs in later life.

The importance of ensuring positive mental health for children and young people is supported by a raft of evidence and national policy. The National Service Framework for Children, Young people and Maternity Services (DH, DfES 2004) states:

*"The importance of psychological well-being in children and young people, for their healthy emotional, social, physical, cognitive and educational development, is well-recognised. There is now increasing evidence of the effectiveness of interventions to improve children's and young people's resilience, promote mental health and treat mental health problems and disorders, including children and young people with severe disorders who may need admission."*

Mental health problems in children are associated with educational failure, family disruption, disability, offending and antisocial behaviour, placing demands on social services, schools and the youth justice system. Untreated mental health problems create distress not only in the children and young people, but also for their families and carers, continuing into adult life and affecting the next generation.

The Better Care Together Programme is an ambition programme to develop a five-year plan to transform services to deliver stronger co-ordination, improved quality and financial benefits. The emotional health and well-being of children and young people is part of the Children's Strand of the Better Care Together Programme. A multi-agency reference group met on three occasions so far to develop an outline strategy and priorities for action for this work. There has been strong City Council involvement in this work. The strategic priorities are set out below:

## 2 EMOTIONAL HEALTH AND WELLBEING STRATEGIC PRIORITIES

### 2.1 Promotional of good emotional health

*Emotional Health and Well-being campaigns within schools and colleges*

All children at school and college in LLR will be encouraged and enabled to maintain good emotional health and well-being. This will be though pastoral teaching support, strategies to tackle issues such as bullying and anxiety and access to school nursing and counselling services.

*Jointly commission training for staff in universal settings on emotional health and wellbeing*.

All front-line staff in organisations working with children and young people in LLR will have access to training and development opportunities to learn about emotional health issues. This will provide practical skills in supporting children and knowing when and how to refer for specialist intervention and support.

## 2.2 Early and targeted support

*Map current services*

The current range of services needs to be mapped and understood with a view to identify duplications and gaps. Identify all services presently provided by statutory and voluntary sectors. Understand the types of interventions offered, targeted client groups, duration, costs and outcomes.

*Joint commissioning of comprehensive Tier 2 services*

Jointly commission a comprehensive Tier 2 service which provides early and targeted support for those with mild to moderate difficulties An LLR wide multi-agency Tier two service which will receive referrals from front-line practitioners, conduct assessments, and offer a range of short time low intensity interventions for children, young people and their families. These could include peer support, counselling, group work, parental training, short-term therapies. This would also be the gateway to more specialist assessments and longer- term interventions.

## 2.3 Improving Service Pathways

*Review present pathways to specialist services*

Map the present specialist services (Tier 3 and Tier4) to confirm function, capacity, and pathways to and from services. Understand all specialist services, and how they work together to provide holistic care and support for children and young people with severe or complex needs.

*Transform the way the CAMHS service works to improve access and joint working with partner organisations*

Review the CAMHS service and produce an improvement plan based on enhancing access to assessment and interventions, and improving communication and engagement with partner organisations and with service users.

*Improve experience of transition from child to adult services.*

Clarify the age of transition and how child and adult services work together to support the young person through the change of services.

## 2.4 Leadership and Management of Resources

Establish structural framework for leadership of implementation of the strategy. This will include:

a. Joint Leadership Board – to give vision, direction and make decisions
b. Stakeholder reference group – to shape and influence the strategy
c. Project task and finish groups – to deliver the agreed priority projects

Consider options for joint management of resources and commissioning Identify current commissioning arrangements and funding levels for all services. Agree model for future joint commissioning and financing.

Set success criteria and systems of measurement. Agree the overall outcomes that should be achieved through this strategy and how they will be measured.

### 2.5 Engaging with Schools

It is vital to engage schools and colleges in this work. They are in contact and support almost all children and ca also be significant commissioners of services in their own right. The CAMHS Commissioning Manager is therefore setting up a number of focus groups with schools to understand their perspective and priorities for action. This will shape the strategy and the Better Care Together Programme.

## 3 TRANSFORMATION OF THE CAMHS TIER 3 SERVICE

### 3.1 Background

The CAMHS Tier 3 service is a specialist service which supports children with severe or significant mental health or neurodevelopmental conditions. It is commissioned by the Clinical Commissioning Groups for Leicester, Leicestershire and Rutland and delivered by Leicestershire Partnership Trust, Families, Young People and Children's Division.

In June 2014 the CCGs commissioned an independent review of CAMHS Tier 3. The broad aim was to develop and implement an improvement plan: a key element of which will be to address contractual waiting time requirements. The review was requested because of increasing concerns over a number of issues:

- variable practice across the three CAMHS community teams (City, County West and County East) and between clinicians
- 35% of referrals are returned to the referring agency as inappropriate

- limited communication with service users / carers and referring agencies whilst a case is being assessed by CAMHS
- reported reluctance to share patient data across agencies despite agreed protocols

A multi-agency project group, chaired by the CAMHS Commissioner steered the review. Tim Jones, an independent consultant, was appointed to conduct the review. He held a number of interviews with staff within the CAMHS service and external stakeholders. This included representatives from the City Council, and voluntary groups operating within the City. He has also collated and analysed data about the service and the views of service users.

It was important for the staff within CAMHS to have an early opportunity to hear the outcomes from the review, validate or challenge the findings, and then take ownership for the recommendations and action plan. Therefore a special event for the whole CAMHS service was arranged for 22nd September. A briefing seminar for external stakeholders was held in the evening.

### 3.2 Key Findings

1. The waiting time from referral to assessment and treatment is very long for "routine" referrals, with a large proportion breeching the 13 week contractual target for an initial assessment to be completed. The trend is upwards and the waiting times vary between the three community teams, City, West and East. (More breaches in the West team). However all "urgent" referrals are seen within 4 weeks.
2. All assessments are presently undertaken by a multi-disciplinary team of two or more practitioners including a consultant. This approach may not be an efficient or effective use of clinical time and should be revisited.
3. There are different referral patterns from GPs and geographical areas. Referrals fluctuate by month to month. There is an upward trend of about

10% a year increase in referrals over the past two years. Referring agencies, such as GPs, School Nurses, Paediatricians, may not understand the referral criteria for CAMHS. Need for clarity about "the CAMHS offer" and what a specialist CAMHS service provides and does not provide.

4. There isn't consistency in the ways in which the three teams work. Perception from external stakeholders that cases are assessed differently according to the team or clinicians involved. Little flexibility to move resources between the teams.

5. Referral rates from the County are higher than would be expected. Referrals rates from the City are lower than expected. There may be a variety of reasons for this including prevalence rates, hidden unmet needs, and availability of alternative services to CAMHS.

6. Arrangements and criteria for discharge or step down from the CAMHS service are not clear. The discharge rate is substantially below the average for CAMHS across England. CAMHS may be holding on to cases which could be safely discharged to lower tier services.

7. Clear clinical care pathways are required to guide clinicians, referrers and service users through the assessment, diagnostic and intervention services. These include the pathways from primary care, between tiers of CAMHS service and to adult mental health services.

8. Families who are waiting for an assessment or for an intervention to start are not always kept informed or offered resources and advice whilst they wait.

9. Significant variation in the number of patients seen by senior clinicians. Some clinicians not using the standard administrative systems for booking appointments and contacting patients. Administrative functions can be used more effectively to free up clinical time.

10. Clinical and patient outcome measures are not used to inform and improve clinical or organisational practice. Data is gathered but is not analysed or shared with clinicians.

11. Other findings related to accommodation pressures, a requirement for better electronic clinical record systems, improving engagement with stakeholders and strengthening clinical leadership.

### 3.3 CAMHS Response

The key findings of the review were broadly accepted by the CAMHS Service at the seminar. There was some challenge to the validity of the data relating to different teams (as the County East and West teams had only been established a year ago) and to the referral patterns by GP practices. There was also a sense that the perception of CAMHS as not accepting referrals or being unwilling to engage with other agencies was unjust. CAMHS has been seeking to do this and to explain the way it operates. It would also be useful to describe the context in which CAMHS operates (the budget, number of staff, service structure, etc.). However the seminar did agree with the broad qualitative findings about long waiting times, vague clinical care pathways, and team and clinical variation.

In the afternoon sessions the participants developed ideas for tackling these issues. Some of these ideas included:

- Establishing a team that would focus on new referrals and assessments, thereby ensuring consistency in accepting referrals, and freeing other clinical staff to focus on their caseloads.
- Sharing good practice on arrangements or managing safe discharge from the service
- Ensuring that the results of outcome measurement are shared with clinicians to inform and improve clinical practice.

- Improve communication with families who are waiting for their child to be assessed.
- Understanding reasons for variations in clinical workload, and tackling this accordingly.

There was strong energy, enthusiasm and commitment to develop and implement these ideas, but some wariness that CAMHS was being blamed for issues outside its control.

### 3.4 Seminar for stakeholders

In the evening, about a dozen external stakeholders attending an evening presentation of the findings. This included a CCG GP clinical lead, and representatives from both Leicester City and Leicestershire County Council.

The meeting supported the findings and noted in particular the differing approaches within the City and County Teams, and the benefits of strong partnership working with local authorities.

County teams may be able to learn from the City team where referral rates are lower; there is greater workforce flexibility to response to fluctuating demand, and experience of effective joint working with the local authority.

### 3.5 Next Steps

Tim Jones will validate the data that was presented in the initial findings and then prepare a final written report. This will include contextual information about the CAMHS service as well as the detail of the interviews. This final report will be prepared for the Contract Performance Meeting, as the commissioner of the review.

The Project Steering Group will be meeting shortly to consider the best way of taking forward the recommendations from the review and the idea and proposals that have been generated by internal and external stakeholders.

This may include a communications bulletin and interim update reports to a variety of stakeholder groups.

## 4 CONCLUSION

This report has set out the strategic work that is being undertaken to develop and co-ordinate services for children and young people with emotional health and mental health difficulties. This is part of the Children's Strand of the Better Care Together Programme. The report has also providing an update on the current review of the CAMHS Tier 3 service. The transformation of this service will be a key element of the overall strategy.

Appendix F

# Have your say

## Draft Pharmaceutical Needs Assessment


## PUBLIC CONSULTATION

29 September – 28 November 2014

Leicester City Council

# Introduction

Every few years, pharmaceutical needs assessments (PNAs) are carried out around the country to ensure that local community pharmacies are meeting the health needs of local people. These assessments help the organisations which commission, or buy, pharmacy services on behalf of the community to make sure they are in the right place and provide what local people need.

PNAs are now the responsibility of Health and Wellbeing Boards, which were created following the Health and Social Care Act 2012. These Boards bring together local authorities, the NHS and other key partners to oversee health and wellbeing in their areas.

Leicester City Health and Wellbeing Board has produced a draft PNA for Leicester and we would like your comments on it.

Earlier in the year we asked for people's views on their local pharmacies, and we took into account what we were told then. We'd now like you to take some time to look at what the PNA says about local pharmacies in Leicester, and to tell us if you agree.

The draft PNA is a long document, so we've also created a summary which is available in the next few pages. If you'd like to look at the full document, it's available in local libraries, or online at www.Leicester.gov.uk/pna

After the summary, there are a few questions. Please take a few minutes to complete the questionnaire and to send it back to us by FREEPOST (address at the end of the questionnaire). Alternatively, you can complete it online at www.consultations.leicester.gov.uk/adult-social-care-health-and-housing/leicestercitypna.

If you'd like to meet with us and discuss the PNA before you complete the questionnaire, there will be a public meeting on 12 November at 6pm at the Peepul Centre, Orchardson Avenue, Leicester LE4 6DP.

The public consultation runs until 28 November 2014. The Health and Wellbeing Board is aiming to approve the final PNA by the end of March 2015.

Thank you for your help. This will help us make sure that the final document truly reflects the needs of the people of Leicester.

**Rory Palmer**
**Deputy City Mayor**
**Chair, Leicester Health and Wellbeing Board**

## Summary

The text below summarises the full draft Leicester Pharmaceutical Needs Assessment (PNA). It contains the key points from the PNA to help you decide answers to the questions in the public consultation.

However, if you would like more detail, it is recommended that you look at the full draft PNA, which is also available at www.Leicester.gov.uk/pna. This includes many useful tables which give more detail about different elements of the assessment.

## 1. Introduction

The purpose of the Pharmaceutical Needs Assessment (PNA) is to:

- identify pharmaceutical services currently available in the community and assess the need for them in future
- provide information which helps with planning and commissioning pharmacy services
- provide information which helps make a decision if someone applies to provide a new pharmacy

The PNA is a legally required document which NHS England will use to make decisions about market entry of new pharmacies in the city. The local authority and local clinical commissioning group will also use the PNA to help identify any changes to the local pharmaceutical services they commission from pharmacies.

This PNA has looked at pharmacies in Leicester in terms of what the needs are of the people of Leicester. It only includes community pharmacies, not hospital or prison pharmacies.

For information about the detail of pharmacy provision, please see the detailed graphs and tables in the full PNA.

## 2. Health needs of the population of Leicester

Leicester's health needs are detailed in city's Joint Strategic Needs Assessment, which has informed the development of the city's Joint Health and Wellbeing Strategy, developed by the Health and Wellbeing Board.

The strategy's priorities are:

- Improve outcomes for children and young people
- Reduce premature mortality
- Support independence for people with long term conditions, older people, people with dementia and carers

- Improve mental health and emotional resilience
- Focus on the wider determinants of health through effective deployment of resources, partnership and community working

The statistics below provide some key information about the population and their health needs:

- The current population of Leicester is 333,812 people
- Leicester's population is relatively young compared to England
- A third of all households include dependent children
- One fifth (64,500) of Leicester's population are aged 20-29 years
- 12% (38,750) of the population are aged over 65
- The population is predicted to grow to around 356,000 by 2025, an increase of over 22,000 from 2013
- Leicester is the 25th most deprived local authority region (out of 354)
- 40% Leicester's population live in areas classified as the fifth most deprived in the country
- Around 50% (half) of Leicester's residents are from Black, Minority,Ethnic backgrounds
- Over one third of Leicester's population are of South Asian origin, 6% are Black/British, 4% mixed and 3% from other ethnic origins
- A third of Leicester's residents were born outside the UK
- Life expectancy in Leicester is 77.0 years for men and 81.8 years for women. This is significantly lower than the average England life expectancy
- Death rates from heart disease and stroke and from Chronic Obstructive Pulmonary Disease (COPD) are statistically higher in Leicester than in England
- Teenage pregnancy rates are significantly higher than in England
- Diabetes prevalence is higher than nationally, particularly in the east of the city

The health of Leicester's residents varies across the city and it is useful to look at local areas, or wards to highlight some of these differences. In the full draft PNA and below, we have made use of wards. It should be recognised that wards are primarily electoral areas and thus may not be wholly meaningful or confer identity on different parts of the city. Their use here is to provide some way of discussing local need and provision, and this limitation should be taken into account in making judgements about need or provision.

There will be some changes to Leicester's ward boundaries at the council elections in 2015. These will be taken into account in future analyses of the city.

## 3. Community pharmacies currently in place

Leicester has 87 pharmacies including; 5 internet/distance selling pharmacies and one Essential Small Pharmacies Local Pharmaceutical Services (ESPLPS) and one appliance contractor (providing services such as stoma care aids, trusses, surgical stockings and dressings, but not drugs). There are no dispensing GP practices in Leicester. Overall, Leicester has 2.4 pharmacies per 10,000 of the population. This is higher coverage than the national average.

All the pharmacies in Leicester provide what are nationally classified as 'essential' services. These include: dispensing drugs, repeat dispensing, ensuring professional standards (clinical governance) and checking patient views, promoting healthy lifestyles, getting rid of unwanted medicines, signposting people to other services, supporting people to care for themselves.

Most Leicester pharmacies are open for at least 40 hours and 8 are open for 100 hours per week.

Bank Holiday – Details of bank holiday opening times are sent to GP practices and urgent access to healthcare can be found via the NHS 111 service.

It should be noted that the out of hours GP service has made arrangements for the dispensing of urgently needed prescriptions to its patients on bank holidays, weekends and outside normal working hours.

The biggest concentrations of pharmacies are in Spinney Hills, Castle and Latimer wards. Latimer has the largest number of pharmacies for its ward population (4.5 per 10,000) whilst New Parks has the fewest (0.5 pharmacies per 10,000). Many of the pharmacies are very close to GP practices.

During 2013/14 the total prescribing costs for Leicester City CCG were nearly £46 million, excluding prescribing done in hospitals.

## 4. Travel time to pharmacies

There are only a few small areas of the city where the nearest pharmacy is further than 1km travel from home. In addition to the pharmacies within the city boundary, there are 9 pharmacies within 0.5 km and a further 15 between 0.5 and 1km from the Leicester boundary.

By car: All residents should be able to access their nearest pharmacy within 5 minutes, based on an average speed of 25mph. However, nearly 40% of the city's population do not own a car.

On foot: In a few areas of Leicester there is a more than a 20 minute walk to the nearest pharmacy. These include a mix of residential and non-residential areas. Non-residential areas include parts of the city used for industry, parks and sports facilities, hospitals and schools.

By public transport: Residents should be able to travel to their nearest pharmacy within 20 minutes using public transport, based on travel times on a weekday morning (8am-10am). Times will be more variable with reduced transport services on an evening, weekend, bank holiday.

## 5. Advanced services

'Advanced' services are services some pharmacies provide in addition to the essential services. The advanced services that pharmacies can provide are:

- Medicines Use Reviews to help improve the patient's knowledge, understanding and use of their medicines
- New medicines service, to provide support to patients who have been prescribed with a new medicine e.g., for asthma, diabetes, anti-platelet/ anti-coagulation therapy or high blood pressure.
- Stoma customisation, to make sure that people's stoma appliance is comfortable based on their measurements
- Reviews of appliance use to improve the patient's knowledge of any appliance (for example a catheter appliance) – this can be carried out in the pharmacy or in a patient's own home

Of the 87 pharmacies in Leicester, 75 offer medicines use reviews (86%, England 92%), 65 offer new medicines services (75%, England 68%), 7 offer stoma customisation and 11 offer appliance use reviews.

There is some variation in the numbers of pharmacies offering additional services across Leicester

- There is only one pharmacy in Freemen Ward and one in New Parks ward
- No additional services are offered in the pharmacy in Freemen Ward (ie only essential services)

- Fewer additional services are offered in New Parks and Eyres Monsell (5 additional services)
- Most services are offered in Stoneygate (33 services across 10 pharmacists)

More than 16,000 medicines use reviews were carried out in Leicester in 2013/14, an average of 215 per accredited pharmacy. Only 3 pharmacies carried out the maximum 400 reviews permitted each year and 4 pharmacies carried out 3 reviews.

The average number of New Medicines Reviews was 88 for accredited pharmacies, within a range from 2 to 443. The lowest rates were in Abbey and Rushey Mead and the highest rates in Aylestone.

With regard to stoma appliance customisation, Leicester is below the national average for providing this service.

The number of pharmacies providing appliance Use Reviews is similar to the national rate.

## 6. Community based services

Community based services is the name given to services that pharmacies can offer locally to meet the needs of the population.

As at 31 March 2014 the following services are commissioned from local pharmacies either by Leicester City Council or Leicester City Clinical Commissioning Group (CCG):

- 55 pharmacists offer Emergency Hormonal Contraception (morning after pill), but the uptake of this service is mainly in city centre pharmacies

and it is probable that young women prefer to use this service in an anonymous setting

- 38 pharmacies in Leicester offer chlamydia screening. A limited scheme started in Leicester to screen young people aged 15-24 but this has had limited success, with 112 young people screened during 2013/14. Most of these screenings were through Boots in Highcross followed by Patel's Chemist on Narborough Road
- 36 pharmacies in Leicester can carry out H-pylori breath testing. This is a test to help with treatment of indigestion and its causes
- Minor ailments services are offered at 44 of Leicester's pharmacies providing advice and medicines and/or appliances without the need to visit a GP. Fewer pharmacies in the west of the city provide this service. It is not provided at all in Eyres Monsell, Fosse, Freemen, Humberstone and Hamilton; there is low provision in New Parks, and there is high provision in Belgrave
- A palliative (end of life) care service is provided by 9 pharmacies. The pharmacists are trained in the use of end of life care medicines and can provide advice to carers and other healthcare workers
- Smoking cessation – giving up smoking. Across Leicester 50 pharmacies provide stop smoking services. Generally, smoking levels are higher in the west of the city and lower in the east of the city
- Substance (drug) misuse services. There are two services for substance misuse, the needle exchange service and the supervised methadone consumption service. Overall, 12 pharmacies provide needle exchange and 49 pharmacies provide supervised consumption of methadone. In 2013 the highest uptake for needle exchange was provided by pharmacies in Stoneygate and Western Park

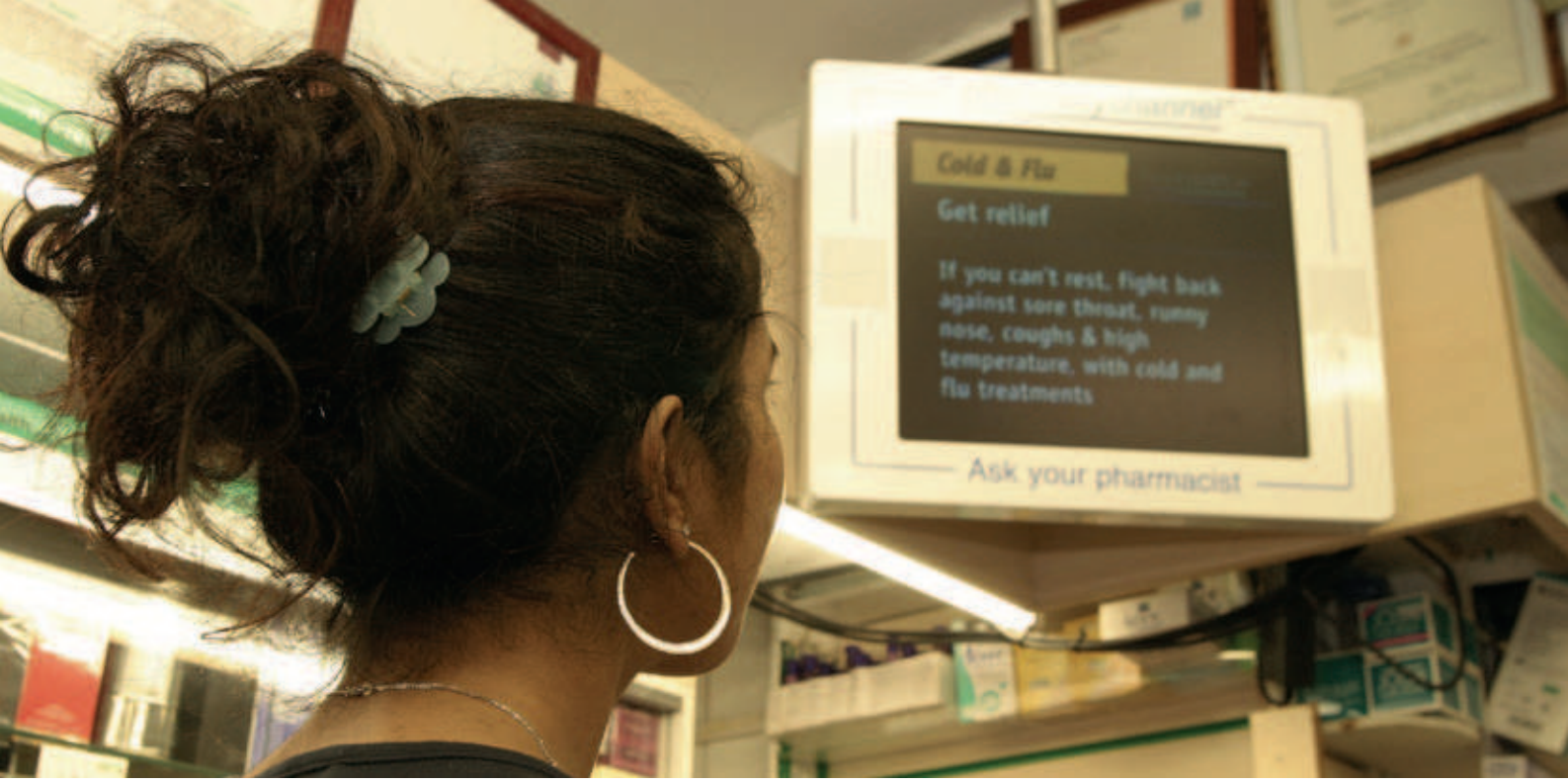
## 7. Patient Views

75 people from Leicester responded to a questionnaire about pharmaceutical services in Leicester which provided information to help develop the PNA. More information about their responses is available in the full draft PNA. The information they provided helped with the overall conclusions of the PNA.

85% of respondents reported that they had not had any problems accessing a pharmacist in the last 12 months.

The main issues people commented on were waiting times, opening hours and access.

People would also like to use further pharmaceutical services such as travel vaccinations/flu vaccinations, cholesterol checks/NHS checks/blood pressure checks and weight management advice if not already provided.




Communication with people from 'seldom heard groups' needs to be improved, e.g. with deaf people and people who need an interpreter.

## 8. Professionals' views

A questionnaire was also sent to health and social care professionals who use, or work with people who use, pharmacies and also to pharmacists. 36 responses came from within Leicester, and all 36 felt that the community pharmacy provision in the area they work in was adequate. There was one comment about the minor ailments scheme not being provided in the local pharmacy but in one some 25 minutes walk away.

## 9. Future needs

It is predicted that the Leicester population will grow from 337,700 in 2015 to be 378,200 by 2037. There will be increases in numbers of people aged between 10 and 15 years, and those aged over 55. It is thought that numbers of 15-34 year olds will fall.

## 10. Long term conditions

The biggest increases in numbers of people with long term conditions will be for over 65s with moderate or severe hearing problems (around 1,500 over the next 5 years). Those with a long term illness limiting their day to day activities, those suffering falls and numbers who are obese could each increase by nearly 1,200 by 2020. The number of diabetics could increase by around 600 over the next 5 years.


## 11. Future housing

It is predicted that Leicester will need 27,200 to 31,700 new homes to be built between 2011 and 2036.

The largest housing developments over the next 3 years are planned in Abbey, Castle, Westcotes, Beaumont Leys and Humberstone and Hamilton. Currently in these wards, Abbey has 1.2 pharmacies per 10,000, Beaumont Leys has 1.7, Castle has 3.0, Humberstone and Hamilton 1.5 and Westcotes has 4.3.

Leicester City Council will be changing the city's ward boundaries at the council elections in 2015, and these ward boundaries will be taken into account in future analyses of the city.

## 12. Are there any gaps in pharmacy services?

### *Essential services*

All Leicester residents have similar or better levels of access to essential pharmacy services to the England average. There are more pharmacies in the east of the city, with several close together in Belgrave and Latimer wards (around Belgrave Road) and another cluster around Spinney Hills/Charnwood and Stoneygate wards. In the west of the city the pharmacies are more widely spread, although there are a number along the Narborough Road area in Westcotes ward.

The rate of pharmacies per 10,000 people living in each ward ranges from 0.5 in New Parks to 4.5 in Latimer. Opening hours per week per 10,000 ward population range from 27.4 in New Parks to 287.7 in Westcotes.

Most pharmacies are open for at least 40 hours per week; 8 pharmacies


are open for less than 40 hours, over half (44) are open between 40 and 50 hours per week, 19 between 50 and 60 hours, 10 between 50 and 100 hours and 4 are open more than 100 hours per week. The 100 hour pharmacies are in Westcotes, Eyres Monsell, Spinney Hills, Stoneygate, Latimer and Humberstone. There is lower provision for extended opening hours on the west of Leicester, however there are a couple of 100 hours pharmacies within 1km of the city border.

Leicester people should be able to reach their nearest pharmacy within a few minutes by car. Most should be able to walk to their nearest pharmacy within 20 minutes, however there are a few areas of the city where it takes longer. Based on a weekday morning, it should not take longer than 20 minutes to reach the nearest pharmacy by public transport.

A review of pharmacies providing a collection and delivery service could show whether this is used in the areas where local pharmacy provision is lower.

## *Advanced services*

Across Leicester, the two key advanced services Medicines Use Reviews (MURs) and New Medicines Service (NMS) are provided by most pharmacies. Most pharmacies do not carry out their full allowance of MURs. It is recommended that pharmacies are encouraged to carry out more MURs and that better communication between GPs and pharmacists is encouraged to gain a greater benefit from this service.

Very few pharmacies provide stoma appliance customisation and appliance use reviews. There are providers who deliver direct to patients and order on their behalf. There is concern that because of this direct delivery there has been a de-skilling of those able to provide this service in pharmacies.

Often the companies who order on behalf of patients are also wholesalers or manufacturers of products in this field.

## *Community Based Services*

Across Leicester a good range of community based services is offered by pharmacies. Pharmacies can be particularly effective in providing services to more hard-to-reach groups as they offer a walk-in service and do not need an appointment. They also offer valuable advice for better self-care.

The following points are made about community based services:

- Although the morning after pill is offered by 55 pharmacies, most of the uptake is through city centre and Narborough Road pharmacies. It is likely that this is because they may offer greater anonymity than the users' most local pharmacy
- At the moment not many people take up chlamydia screening. A review of why this is may help to improve screening levels in young people
- H-Pylori breath testing is available at 36 pharmacies. GPs can refer people to these pharmacies, but they are not the only providers of this service
- The minor ailment service in 44 pharmacies provides an alternative to attending A and E or seeing a GP. A review is taking place to see how effective the service is
- Leicester Recovery Partnership is the main provider of needle exchange services and they are also provided by 11 pharmacies. Supervised methadone consumption is offered by 47 pharmacies. These services are part of a wider approach to help people who misuse drugs
- An Alcohol Brief Intervention is currently being reviewed for pilot in Leicester pharmacies.
- More than 1,400 people were helped to stop smoking through 50 pharmacies in Leicester in 2013-14. The service is constantly looking for new ways to improve effectiveness
- 11 pharmacies currently offer end of life care. A review of the uptake of this service would provide information about how well it is being used and the potential for further demand in future as the population ages
- At the moment Healthy Living Pharmacies is not commissioned in Leicester. This service offers people healthy living advice
- Communication – at the moment there is not an effective method for electronic transfer of patient information between the pharmacist and the GP practice. A shared electronic patient record would allow the pharmacy to input information on matters such as vaccinations or other health checks which the GP could then see


## 13. Conclusions and draft recommendations

The PNA looks at pharmacy cover across Leicester in relation to the health needs of the people who live there. It includes existing services, where they are, the breadth of services they are providing and the views of people using them.

Overall, the community based pharmacies are adequate for the people of Leicester. There are local differences however which mean that some people may have to travel a little further to access a particular service or pharmacy out of normal working hours.

The number of Medicines Use Reviews and New Medicines Services vary across the city, and pharmacies could be encouraged to carry out more of these reviews, which are very beneficial to patients.

A review of community based services, including consideration of cultural needs, could help to understand their effectiveness. Hard-to-reach groups may find pharmacies more convenient or appealing to use because they can be a drop-in service and are less formal than a GP surgery.

In 2015 electronic prescribing will be introduced that this will have implications for pharmacies because drugs may be delivered to people's homes and there may be fewer face-to-face contacts at local pharmacies.

In light of the fact the Leicester's pharmacies are not evenly distributed throughout the city it is recommended that commissioners should:

- Keep reviewing where pharmacies are and what their opening times are to understand whether all Leicester people have equal access to pharmacies
- Find out why some pharmacies provide fewer community based services than others – is this in response to lower need in the local community?

- Think about whether there are too many community based services in pharmacies close to one another and whether these could be replaced by other services
- Explore how to encourage more pharmacies in areas of the city where there are relatively few currently

In addition, in order to make sure that the best use is made of pharmacy services, commissioners should:

- Consider greater monitoring and quality visits to promote service improvement and ensure effectiveness
- Examine how to promote healthy lifestyles through pharmacies
- Consider including pharmacies in commissioning strategies and in plans for healthcare across Leicester as a whole
- Consider feedback received from the public so far which says they would like pharmacies to offer services including flu and holiday vaccinations, blood pressure and cholesterol checks
- Consider introducing visits to assess the quality of premises and services at individual pharmacies and work with them to improve where this is necessary
- Assess uptake of services and share best practice between pharmacies

With regard to communication, commissioners should:

- Consider ways to promote sharing of patient information electronically between pharmacists and GPs
- Ensure effective communication about patients' drugs between GPs, pharmacists and healthcare or social workers

Now you have read the summary, please take a few minutes to complete the questionnaire.

Leicester City Council

# Questionnaire

**1. Do you think the purpose of the PNA has been adequately explained?**

☐ Yes ☐ No

If no, please explain

**2. Do you think the PNA provides an adequate assessment of pharmaceutical services in Leicester?**

☐ Yes ☐ No

If no, please explain

**3. Do you think the PNA provides a satisfactory overview of the current and future pharmaceutical needs of the Leicester population?**

☐ Yes ☐ No

If no, please explain

4. **Do you agree that the current pharmacy provision and services in Leicester are adequate?** (Please refer to section 4 of the PNA or section 3 to section 8 of the summary)

☐ Yes ☐ No

If no, please explain

5. **Do you agree with the PNA conclusions and draft recommendations?** (Please refer to section 10 of the PNA or section 13 of the summary)

☐ Yes ☐ No

If no, please explain

6. **Do you have any other comments? Please specify below with reference to page and section number in either the full PNA or the PNA summary**

**7. Are you responding:**

On behalf of an organisation?

☐ Yes ☐ No

If yes, please state the name of the organisation .....

If no, and you are responding as an individual, please complete the rest of the questionnaire to help our equalities monitoring

## Equalities monitoring

So that we can ensure that our survey is representative of the population we would like you to complete the information below. This will only be used for the purposes of monitoring and will not be passed on for use by third parties.

**8. Which Part of Leicester do you live in? Please state the name of your ward or area.**

.....

**9. Please state the first 4 letters and numbers of your postcode eg LE2 8 etc.**

.....

**10. What is your gender?**

☐ Male ☐ Female

Are you transgender? ☐ Yes ☐ No ☐ Prefer not to say

**11. What is your age?**

☐ Under 16 ☐ 16-24 ☐ 25-34 ☐ 35-59

☐ 60-74 ☐ 75+ ☐ Prefer not to say

**12. What is your ethnic group?**

☐ Asian or Asian British ☐ Black or Black British

☐ Chinese ☐ Mixed dual heritage

☐ White or White British ☐ Gypsy/Romany/Irish traveller

Other (please specify) .....

☐ Prefer not to say

**13. Do you consider yourself to have a disability?**

☐ Yes ☐ No ☐ Prefer not to say

**14. What is your sexual orientation**

☐ Bisexual ☐ Heterosexual ☐ Gay

☐ Lesbian ☐ Prefer not to say

**15. What is your religion and belief?**

☐ No religion ☐ Baha'i ☐ Buddhist

☐ Christian ☐ Hindu ☐ Jain

☐ Jewish ☐ Muslim ☐ Sikh

Other (please specify) .....

☐ Prefer not to say

**Thank you for taking the time to complete this questionnaire. Please send it to: Leicester PNA, FREEPOST NAT 18685, Public Health, Leicestershire County Council, County Hall, Glenfield, Leicester, LE3 8TB.**

**Alternatively you can complete the questionnaire online by going to www.consultations.leicester.gov.uk/adult-social-care-health-and-housing/leicestercitypna**

**If you wish to email us in connection to any PNA response or to get in touch please email us at www.PNA@leics.gov.uk and specify in the subject title if your response is on behalf of Leicester City, Leicestershire or Rutland.**

**The closing date is 28 November 2014.**

# About this consultation

## Cabinet Office Code of Practice on Consultation

This consultation is being carried out in accordance with the guidelines published by the Cabinet Office on 17 July 2012, and available at www.gov.uk/government/publications/consultation-principles-guidance.

## Making sure we consider equalities

A 'due regard' assessment in line with the Equality Act 2010, is being completed, to ensure that the PNA is unlikely to have a negative impact on people from the groups protected by this legislation. This means that the assessment covers issues such as age, race, gender, maternity, disability, marital or civil partnership status, sexual orientation, religion or belief.

## Would you like to talk to someone about how this consultation has been run?

Would you like to talk to someone about how this consultation has been run please contact Jay Hardman, Research and Intelligence Manager, Leicester City Council, jay.hardman@leicester.gov.uk.

## Thank you…

Thank you for taking the time to read this and tell us what you think.

**Other languages and formats**

**We can provide versions of this leaflet in other languages and formats such as Braille and large print on request. Please contact the Engagement and Involvement department, telephone 0116 295 1486.**

***Somali***
Waxaan ku siin karnaa bug-yarahaan oo ku qoran luqado iyo habab kale sida farta indhoolaha  Braille iyo daabacad far waa-wayn markii aad soo codsato. Fadlan la soo xiriir qaybta Ka-qaybgalka iyo Dhex-gelidda, lambarka telefoonka waa  0116 295 1486.

***Polish***
Jeżeli chcieliby Państwo otrzymać kopię niniejszej ulotki w tłumaczeniu na język obcy lub w innym formacie, np. w alfabecie Braille'a lub w powiększonym druku, prosimy skontaktować się telefonicznie z zespołem ds. zaangażowania (Engagement and Involvement) pod numerem telefonu 0116 295 1486.

*Cantonese*

如有要求，我們可以將本宣傳手册用其他語言或格式顯示，如盲文或大號字體。 請致電我們的"參與部門" (Engagement and Involvement Department)0116 295 1486.

***Gujarati***
અમે આ ચોપાનિયાનું ભાષાંતરો બીજી ભાષાઓમાં અને શૈલીઓમાં જેમ કે બ્રેઇમાં અને વિનંતી કરવાથી મોટા અક્ષરોમાં છાપેલા પૂરાં પાડી શકીએ છીએ. ઇંગેજમન્ટ અને ઇન્વોલ્વમન્ટ વિભાગનો ટૅલિફોન 0116 295 1486 દ્વારા સંપર્ક કરો.

***Hindi***
हम आपको यह परचा दूसरी भाषाएँ में और ब्रेल एवं बडे अक्षरो जैसी रूपरेखा में निवेदन करने पर प्राप्य कर सकते है। कृपया कर के इनगेज्मन्ट और इन्वाल्वमन्ट विभाग में टॅलिफॉन द्वारा 0116 295 1486 पर संपर्क कीजिए।

***Urdu***
ہم درخواست کرنے پرلیفلیٹ کے اس ترجمے کو دیگر زبانوں اورصورتوں مثال کے طورپربریل اور بڑے حروف میں بھی فراہم کرسکتے ہیں۔ براہ کرم اس ٹیلی فون نمبر14862950116 پر اینگیجمنٹ اینڈ اینوالومنٹ ڈیپارٹمنٹ کے ساتھہ رابطہ قائم کریں۔

***Arabic***
يمكننا تقديم نسخ من هذه النشرة بلغات أخرى وصيغ مثل برايل والطباعة الكبيرة في الطلب. يرجى الاتصال انخراط وإشراك وزارة، والهاتف 1486 295 0116

**LEICESTER CITY HEALTH AND WELLBEING BOARD**
October 2014

| | |
|---|---|
| **Subject:** | Submission of the Leicester City Better Care Fund |
| **Presented to the Health and Wellbeing Board by:** | Dr Simon Freeman, Managing Director, Leicester City Clinical Commissioning Group<br><br>Deb Watson, Strategic Director, Adult Social Care and Health, Leicester City Council |
| **Author:** | Rachna Vyas, Head of Strategy and Planning, Leicester City Clinical Commissioning Group |

**EXECUTIVE SUMMARY:**

This paper outlines the process followed to achieve the national deadline for the resubmission of the Better Care Fund of September 19th 2014. The paper outlines the key sections of guidance which have impacted the resubmission and the actions taken locally to address these. Finally, the paper outlines the assurance process which is currently being undertaken.

The pack attached to this paper includes the totality of the Leicester City Better Care Fund Plan, as submitted to NHS England and the Local Government Association on September 19th 2014. Delegated authority to approve the submission was given by the Health and Wellbeing Board at its meeting on 3 April 2014 to Councillor Palmer, Chair of the Board, Dr Simon Freeman, Managing Director Leicester City Clinical Commissioning Group, and Andy Keeling, Chief Operating Officer, Leicester City Council. (Minute 63 refers)

**RECOMMENDATIONS:**

The Health and Wellbeing Board is requested to:

Note the Leicester City Better Care Fund submission

## Submission of the Leicester City Better Care Fund

### Introduction

1. This paper outlines the process followed to achieve the national deadline for the resubmission of the Better Care Fund of September 19th 2014. The paper outlines the key sections of guidance which have impacted the resubmission and the actions taken locally to address these. Finally, the paper outlines the assurance process which is currently being undertaken.

2. The pack attached to this paper includes the totality of the Leicester City Better Care Fund Plan, as submitted to NHS England and the Local Government Association on September 19th 2014.

### Guidance for the resubmission

3. A significant amount of guidance was released through July and August 2014 detailing the requirements for the resubmission; this has substantially increased the depth and length of the Leicester City BCF. However, it is important to note that the content of the Leicester City BCF remains the same, with no material change to the schemes planned or metrics previously submitted. However, the introduction of the payment for performance element for the 'reducing emergency admissions' metric has resulted in the creation of a contingency fund and the key points regarding this are outlined below.

<u>Refreshing BCF Metrics and Implementing Pay for Performance</u>

4. There is now a pay for performance requirement on the fund linked to achieving a reduction in *total emergency admissions*.

5. Each Health and Wellbeing Board must approve the local threshold for the reduction in total emergency admissions. However there is an expectation that this will need to equate to a 3.5% reduction in 2015/16.

6. The metric is defined as follows: general and acute non elective admissions (*this excludes some categories of admissions, specifically those relating to maternity and mental health acute admissions).* For Leicester City, this equates to a minimum reduction of 1013 admissions, with a total of £1,509,370 at risk.

7. The first period against which performance against the emergency admissions metric will be measured is Q4 2014/15. Payment will be made in May 2015 and will be issued by CCGs. It will be based on the level for performance, so if only 70% of the target has been achieved, only 70% of the payment will be made. Payments will then be made quarterly in arrears on the same basis. Any monies not paid into the fund due to lack of performance will be held by the CCG and spent by agreement with the Health and Wellbeing Board. It is intended that the monies will offset activity incurred in the acute sector as a result of failing to avoid sufficient admissions.

8. To mitigate against this risk, a joint meeting of the Local Authority and the CCG was held in August, with an agreement that a contingency fund of £1.509m would be created from uncommitted funds for 15/16.

9. Of the £1bn to be allocated to BCF plans nationally in 2015/16, £300m will be allocated against the pay for performance requirement for reducing emergency admissions. The remaining £700m must be shown to be invested on care outside of hospital, which must be commissioned from NHS providers.

10. The other national metrics which were introduced with the BCF plans in April will still apply to the BCF resubmissions.

Improving BCF Scheme Benefits and Confirming Provider Support

11. Template Part 1 of the BCF resubmission (the narrative BCF plan) includes two new appendices:

    a. The first of these is designed to provide a clearer articulation of each individual scheme within the BCF, showing more detail on the evidence base, activity/financial assumptions, how benefits are to be apportioned across the system and the overall outcomes linked to the vision for health and care integration. This is provided as part of this pack as Annex 1.

    b. The other is for local acute providers to complete, to provide written assurance to the BCF plan, and in particular their agreement to the activity assumptions with respect to emergency admissions reduction. This was agreed by the UHL Executive Team on September 9th 2014 and provided as Annex 2 of this pack.

12. The technical guidance for Template Part 1 includes an extensive checklist against which each plan should be constructed, with a definition of “what makes a good response” in each section of the template. Further toolkits on population segmentation, evidence based planning, outcomes mapping and finance were released in August 2014, and used to supplement both the narrative plan and the appendices which form part of this pack.

13. The guidance also highlights where various sections have been updated/added in Template Part 1. These include:-

- A more structured section on implications of the Care Act and 7 day services, reflecting the national developments in these areas since the last BCF submission was made
- A stronger set of tests on governance of the delivery of the BCF/integration
- Greater visibility of the alignment to the 5 year planning arrangements
- Greater emphasis on how the acute activity shifts will be delivered and managed locally.

14. Template Part 2 (metrics projections and financial analysis) has also been extensively updated per the payment for performance scheme etc., and includes a much more detailed breakdown of benefits analysis by BCF scheme to tie in with the changes in the narrative plan.

15. Due to the requirement to spend a proportion of the fund on local NHS provided care outside of hospital, a detailed breakdown is also required by provider by scheme showing the exact proportion of activity being applied to each scheme and benefits impact by provider.

16. An outline timetable has been given for the assurance of BCF plans. There were 3 regional check points prior to 19th September, with support from within local government and the NHS to ensure local areas are on track with resubmission requirements.

**BCF submission**

17. National BCF support was made available and the Leicester City BCF team has taken advantage of this, both through attendance at 121 clinics regionally as well as a critical friend review of the model and accompanying narrative through an external consultancy.

18. The final draft of the Leicester City BCF was approved by Simon Freeman, Andy Keeling and Rory Palmer on behalf of the Leicester City HWB on Wednesday 17th September, prior to formal submission on Friday 19th September 2014.

**BCF Assurance Process**

19. The assurance process is being led by North East London Commissioning Support Unit. On 20th August details of this process were published showing the methodology and criteria for assessing BCF plans, aiming to give a consistent process across the country. See BCF web pages *NHS England* and *LGA* for the detail.

20. This is an intensive process involving a technical desk top review, triangulation of other evidence about the wider context of the financial

and delivery challenges facing local health and care economies, plus it involves a telephone interview with representatives from each BCF plan/HWB Board area.

21. The outcome of the review will be that all BCF plans fall into one of four categories below, which have specific definitions:
    - *Approved*
    - *Approved with support*
    - *Approved with conditions*
    - *Not approved*

22. The assessment for categorisation will be determined by:

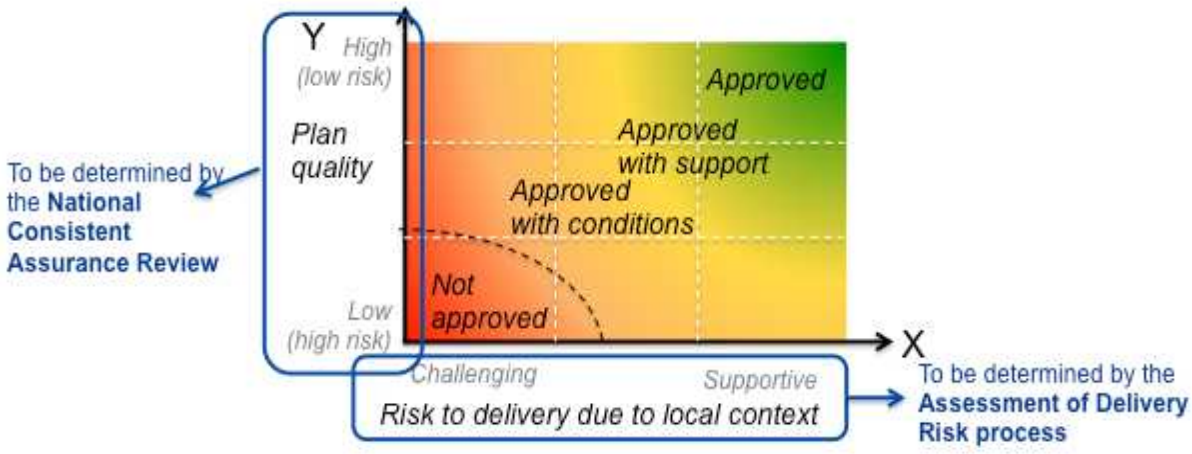
a. The National Consistent Assurance Review of the quality of the plans

The Leicester City NCAR review took place on September 25th 2014. No major issues with the Leicester City BCF were highlighted, with team complimenting the overall quality of the plan. Minor changes were requested and these are being worked through.

b. The assurance checkpoints' assessment of the risk to delivery due to the local context facing each local health economy

As Leicester, Leicestershire and Rutland has been nationally rated as a 'challenged health economy', the risk rating for the Leicester City BCF is automatically 'High Risk'.

23. The diagram showing the two axis for assurance is given below:




24. The formal rating of the Leicester City BCF is expected in mid-October 2014, following ministerial review.

**RECOMMENDATIONS:**

The Health and Wellbeing Board is requested to:

APPROVE the Leicester City Better Care Fund submission

Updated July 2014

# Better Care Fund planning template – Part 1

Please note, there are two parts to the Better Care Fund (BCF) planning template. Both parts must be completed as part of your Better Care Fund submission. Part 2 is in Excel and contains metrics and finance.

Both parts of the plans are to be submitted by 12 noon on 19th September 2014. Please send as attachments to bettercarefund@dh.gsi.gov.uk as well as to the relevant NHS England Area Team and Local government representative.

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: | **Leicester City Council** |
| Clinical Commissioning Groups: | **Leicester City Clinical Commissioning Group** |
| Boundary Differences: | **None** |
| Date agreed at Health and Wellbeing Board: | **Sign off under delegated authority on behalf of HWB: 18th September 2014**<br><br>**Full Board will sit on 9th October 2014** |
| Date submitted: | **19th September 2014** |
| Minimum required value of BCF pooled budget:<br>2014/15<br>2015/16 | <br>**£14,769,453**<br>**£23,261,000** |
| Total agreed value of pooled budget:<br>2014/15<br>2015/16 | <br>**£14,769,453**<br>**£23,261,000** |

**b) Authorisation and signoff**

| | |
|---|---|
| **Signed on behalf of NHS Leicester City CCG**  | |
| **By** | Dr Simon Freeman |
| **Position** | Managing Director |
| **Date** | September 17th 2014 |
| **Signed on behalf of Leicester City Council**  | |
| **By** | Andy Keeling |
| **Position** | Chief Operating Officer |
| **Date** | September 17th 2014 |
| **Signed on behalf of the Leicester City Health and Wellbeing Board**  | |
| **By Chair of Health and Wellbeing Board** | Cllr Rory Palmer |
| **Position** | Deputy City Mayor and Chair of Leicester City Health & Wellbeing Board |
| **Date** | September 17th 2014 |

**c) 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 | Web link or Appendix reference |
|---|---|
| Better Care Together: LLR five year vision/strategy - June 2014 | http://www.bettercareleicester.nhs.uk/information-library/better-care-together-plan-2014/ |
| Leicester City Joint Strategic Needs Assessment (JSNA) | http://www.leicester.gov.uk/your-council-services/social-care-health/jsna/jsna-reports/ |
| Joint Health & Wellbeing Strategy (JHWS) | http://www.leicester.gov.uk/your-council-services/health-and-wellbeing/health-and-wellbeing-board/joint-health-and-wellbeing-strategy/ |
| Director of Public Health Annual | http://www.leicester.gov.uk/your-council- |

| | |
|---|---|
| Report | services/health-and-wellbeing/reports/ |
| Leicester City CCG Operational Plan 2014-2016 | http://www.leicestercityccg.nhs.uk/about-us/strategies-and-reports/ |
| Leicester City Council Care Act Implementation Plan |  Care Act Programme 29 August 2014.pdf |
| **Programme specific documents** | |
| Detailed scheme descriptions | Annex 1 |
| Provider commentary | Annex 2 |
| Leicester City: contextual analysis | Appendix 1 |
| Leicester City: financial analysis | Appendix 2 |
| Leicester City: Metrics model | Appendix 2a |
| BCF evidence base | Appendix 3 |
| Leicester City Integrated Care Mobilisation Plan | Appendix 4 |
| Leicester City Joint Integrated Commissioning Board terms of reference 14/15 | Appendix 5 |
| BCF Implementation Group terms of reference 14/15 | Appendix 6 |
| Leicester City Integrated Care performance dashboard – Sept 2014 | Appendix 7 |
| Leicester City Integrated Care risk register – Sept 2014 | Appendix 8 |
| Leicester City Integrated Care: risk stratification guide | Appendix 9 |

## 2) VISION FOR HEALTH AND CARE SERVICES

**a) Drawing on your JSNA, JHWS and patient and service user feedback, please describe the vision for health and social care services for this community for 2019/20**

**Our core vision for Leicester City**

Our core vision for this programme, as set out in Leicester's Health and Wellbeing Strategy, '*Closing the Gap'*, remains the same:

*Work together with communities to improve health and reduce inequalities, enabling children, adults and families to enjoy a healthy, safe and fulfilling life*

Our vision for a healthier population goes much further than just ensuring people get the right care from individual services. We want to create a holistic service delivery mechanism so that every Leicester citizen benefits from a positive experience and better quality of care. We will do this through focussing on three priority areas, delivering one integrated model of care:

**Priority 1:** Prevention, early detection and improvement of health-related quality of life

We will achieve this by:

- Increasing the number of people identified as 'at risk' and ensuring they are better able to manage their conditions, including out of hours, thereby reducing demand on statutory social care and health services. This will include both physical and mental health.
- Delivering 'great' experience and improving the quality of life of patients with long term conditions by expanding our use of available technology, patient education programmes and GP-led care planning, reducing avoidable hospital stays.

**Priority 2:** Reducing the time spent in hospital avoidably

We will achieve this by:

- Reducing the number of avoidable hospital admissions through the provision of rapid community responses, instead of a 999 response.
- Ensuring every person in the cohort experiences coordinated unplanned and planned care from an integrated team, ranging from health and social care to housing and financial services, which responds in a coordinated way to ensure care is delivered in the community and around the individual.
- Enabling the use of the NHS number as a primary identifier for all patients, linked to high-quality care plans for our frail elderly patients or those with complex health needs.
- Coordinating the flow across our integrated model of care, to ensure that time spent in hospital is minimised.
- Increasing community capacity to look after people in their own homes rather than in a hospital bed.

**Priority 3:** Enabling independence following hospital care

We will achieve this by:

- Ensuring timely hospital discharge via the provision of in-reach (pull) teams to swiftly repatriate people to community-based services and maintain independence across physical and mental health services.
- Increasing the number of patients able to live independently following a hospital stay.
- Mobilising community-based capacity specifically targeted at mental health service capacity.

At the core of our vision remains a thorough understanding of our population and the health inequalities faced and what we need to do to achieve better outcomes in the short and medium term. A full contextual breakdown of these issues is provided in Appendix 1.

**Our vision for 2018/19**

Building on our last JSNA in 2012, health and social care organisations across Leicester City (including acute and community providers), embarked upon a transformative approach to integrated care. This was in recognition that our acute-centric model of care required fundamental redesign and on the bases of what our patients and the public had been telling us about their experience of current services.

During 2013/14, a series of pilots were launched based on the vision above, including models of care coordination, integrated crisis response services and enhanced care planning, all designed to reduce the time spent avoidably in hospital through provision of community services. We have used these pilots as the key building blocks upon which our BCF is constructed and we will use the BCF to accelerate our progression towards our end vision, delivered over the next five years:

**As at 2012/13:**

Fragmented pathways across health and social care, not mapped to general practice

Unsustainable demand on all services, creating a significant financial gap by 2018/19

Significant variation in outcomes from care as a result of health inequalities

Sub-optimal provider performance as a result of demand on services and processes between sectors

Insufficiant workforce, both in terms of capacity and capability to deliver new models of care

Sub-optimal use of assets & resources across LLR

**By the end of 2015/16:**

Preventative services co-located into one **Lifestyle Hub**, with a single referal process

**Joint health and social care teams**, with streamlined referal pathways, matched to GP localities, providing a two hour response in crisis

Increased p**lanned care** community capacity, including in g**eneral practice capacity** to provide care in the community, focussing on acute demand reduction

**Co-located access teams**, making the best use of assets across the health and social care system, with **joined up IT systems**

**By the end of 2018/19:**

Preventative models of care embedded into every pathway of care, with a city-wide **Lifestyle Hub**

A new **model of primary care** launched across the city, ensuring timely access, care planning and management, with **one simple integrated pathway into community support**

**Neighbourhood health and social care teams** with single referral pathways & assessment processes, working in specific GP localities, **with one IT system**

A new model of integrated care, fully utilising **joint teams across neighbourhood areas** to deliver seamless care

Although organisations across the city had been moving towards a more integrated model of care, a transformation of this scale and ambition would not have been possible without the advent of the Better Care Fund process. The level of integration suggested over the first two years of this five year vision would perhaps have not been delivered at

the scale and pace proposed in this plan. Certainly, the level of system-wide focus and engagement required to construct our plan has only accelerated both our ambition and motivation to make our system better for those it services.

**Delivery of the Leicester City vision for integrated care**

***Aims of our system***

Based on our vision and the context in which we are working, the Leicester City Better Care Fund aims to:

- Design and commission services centred on our patients, public and carers, with our patients, public and carers
- Empower our population to be both better informed and better manage their own health and wellbeing using a range of traditional and digital media and technology
- Develop a new model of primary care that provides a more proactive, holistic and responsive community service across physical and mental health, increasing capacity where required
- Provide a modern model of integrated care with a senior clinician taking responsibility for coordination of care
- Reduce the amount of time spent in hospital avoidably by our citizens, by focussing on health and social care pathways and services such as housing
- Ensure that people are kept independent for as long as possible following hospital care

Delivery of these aims will be through our model for integrated care, which is based on a menu of services for different scenarios in a patient's life, supporting prevention through to end-of-life care. In enacting our BCF plans we will maintain our responsibilities for patient safety and quality.

***Target population***

Since 2012 Leicester City CCG has supported practices in using the Adjusted Clinical Groups (ACG) risk predictive software (licenced from Johns Hopkins University in the USA) to risk stratify their registered population and identify those at highest risk of admission to hospital in the next year. We have invested in this to enable our practices

to proactively identify patients at high risk of admission and apply a Multi-Disciplinary Team approach to their care.

We have used ACG-derived risk stratification, along with other methods of grouping the population outlined in the BCF technical toolkit such as grouping by age and condition, to identify our target BCF cohort, i.e. those patients who are at most risk of deterioration or at risk of a significant care event. Through the provision of high quality, integrated health and social care services, our core aim is to reduce the probability of an emergency admission in this cohort.

Our analysis has concluded that the highest 20% at-risk patients account for over 60% of the total cost of emergency admissions for the CCG. Our analysis has also shown us that those patients, regardless of age, who have three or more co-morbidities, have more Non-elective (NEL) spells at a far greater cost than the rest of the population.


Figure 1: Population segmentation by age, multi-morbidity (May 2014)

Combining these sources of intelligence, leads us to a target the following segments of the population:

- those aged 60 and over;
- those who are 18-59 with three or more health conditions (from a locally defined list of conditions that should be treated out of hospital);
- those with dementia.

This gives us a target BCF cohort of approximately 93,605 patients; this is small enough to be manageable by the BCF interventions but a sufficient number through which large scale change can be evidenced.

Further detailed analysis for this cohort is outlined in Section 3 of this plan.

**The Leicester City integrated care model**

Our priority areas for the Better Care Fund have been chosen primarily to ensure pathways of care are changed across our whole system for the benefit of our target BCF population, effectively responding to the public health needs identified throughout this plan and the broader demographic and socio-economic context across the city.

To deliver this change we have been focussing on the three priority areas outlined below since 2013/14. We are using the BCF to either accelerate specific, evidence-based interventions which have been piloted in 2013/14 or implement new interventions based on our learning.


What each of these will deliver and how they will impact on patient outcomes is detailed below.

| Priority 1: Prevention, early detection & improvement of health related quality of life | | | | |
|---|---|---|---|---|
| **Public health need** | **Intervention** | **Impact on system** | | **Impact on patients** |
| | | **Two Year** | **Five Year** | |
| **P**oor health outcomes are associated with social and biological determinants, such as age, sex, deprivation, income and environment.<br><br>We know that:<br><br>41% of the population live in areas classified as the fifth most deprived<br><br>50% of the population is from a BME background, with large segments of the population at greater risk of specific diseases such as CVD.<br><br>Premature deaths are mainly as a result of CVD, cancer or respiratory disease<br><br>Life expectancy is significantly lower than England average<br><br>Only 12% of the population is 65 years+ | **Risk stratification**<br><br>Implementation of the Adjusted Clinical Group RS tool, allowing GPs and health and social care commissioners to stratify their population in terms of probability of emergency admission | Ability to identify patients at varying levels of predicted risk in order to ensure a more personalised approach to prevention and early intervention and LTC management | Use of system to:<br>1. Allocate resource according to case mix of population<br>2. Population segmentation and profiling to better understand opportunities for further population health improvement<br>3. Transparent and open performance management of a range of providers, reducing health inequalities and increasing value for money | 63 year old male patient with diagnoses of type 2 diabetes, elevated serum cholesterol/marginally raised blood pressure / stable angina and recent admission to emergency department for management of diabetic ketoacidosis. ACG prediction of risk of unplanned admission of 32.7%, and relative risk of 9.37 (= likely to use 9.37 times the CCG average amount of health care resources) 7 OPD appointments and 1 emergency admission in the last 12 months. Identified by the ACG system as part of the GP's top 2.1-10% highest risk cohort.<br>Letter sent to patient explaining he had been identified for extra support – including having a GP appointment to discuss health needs and plan care. Following GP appointment the patient:<br>• Has had a pneumococcal vaccine and been booked for his seasonal flu vaccine<br>• Has agreed to attend the local DESMOND course (type 2 diabetes education)<br>• Has been prescribed medication to address erectile dysfunction associated with his diabetes<br>• Has a written care plan focusing on weight management and a structured approach to monitoring blood sugars and a tiered self-management response to abnormal glucose readings – both in and out of hours<br>Following referral to the Life style Hub the patient enrolled in the Fit and Active Families programme with the aim of losing a stone in 3 months under the supervision of a health trainer. Now plays "Walking Football" twice a week and has been on a guided supermarket visit |
| | **Lifestyle Hub**<br><br>A telephone-based referral hub will manage the referral of adults to relevant lifestyle services, such as smoking cessation, nutrition classes, exercise referral etc | GPs city-wide will be able to refer into the service, with additional classes made available as demand increases | One streamlined lifestyle centre servicing the city, with GPs, health professionals and citizens able to access the lifestyle hub, with prevention embedded into all services. | |
| | **GP care planning**<br><br>Using risk stratification, identification and systematic care planning for the 2.1-10% highest risk patients. Patients will get a 30 min consultation with practices for care planning purposes, covering lifestyle, health needs and the support needed from health and social care to prevent episodes of crisis potentially leading to acute activity | 16, 921 care plans completed for high risk patients, with identified health and social care support to keep patients safely in their own homes and reduce the reliance on acute services | Continuous care planning cycle across the city population, ensuring that patients have access to high quality community services, preventing acute activity and improving patient experience of care | |

## The target population for this priority

This priority area targets those in the 2.1-10% and 10%+ populations as these are the segments which are most amenable to intervention.

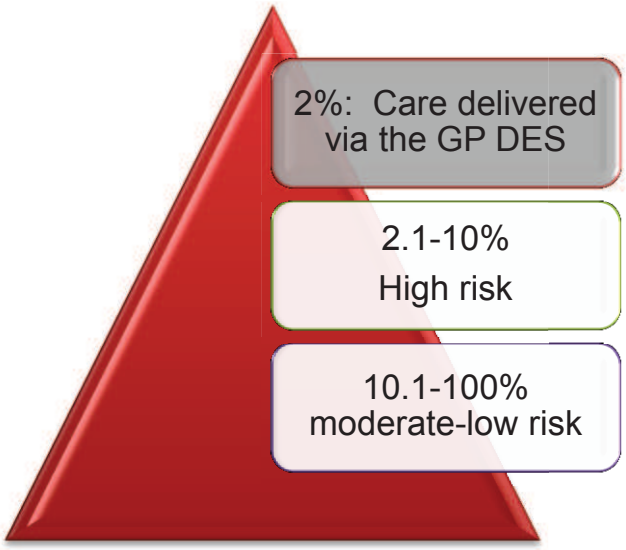



Figure 2: The target population for the Leicester City BCF Priority 1

People who can manage their condition alone need effective and timely professional support in order to prevent progression to more severe stages of the disease and to remain independent for as long as possible. This group also needs effective lifestyle intervention to reduce their risk of other LTCs.

Less than a third of patients with LTCs will require more involvement of healthcare services in managing their disease. This care may be given by increasingly specialist multidisciplinary teams providing high-quality, evidence-based care.

## The interventions targeted to this priority area

**Intervention 1: Risk stratification**

As detailed throughout this plan, the risk stratification tool has enabled commissioning of targeted health and social care and is a vital resource for the future. Using the BCF investment, we plan to accelerate the use and function of our ACG model (licenced from Johns Hopkins) to enable functionality in the following areas:

- research
- public health
- case management
- resource allocation
- performance management.

The LLR Information Management and Technology programme board, which is part of the governance system for the LLR five year plan, is taking the lead with respect to the developments needed locally to improve the data sharing, information management and

technological platform for the local health and care system. The status of the current information sharing agreements has already been identified as a key issue to resolve.

An action plan is being developed to address this and will be designed to enable the approach recommended in the BCF guidance to become a routine part of system-wide analysis for the health and care economy in the medium term.

**Practice-level use of this data**

We are working with Greater East Midlands Clinical Support Unit and practices to complete this work and currently all 62 practices across Leicester City are actively using the risk stratification tool to manage three key population segments of interest:

1. the 2% highest risk patients in the city;
2. the segment of the population comprising the 2.1-10% highest risk patients in the population;
3. a frail and multi-morbid segment older segment of the population at high risk of adverse effects of polypharmacy.

For the BCF cohort we have set individual practice targets based on key evidence-based interventions for long term conditions and on ensuring that patients are given ready access to the wide range of health and social care services and pathways which can support patients, carers and practices in dealing with the challenges of living with LTCs.

The interventions for these cohorts include:

- more eligible patients and carers having the seasonal flu and pneumococcal vaccines;
- all patients being offered a care plan which will be shared with other relevant providers using the special patient note system;
- frail over 75 patients being referred to Care Navigators for a proactive holistic assessment of health and care needs;
- more older people having cognitive function screening to increase the numbers with a confirmed diagnosis of dementia and therefore access to a whole suite of support and monitoring options;
- access to environmental assessments and medication reviews for patients who have had a previous fall (as per NICE guidelines);
- medicines reviews for patients on multiple medicines.

In addition; we have worked with our medicines management team to produce a guide for GPs on using the filters on the risk stratification system to identify a frail older population with multi morbidity for invitation to attend the practice for a GP consultation based on the STOPP/START tool – a medicines review tool for elderly patients. The aim here is to systematically reduce iatrogenic harm from polypharmacy. See Appendix 9 for a copy of the guide.

Guides have been produced for practices to identify and then manage their DES and BCF cohorts; these are attached to this submission as Appendix 9. The screen shot below illustrates the wealth of information derived from the risk stratification system (patient identities have been removed). The arrows seen towards the right of the screen indicate whether the patient's risk has been going up, down or staying the same compared to 6 months ago.

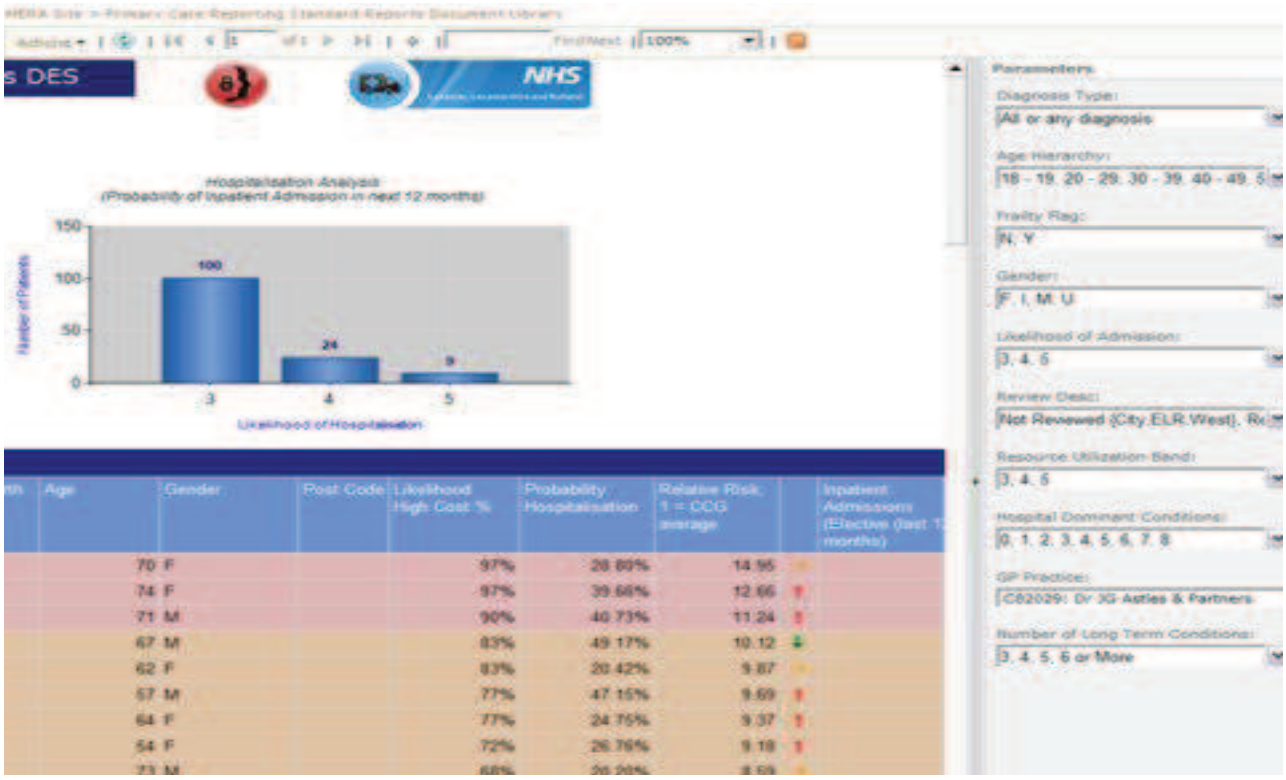


Figure 3: Example of Risk Stratified practice population

Once identified, each patient is reviewed at an MDT if they have highly complex health and social care issues – or by the GP or practice nurse if their medical issues are more focused on a single dominant LTC. Many patients are also referred on to adult social care (ASC) and or community health services for further assessment. This results in patients accessing a variety of interventions across health and social care, all coordinated through the patient's GP. The MDT guide in use across the city is attached as Appendix 9.

**System level use of this data**

The planned and unscheduled care teams, described later in this section, form a core part of the Leicester City Integrated Care pathway. To ensure all teams from general practice through to community teams and indeed clinicians in ED have appropriate access to relevant patient care plans etc, we have strived for a single system to be used across the city using the BCF as an accelerator. 97% of the city general practices use SystmOne as do all community teams. SystmOne Viewer has been installed in both ED and on EMAS hardware, to ensure that the patient's care plan is followed where appropriate.

In September 2014, 'Status Alerts' within SystmOne were introduced for those patients on the Admission Avoidance and Better Care Fund registers. The aim of these is to help identify patients at risk of emergency admission etc. so that the appropriate actions can be taken and they alert the user to any outstanding actions (e.g. patient does not yet have care plan in place). The relevant template can be accessed by clicking on the icon and the personalised care plan can thus be easily accessed and completed.

There is also now a Status Alert to identify those patients marked as at risk of dementia or who are in the Dementia DES at risk group but who have not been offered or have declined either initial dementia questioning or a dementia assessment. Patients with this icon should be offered initial dementia questioning and those patients with a memory concern should be offered an assessment for dementia. The LCCCG dementia template can also be accessed by clicking on the icon in the SystmOne demographic box.

These alerts will not only aid practices to identify at-risk patients but will enable the Leicester City Planned and Unscheduled teams to access care plans ahead of winter to enable them to support the integrated health care team to keep people out of hospital when it is safe to do so.

**What will this mean for our citizens?**

| Health &/or wellbeing need: | Impact of this intervention on patient outcomes: |
|---|---|
| Reduction in health inequalities<br><br>Reduction in barriers to access | The system will allow a change in the way in which we commission health and social care.<br><br>Once we are able to segment the population, this will allow us to better understand opportunities for further population health improvement and could potentially enable allocation of resource according to case mix of population<br><br>This will also allow transparent and open performance management of a range of providers, reducing health inequalities and increasing value for money |

**Intervention 2: The Lifestyle Hub**

The Lifestyle Referral Hub is an integrated approach to supporting people to attain and maintain good health, based on a model of best practice in Nottingham City.

The Lifestyle Hub will:

- Provide a simple, effective and reliable “one stop” referral service for GPs and other health care professionals;
- Look beyond single issues and undertake a holistic assessment of clients’ needs, state of readiness to change, and identify any barriers to change that may need addressing before the client can engage with services e.g. debt, housing problems;
- Support clients to access appropriate lifestyle services such as Food & Activity Buddies, DHAL, Active Lifestyle, walking groups, cycle training, Heart Smart group and smoking cessation, and build emotional resilience and self-confidence;

- Motivate clients to make and sustain behavioural changes to reduce their risk factors;
- Work with individual GP practices to maximise appropriate referrals;
- Monitor the progress of clients and ensure appropriate feedback is provided to GPs.

A telephone based referral hub will manage the referral of adults to relevant lifestyle services. Individuals in need of support to address lifestyle risk factors (e.g. smoking, poor diet, inactivity, obesity etc) will be referred to the Lifestyle Hub by GPs and other health professionals in primary care. In the longer term it is proposed to expand the hub to allow clients to self-refer.

The provider will initially contact the referred client by phone. Trained staff will then introduce the service, assess the needs of the client (including lifestyle risk factors and willingness to change), provide client-centred motivational support, identify lifestyle services appropriate to the client's needs and preferences and obtain and document the consent of the client to transfer details to other service providers. Clients will then be followed up after 4-6 weeks to assess whether further support is required. Clients will also be followed up 6 months after the final contact to assess progress and maintenance of behaviour change, provide additional motivational support as required and refer to other relevant services as appropriate. Clients may also be signposted to unstructured activities such as volunteering opportunities, parks and active transport initiatives depending on their needs.

If it is apparent during the initial contact that the client requires additional support and is eligible for the full health trainer service (i.e. lives in an area of high deprivation), one to one support with a health trainer will be offered. This gives clients the opportunity to work with a health trainer for a maximum of 12 months to develop a Personal Health Plan (PHP) and work towards achieving sustainable behaviour change.

The Lifestyle Hub has been approved by the Health and Wellbeing Board, as well as the CCG Governing Body as an integral part of the prevention offer across the City, with the aim of offering this service to only targeted areas of the population. With the introduction of the BCF, this is being accelerated to all parts of the City by 2015/16.

**What will this mean for our citizens?**

| Health &/or wellbeing need: | Impact of this intervention on patient outcomes: |
|---|---|
| Reduction in health inequalities | Lifestyle risk factors are socially patterned and more prevalent in deprived communities. Addressing lifestyle risk factors will benefit deprived communities proportionately more.<br><br>80% of health trainers to be recruited from the most economically deprived areas in Leicester |
| Reduction in barriers to access | 50% of new client registrations will be from BME communities |

| | |
|---|---|
| | 50% of new client registrations will be men (men are currently under represented in clients accessing health improvement service) |
| Achievement of Personal Health Plans:<br>• % weight loss for clients with weight loss as a goal<br>• Increased fruit and vegetable consumption for clients with diet improvement as a goal. Increased sessions of moderate/vigorous intensity activity for clients with physical activity as a goal<br>• Proportion of clients achieving four week quit where smoking cessation is a goal<br>• Proportion of clients not exceeding guidelines for safe drinking levels | 60% of users will reach partial achievement, 45% full achievement |
| | Clients will aim to lose an average of at least 3% total body weight |
| | Clients will aim to intake an average of at least 1.5 portions/day |
| | Clients will access at least 2 sessions/week |
| | 50% of clients will quit smoking |
| | 70% of clients will reduce their alcohol intake to safe levels |

Figure 4: Key impact measures of this intervention

**Intervention 3: GP practice support**

To support the BCF identified cohort , practices across the city will aim to address their top 0 – 2% high risk patients via the Unplanned Admission DES, allowing them to maximise the BCF funding on the 2.1 -10% high risk population.

This proposal will ensure the identification of patients who are in need of better care and provide experienced clinical time to:

- Undertake routine assessments of patients with long term conditions in their home. This helps people with such conditions to better manage their own health and avoid unnecessary visits to hospital;
- Increase population-based interventions e.g. access to vaccinations, reducing social isolation, increasing access to third-sector and Local Authority services;
- Improve, for selected high-risk individuals, chronic disease management, medicines related safety and concordance;
- Improve self-care and self-management skills; reiterating local 'Choose Better' campaign messages where appropriate
- Promote use of personal health budgets;
- Provide both proactive and reactive care;

- Assess carers' health needs; enhancing the resilience of the carer population;

- Prescribe and administer medications within the remit of local Patient Group Directive (PGD), where appropriate, and undertake medication reviews across the cohort;

- Take a holistic approach to patient care, bringing together their medical, social and psychological needs – both for patients and carer;

- Refer patients to alternative health and/or social services through appropriate signposting and guidelines, linking with the wider BCF services and supporting patients in their own homes;

- Ensure high quality, detailed care plans are in place and up to date/reviewed.

7 of 11 published reviews which were analysed found a positive impact of assessing care plans, (McKinsey, 2013). Other studies showcased in the North West London Toolkit (2014) have shown a reduction in hospitalisations by ~23%. By concentrating the work on this cohort of patients, each locality will be maximising the impact on the workload in avoiding unnecessary emergency admissions whilst providing patients with appropriate support and advice to minimise ill health.

**What will this mean for our citizens?**

| Health &/or wellbeing need: | Impact of this intervention on patient outcomes: |
|---|---|
| Reduction in health inequalities | Increase in number of seasonal flu/pneumococcal vaccinations undertaken<br><br>Increase in recording of Residential Institute (RI) codes on patient records<br><br>Increase in the number of people on the dementia registers<br><br>Increase in the number of MURs undertaken (Medicine Usage Reviews) |
| Reduction in barriers to access<br><br>Reduction in premature mortality | Evidence of increased referrals to the following self-care services:<br>• DESMOND/DAFNE for diabetic patients<br>• Pulmonary rehabilitation<br>• Heart Failure Nurse Specialist<br>• SPRINT for COPD patients<br>• STOP for smokers |

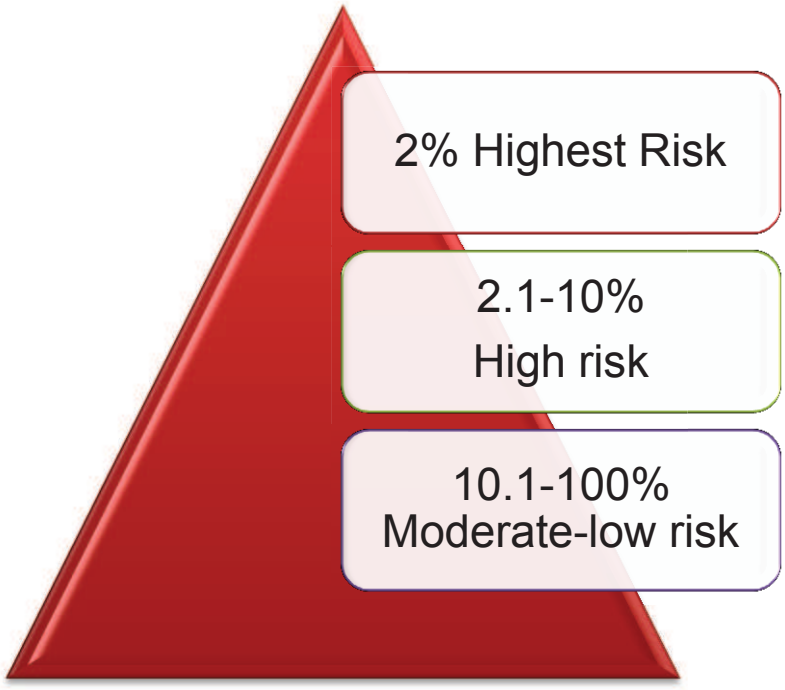
| | |
|---|---|
| | • Lifestyle hub<br><br>Additional hours/appointments for planned services<br><br>Additional hours/appointments |
| Support independence for people with LTC/older people/people with dementia | Increased number of care plans in place for the 2.1-10% high risk cohort<br><br>Care Navigator for 75+ patients<br><br>Less reliance on acute activity, evidenced by:<br><br>• QIPP reductions in activity at UHL, both in expenditure and activity; across outpatients; A&E and emergency admissions<br>• A&E reductions in activity at UHL, both in expenditure and activity;<br>• Reductions in emergency admissions from care homes. |

Figure 5: Key impact measures of this intervention

| Priority 2: Reducing the time spent in hospital avoidably | | | | |
|---|---|---|---|---|
| **Public health need** | Intervention | Impact on system | | Impact on patients |
| | | 2 Year | 5 Year | |
| We know that:<br><br>Leicester City patients over 60 yrs of age have a 69% chance of being admitted to a bed, regardless of why they attend ED<br><br>20% of admissions are unnecessary and should be treated in the community<br><br>The risk of a diabetes related admission is twice as high in the disadvantaged areas of the city<br><br>Leicester City historically is acute centric, with poor use of community services<br><br>1 in 5 999 conveyances could be avoided if care plans were shared | The Clinical Response Team<br><br>A GP-led team of clinicians who respond to non-life threatening 999 calls which do not need conveyance to hospital | Reduction in bed base | Reduction in bed base | 80 year old female presses her Leicester Care pendant alarm and tells the call handler that she is sitting on her sofa and cannot get up. Call handler calls 999 to request an ambulance. Call is categorised as G3 (non life-threatening) and is passed to the Clinical Assessment team at EMAS who alert the CRT GP.<br><br>CRT GP diagnoses a bladder infection and dehydration. GP phones Single Point of Access to mobilise Unscheduled Health and Social Care Team.<br><br>Nurse and care management officer arrive within 40 minutes. Three times daily calls commenced for personal care, assistance with eating and drinking, administration of antibiotics, monitoring of vital signs.<br><br>Further assessment of home reveals need for grab rail in bathroom and stair case, chair riser, threshold levelling and half step from kitchen to garden.<br><br>Following discussion with system coordinator, patient admitted to Intensive Community Support Service as she requires overnight nursing monitoring and personal care at home.<br>Remains for two weeks with ICS.<br><br>Infection resolved after 8 days but patient very deconditioned from prolonged immobility and poor nutrition.<br><br>Enters 6 week programme of reablement with therapy goals of re-establishing independence with regard to dressing, washing and walking to post office/hairdresser.<br><br>Outside light installed in garden. Kitchen fitted with range of aids and appliances to improve safety and promote independence. On exit from reablement patient is fully independent. She attends a lunch club each Friday. |
| | The Unscheduled Care Team<br><br>A joint health and social care team, designed to keep patients safely at home and avoid an emergency admission. 2 hour response for up to 72 hours of care | Reduction in bed base | Reduction in bed base | |
| | The system coordinator<br><br>A post which will ensure flow across the system; breaking down barriers and cultural historical issues between and within organisations | Reduction in bed base | Reduction in bed base | |
| | Intensive Community Support Service<br><br>30 virtual beds to enable discharge home for patients who have had an acute episode of care | Reduction in bed base | Reduction in bed base | |
| | IT integration<br><br>New systems to enable joint record sharing and the use of the NHS number as the primary identifier across teams | Better communication between agencies will result in efficient services and better patient experience | One system, linked across every agency in LLR will lead to reduced numbers of patients accessing acute care | |

## The target population for this priority area

The BCF cohort in its entirety will be targeted by the interventions listed in this priority area.




## The interventions targeted to this priority area

**Intervention 4: The Clinical Response Team**

The Better Care Fund will be used to commission a range of services designed to treat suitable patients who are in crisis in the community, rather than at the acute site.

This intervention will involve the mobilisation of a virtual team of up to six local GPs/ECPs who will respond to 999 calls deemed clinically appropriate, seven days a week between 8am and 8pm. The teams will respond to a pre-agreed referral criteria, either as a first response for lower category calls or as a secondary response from paramedics on scene to provide appropriate safe and timely clinical treatment to maximise opportunities to avoid unnecessary ambulance dispatches, visits to A&E or short stay unplanned medical admissions when they could be looked after at home by a GP.

The clinicians will assess, treat and stabilise the patient and, if appropriate, prevent the requirement for conveyance to the ED at the acute site, preventing the ED attendance and preventing a potential admission into an acute bed. Referrals to community services will be utilised wherever possible to ensure an appropriate immediate intervention and a programme of ongoing care developed to try and prevent the need for unnecessary contact with emergency services in the future. In addition, it will help to educate the public around the range of community services available within the city.

**What will this mean for our citizens?**

| Health &/or wellbeing need: | Impact of this intervention on patient outcomes: |
|---|---|
| Reduction in health inequalities<br><br>Reduction in premature mortality | More people will be referred to their own GP practice for further care planning and assessment of needs |
| Support independence for people with LTC/older people/people with dementia | More people will be treated in their own homes, with no acute intervention<br><br>More people will be directly referred to the Unscheduled Care Team/Planned Care Teams<br><br>Less reliance on acute activity, evidenced by:<br>• QIPP reductions in activity at UHL, both in expenditure and activity; across outpatients; A&E and emergency admissions;<br>• A&E reductions in activity at UHL, both in expenditure and activity;<br>• Reductions in emergency admissions from care homes. |

Figure 6: Key impact measures of this intervention

**Intervention 5: The Unscheduled Care Team**

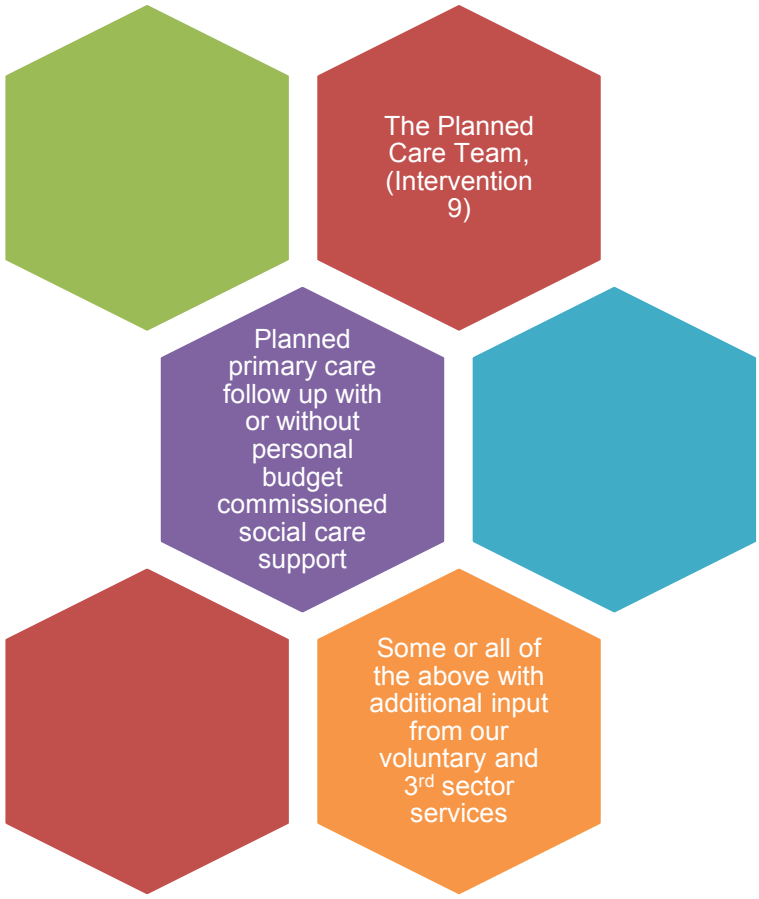
This intervention will bring together health and social teams piloted in 2013/14 into one integrated Unscheduled Care Team, which is aligned to a geographic area and set of GP practices. The team will provide a 2 hour response 24/7 through one Single Point of Access.

**The team will provide:**

- a Single Point of Access (SPA) for integrated unscheduled community health and social care;
- physical co-location of unscheduled health and social care staff to facilitate integrated response and to reduce duplication for the patient;
- a maximum response time of 2 hours 7 days a week across the 24 hour cycle;
- holistic assessment of patients' health (including mental health)and social care needs in their home setting followed by:

- rapid deployment of domiciliary care, nursing, therapy and equipment services with the aim of stabilising the patient and identifying ongoing care needs;
- an increase in evening and overnight staffing in health and social care teams (including at weekends) to ensure that there is prompt response and continuity of care for frail older people in crisis;
- a continuous cycle of reassessment and evaluation over the next 72 hours with close cooperation from the patient's primary care team.

Planned discharge from the Unscheduled Care Team will be into:




The discharge plan will address any outstanding interventions relating to environmental safety and safeguarding, health interventions such as missing vaccinations, medication-related issues and mental health or cognitive concerns with details of how these will be followed up.

The BCF investment in this element – the joint Health and Social Unscheduled Care Team - specifically accelerates the following elements of our model described below:

- uplift and development of the capacity of the Unscheduled Integrated Community Health Services Team and development of integrated pathway for joint response with rapid response social care team (ICRS);
- increase in the capacity in Overnight Nurse Service – to work side by side with ICRS;

- increase in the capacity of Adult Social Care Rapid Response team (ICRS) – for both day and overnight rotas to work jointly with unscheduled health care team;
- co-location of both Health and Social Care Unscheduled Care Teams to develop integrated working, joint visiting and sharing of intelligence and skill sets;
- increase in investment in Assistive Technology and Practical Help at Home teams. Minor home adaptations and equipment and Assistive Technology devices can be key facilitators of independence and safety at home for older people.

**What will this mean for our citizens?**

| Health &/or wellbeing need: | Impact of this intervention on patient outcomes: |
|---|---|
| Reduction in health inequalities<br><br>Reduction in premature mortality<br><br>Reduction in barriers to access | More people will be referred to their own GP practice for further care planning and assessment of needs |
| Support independence for people with LTC/older people/people with dementia | More people will be treated in their own homes, with no acute intervention<br><br>More people will be able to remain independently at home<br><br>Reduction in the numbers requiring permanent admission to residential care<br><br>More people will be directly referred to the Planned Care Teams and/or their GP practice<br><br>Less reliance on acute activity, evidenced by:<br>• QIPP reductions in activity at UHL, both in expenditure and activity; across outpatients; A&E and emergency admissions<br>• A&E reductions in activity at UHL, both in expenditure and activity<br>• reductions in emergency admissions from care homes<br>• reduction in emergency readmissions<br><br>Less people will require permanent admission to residential care<br><br>Less people will be delayed in a hospital bed due to a |

| | |
|---|---|
| | lack of community services |

Figure 7: Key impact measures of this intervention

**Intervention 6: The system coordinator**

As our enhanced community based services and pathways have developed over the last few years, a variety of both in-patient intermediate care type facilities and intensive domiciliary services have been commissioned. The challenge remains to ensure that the total available capacity in the community – in-patient and domiciliary, health and social care, NHS and independent sector – is used to optimum (not necessarily maximum) capacity throughout the year **and** throughout the 7 day cycle.

The role of the system coordinator is to act on behalf of the whole health and social care economy across the city – including our acute provider - to ensure that our entire community in-patient bed stock and our total resource for intensive and/ or urgent domiciliary support is being utilised in such a way as to:

- support flow through the system;
- take pressure off the acute sector by facilitating discharge and reducing inappropriate admission;
- ensure that patients are managed in the least intensive setting consistent with their meeting their treatment and therapy goals safely.

Skilled nurse leadership is fundamental to the achievement of integrated care and to the optimal functioning of the total health and social care community based resource. The system coordinator will achieve this through:

1. Bed and other resource management at whole system level outside of UHL – and close liaison with UHL bed manager on twice daily or more frequent basis;
2. Providing input into decision-making processes (for example challenging decisions to keep patients in hospital where there is a lack of knowledge about what can be offered in the community setting);
3. Clinical leadership;
4. Proactive communication with all partners. Providing patient care to ensure that resources are freed up in a timely manner and that where a chain of patient moves through several services is required to happen in order to ensure that each patient is treated in the right place at the right time; that such moves occur in a timely fashion.
5. Leading a twice daily conference call with UHL, LPT CHS and Adult Social Care to coordinate the discharge planning and movement between services from UHL into the community and between various community services.
6. Providing a series of ward based education opportunities over the course of the winter 2014-15 periods to UHL staff on base wards to educate them as to the

capacity of community services to support patients with quite complex needs at home.

**What will this mean for our citizens?**

| Health &/or wellbeing need: | Impact of this intervention on patient outcomes: |
|---|---|
| Support independence for people with LTC/older people/people with dementia | Less people will be delayed in a hospital bed due to a lack of community services<br><br>More people will be treated in their own homes, with no acute intervention<br><br>More people will be able to remain independently at home, with access to a larger base of rehab, therapy and mental teams as required<br><br>Reduction in the numbers requiring permanent admission to residential care<br><br>More people will be directly referred to the Planned Care Teams and/or their GP practice<br><br>Less reliance on acute activity, evidenced by:<br>• QIPP reductions in activity at UHL, both in expenditure and activity; across outpatients; A&E and emergency admissions<br>• A&E reductions in activity at UHL, both in expenditure and activity<br>• Reductions in emergency admissions from care homes<br>• Reduction in emergency readmissions<br><br>Less people will require permanent admission to residential care |

**Intervention 7: Intensive Community Support**

Intensive Community Support is a model of care underpinned by the principles of comprehensive geriatric assessment (CGA), which has a strong evidence base for improving outcomes for older people. The CCG piloted the use of a small number of these beds in 13/14 and following evaluation this will be increased to 30 ‘virtual ward” beds using the BCF investment in 14/15. This which allow patients with complex health and social care needs and relatively high levels of dependency to be stabilised and re-abled at home and access the other elements of our integrated care model easily.

**The model of care**

A patient-centred and holistic approach to providing intensive integrated health and social care to patients with long term conditions and /or frailty syndrome through intensive community nursing, therapy and social care input to patients in their own homes.

- The service will operate from 8 AM - 10 PM, 7 days per week.
- Treatment and care will be delivered to the patient in their own home but on a more intensive and extended scale than is the case with routine community nursing care.
- Patients will be able to receive up to four visits per day from health and social care staff and are kept on with the ICS for up to six weeks.
- For those patients with overnight monitoring or care needs care after 10PM will be provided by the increased night nursing capacity commissioned via the BCF investment – working side by side with the Unscheduled and Planned Care Teams.
- Although the team will be led by an advanced nurse practitioner, there will be access to the community consultant geriatrician in the Rapid Intervention Team for additional clinical input if required as well as community mental health teams as required.

The ethos of ICS care is rehabilitative where possible and therefore dedicated occupational and physiotherapy staff contribute to assessment and treatment of patients – working in partnership with domiciliary care staff to restore independence in activities of daily living.

**What will this mean for our citizens?**

| Health &/or wellbeing need: | Impact of this intervention on patient outcomes: |
|---|---|
| Reduction in health inequalities<br><br>Reduction in premature mortality<br><br>Reduction in barriers to access | More people will be referred to their own GP practice for further care planning and assessment of needs |
| Support independence for people with LTC/older people/people with dementia | Less people will be delayed in a hospital bed due to a lack of community services<br><br>More people will be treated in their own homes, with no acute intervention<br><br>More people will be able to remain independently at home, with access to a larger base of rehab, therapy and mental teams as required |

| | |
|---|---|
| | Reduction in the numbers requiring permanent admission to residential care<br><br>More people will be directly referred to the Planned Care Teams and/or their GP practice<br><br>Less reliance on acute activity, evidenced by:<br><br>• QIPP reductions in activity at UHL, both in expenditure and activity; across outpatients; A&E and emergency admissions<br>• A&E reductions in activity at UHL, both in expenditure and activity<br>• Reductions in emergency admissions from care homes<br>• Reduction in emergency readmissions<br><br>Less people will require permanent admission to residential care |

Figure 8: Key impact measures of this intervention

**Intervention 8: IT integration**

The incorporation of the NHS number into the social care record has been identified as one of the main strategic priorities in relation to the BCF and is a national condition. It is also one of the core metrics identified by the Better Care Fund Guidance. To develop the delivery of more seamless and integrated health and social care for those with complex needs a single unique identifier will be required where records are to be shared to improve communication across the local health and social care economy.

This scheme is fundamentally concerned with developing a technical and information governance infrastructure across health and social care in Leicester. The system integration project is aimed at meeting the national condition of data sharing through enabling the NHS number to be used as the primary identifier. It will also have the potential to support each of the key projects to integrate its business process and information sharing to an optimised level. This will bring capability for the generation of integrated management information to support strategic and operational decision making.

**Phase 1**
Phase 1 will firstly involve the development of an overarching information governance framework between the NHS Leicester City and Leicester City Council Adult Social Care. This will allow the sharing of information and the development of a set of associated Individual Information Sharing Agreements (ISA) to support particular functions/services as they integrate more closely in a phased way, in line with the wider programme. Compliance with the IG toolkit is an activity in this phase and a key enabler to allow phase 2 to commence. The establishment of NHS numbers through the Demographic

Batch Service (DBS) for all customers known to Adult Social Care is a key milestone for this phase and is a key enabler in supporting; strategic and operational decision making, service redesign and understanding performance across functions of the integrated care pathway.

**Phase 2**
This phase aims to build an integral link between NHS and Council information systems respectively. This will facilitate a long term solution to enable day to day transfer of the NHS number and other Personal Demographic data from the NHS SPINE to the Adult Social Care case management system namely Liquid Logic IAS. This link will involve dedicated technical work with the deployment of specialist software modules which are designed to support this type of integration.

**What will this mean for our citizens?**

This intervention does not have specific measurable targets; rather, the success of the scheme will be judged on the outcomes noted across health and social. For example, we would expect that Information sharing should

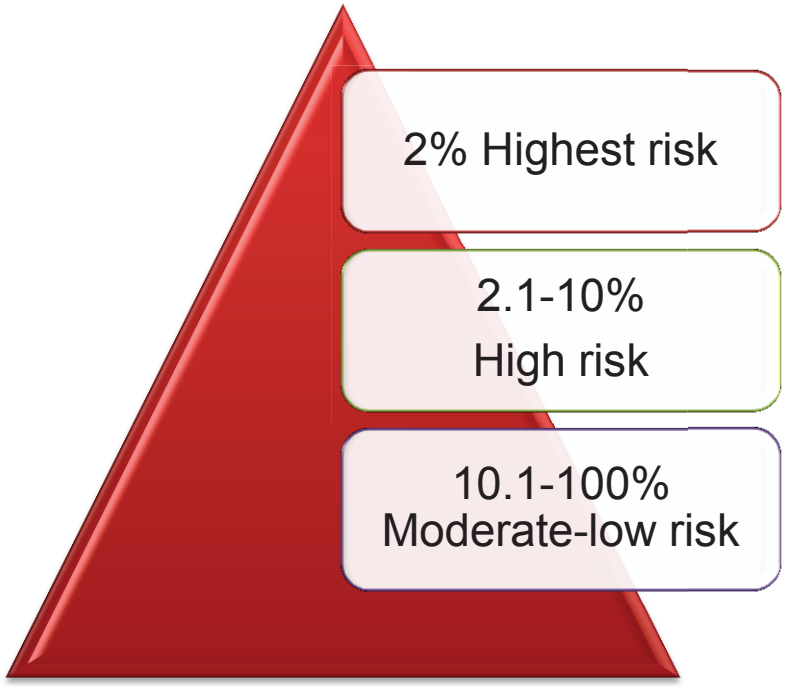
- Facilitate seamless delivery of care across both Health and Social Care economies;
- Increase speed of communications/referrals between integrated functions across the Health and Social Care economy;
- Support systematic tracking of customer journey across Health and Social Care boundaries providing the platform for integrated management information which will support strategic decision making;
- Prevent duplication or inaccuracy across patient / customer records;
- Enhance data integrity in Adult Social Care systems resulting in trusted information to inform decision making both strategically and operationally.

These will be managed by the BCF Implementation Group as well as via the LLR IM&T group to ensure alignment across the wider system.

| Priority 3: Enabling independence following hospital care | | | | |
|---|---|---|---|---|
| **Public health need** | Intervention | Impact on system | | Impact on patients |
| | | 2 Year | 5 Year | |
| We know that:<br><br>Leicester City patients stay in acute beds for longer than necessary on average<br><br>Dementia patients stay in acute beds for up to 7 days longer than the average<br><br>Mental health patients stay in acute beds for up to 7 days longer than the average<br><br>Capacity in primary care for coordination of care for physical or mental health is stretched | Planned Care Team<br><br>A joint health and social care team, designed to keep patients safely at home and avoid an emergency admission or discharge safely back home.<br><br>2 weeks of holistic care provided, with ongoing referral to GP if required | Reduction in bed base | Reduction in bed base | 77 year old female identified via risk stratification system as having a relative risk of 7.4 (likely to use 7.4 times the CCG average of health care resources) with a probability of emergency admission of 32.1% . History of chronic Schizoid disorder, bilateral arthritis of hips and knees), depression, and COPD. Has had 4 emergency admissions of 0-2 days and a further 5 ED attendances in the last year – all with presenting symptom of chest discomfort. Recent emergency in-patient admission to mental health ward for assessment following acute episode of symptoms associated with mental health diagnosis.<br>Patient's discharge planning was supported by new mental health social worker for discharge. This resulted in planned discharge to community mental health bed for a period of planned step down care focusing on 4 things<br>• wound care to heal skin tear sustained during period of acute ill-health;<br>• further medication titration for mental health symptoms;<br>• assessment of home circumstances and ability to safely manage activities of daily living;<br>• a structured programme of CBT to help the patient manage symptoms of anxiety related to worry about the significance of transient non-cardiac chest pain.<br>During the next two weeks the patient's home has a number of minor adaptations made by the LA Practical Help at Home Team and the patient undergoes assessment and intervention with the occupational health team. She returns home with follow up from a Community Mental Health Practitioner. She has had no further ED attendances to date and her mental health symptoms are stable. |
| | Mental Health Discharge Team<br><br>Support to enable discharge of patients on mental health acute wards. Includes liaison across health and social care and allied services such as housing and finance | Reduction in mental health bed base | Reduction in mental health bed base | |
| | Mental Health Step Down Service<br><br>6-8 beds in a community setting to provide step down from acute episode of care | Increase in community MH bed base | Reduction in acute MH bed base | |

## The target population for this priority area

The BCF cohort in its entirety will be targeted by the interventions listed in this priority area.




**The interventions targeted to this priority area**

**Intervention 9: The Planned Care Team**

The Planned Care Team is a new joint health and social care team which provides ongoing support to patients discharged from the unscheduled care services across the system. Patients will be cared for in their own homes for up to 2 weeks by a multi-disciplinary team of practitioners across health and social care with direct links back to the patient's own GP practice.

This team will provide:

- Deployment at scale of proactive community interventions to reduce risk of admission in those with LTCs (care planning and patient education) and to reduce incidence of preventable admission for ambulatory care sensitive conditions.

- Care coordination for the most complex older people through our Care Navigator team – targeted to coordinate the health and social care services deployed to the frailest cohort of the over 75s. This team will have access to read and entry access to both the health and social care electronic record systems to facilitate joined up communication for the most vulnerable and complex patients. We have identified at least 18 different health and social care agencies and services that the Care Navigators can refer into on behalf of their patients.

- Co-terminus health and social care neighbourhood boundaries to facilitate more integrated working via multi-disciplinary team meetings hosted by primary care and greater continuity of care for those with complex health and social care needs.

- Increased access to adult social care services though the Single Point of Contact (SPoC)

- Increased Adult Social Care Locality staff to facilitate more community assessments and sign posting to advice, information and guidance. The proactive identification of greater numbers of patients at potential risk of admission will require more capacity in ASC locality teams to deliver timely responses to requests for non-urgent help.

- Up to 6 weeks of free access to reablement services will be offered to all those who might benefit. Reablement will aim to optimise the functional independence of older people at home by providing therapy and equipment as needed to promote achievement of agreed therapy goals. In addition part of the planned health care provision will include a community nurse assessment on entry into reablement as standard.

The BCF investment in this element – Planned Care Health and Social Care teams - specifically enables the following elements of our model described below:

- uplift and development of the capacity of the Community Mental Health Practitioner team to proactively address the needs of older people's mental health in the community;
- establishment of a new Care Navigator Service – a team of health and social care coordinators to coordinate health and social care services for the frailest over 75s;
- increase in the capacity of Adult Social Care (ASC) Single Point of Contact (SPoC) to facilitate alignment of their working times of the Health Single Point of Access (SPA);
- year long process of organisational development by Leicester City Adult Social Care Services to redesign their current locality boundaries to align them to be co-terminus with the neighbourhood structure of Leicestershire Partnership Trust Community Health Services.

**What will this mean for our citizens?**

| Health &/or wellbeing need: | Impact of this intervention on patient outcomes: |
|---|---|
| Reduction in health inequalities<br><br>Reduction in premature mortality<br><br>Reduction in barriers to access | More people will be referred to their own GP practice for further care planning and assessment of needs |

| | |
|---|---|
| Support independence for people with LTC/older people/people with dementia | Less people will be delayed in a hospital bed due to a lack of community services<br><br>More people will be treated in their own homes, with no acute intervention<br><br>More people will be able to remain independently at home, with access to a larger base of rehab, therapy and mental teams as required<br><br>Reduction in the numbers requiring permanent admission to residential care<br><br>More people will be directly referred to the Planned Care Teams and/or their GP practice<br><br>Less reliance on acute activity, evidenced by:<br><br>• QIPP reductions in activity at UHL, both in expenditure and activity; across outpatients; A&E and emergency admissions;<br>• A&E reductions in activity at UHL, both in expenditure and activity;<br>• reductions in emergency admissions from care homes;<br>• reduction in emergency readmissions.<br><br>Less people will require permanent admission to residential care |

**Figure 9:** Key impact measures of this intervention

**Intervention 10: Mental health discharge support**

In order to meet the demand identified and to negate any detrimental impact on patients, this intervention will increase the capacity of the social work assessment team on two key units:

1. The Bennion Ward (mental health services for older people)
2. The Bradgate Unit (adult mental health)

It is envisaged that these posts will work in partnership with the Unscheduled and Planned Care Teams described earlier in this plan to ensure that holistic care is provided for these patients.

Delays to discharge attributable to housing have also been a long-standing problem with the inpatient service at the Bradgate Unit. Aligned to this intervention, LPT has worked

with colleagues in the city to develop plans for a 6 month pilot whereby dedicated housing support posts are available, based at the Bradgate unit. It is intended that this will enable quicker processing of applications and will facilitate innovative solutions to be implemented where there is a shortage of suitable accommodation available. The pilot also includes the establishment of a small fund, which will provide rent deposits and essential furniture, where this is a barrier to discharge. The pilot will be hosted by Blaby District Council on behalf of LLR. The pilot also includes a support post, which will ensure service users are supported as they make the transition from hospital into their new accommodation.

**What will this mean for our citizens?**

| Health &/or wellbeing need: | Impact of this intervention on patient outcomes: |
|---|---|
| Reduction in health inequalities<br><br>Reduction in premature mortality<br><br>Reduction in barriers to access | More people will be referred to their own GP practice for further care planning and assessment of needs<br><br>Improved quality of care within MH inpatient units by being able to focus on patients who are medically unwell as medically fit patients are discharged more quickly<br><br>Mental health patients will be able to access a range of integrated care services as easily as those with physical health through the increased staffing provision |
| Support independence for people with LTC/older people/people with dementia | Less people will be delayed in adult MH and MHSOP inpatient wards due to a lack of knowledge of community support<br><br>More people will be treated in their own homes, with no acute intervention<br><br>More people will be able to remain independently at home, with access to a larger base of rehab, therapy and mental teams as required<br><br>More people will be directly referred to the Planned Care Teams and/or their GP practice<br><br>Less reliance on acute activity, evidenced by:<br><br>• QIPP reductions in activity at UHL, both in expenditure and activity; across outpatients; A&E and emergency admissions;<br>• A&E reductions in activity at UHL, both in |

| | |
|---|---|
| | expenditure and activity;<br>• reductions in emergency admissions from care homes;<br>• reduction in emergency readmissions.<br><br>Less people will require permanent admission to residential care |

**Figure 10:** Key impact measures of this intervention

**Intervention 11: Integrated Mental Health Step Down Service**

LPT have been working with the InMind Healthcare Group over recent months to develop a proposal with them to provide a step down facility from Sturdee Community Hospital (Eyres Monsell). It will be for service users leaving the acute inpatient unit and aims to ease bed pressures at the Bradgate Unit, by offering support to service users making the transition from acute care back in to the community.

The current proposal involves LPT commissioning 6-8 step down apartments from InMind Healthcare Group. The service will receive referrals from the Bradgate Unit acute wards for low risk individuals who could benefit from the opportunity to function semi-independently in the community, prior to discharge from hospital. The service is provided within a hospital setting, and patients will be under the care of the medical and nursing staff at InMind. The anticipated length of stay for individuals is 14 to 28 days.

The service aims to:

1. Provide a short term step down facility that promotes independence, inclusion and community engagement for service users, following an episode of acute mental illness;
2. Facilitate a successful and sustainable discharge from hospital, back in to the community for service users;
3. Facilitate reduced lengths of stay within LPT acute inpatient beds;
4. Provide a cost effective service that meets the needs of service users who no longer require the intensity of support provided within an acute ward.

**What will this mean for our citizens?**

| Health &/or wellbeing need: | Impact of this intervention on patient outcomes: |
|---|---|
| Reduction in health inequalities<br><br>Reduction in premature mortality<br><br>Reduction in barriers to access | People will have a greater choice of services available to service users at the point of crisis<br><br>People will have a greater ability to access support swiftly and directly when they feel they are reaching crisis point |

| | |
|---|---|
| | Inpatients will have access to better support making the transition from acute care back to the community and developing their skills for independence |
| Support independence for people with LTC/older people/people with dementia | Less people will be delayed in adult MH and MHSOP inpatient wards due to a lack of knowledge of community support<br><br>People will have access to quicker processing of housing applications and the sourcing of suitable housing for inpatients preparing for discharge<br><br>More people will be treated closer to their own homes, and not at a distance from their friends and family<br><br>More people will be able to remain independently at home, with access to a larger base of rehab, therapy and mental teams as required<br><br>More people will be directly referred to the Planned Care Teams and/or their GP practice<br><br>Less reliance on acute activity, evidenced by:<br><br>• QIPP reductions in activity at UHL, both in expenditure and activity; across outpatients, A&E and emergency admissions;<br>• A&E reductions in activity at UHL, both in expenditure and activity;<br>• reductions in emergency admissions from care homes;<br>• reduction in emergency readmissions.<br><br>Less people will require permanent admission to residential care |

**Figure 11:** Key impact measures of this intervention

This intervention is part of a wider transformation of the mental health pathway across the city.

This integrated model of delivery will enable us to achieve what we set out originally to do: work together with communities to improve health and reduce inequalities, enabling

children, adults and families to enjoy a healthy, safe and fulfilling life and will also enable the delivery of the nationally set outcomes of the BCF programme:

| |
|---|
| BCF National Metric 1: Less people going into nursing and residential care |
| BCF National Metric 2: More people receiving help to recover at home |
| BCF National Metric 3: A reduction in hospital bed days due to discharge being delayed |
| BCF National Metric 4: A reduction in total hospital admissions |
| BCF National Metric 5: Improved patient/service user experience |
| BCF Local Metric: More people being identified as living with Dementia |

These are outlined in more detail in template 2 of this submission.

**2b) What difference will this make to patient and service user outcomes?**

We recognise that our previous model of care provided unaffordable and variable quality of care, placing a high demand on the acute sector. Our resources were concentrated on crisis and statutory services, rather than services designed to keep people independent and this contributed in part, to too large a variation in health outcomes across the city.

As outlined in each priority area above, each intervention has been designed specifically to impact directly on the local public health needs and the broader demographic and socio-economic issues identified in both our JSNA and HWB strategy.

Many of the interventions have been enabled by the creation of a BCF in 2014/15 to prepare for full implementation in 15/16 and this is already having an impact on our patients as evidenced by the case study below of a real City patient in August 2014:

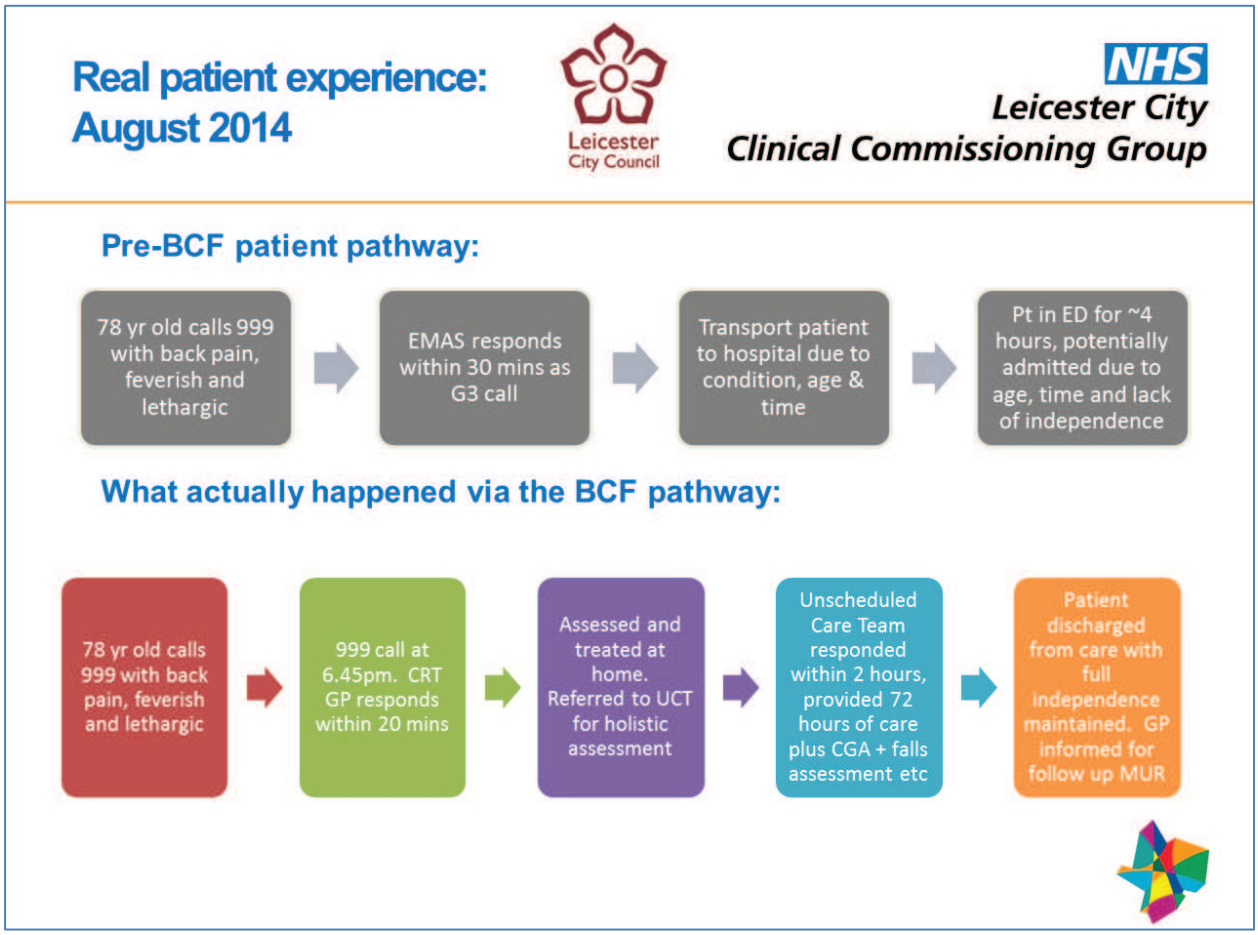



Figure 12: A real patient story from August 2014 presented at the Leicester City Protected Learning Time event for our general practices

The National Voices document *Person Centred Care 2020 (September 2014)* suggests that the system wide characteristics presented in column 1 below should be demonstrated by 2020; the second column outlines the impact on our patients and service users:

| Characteristic | The Leicester City BCF will achieve this by 15/16 through delivery of: |
|---|---|
| Much greater emphasis on promoting health and preventing illness, especially for those most at risk. | 5,000 people will be referred to primary prevention services at the Lifestyle Hub |
| | 7,200 care plans completed for the highest 2% at risk patients |
| | 16,921 care plans completed for the highest 2.1-10% at risk patients |
| | 4000 GP-led sessions delivered in primary care to deliver targeted care plans for high risk patients |
| | 2,100 people will be cared for by a Care Navigator |
| | Approx. 2,000 emergency admissions will be avoided providing GP response |
| | Health and social care systems will be aligned, with the NHS number in use by December 2014 |

| | |
|---|---|
| | Approx. 25,000 people will be assessed by the joint Health and Social Care Unscheduled Care team each month, ensuring the services are delivered in the citizen's place of residence where appropriate |
| | Approx. 8,000 people will be assessed by the joint Health and Social Care Planned Care team each month, ensuring the services are delivered in the citizen's place of residence where appropriate |
| | 205 less people will be admitted to permanent residential care due to the support provided in the community |
| | Joint 7 day community health and social care services to keep citizens out of hospital will be the norm, rather than the exception |
| | Readmissions will have been avoided by efficient discharge processes and subsequent appropriate management of care in the community |
| | Delayed transfers of care will reduced through the provision of high quality care packages at appropriate times |
| | Length of stay, specific to mental health, will reduce to the national average of 30 days with the support of MH specific discharge facilitators |
| | Housing issues will not be a barrier to discharge for either physical or mental health conditions through the new joint teams, including housing support |
| What really matters to people will be a key outcome | The JICB will continue to explore outcomes based commissioning options, ensuring that regulatory, financial and organisational priorities do not impede person centred delivery models of care |
| | User experience metrics will be key to informing future service provision |
| Agencies with an impact on health and care will increasingly work together | The CCG and the Local Authority will continue to work with partner agencies across both the city and surrounding areas to ensure the design and delivery of care is seamless, no matter where our citizens access care. |
| Voluntary and community sector organisations (VCS) will be full partners in the design and delivery of person centred care | VCS organisations will have had a clear opportunity to co-produce elements of the BCF, both in terms of design and delivery. |
| Statutory services will support and enable the "informal workforce" | The Citizen Participation Strategy will promote the work of the informal workforce, encouraging more participation through specific community events, using the NHS 'winter friends' model. 500 winter friends will be recruited per winter period. |
| | 1000 dementia champions and friends will be recruited to promote the assessment, management and support of people with dementia and their carers |

*Patient experience of care*

We will also measure the experience of our patients through our patient experience metrics, both at a strategic BCF Programme level as well as through individual project metrics focussed on patient experience.

Our strategic patient experience metrics have been agreed locally through the BCF Implementation Group. We have chosen patient experience metrics covering each part of our integrated model of care in order to test each component part.

| CQC Inpatient Survey | GP Survey | Adult Social Care Users Survey |
|---|---|---|
| Q64. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital (e.g. services from a GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector) | (For respondents with a long-standing health condition) Q32. In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)? Please think about all services and organisations, not just health | 3a. Which of the following statements best describes how much control you have over your daily life? |

Measurement of these metrics will enable us to ensure that the experience of our target group is positive, with outcomes being improved and services being delivered around patient needs.

Each project also has patient experience metrics appropriate to the project. These will be measured more frequently than the national metrics to ensure a robust test of the system from a patient perspective.

**c) What changes will have been delivered in the pattern and configuration of services over the next five years, and how will BCF funded work contribute to this?**

**The resultant model of care**

At a local level, by joining up our services from the bottom up we will make a fundamental change in both culture and delivery mechanisms within our local health and social care economy, resulting in a joined up system across health and social care:


This model will result in a significant shift in activity which has traditionally been delivered through the acute sector to a modern model of integrated care, provided at scale in the community. We expect this new model of integrated care to change patient flows to the extent that in five years, we will have seen up to a 15% reduction in the form and function of the acute sector and a significant growth in the services offered in the community.

This transformative change in form and function, while keeping with each organisation's individual responsibilities, will change the landscape of all future commissioning of integrated care models for our city. We will not let traditional boundaries stop us from progressing towards our vision of whole-scale transformational change.

**Which aspects of this change will be delivered through the BCF?**

The Leicester City Better Care Fund has been used to significantly accelerate the mobilisation of the local integrated care pathway. We started our journey towards integrated care in 2013/14, with a clear vision of how we wanted the services to work seamlessly together for the benefit of our patients. The BCF has enabled a sub-set of these plans to be fast-tracked into mobilisation through 14/15 and 15/16 combined with a set of new interventions mobilised as part of the new BCF programme.

| Intervention | Status | How has the BCF contributed to accelerated mobilisation? |
|---|---|---|
| Risk stratification | Acceleration | Enabled further functionality of the system which will be used to change the pattern and configuration of future service provision |
| Lifestyle Hub | Acceleration | Enabled extension of the Hub to City wide in 15/16 |
| GP practice scheme | Acceleration | Enabled 2.1-10% of the high risk population to be provided with enhanced support |
| Clinical Response Team | New | New scheme, funded entirely through new BCF funds |
| Unscheduled Care Team | Acceleration | Enabled full co-location of teams, as well as increased capacity in both social care and health sections of the team |
| System integration coordinator | New | Enabled a joint integrated system wide flow coordinator funded entirely through new BCF funds |
| Intensive Community Support Service | Acceleration | Enabled significant upscale of service, with 30 virtual beds added to community service provision |
| IT integration | New | Enabled the NHS number as a primary identifier across health and social care |
| Planned Care Team | Acceleration | Enabled full co-location of teams, as well as increased capacity in both social care and health sections of the team |
| Mental Health Discharge Team | New | New scheme, funded entirely through new BCF funds |
| Integrated Mental Health Step Down Service | New | New scheme, funded entirely through new BCF funds |

These interventions will continue to deliver the changes required to deliver systematic change over the next five years.

This programme is purposely aligned with longer-term strategic changes planned across the Leicester, Leicestershire & Rutland health and social care economy. This is coordinated through the Leicester, Leicestershire and Rutland *Better Care Together* programme and our plans will be a key enabler to the Leicester, Leicestershire & Rutland five year Strategic Plan.

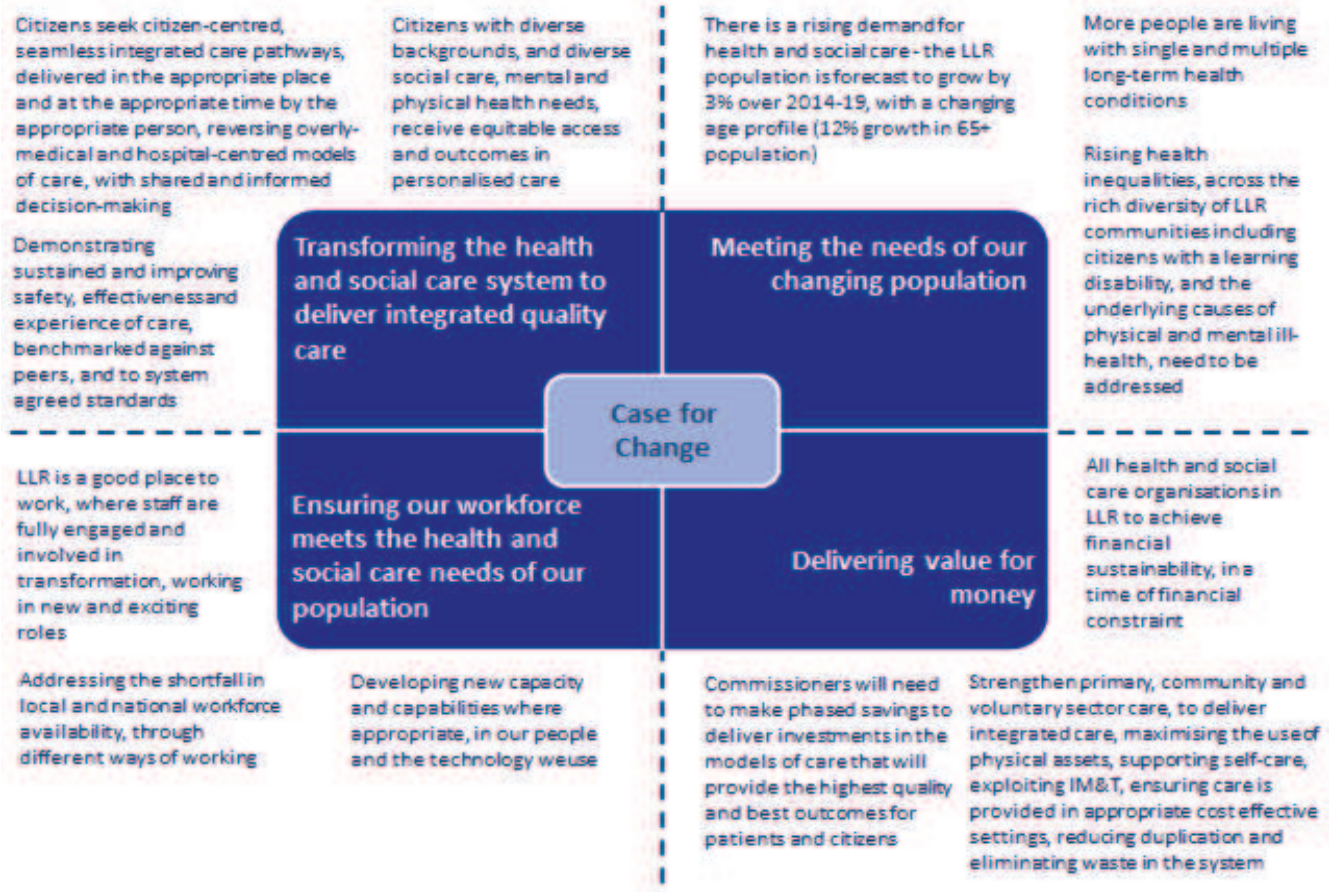
## 3) CASE FOR CHANGE

Please set out a clear, analytically driven understanding of how care can be improved by integration in your area, explaining the risk stratification exercises you have undertaken as part of this.

*Everyone Counts: Planning for Patients 2014/15 to 2018/19* sets the overall medium term planning framework for the NHS and describes what the NHS must deliver to patients nationally. The NHS 'Call to Action' asks all NHS providers and commissioners to respond to the significant challenges facing the NHS in delivering health and care policy into the future, including:

- an ageing society
- the rise of long-term conditions
- rising expectations
- increasing costs of providing care
- limited productivity
- pressure of constrained public resources that the NHS face
- variation in quality of care across the health system.

In June 2014, the LLR wide programme "Better Care Together" published an overarching strategic case for change to respond to these challenges, which has been co-produced across the health and social care system, including via public engagement, illustrated below:



**Analysis and modelling which supports the LLR case for change**

Across LLR, an integrated long term system model has been constructed for the Better Care Together programme which describes and measures how the system challenges will be addressed. This models the impact of actions/ interventions to improve the quality of services provided to patients and/or improve the financial value of services without quality being compromised.

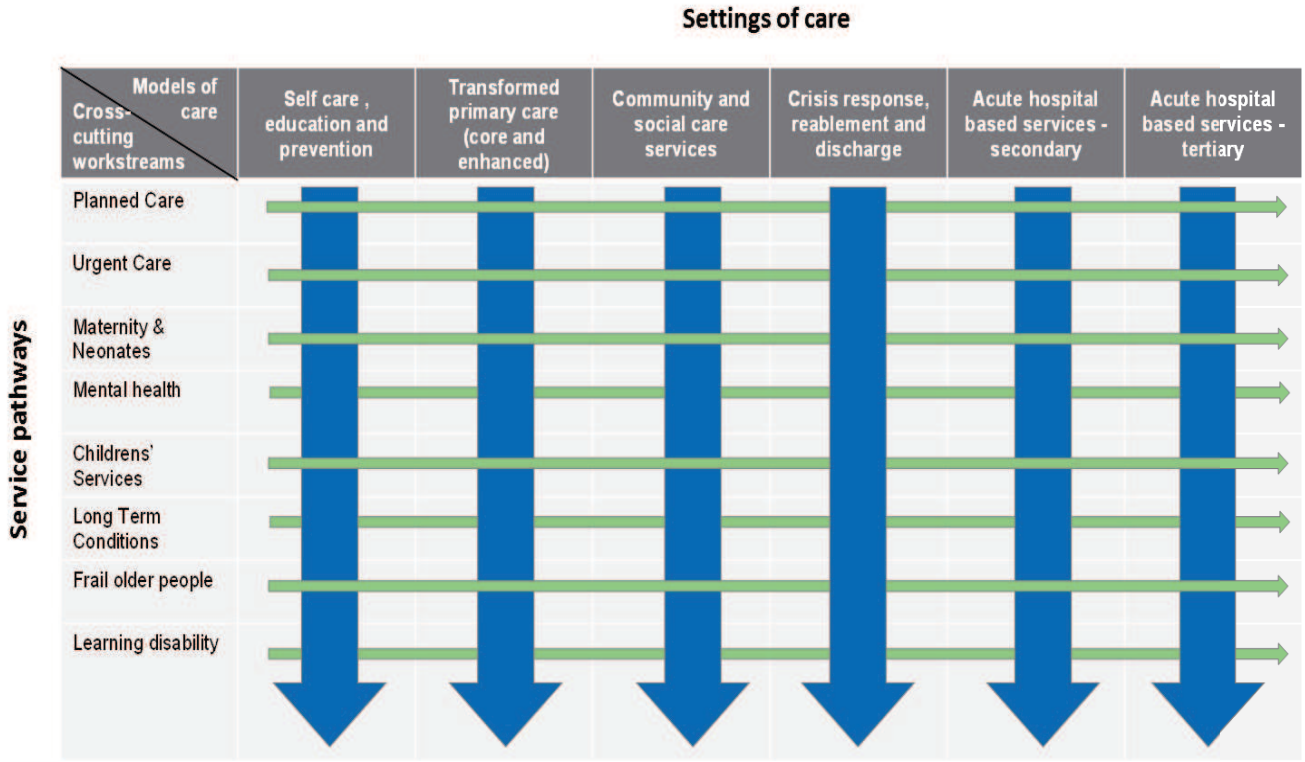
The model has been constructed as an integrated tool based on a shared set of planning assumptions, which are mirrored in the individual plans of constituent organisations. It factors in the financial assumptions of all partners across health and social care economy and illustrates the impact of proposed changes on activity and costs across the system including the impact of:

- implementing new models of care;
- shifting care between settings;
- planned efficiency programmes;
- planned investments across health and social care including those linked to the BCF.

The work to develop the Better Care Together five year strategy has involved analysing and prioritising the case for change in eight main service areas, setting out:

- the main changes that are needed to these service models;
- how care will need to shift across settings in the future.

The matrix below shows the eight service pathways and six settings of care being addressed by the LLR five year strategy.



The Leicester City BCF plan is constructed under three priority themes, in support of the BCT five year plan analysis. The table below show how each theme within the BCF maps to the workstreams and settings of care in the BCT matrix:

| BCF Theme | BCT Matrix |
|---|---|
| **Priority 1:** Prevention, early detection and improvement of health-related quality of life | Self-care, education and prevention<br>Long term conditions<br>Community and social care services<br>Transformed primary care |
| **Priority 2:** Reducing the time spent in hospital avoidably | Urgent care<br>Crisis response<br>Community and social care services<br>Transformed primary care<br>Frail older people |
| **Priority 3:** Enabling independence following hospital care | Acute hospital based services<br>Reablement and discharge<br>Community and social care services |

| The Leicester City BCF plan will deliver specific changes in five of the BCT settings of care | The Leicester City BCF plan will deliver specific changes in three of the BCT models of care |
|---|---|
| • Self-care, education and prevention<br>• Community and social care services<br>• Crisis response, reablement and discharge<br>• Transformed primary care<br>• Acute hospital based services | • Frail older people<br>• Urgent care<br>• Long term conditions |

**Our local evidence based planning process**

The approach taken to the development of the Leicester City Better Care Fund has been no different to a normal commissioning process within Leicester City. The NHS Commissioning Cycle has remained the key reference document for the city when commissioning any service:

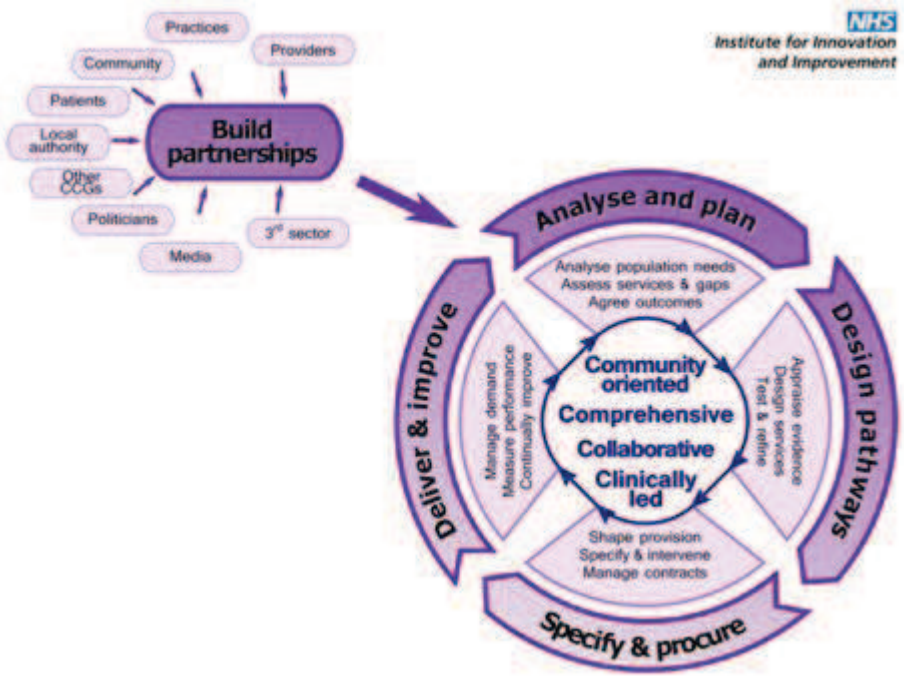



Figure 12: The Clinical Commissioning Cycle, (NHS Institute, 2013)

The key actions detailed in Figure 12 ensure a robust planning process is undertaken and resonates with the 'Four steps for robust planning' outlined in the BCF technical toolkit. Financial analysis and benefits modelling, as described in the BCF toolkit, have been provided as Appendix 2 and 2a.

By enacting these steps, we have strived to create the 'foci of integration' (NHS Institute, 2013) to ensure that integration is fully achieved for the benefits of our patients. This is illustrated below:

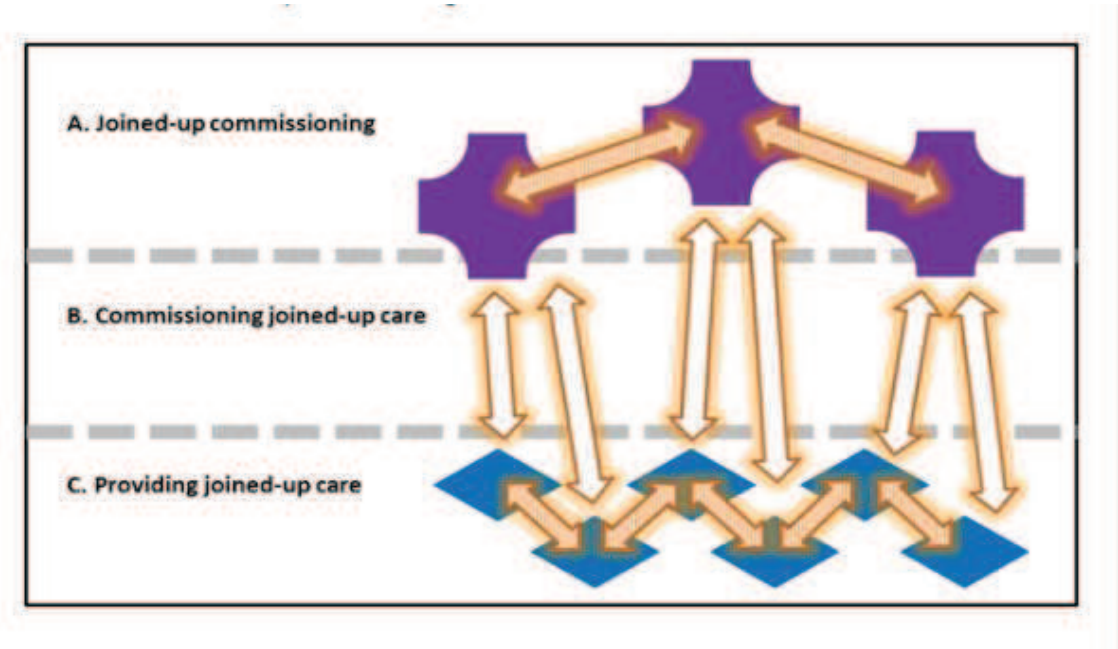



Figure 13: The Foci of Integration, NHS Institute 2013

We will continue to follow this cycle to ensure that evidenced based planning is the driver to achieving real change across the city.

## Step 1: Defining our target BCF population: population segmentation, risk stratification and information governance

### Information governance

Current information sharing agreements within the Leicester, Leicestershire and Rutland Unit of Planning do not permit the use of aggregated practice data at population level for secondary purposes, and this presents a barrier in being able to progress the risk stratification and population segmentation analysis recommended in the latest BCF guidance.

For the purposes of the BCF resubmission, we have undertaken some initial population segmentation analysis with the support of the Greater East Midlands Commissioning Unit. This has been developed in the format recommended by the BCF guidance and webinar materials, e.g. to show segmentation by age and condition, and has been developed in support of the case for change and evidence base for the BCF interventions with respect to frail older people and those with long term conditions.

The LLR Information Management and Technology programme board, which is part of the governance system for the LLR five year plan is taking the lead with respect to the developments needed locally to improve the data sharing, information management and technological platform for the local health and care system. The status of the current information sharing agreements has already been identified as a key issue to resolve.

An action plan is being developed to address this and will be designed to enable the approach recommended in the BCF guidance to become a routine part of system wide analysis for the health and care economy in the medium term.

The action plan will include:

- a proactive GP practice engagement plan across the primary care sector to promote the need for the changes to the agreements and to work in a coordinated way to achieve this across the whole unit of planning, supported by all three CCGs and the Local Area Team;
- a project plan with clear milestones and responsibilities to authorise new agreements and implement the practical tools and reports needed to enable this data to be generated and applied effectively in LLR, with governance via the LLR IM&T workstream;
- briefings for all three health and wellbeing boards about the rationale and scope of the work to deliver an enhanced approach to risk stratification and population segmentation, showing how this supports not only the BCF related activities but also JSNA refresh activities and the Joint Health and Wellbeing Strategy priority outcomes and work plans.

- The action plan will also be informed by:
    - examples of work and products in areas who have made early progress in this work such as the work in progress in South Central Region Commissioning Support Unit (Examples of the analysis we are seeking to develop in LLR are given in the slides at Appendix 9);

- imminent national regulatory changes affecting section 251 agreements and related information governance matters;
- related work in progress on business intelligence transformation within the County Council including how public health intelligence is developing in conjunction with other departments in areas such as unified prevention;
- the engagement and advice of partner agencies and IG experts across LLR.

From a Leicester City CCG/Council perspective we are progressing the following actions which already form part of the enabling work associated with the BCF:

- Public Health will continue to work with the Greater East Midlands Commissioning Support Unit to develop some initial specific reports on the health needs of the population of Leicester City using the GP held risk stratification data, allowing us to segment our population by different levels of vulnerability, frailty and health and social care needs.
- We will develop the applications of the risk stratification data to improve our understanding of social care needs, with particular emphasis on BCF interventions.
- We will explore the implications of incorporating social care data into the risk stratification tool, allowing us to understand health and wellbeing needs better across the whole pathway of care.
- We have also engaged the National Centre of Excellence for Information Sharing which is hosted by Leicestershire County Council at this early stage in order to influence national developments and access national best practice to shape our approach.

**Our approach using risk stratification and population segmentation**

Since 2012 Leicester City CCG has supported practices in using the Adjusted Clinical Groups (ACG) risk predictive software (licenced from Johns Hopkins University in the USA) to risk stratify their registered population and identify those at highest risk of admission to hospital in the next year. We have invested in this to enable our practices to proactively identify patients at high risk of admission and apply a Multi-Disciplinary Team approach to their care.

We have used ACG-derived risk stratification, along with other methods of grouping the population outlined in the BCF technical toolkit such as grouping by age and condition, to identify our target BCF cohort, i.e. those patients who are at most risk of deterioration or at risk of a significant care event. Through the provision of high quality, integrated health and social care services, our core aim is to reduce the probability of an emergency admission in this cohort.

Running data through the ACG tool has provided an output that shows the number of people in each risk stratum:

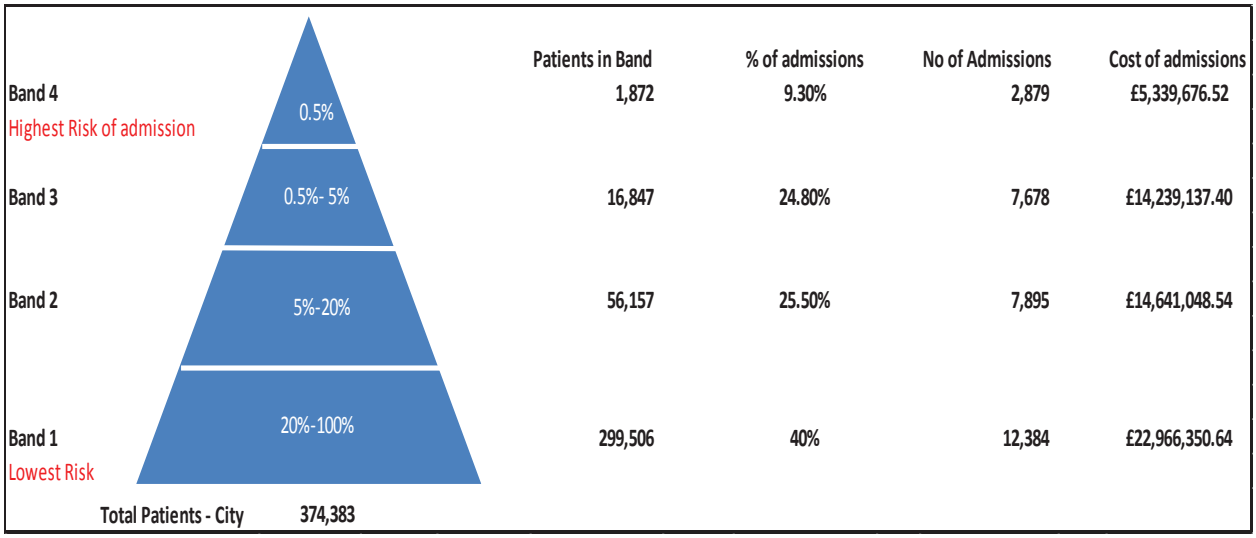



Figure 14: Leicester City CCG Risk Stratification exercise, 2014

As illustrated above, the highest 20% at risk patients account for over 60% of the total cost of emergency admissions for the CCG. Our analysis has also shown us that those patients, regardless of age, who have three or more comorbidities have far more NEL spells at a far greater cost than the rest of the population:

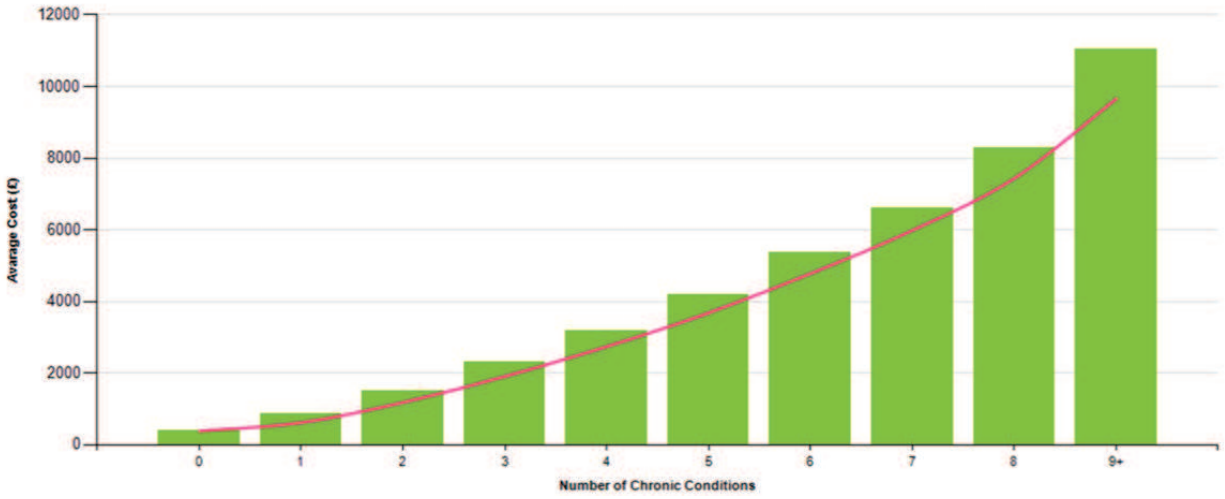



Figure 15: Three or more comorbidities = high usage of acute care and increased cost

We have also analysed data from our GP systems to understand the impact of age and multi-morbidity in these cohorts. As recommended in the BCF technical guidance, this was done at a population segmentation workshop, which included GPs, health and social care commissioners, public health, local providers from acute and community organisations and other local experts in analysis and data segmentation. This workshop looked at various sources of data across both health and social care and mapped these to both the BCF national metrics as well as a range of data from the NHS, ASC and public health outcomes frameworks. National segmentation methodology was also critically analysed with the following conclusions accepted by the group:

1. Academics and clinicians agree that with advancing age comes a higher use of health and social care; however, many national documents and academic papers look at the rising cost of care associated with people who are 75 years and older.

In Leicester City, whilst the average age expectancy is growing, it is still significantly lower than the England average, with life expectancy currently at 74.2 years for men and 81.8 years for women. The rate of improvement compared to nationally is also slower. Put simply, people do not live long enough to use health and social care in these age segments. This, coupled with the cost analysis by age presented previously, had led us to focus on those aged 60 years and over.

2. Given the low health outcomes historically seen in the city, a number of other segments have been assessed as potentially benefitting from integrated care; our analysis shows that the activity and cost associated with the 18-59 year segment of the population rises exponentially once 3+ comorbidities have been recorded. Analysing ACG data from the past year on these segments shows that this segment of the population, whilst smaller in size, has a higher number of emergency admissions at significant cost to the system than the 60+ segment.

3. The workshop participants also agreed that the risk of admission for those patients diagnosed with dementia would also be greatly reduced; we know from local and national sources that patients with dementia are often admitted from ED without a medical need but because there is nowhere else safely for the patient to go, particularly late at night. Also, the length of stay for dementia patients is excessive, with current analysis showing 7 bed days could be avoided if integrated discharge was made available.

Combining these sources of intelligence, leads us to a target BCF cohort of approximately 93,605 patients; this is small enough to be manageable by the BCF interventions but a sufficient number through which large scale change can be evidenced.


Figure 16: Population segmentation by age, multi-morbidity (May 2014)

**Combining risk stratification and population segmentation intelligence**

We are in the process of allocating the whole population within our segmentation model as described above in the information governance section. Thus far, we have identified our core segments through both population segmentation and then the running of the ACG risk stratification tool across all practices.

For the top 2% highest risk patients we have used the ACG system to create a segment defined as:

- Aged 18+
- Risk of hospitalisation in next 12 months 30%+
- Risk of being in the top 5% highest costing group of patients in LLR 60%+ (this prediction is one of the standard outputs of the ACG system for each patient based on their Adjusted Clinical group cell. Patients are then assigned by the software into one of five Resource Utilisation Bands (RUB). RUBs 3, 4 and 5 have progressively increasing probability of being high cost patients (largely, though not exclusively, due to hospital use as either in-patients, outpatients or ED attenders) and are suitable candidates for proactive intervention by health and social care in the community.
- See the following example of how a patient with diabetes and associated co-morbidities is assigned to their ACG cell and how this maps to a level of health care resource use:

## How Morbidity Patterns Affect ACG Assignment (2)

| High Cost Patient with Diabetes | | |
|---|---|---|
| **Input Data/Patient Characteristics** | **ACG Output** | **Resource Consumption Variables** |
| Age/Gender: 54/Female | ACG-4930: 6-9 other ADG combinations, age > 34, 3 major ADGs | Total Cost: £1,800<br>OP Attendances: 6<br>GP Visits: 10<br>IP Admissions: 0 |
| Conditions: Diabetes Mellitus, general medical exam, congestive heart failure, thrombophlebitis, contusions and abrasions, non-fungal infections of skin, disease of nail, chest pain, vertiginous syndrome, fibrositismyalgia, respiratory signs/symptoms and cough | ADGs: 01, 04, 09, 10, 11, 21, 27, 28 and 31. | |

- three or more ACG defined LTCs
- 0-8 ACG defined “Hospital Dominant Conditions” (i.e. combinations of problems associated statistically with a 50%+ chance of hospitalisation in the next 12 months)
- ACG frailty flag positive as preference (frailty flag is switched on when a patient has one or more conditions highly associated with significant functional deficit – incontinence of urine or faeces, dementia, falls, carcinoma of lung etc.)

This has given each practice a list of their highest 2% at-risk patients (including those under 18 who have complex health problems) and accommodates those with mental health problems as well as physical health disorders – both major and minor. This allows each practice to participate in the national DES for unplanned admissions.

The CCG furthermore has used the ACG system to support the identification of the next highest risk group comprising the segment of the city population in the 2.1-10% highest risk cohort to target for a variety of interventions by health and social care with the aim of increased quality of holistic care leading to fewer unplanned admissions and shorter LOS this winter. While this population is characterised by having fewer hospital dominant conditions and more patients negative for the frailty flag; they are still a relatively high risk segment of the population. Anecdotal feedback from GPs and Practice nurses indicates that this cohort tend to offer greater opportunities for optimisation of their medical management and are likely to benefit from social care assessment.

Analysis of these lists has resulted in the 'typical profiles' for each risk band to be identified to aid planning:

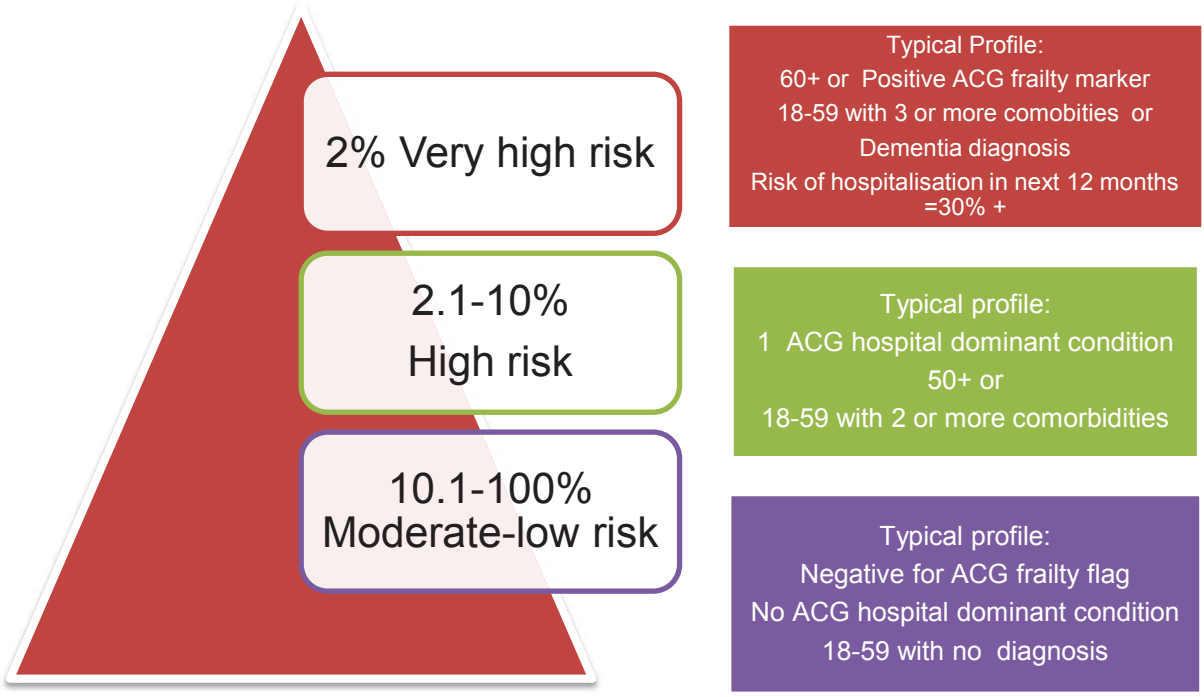



Figure 17: Combining risk stratification and population segmentation intelligence

Once access to the full data is granted, we plan to project our spend by segment for the whole population to inform not only BCF plans in the future but also to drive core commissioning.

## Step 2: Understanding the evidence for this population

The evidence base used for each priority area is outlined in each section below. This broadly resonates with the evidence bases provided in the BCF technical toolkit which has predominantly been used to sense check our plan.

For example, our priority areas and interventions map onto the review of case study evidence in the toolkit, shown below:

**REVIEW OF CASE STUDY EVIDENCE**

| Intervention | Case study: Torbay | Greenwich | Tower Hamlets | Dementia | Midlands | Australia | Knappschaft | Valencia | ChenMed | Geisinger | CareMore | Kaiser | NYCC[1] |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 Self-empowerment and education | | ✓ | ✓ | ✓ | ✓ | ✓ | | | | ✓ | | ✓ | ✓ |
| 2 Multi-disciplinary teams | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 3 Care coordination | ✓ | ✓ | ✓ | ✓ | | | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| 4 Individualised care plans | ✓ | | ✓ | ✓ | ✓ | ✓ | | | ✓ | ✓ | ✓ | | ✓ |
| 5 Rapid response | ✓ | ✓ | | ✓ | | | | | | ✓ | ✓ | | ✓ |
| 6 Training for care professionals | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | ✓ | | ✓ | ✓ | ✓ |
| 7 Co-location of services | ✓ | ✓ | ✓ | | | | | ✓ | ✓ | ✓ | ✓ | ✓ | |
| 8 Shared electronic care records | | ✓ | | | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | |
| 9 Frequent primary-care appointments | | ✓ | | | ✓ | | | | ✓ | | ✓ | | |
| 10 Risk stratification | ✓ | | ✓ | | | ✓ | | | ✓ | ✓ | ✓ | ✓ | ✓ |
| 11 Case management | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | ✓ | ✓ | ✓ | ✓ | ✓ |
| 12 Discharge support | ✓ | ✓ | | ✓ | | | | | | | ✓ | | ✓ |
| 13 Service user registries | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |
| 14 Scheduled service user follow-ups | | ✓ | ✓ | ✓ | ✓ | ✓ | | | ✓ | | ✓ | | ✓ |
| 15 Co-located pharmacies | | | | | | | ✓ | ✓ | ✓ | | ✓ | ✓ | |

1 New York Coordinated Care

SOURCE: Richardson, Dorling – Global Integrated Care Case Compendium (McKinsey)

*Inclusion criteria*

- Strong, consistent published **evidence of efficacy**
- Also used in the overwhelming **majority of the 13 case studies looked at**

| *Intervention* | *Number of reviews showing positive evidence* | *Additional insight from evidence base* | *Average impact[1]* |
|---|---|---|---|
| **1. Self-empowerment and education** | 83% (20 of 24 reviews) assessed patient support for self-care and found a positive impact | Supported self-management has the strongest effect on clinical outcomes of all IC components when estimated at component-level<br>*Tsai et al, Am J Manag Care, 2005 (August), 11(8), 478-88 (Table 4)* | Hospitalisations reduced by 25-30% (inter-quartile range) |
| **2. Multi-disciplinary teams** | 81% (13 of 16 reviews) assessed MDTs and found a positive impact | All reviews have concluded that specialised follow up of patients by a multidisciplinary team can reduce hospitalisation<br>*Holland et al, Heart, 2005, 91, 899-906* | Hospitalisations reduced by 15-30% (inter-quartile range) |
| **3. Care coordination** | 57% (8 of 13 reviews) assessed care coordination and found a positive impact | Interventions involving case management reduce HbA1c [in patients with diabetes] by 22% more than interventions without case management.<br>*Shojana et al, JAMA, 2006, 296(4), 427-440* | Hospitalisations reduced by ~37% (pooled estimate only reported in 2 relevant reviews) |
| **4. Individualised care plans[2]** | 64% (7 of 11) reviews) assessed care plans and found a positive impact | Personalised approaches using tailored information influence health behaviour more than uniform approaches<br>*Graffy et al, Primary Health Care Research & Development, 2009, 10(3), 210-222* | Hospitalisations reduced by ~23% (pooled estimate only reported in 2 relevant reviews) |

1 Impact measured from systematic reviews, including relevant interventions and containing meta-analyses of hospitalisation rate
2 Cochrane review of the evidence for personalised care planning (Coulter et al.) currently in process

SOURCE: Richardson, Dorling – Global Integrated Care Case Compendium (McKinsey)

Given the correlation between the interventions outlined above and those contained within our BCF plan, reviewing the evidence has reinforced the approach and subsequent interventions outlined in this plan.


## The case for change

Current estimates suggest that only 4% of the NHS budget is spent on preventative interventions but literature suggests that investing wisely and early into prevention could potentially lead to transformative change across Health and Wellbeing Board areas, (NHS Call to action, November 2013). We know that across the UK, health outcomes are poorer compared to our European neighbours (Law & Wald, 1999) and that we do not do enough to prevent long term disease and subsequent chronic disability. National evidence also suggests that we do not do enough to tackle the underlying risk factors associated with ill health, such as alcohol, smoking and obesity (NICE, 2014).

Prevention and effective management of conditions in the community is also likely to be more cost effective than waiting for patients to turn up sick at the doors of our GP surgeries or hospitals. Of more than 250 studies on prevention published in 2008, almost half showed a cost of under £6,400 per quality-adjusted life year and almost 80% cost less than the £30,000 threshold used by NICE. And although some interventions take many years to pay-off, others do not - for example, effective management of atrial fibrillation or hypertension can show results within a couple of years. Smoking cessation programmes can have an impact over the short term when targeted on Chronic Obstructive Pulmonary Disease patients at risk of acute admission, (NHS call to action, Nov 2013).

### Analysis of local data

As set out in the earlier sections of this plan, we know that citizens in Leicester City already suffer reduced life expectancy and more ill health than the national average. Moreover, analysis of specific diseases which are amenable to early intervention and preventative strategies shows equally adverse outcomes; therefore it is even more important for Leicester City to invest in the right interventions for these groups of patients, especially in light of the health inequalities seen across the City. The Marmot Review called for a strengthening in the role and impact of ill-health prevention, through

prevention and early detection of the key long term conditions related to health inequalities.

Many long term conditions are preventable and have common behavioural risk factors, amenable to public health intervention. Even when someone may have been identified as having one of these conditions there may still be opportunities, through appropriate health and social intervention, to prevent or delay the onset of complications and extend disability-free life. However, managing these conditions appropriately can be complex and challenging. The Better Care Fund programme provides major opportunity to improve services and their organisation locally, for the effective management of people with LTC.

**Current epidemiology**

In recent years, as part of the Quality and Outcome Framework (QOF), general practices collect information on patients with a number of common long term conditions. This is a useful local up-to-date source on disease prevalence:

| **Long-term condition** | **Number** (xi) | **%** | **England (%)** |
|---|---|---|---|
| High blood pressure | 43,233 | 11.4% | 13.7% |
| Diabetes (17+) | 24,554 | 8.3% | 6.0% |
| Depression (18+)(xii) | 17,253 | 6.1% | 5.8% |
| Asthma | 19,858 | 5.2% | 6.0% |
| Chronic Kidney Disease (18+) (xii) | 8,602 | 3.0% | 4.3% |
| Coronary Heart Disease | 10,022 | 2.6% | 3.3% |
| COPD | 5,145 | 1.4% | 1.7% |
| Stroke/TIA | 4,442 | 1.2% | 1.7% |
| Cancer | 4,171 | 1.1% | 1.9% |
| Mental health | 3,709 | 1.0% | 0.8% |
| Atrial fibrillation | 3,314 | 0.9% | 1.5% |
| Heart failure | 2,571 | 0.7% | 0.7% |
| Learning disabilities (18+) | 1,680 | 0.6% | 0.5% |
| Dementia | 1,745 | 0.5% | 0.6% |

*Source: Health and Social Care Information Centre QMAS database - 2012/13*

Many of these long term conditions are preventable and have common behavioural risk factors, amenable to intervention.

Modelled estimates derived from large health surveys, such as the Health Survey for England give a more complete estimate of the potential disease burden in Leicester, including people who are not aware of their condition or seeking medical help. These estimates show that whilst coverage of potential cases of diabetes, coronary heart disease and stroke are being relatively well identified, there is a need to focus attention on finding patients with COPD, high blood pressure, kidney disease or dementia who are not receiving routine care for their condition through primary care (see Table 7).

| Long-term condition | Estimated total | Potentially Undiagnosed (%) |
|---|---|---|
| High blood pressure | 63,524 | 32% |
| Diabetes (17+) | 24,285 | -1% |
| Chronic Kidney Disease (18+) | 15,851 | 46% |
| Coronary Heart Disease | 11,718 | 14% |
| COPD | 9,077 | 43% |
| Stroke/TIA | 4,782 | 7% |
| Dementia | 2,677 | 35% |

*Table 7: Potentially undiagnosed LTC's across Leicester City*
*Source: Association of Public Health Observatories*

### Estimating the future long term condition disease burden

The local population over the age of 50 is estimated to increase by 10% (over 9,000) between 2013 and 2021. As a consequence the prevalence of long term conditions is also likely to rise in the future, in line with the general ageing of the population and reductions in mortality for a number of diseases. Among those aged 65 and above, it is estimated locally that half (51%) have at least one long term illness.

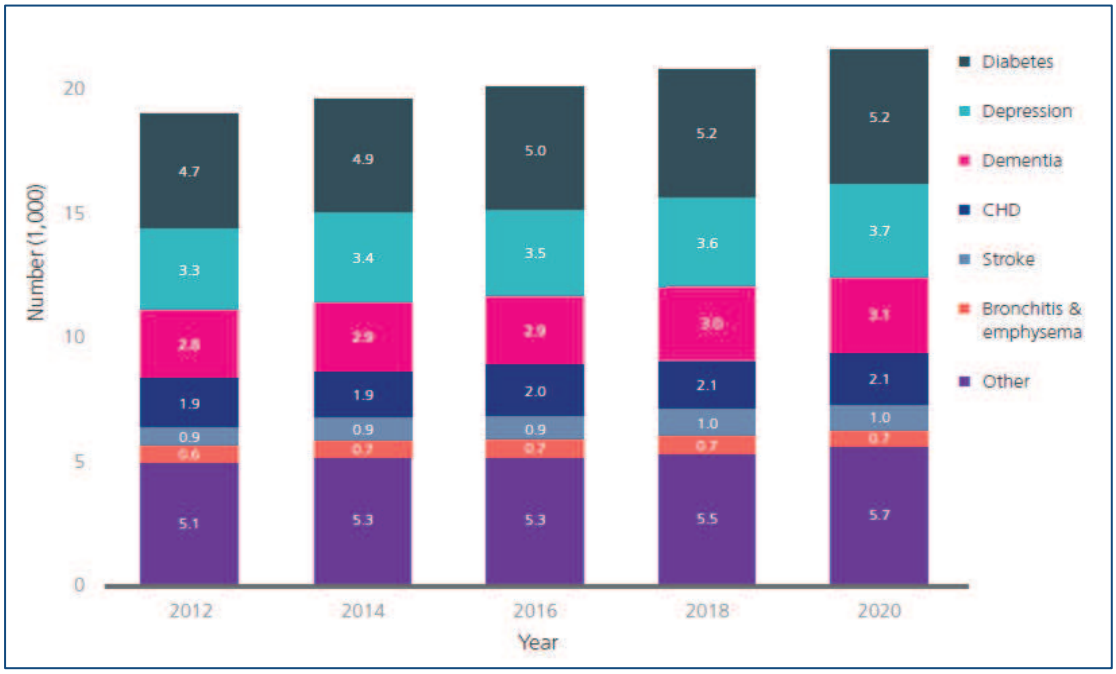



Figure 18: Estimated burden of long-term conditions in Leicester between 2012 and 2020 (ages 65 and above)

### Emergency hospital admissions for long term conditions

When someone has a chronic condition they need to be able to manage it effectively and minimise situations that result in their avoidable admission to hospital. Over the last nine years there has been a significant reduction in the rate of such admissions in Leicester. In 2003/04 local admission rates resulted in more than 1,300 excess admissions, when compared to the national average in that year. By 2011/12 this fell to just 250 excess admissions, making the rate only slightly higher than the England average.

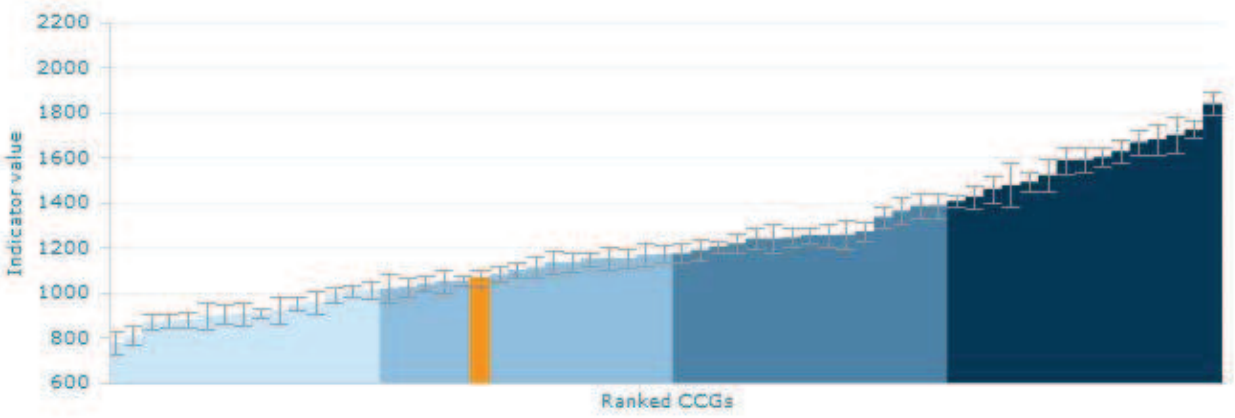



Figure 19: Emergency Admissions for conditions not normally requiring hospital admissions

Whilst this indicates an improvement in how well LTC are managed in the community but as Figure 19 shows, there is more that can be done in order to move to the top performing quartile nationally.

**Health inequalities in the distribution of long term conditions**
There are persisting inequalities in health of people with LTC in Leicester. In 2009-2011, emergency admissions for COPD were almost 5 times higher in the most deprived population of the city (standardised rate of 10 per 1,000 population) compared to the most affluent (2 per 1,000). The risk of a diabetes emergency admission is twice as high among the most disadvantaged population (16 per 1,000) when compared to their affluent counterparts (8 per 1,000).

Premature mortality due to cardiovascular and respiratory conditions is twice as high in the most disadvantaged population of the city (116 per 100,000 vs. 53 per 100,000 and 54 per 100,000 vs. 19 per 100,000, respectively), as is the risk of death due to diabetes (70 per 100,000 compared to 37 per 100,000).

**Financial case for change**
Finally, evidence that both primary and secondary prevention can impact positively on financial spend across a health economy can be found, with Wanless (2002) suggesting that £30b could be saved across healthcare spend if the public were fully engaged in preventative activities and Heckman (2006) estimating that the annual expected rate of return for preventative interventions to be between 6-10%. However despite this, investment in preventative services remains lows nationally and indeed, locally.

However, Leicester City is committed to changing this and this is evidenced both in this plan and the strategies on which this plan is aligned, including the HWB strategy, the Five Year Strategic Plan and the CCG Two Year Operating Plan.

**References**
As well as the evidence used in the national BCF toolkit, we have used a range evidences bases, drawing on both nationally produced documents, to journal articles and local evidence from our within our health and social care economy. These are provided in Appendix 3: Evidence base.


## The case for change

Improving urgent and emergency care is a key priority for the CCG, and aligns both strategically and operationally with this priority of 'reducing time spent avoidably in hospital'. Historically the model of care in Leicester City has been acute-centric, with over-reliance on hospital services and subsequently less early management of disease within community and primary care.

Our rationale for changing the way urgent care is delivered across the city is based on five challenges:

1. We are experiencing difficulty achieving national standards, for example we need to make sure we deliver to our four hour targets.
2. Existing urgent care settings are crowded and uncomfortable – citizens tell us that we need to improve the urgent care environment.
3. Navigating the urgent care system is complex and different depending on where you live in LLR, for example alternatives to A&E can be confusing with different models in place between different urgent care and minor injuries units. Patients and their families need to know where is it best for them to go when they are ill.
4. Urgent care services are not well connected to community health services – we need to deliver joined up services so, for example the ambulance service is aware of elderly frail patients being case managed by community staff.
5. We need to deliver on the national ambition to reduce emergency admissions to hospital.

We aim to fulfil the challenge set in *Everyone Counts* of a reduction of 15% in hospital emergency activity through the plans set out in the CCG Operating Plan 2014-16 and the wider Five Year LLR Strategic Plan but the size of this reduction against a context in which NHS Leicester City CCG and its legacy commissioners have held emergency admissions at or below 2008/9 outturn will be a significant challenge.

Our BCF plans are central to this transformative change, designed to keep people out of hospital where clinically appropriate and if they do require hospitalisation, to facilitate an efficient discharge process to ensure that time in hospital is reduced.

Looking at the outcome measure of 'reducing time spent avoidably in hospital' for those patients with chronic long-term conditions, when compared to the 10 similar CCGs in the 'Commissioning for Value' data set tells us that we perform better than most of our peer cohort:

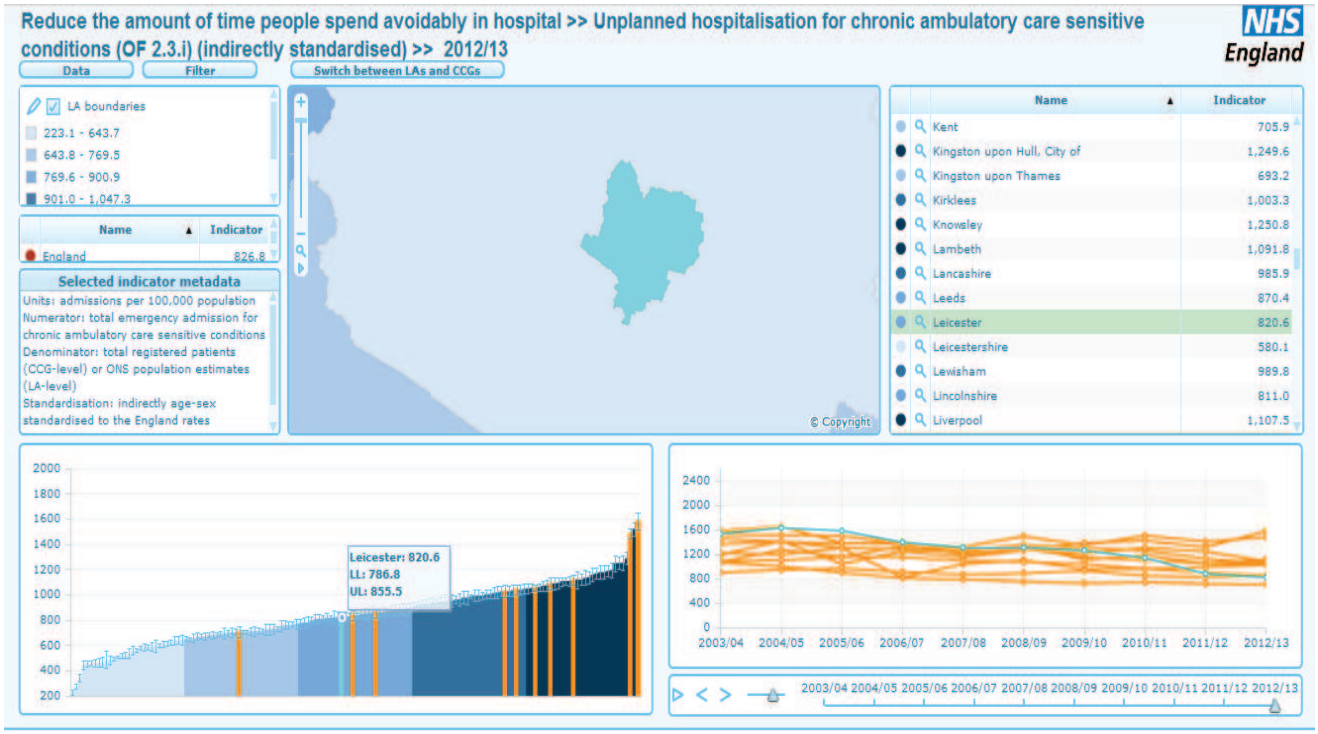



**Figure 20: The NHS Levels of Ambition Atlas: Reducing the time spent avoidably in hospital. Comparison of Leicester City CCG vs. nine similar CCGs in the country**

However, when compared to our neighbouring Health and Wellbeing Boards Areas and CCG's across LLR, the atlas tells us some of the reasons underlying the life expectancy gap between the city and the county, many of which have been discussed in earlier sections of this plan.

The Commissioning for Value data pack provides high-level data on elective and non-elective service areas to support effective commissioning for value. It identifies opportunities for CCGs to improve outcomes and increase value for local populations. The data compares Leicester City CCG to other CCGs of a similar population context and outlines areas where the greatest improvement could be made.

The data for Leicester City, shown in figure 21 below, clearly demonstrates that scale of opportunity in various key disease areas is substantial. These specific disease areas are targeted through the interventions described in this section, with priority placed on circulatory and respiratory diseases.

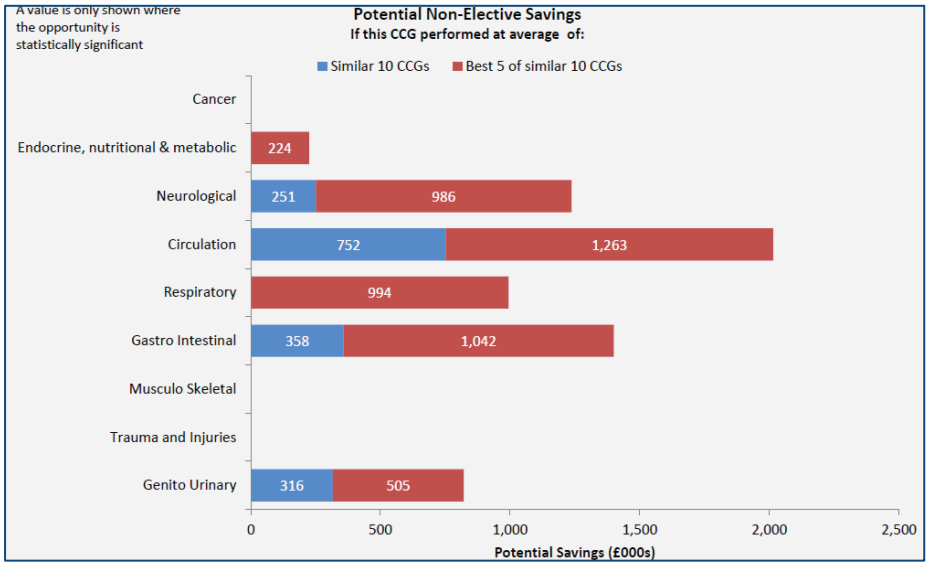


Figure 21: Potential areas of non-elective savings for Leicester City CCG produced by C4V, (2013)

System wide analysis has also provided commissioners with evidence that not enough is being done within primary and community services to keep patients out of hospital; and local analysis of ambulance data shows that once a 60+ year old Leicester City patient reaches the acute site, there is almost 67% chance of admission, regardless of the reason for attendance.

Repeated reviews of the urgent care pathway in Leicester have all concluded that patients are often admitted, particularly older patients, because there is either no service available at that specific time/day or that the admitting clinician did not know of any other service available (ECIST review, 2010, 2011) and this leads to almost 20% of all emergency admissions via ED being potentially avoidable (Utilisation Review, EMPACT, 2011). The same conclusions are drawn when reviewing the discharge pathways and DTOC data for the City – either community step down services were lacking or clinicians were not aware of what was (Utilisation Review, EMPACT, 2012).

In 2013/14, the CCG trialled a 'GP in a Car' service, designed to divert potential admission to community settings. This was successful in avoiding both ED attendance and admission and we have therefore commissioned a larger scale service, the Clinical Response Team, as the first response when an eligible patient calls 999 in crisis.

The CCG and Local authority have worked together over a number of years to test out what works for our population. We know that patients trust their GPs and therefore targeted, individualised care planning & coordination is essential, (Kings Fund, 2011). However, evidence also tells us that a team approach is vital to the successful management of complex patients (Graffy, Grande & Campbell, 2008) and therefore we have commissioned one joint Health and Social Care Unscheduled Care Team, co-designed between commissioners and providers across health and social care services to work with general practice and the Clinical Response Team to make best use of integrated community services with a two hour response time.

Finally, in response to the discharge pathway reviews and the increasing number of DTOCs noted in the system, 30 virtual beds will be commissioned to provide care in the

patient's own home. Again, this is based both ECIST & Utilisation Review recommendations (2010 & 2011) and on local analysis of a pilot site in a neighbouring CCG area, where Delayed Transfers of Care have been minimised as a result.

Our interventions, described fully below, are designed to stop both of these happening at both inflow and outflow points, thus reducing the time spent avoidably in hospital.

**References**

As well as the evidence used in the national BCF toolkit, we have used a range evidences bases, drawing on both nationally produced documents, to journal articles and local evidence from our within our health and social care economy. These are provided in Appendix 3: Evidence base.


**The case for change**

The final element of our plan enables a holistic approach to enabling independence for our BCF cohort.

The key to delivery of this sits with our Planned Care Team, described fully below, which delivers a more integrated community response to providing health and social care services and is centred around the individual patient and their needs as per our core vision for integrated care.

This element of the pathway will improve the quality and patient experience of care. It will ensure that patients receive a holistic assessment of their health and social care needs at an early stage rather than simply a restricted single track focus on addressing a presenting complaint without trying to address the underlying issues causing the problem. We know that many older people experience care that is fragmented between health and social care components which do not communicate well with one another and which address single problems rather than looking at the complete interaction between health and social care factors. This MDT model of care has been shown to benefit patients in a variety of pilots; a meta-analysis of published academic articles on integrated care showed that such schemes delivered an overall reduction in hospitalisation of 19%, (McKinsey, 2013). Equally, case management and care coordination of this type have also been evidenced, with models such as those in Croydon, Torbay & Tower Hamlets showing a positive impact on care, (McKinsey, 2013)

The inclusion of a mental health component to this integrated service allows us to address the often critical but under recognised psychological and psychiatric components of morbidity, in older people especially, which can have an adverse impact on ability to self-manage long term conditions especially when combined with issues of social deprivation as is the case with significant sections of the Leicester City population. Putting this resource within the planned care team will promote the parity of esteem agenda and offer patients and staff resources at an early stage to establish diagnoses and provide support to avoid crises.

We know that frailer older people are often taken to hospital with problems which do not require acute care management (see for example Tan et al. "Emergency Hospital Admissions for ambulatory Care Sensitive Conditions: Identifying the Potential for Reductions" King's Fund 2012"). We know that while acute hospital services can be essential and life saving for some older people, all too often an acute hospital spell can lead to subsequent hospital induced problems such as infections, delirium, falls, loss of confidence and loss of independence. Providing the right resources in the community will enable older people to be appropriately managed in their own homes or close to home where the experience of care will be better and the return to independence accelerated.

Those with complex mixture of health and social care needs and especially those who are older often find that care is fragmented. This planned care service will ensure that the most vulnerable and highest risk older patients have a seamless experience of care between health (including mental health) and social care.

Greater integration between the neighbourhood community nursing teams and their social care locality-based colleagues ought to improve communication and cooperation around key issues of safety such as safeguarding, prevention of potential harm from falls due to environmental or care requirement issues e.g. continence, nutritional concerns or medicines safety concerns.

**Mental health services**
Improving mental health service outcomes are a priority for both the CCG and local authority and a LLR Better Care Together priority. In particular the plans are to increase resilience in the population, earlier and more effective intervention, integrated local care delivery and proactive timely response to crisis and to managed demand for secondary care services.

A recent independent review of the LLR mental health pathway has evidenced that it is under significant pressure, with increasing delayed transfers of care, increasing length of stay, and people placed in out of county acute placements due to lack of local provision.

Benchmarking indicates bed capacity is within range of peer services but that community options are less developed leading to a higher LOS. Analysis shows:

1. In 2013/14 out of county (OOC) placements increased significantly. LLR spend on OOC placements in 2013/14 was £4m, with Leicester City CCG contribution of £1.9m towards this.

2. The average weekly cost of OOC placement was £3,600 per week, significantly higher than local provision.
3. City MH/LD DTOC has been increasing during 2013/14. It has been consistently higher per weighted population than county HWB areas, on average 4.5 higher per 100,000 population.

Based on this evidence, the health and social care system is jointly embarking on an improvement programme for mental health in line with the principles outlined in Service Transformation; lessons from Mental Health (Kings Fund, 2014); the interventions described in this plan are simply the first steps towards realisation of the whole vision for mental health services in the city.

**References**

As well as the evidence used in the national BCF toolkit, we have used a range evidences bases, drawing on both nationally produced documents, to journal articles and local evidence from our within our health and social care economy. These are provided in Appendix 3: Evidence base.

## Step 3: Using the evidence base to design of the Leicester City BCF

Leicester City CCG and the Leicester City Council have been working with our citizens, clinicians, practitioners and partner organisations to define and prioritise the interventions required to transform our pre and post hospital pathways. This has been a process conducted since November 2013 and achieved through multi-agency workshops, each with a specific aim.

| Workshop | Attendees | Objective |
|---|---|---|
| **Workshop 1: Population segmentation (November 14th 2013)** | Core BCF planning group | • To identify the population on which to focus the BCF |
| **Workshop 2: NHS call to action (December 3rd 2013)** | CCG GPs, LA representatives, patients & public, stakeholders | • To gain views from citizens on what the BCF should focus on and how it could be delivered |
| **Workshop 3: Integrated Care pathway design (December 17th 2013)** | Core BCF planning group | • To assess the evidence base for IC models nationally and internationally<br>• To assess local analysis of acute care usage<br>• To co-design a high level model of intergaretd care |
| **Workshop 4: Specific focus – Pre-hospital pathway I** | Core BCF planning group | • To assess the evidence base for admission avoidance interventions nationally and internationally |

| | | |
|---|---|---|
| **(December 31st 2013)**<br>**Workshop 5: Specific focus – Pre-hospital pathway II**<br><br>**(January 7th 2014)** | | • To assess local analysis of acute care usage<br>• To co-design a series of integrated services to keep people away from the acute site where appropriate |
| **Workshop 6: Discharge planning & maintaining independence**<br><br>**(February 5th 2014)** | Core BCF planning group | • To assess the evidence base for reducing occupied bed days nationally and internationally<br>• To assess local analysis of acute care usage/DTOC reports<br>• To co-design a series of integrated services to enable efficient discharge and independence at home |
| **Workshop 7: Alignment of the pathway with the VCS across the City**<br><br>**(March 11th 2014)** | CCG & LA representation<br><br>30+ VCS organisations | • To understand from the VCS how the services they provide would complement the BCF pathway |

Following the workshops, project managers from the Better Care Fund Team across organisations formed teams for each project and followed the Leicester City CCG commissioning process, including a financial impact assessment, a quality impact assessment, an equality impact assessment and a privacy impact assessment. This process culminated in the production of detailed business cases for each of the priority schemes which were then presented to the Joint Integrated Commissioning Board for approval on behalf of the Health and Wellbeing Board. Concurrently, all schemes were subject to the CCG and LA governance procedures to ensure robust critique of the proposed pathway as well as to secure strategic support for the programme.

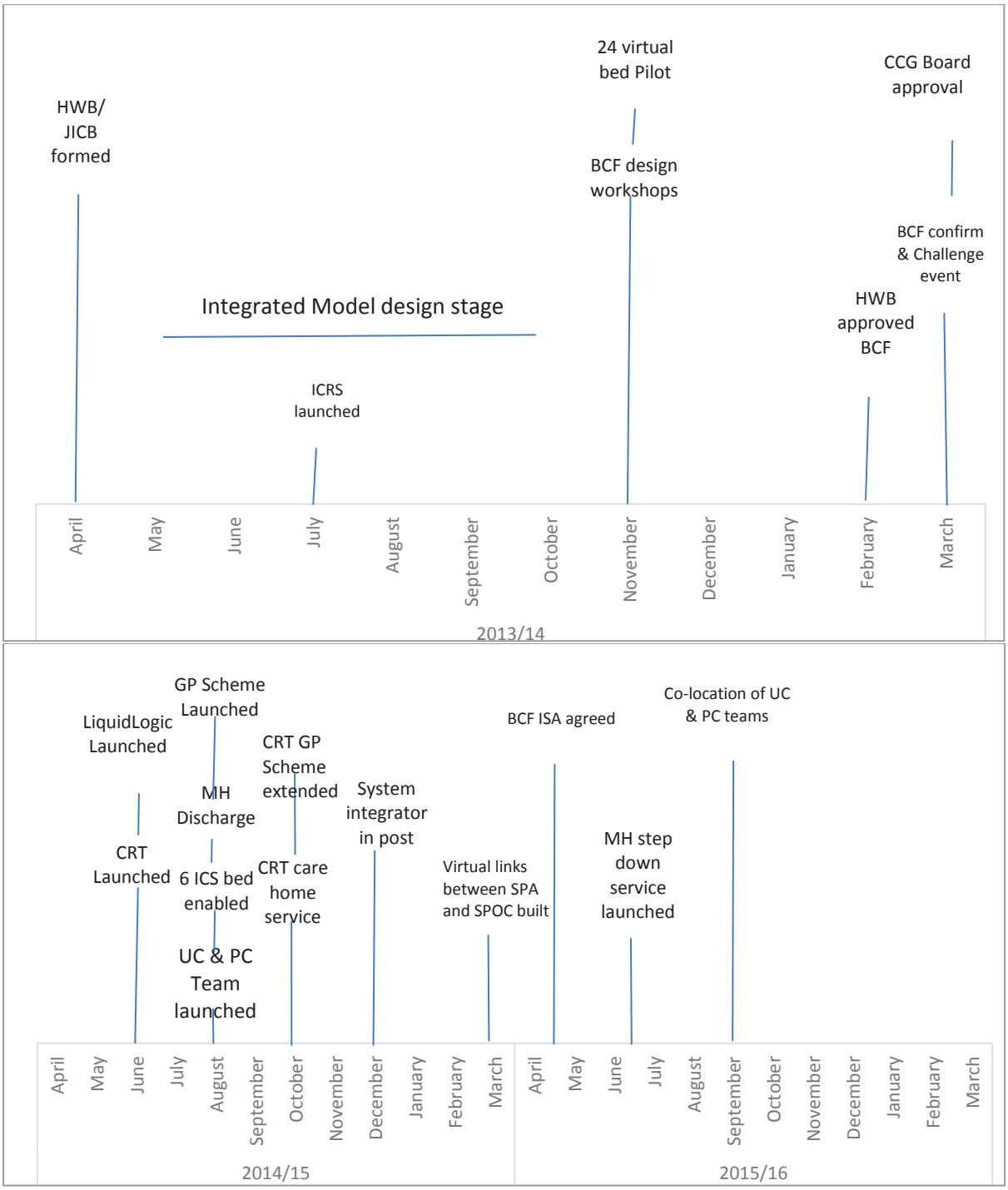
This also ensured alignment with other related programmes of ongoing work, such as the LLR Five Year Strategic Plan and specific pieces of work through, for example, the Urgent Care Working Group.

A final 'confirm and challenge' workshop took place on February 25th 2014 to ensure that all partners were in support of the proposals prior to mobilisation and to ensure that all partners across the BCF team were in agreement to the financial allocations in an open and transparent manner. Priority schemes for mobilisation were selected based on the impact modelled in terms of quality, cost and activity, outlined in later sections of this plan.

## 4) PLAN OF ACTION

### a) Please map out the key milestones associated with the delivery of the Better Care Fund plan and any key interdependencies

The key milestones associated with delivery of our vision extend back to 2013/14 and forward to 2015/16. A full mobilisation plan is attached as Appendix 4.



Key interdependencies are as follows:

- the LLR Five Year Plan and Delivery Programme;
- Government policy in relation to integrated health and care, pooled budgets and the future arrangements for the better care fund;
- the implications of operating in a challenged health economy;
- the roll out of 7 day services, in primary care and other settings;
- adoption of the NHS Number;
- development of the Single Point of Access;
- revised information sharing agreements for LLR;
- recruitment to a number of new services, and extended services and training programmes associated with new ways of working;
- ongoing evaluation of schemes against the metrics and financial benefits within the plan, supported by improved KPIs and data quality by scheme;
- implementation of user experience metrics within individual schemes, as well as by using the nationally prescribed metrics;
- implementation plans associated with the Care Act;
- any future configuration changes to the NHS in particular commissioning bodies.

**Please articulate the overarching governance arrangements for integrated care locally**

**The Programme Structure**

The governance of the Better Care Fund Programme builds on a mix of strong existing partnership groups and a new Better Care Fund Implementation Group.

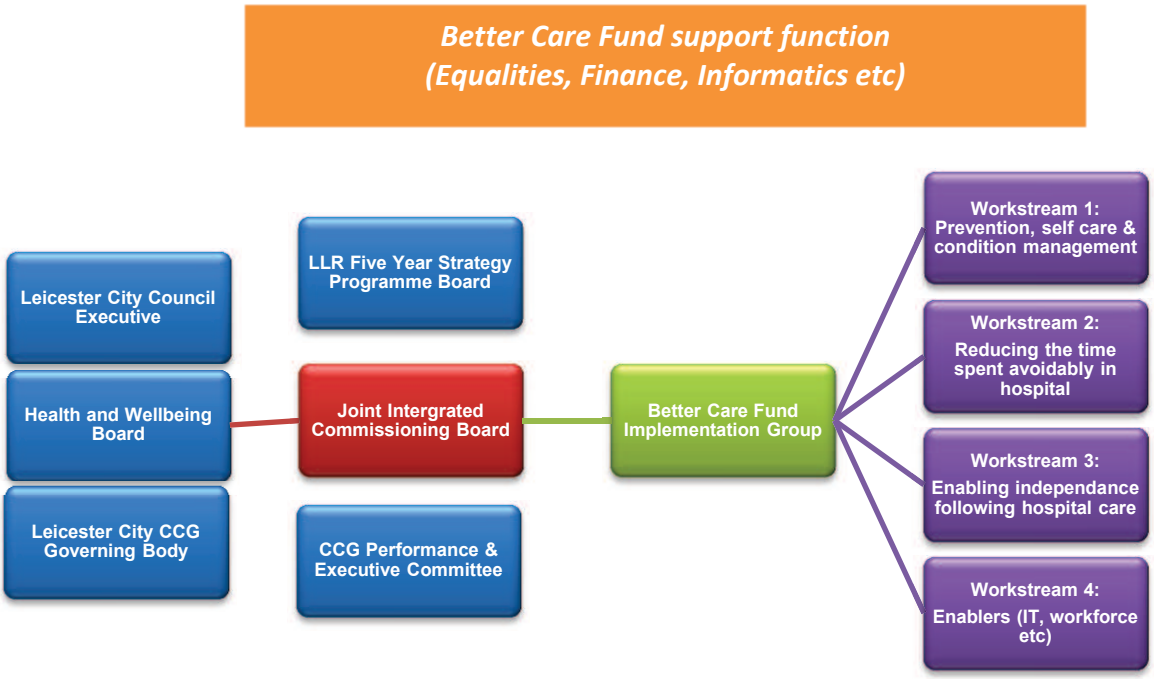



Figure 4: Better Care Fund programme structure

**Governance arrangements: strategic oversight**

Our journey towards integrated care began in 2013/14 following the introduction of the Health and Social Care Act 2012. Prior to this, the Leicester City HWB had been running in shadow form with joint commissioning arrangements in place between the PCT and the Local Authority through a shadow Joint Integrated Commissioning Board.

In April 2013, both the Leicester City Health and Wellbeing Board and the Joint Integrated Commissioning Board were formally established. The JICB held responsibility for delivery of the HWB strategy as well as overseeing joint commissioning between Leicester Clinical Commissioning Group and Leicester City Council.

The JICB consists of executive leaders from the health and social care economy, including the Managing Director of Leicester City CCG, the Chief Operating Officer of the Local Authority, the Director of Adult Social Care, Directors of Finance for the CCG and the local authority as well as clinicians from both the CCG and partner organisations. The Terms of reference for this Board are attached as Appendix 5.

Following a series of joint strategic meetings between partners across the Leicester City health and social care economy in September and October 2013, it was decided that the JICB should formally take over the strategic management of the Leicester City Better Care Fund, reporting progress directly to the HWB.

Given the collaborative nature of this programme, regular progress reports will also be provided to the LLR Five Year Strategy Programme Board to ensure alignment with the overall strategic direction of travel of the LLR health and social care economy.

**Governance arrangements: Delivery**

The delivery of each work stream of the BCF is overseen by the Better Care Fund Implementation Group, which began meeting in January 2014. This runs bi-weekly and is chaired by an independent lay member of the CCG. Terms of Reference are attached as Appendix 6.

The Implementation Group is attended by the following stakeholders:

- the four Chairs of the general practice localities in the CCG;
- Director of Adult Social Care, Local Authority;
- Head of Strategy & Planning, CCG;
- Lead Nurse, CCG;
- Heads of Service at the Local Authority;
- Head of Strategic Change, UHL;
- Heads of Service at LPT;
- Heads of Service at SSAFA;
- Heads of Service at EMAS;
- Workstream Project Managers across organisations.

Relevant functions across the organisations attend for specific items as required.

Each project completes a highlight report, outlining expected and actual progress, key risks and quality issues and actions for the coming fortnight. Any remedial actions are agreed and monitored here, with unresolved issues being escalated to the JICB Chair within 1 working day.

Sub-groups of the BCF Implementation groups, detailed below, are predominantly chaired by Governing Body GPs where relevant; where not, they are chaired by senior officers across health and social care.

**c) Please provide details of the management and oversight of the delivery of the Better care Fund plan, including management of any remedial actions should plans go off track**

**Performance management of the programme**

As the BCF is one of the key enablers to multiple streams of work across the CCG, Local Authority and provider organisations, a comprehensive suite of monitoring has been formulated using the practical outcomes selector (NWL toolkit), based on the Quality/Experience/Cost framework outlined in the BCF technical toolkit. These outcome measures have been agreed at the BCF Implementation Group, with input from all partner commissioner and provider organisations across the Health and social care economy and align to HWB strategy, the JSNA and the two and five year CCG plans.

*Strategic level – Monthly reporting to the JICB and CCG Performance Exec*

At a strategic level, an overarching system dashboard is being formulated, covering the 5 + 1 national metrics as well as other relevant metrics to manage flow at a system level. These have been drawn from the ASC, NHS and public health outcomes frameworks as well as local flow measures and enables all health and social care organisations to understand the quality of services and the patient flow through the system in terms of inflow, throughout and outflow metrics, with the same dashboard serving the Urgent Care Working Group.

Monitoring at this level has enabled the JICB and the CCG Performance Exec to understand issues affecting performance and intervene early to mitigate more strategic issues. For example, monitoring at this level has enabled early identification of issues affecting delayed transfers of care within mental health units and has accelerated multi-organisational change to improve patient experience and performance.

*Operational Level – Bi-weekly reporting to the BCF Implementation Group*

Underneath this, sits a comprehensive Integrated Care Performance Dashboard, specially produced to support the performance management function for the BCF Programme. This shows a suite of local metrics by project, providing a coordinated view which aids understanding of any barriers to achievement of the overarching national metrics, as well as providing further commissioning intelligence across the Leicester City health and social care system.

Again, monitoring at this operational level has already led to change in pathways. For example, monitoring of the Clinical Response Team activity outlined capacity in the service to take on a wider range of calls from EMAS early on in the project. As a result, call categories were increased, leading to a greater number of calls being diverted to the CRT within a few weeks.

*Practice level – Weekly reporting*

Finally, GP practice level monitoring has been added to monitor progress against practice level targets for interventions aligned to the BCF, such as care planning, access to preventative services and overall acute care usage by practice.

In totality, this provides a comprehensive view of both the health and social care system as a whole and tracks performance of the Integrated Care model.

All draft dashboards are provided as Appendix 7.

**Assuring delivery**

a. Pay per performance/risk pool

Following the publication of the revised BCF guidance in July 2014, the impact of the requirement to achieve a 3.5% reduction in emergency admissions was risk assessed, both for the Leicester City BCF plan and as a whole across our the 3 LLR BCF areas.

A reduction of 3.5% equates to 1013 emergency admissions which represents £1.5m of the BCF pooled budget, based on the average cost of an emergency admission of

£1490. This is the proportion of the Leicester City pooled budget fund which will now be subject to pay for performance. The Leicester City BCF plan submitted in April 2014 did not identify a contingency for the risk pool. However, agreement between the CCG, Local Authority (and partner providers, including the Acute Trust) has been reached to hold £1.5m as a contingency fund in 2015/16.

In order to assure delivery against this metric in particular, contributory trajectories for each intervention have been agreed at the BCF implementation Group and these will be monitored bi-weekly.

b. Interdependencies

It is recognised that other factors outside of the BCF interventions and related HRG codes will have an impact on the total emergency admissions performance, given the definition of this metrics. For example, in Q4 2013/14, Leicester City CCG saw its emergency admissions increase by c20% without any corresponding increase in either ED attendance or decrease in community activity. Investigation shows that this is largely due to a change in coding practice as a result of pathway changes in the urgent care system. This increase is currently under review with UHL. The intention within the Leicester City BCF plan is to be clear about the relative contribution of the interventions mobilised and be able to record and demonstrate their impact.

## 4d) **List of planned BCF schemes**

Please list below the individual projects or changes which you are planning as part of the Better Care Fund. Please complete the *Detailed Scheme Description* template (Annex 1) for each of these schemes.

| Ref no. | Scheme |
|---|---|
| **Priority 1:** Prevention, early detection and improvement of health-related quality of life | |
| BCF 1 | Risk stratification |
| BCF 2 | Lifestyle Hub |
| BCF 3 | General practice scheme (2.1-10%) |
| **Priority 2:** Reducing the time spent in hospital avoidably | |
| BCF 4 | Clinical Response Team |
| BCF 5 | Unscheduled Care Team |
| BCF 6 | System coordinator |
| BCF 7 | Intensive Community Support Service |
| BCF 8 | IT integration |
| **Priority 3:** Enabling independence following hospital care | |
| BCF 9 | Planned Care Team |
| BCF 10 | Mental Health Discharge Team |
| BCF 11 | Integrated Mental Health Step Down Service |

## 5) RISKS AND CONTINGENCY

### a) Risk log

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 and any financial risks for both the NHS and local government.

Our BCF programme has a number of projects, each of which has a lead project manager to coordinate risks pertaining to that project. A standard template is utilised to capture any risks which follows the CCG risk management strategy outlined below and uses a consistent impact likelihood scale, outlines mitigating actions and the and areas of action and responsibility. These individual project risks can then be brought to the attention of the BCF programmes Implementation Group to aid in a coordinated oversight and management of any risks (clinical and non-clinical) to the programme. Individual organisations are then able to escalate through their organisations as appropriate utilising their existing processes and back down to the BCF Implementation Group as appropriate.

**BCF Risk management strategy**

The CCG has in place a Risk Management Strategy and Policy that clearly defines the principles, systems and mechanisms in place to manage risk within the organisation. It is embedded in the normal management processes and structures of the CCG and as such is the framework used to manage all risks regarding the Leicester City Better Care Fund.

The Risk Management Strategy and Policy requires all risk management to be systematic, robust and evident, and that risk management processes are applied to business planning at all levels. It provides guidance to staff in managing risk appropriate to their areas of responsibility. The strategy clearly sets out the authority levels and accountability arrangements and identifies key individuals within the organisation who have specific duties with regard to the management of risk.

The strategy and policy clearly describes the processes that the CCG has put into place in order to adequately manage risk. This includes supporting employees to identify, assess, report, treat, control and monitor risks through robust management of directorate risk registers, with the most significant risks being escalated to the Board Assurance Framework.

The CCG has adopted a robust risk assessment and identification process that captures both internal and external sources of risk using proactive and reactive methods. These are detailed below:

- Top down – proactive identification of risks that directly affect the CCG's achievement of its strategic objectives. This includes the consideration of political, economic, social, technological environment and horizon scanning to identify emerging opportunities and threats;

- Bottom up – assessment through the use of Directorate Risk Registers, claims and litigation, trends in incidents, trends in complaints and through performance management mechanisms, for example the CCG's performance dashboard.

Risks are categorised into one of four groupings – clinical, organisational, financial and information. The CCG has adopted the Australia/New Zealand (AS/NZ Standard 4360 1999: Revised Ed. 2004) as this provides a generic model for identifying, prioritising and dealing with risks in any situation. Risk is assessed using the 5 x 5 model, which considers the risk in terms of it resulting in injury/safety, legal or financial threat, performance or service interruption, regulatory action, or adverse publicity and damage to the reputation of the CCG or wider NHS.

Each risk is assigned to an appropriate register (either corporate or directorate) depending on the score for its impact multiplied by the score for the likelihood of that occurring. Each rating is presented as a mitigated score based upon consideration of the controls in place. Once graded they fall into four categories; low, moderate, high and extreme risk. Actions to further reduce the risk rating are recommended. Controls for individual risks are only recorded where they have been verified as making an active difference to reducing or mitigating a risk.

Risks are reviewed by the Chief Corporate Affairs Officer, Head of Corporate Governance or by the Senior Management Team for corporate risks, or by the designated lead for departmental risk registers with guidance and support from the Chief Corporate Affairs Officer.

The full risk log is attached as Appendix 8.

**b) Contingency plan and risk sharing**

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place between commissioners across health and social care

In terms of the changes enacted to BCF policy in July 2014, (ref the implications of the new pay for performance scheme, new metric definitions and baselines provided as part of the resubmission process) a contingency fund has been created given the greater risk to achievement of the emergency admissions target in order to mitigate the proportion of the fund that is subject to pay for performance - £1,560m – in full. This was agreed in August 2014 by a CCG/LA risk workshop and ratified by the Joint Integrated Commissioning Board. This is due to the challenged health economy context and the current gap between performance and the 3.5% threshold needed to achieve.

It is recognised that the pay for performance scheme will operate quarterly in arrears and if the trajectory is not being achieved monies from the risk pool within the pooled budget are released to CCGs so that corresponding activity in the acute sector can be reimbursed. This will be monitored at the BCF Implementation Group, with any deviation from trajectory and recommended actions reported to the JICB chair within 1 working day for resolution.

£1,560m will be held in reserve in the pooled budget and not applied to other expenditure in the BCF in 2015/16 until assurance can be achieved on delivery of the target (at least six months performance information will be required in the first instance).

Depending on the future BCF policy framework beyond 2015/16, a proportion of the reserve may need to be carried forward to provide a contingency on a recurrent basis. It is hoped this would however be a much smaller figure if the BCF plan is performing overall.

Financial principles have been developed for 14/15 outlining the arrangements in place between the CCG and the Local Authority, and a full Section 75 agreement is in production.

Please outline the locally agreed plans in the event that the target for reduction in emergency admissions is not met, including what risk sharing arrangements are in place between providers and commissioners

In the event that target reductions in emergency admissions are not achieved, the contingency will be used to fund the additional activity within the acute sector.

The application of the monies from the risk pool arising from non-performance against the 1013 reduction in emergency admissions will be actioned via the existing contractual routes between the CCGs and University Hospitals Leicester.

**6) ALIGNMENT**

**a) Please describe how these plans align with other initiatives related to care and support underway in your area**

Our BCF plan fully aligns to wider changes within Adult Social Care at Leicester City Council. This includes:

- Care Act implementation programme;
- strategic commissioning reviews for independent and voluntary sector provision (to meet both statutory and preventative needs);
- housing and estates programme;
- ICT strategy;
- capital programme;
- departmental revenue strategy.

**Other key interdependencies**

As referenced in Section 4, there are a range of interdependencies which will impact on the success of this programme. Where possible, these plans have been aligned with resource/plans either shared across programmes or enveloped by the BCF.

For example, a key determinant of being a challenged health economy has been over reliance on an acute bed based model of care. By aligning the interventions in this plan to the acute provider plans to reduce bed stock over the next 5 years, the BCF has become a key enabler of success across these 2 different but aligned programmes of work.

Duplication of effort in inter-dependant workstreams has also been eliminated. For example, much of the IM&T requirements detailed in this plan (Information governance relating to risk stratification and development of the use of the NHS number) has been done at a sub-regional level in line with the LLR IM&T board, a function of the LLR Five Year Strategy in order to reduce duplication and maximise efficiency.

**Communication between initiatives**

As referred to earlier, the BCF Implementation Group and the Joint Integrated Commissioning Group both report into various CCG and system-wide groups. This dual reporting (for example, activity and finance associated with the BCF is monitored at both the JICB and the CCG performance exec) facilitates alignment to other related plans, such as System Resilience Groups and the Five Year Strategic Planning function. This communication is the responsibility of all those who attend the BCF Implementation Group and the JICB, with communication to other groups specifically written into the TOR to assure alignment.

**b) Please describe how your BCF plan of action aligns with existing 2 year operating and five year strategic plans, as well as local government planning documents**

**Alignment with CCG 2 Year Operational Plan and the LLR Five Year Strategic Plan**

Schemes described in this plan are all included as part of both the Leicester City CCG Two Year Operational Plan and the five year strategy and is the key driver to achieving transformative change within both the Leicester City and wider Health and Social Care economy over the next five years. Our core priorities are coordinated with our partner Health and Wellbeing Board areas across Leicestershire County and Rutland County, taking into account the differences in need, demography and geography through differing delivery methods.

The changes presented in this plan will form the first 2 years of an overarching move towards a new way of working in recognition of the significant capacity and demand issues faced within the local health and social care economy. All BCF schemes listed in this plan have therefore been factored into both strategic and financial planning for 2014/15 and 2015/16, and have been contracted with providers for 2014/15.

Through the Five Year Strategic Plan, alignment with Provider Cost Improvement Plans has also been achieved, with the impact of the BCF taken into account in Provider assumptions.

Evaluations of the interventions in this plan will be conducted through 15/16 to ensure that those which will need to be included from 2016-18 can be commissioned as part of the core planning processes.

## c) Please describe how your BCF plans align with your plans for primary co-commissioning

**CCG status**
The CCG believes that co-commissioning of primary medical care represents an intrinsic element in realising our long-term ambitions for health and health services in the city, supporting the delivery of a broader range of services in primary and community settings and reducing over-reliance on acute services – in direct alignment with the direction of the Leicester City BCF. To do this will require radical transformation of current primary care services and the way in which they are now provided. To this end, the CCG has expressed an interest to take on the full scope of primary care commissioning responsibilities.

**Engagement of primary care providers**
The interventions described in this plan were co-designed with our Governing Body GPs and our member practices and designed to complement the enhanced services recommended in Transforming Primary Care.

Our Governing Body GPs have been engaged from the outset, directly co-developing the interventions in this plan. Member practices have been engaged monthly at both a locality level and at Protected Learning Time events since December 2014, through face to face briefings and workshops to ascertain:

1. How practices can support delivery of the aims of the Leicester City BCF and;
2. How the BCF interventions can help support practices during a time of sustained high demand

These events raised a wide range of issues, each of which has been directly resolved where possible and fed back at future meetings.

For example:

| Issue raised: | By who: | Result: |
|---|---|---|
| Capacity in primary care continues to be an issue | Member practice | Locality based schemes have been developed to increase the capacity in primary care to support the BCF cohort |
| The system will not be truly integrated until health professionals have a single number to call for health and social care | Governing Body GP | This has been built into plans for the joint health and social care teams for 15/16 |
| Governing Body GPs do not have capacity to run individual sub groups of the BCF | Governing Body GP | Added to risk register, with teleconference facilities secured for all meetings |

The interventions designed have been approved by the CCG Governing Body on behalf of member practices, with the resultant model of care presented to city-wide Protected Learning Time events through 2014/15.

## 7) NATIONAL CONDITIONS

Please give a brief description of how the plan meets each of the national conditions for the BCF, noting that risk-sharing and provider impact will be covered in the following sections.

### a. Protecting social care services

**i) Please outline your agreed local definition of protecting adult social care services (not spending)**

Protecting social care services in the Leicester means:

- Helping to ensure that those people with eligible needs within our city continue to receive the support they require, in a time of growing demand and budgetary pressures.
- Delivering new approaches to joined up care, which help people to remain healthy and independent.

Eligibility is currently set at substantial and critical, and assumes that this will continue unchanged as the national eligibility threshold is introduced with the Care Act in April 2015.

Leicester does not operate individual service criteria for statutory services, this being based on eligibility for funded care, not a service type; however we expect to maintain the same levels of access to statutory services as now.

By ensuring proactive interventions to our target population, to support prevention, self-care and to enable people to tackle the wider determinants of poor health and poor quality of life.

**ii) Please explain how local schemes and spending plans will support the commitment to protect social care**

Funding currently allocated via the BCF to the Council has been used to enable the local authority to sustain the current level of eligibility criteria and to provide timely assessment, care management and commissioned services to eligible clients. This has also supported the provision of advice, signposting and a range of preventative services to the wider population.

Sustained funding from the Better Care Fund is required to maintain this position, and additional resources will need to be invested in social care to deliver the rapid access services that are required to respond to our agenda to reduce unplanned admissions and admissions to care homes.

A process has been completed which has identified a recommended level of support for social care that both requires Leicester City Council to ensure that it is delivering services in the most cost efficient manner and allows for a protection fund in 2015/16, with an

investment pool equal to the expansion of services needed to meet the required reduction in use of the acute sector. This is achieved through the schemes in relation to investment in crisis services within the unscheduled care team; investment in social work capacity to move towards extended / 7 day services; investments in assistive technology and practical help at home to support additional demands from proactive care models.

The schemes across unscheduled and planned care will contribute to the ongoing protection of social care services, by reducing and delaying the need for statutory services, as well as preventing admissions to long term care through effective crisis intervention and hospital admission avoidance. By investing in preventative services such as technology, this will also reduce the burden on health services, for example in reducing falls and managing medications compliance.

Demographic pressures are well understood and national tools used to forecast their financial impact. Demographic pressures were a part of the discussions on estimating the costs of protecting adult social care although the BCF will not in itself mitigate these pressures in full; the council is separately preparing its budget proposals which recognise the costs of demographic growth.

**iii) Please indicate the total amount from the BCF that has been allocated for the protection of adult social care services. (And please confirm that at least your local proportion of the £135m has been identified from the additional £1.9bn funding from the NHS in 2015/16 for the implementation of the new Care Act duties.)**

A total of £5.65m has been allocated to protect social care, in addition to investment funding to deliver the out of hospital services required in the community as part of the BCF plan.

This includes the £840k that has been allocated to support the implementation of the Care Act.

**iv) Please explain how the new duties resulting from care and support reform set out in the Care Act 2014 will be met**

(Setting aside the funding reform elements proposed for April 2016)

The Care Act 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;
- 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 Leicester City allocation is circa £0.84m.

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.

The Council has a comprehensive Care Act Implementation Programme, covering all aspects of change required from April 2015. This will ensure that the Council is able to meet its new duties. Financial and demand modelling are still an issue of national debate, and at this stage it is unclear whether the funding allocations within BCF will be sufficient to accommodate the new legislative burdens relating to assessment, eligibility and carers specifically, as well as prisoners. This will continue to be monitored as plans are implemented.

The Care Act implementation plan is in part allocated to the Council's BCF implementation team for delivery, where the changes required have inter-dependencies with BCF integration schemes; this is specifically designed to avoid disconnect between these two major change programmes.

**v) Please specify the level of resource that will be dedicated to carer-specific support**

£650k of BCF resources are dedicated to carer specific support. In addition there is £429k (as part of the £840k Care Act monies assumed within the allocation to the Local Authority) for the implementation of Care Act provisions relating to carers assessments and services.

Local financial modelling however has estimated the costs of new duties re carers to be much higher that this (c £800k - £1,000k).

Carers direct support will be delivered by carers personal budgets, enabling carers to have control over the resources they require to maintain their caring role, In addition, a range of preventative services will be available, such as Caring with Confidence training, advocacy and advice. There will also be access to services that are provided to cared-for people, to provide respite to their carer, including a flexible short breaks service offer.

**vi) Please explain to what extent has the local authority's budget been affected against what was originally forecast with the original BCF plan?**

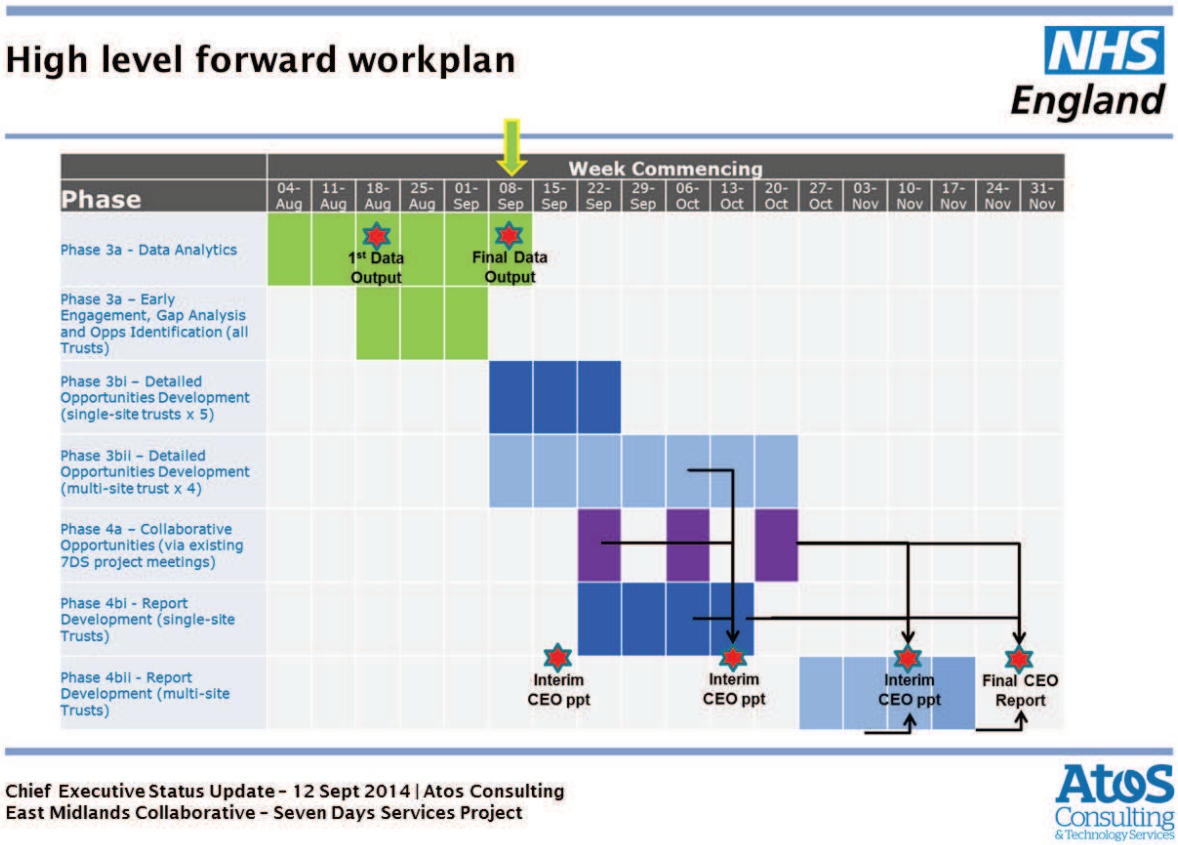
There has been no change to the council's budgetary position against the original BCF plan.

## a) 7 day services to support discharge

Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and to 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 against the ten elements of the clinical standards and a regional workshop has been held to share emerging practice and models of care to support this work. The baseline assessment 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 the Unscheduled Care team which offers a combined health and social care response to avoid admissions where urgent help is needed in the community.

Key milestones associated with this are represented below:




Locally, across the city, there are already specific community health and social care services available over the weekend but we recognise that traditionally these have been poorly utilised, both for admissions avoidance and discharge. Test weekends (run earlier this year) have proven that a more integrated model of seven-day working across front-line health and social care is vital for a more responsive and patient-centred service.

As part of our commitment to deliver seven-day services, the 2014/15 Acute Service Development and Improvement Plan includes a specific action plan to deliver against the clinical standards outlined in the 7DS document. This is monitored and delivered through

the Leicester, Leicestershire and Rutland Urgent Care Working Group but due to the interdependencies, is also aligned with the BCF plans for 14/15. We will evaluate the impact of these and where relevant will move these into the quality requirement section of the NHS Standard Contract for 15/16 and 16/17.

Our Better Care Fund plans include seven-day working (where applicable & feasible) as a standard expectation to support the flow across the health and social care system. For example, most schemes mobilised in 2014/15 through the Better Care Fund have been on a seven-day service expectation. This includes the Clinical Response Team, the Unscheduled Care team and the Planned Care Team in the first instance; however, we expect some services to expand to seven-day working in Q1 2015/6 where workforce allows across health and social care.

Alongside this, the CCG has invested an additional £1.6m in primary care in the city in 2014/15 to support the BCF plans; plans have been proposed by GP localities and been formally approved by the CCG Governing Body. These plans collectively include systematic access to primary care and support to discharge of patients across 7 days where appropriate and evidence-based.

**How will the BCF interventions enable 7 days services to be delivered?**

| **BCF Intervention** | **Impact on 7 day service provision** |
|---|---|
| General Practice scheme (2.1-10%) | Enhanced access to primary care |
| Clinical Response Team | 7 day service to prevent hospital admissions |
| Unscheduled Care Team | 7 day service to prevent hospital admissions |
| System Integration Coordinator | 7 day service to prevent hospital admissions and increase weekend discharge |
| Intensive Community Support service | 7 day service to prevent hospital admissions and increase weekend discharge |
| Planned Care Team | 7 day service to prevent hospital admissions and increase weekend discharge |
| Mental Health Discharge Team | 7 day service to prevent hospital admissions and increase weekend discharge |

## b) Data sharing

### i) Please set out the plans you have in place for using the NHS Number as the primary identifier for correspondence across all health and care services

**What we have done so far**

Leicester City Council and partners are committed to using the NHS number as the primary identifier. Leicester City Council has procured a new social care system called Liquid Logic. Liquid Logic has very recently, April 2014, been deployed and implemented for Children's and Adult Social Care.

Liquid Logic does allow for the NHS number to be imported and used as a primary identifier along with capabilities for real time validation to support day to day operation working.

**What we plan to do next**

To ensure that Liquid Logic can use the NHS number as a primary identifier, Leicester City Council have started engagement with HSCIC to ensure appropriate procedures are in place to have access to the NHS number. The Council is in the process of applying, as a commissioner; to the HSCIC for the NHS numbers in order to bulk populate Liquid Logic records with verified NHS numbers. This phase is anticipated to be complete around November 2014.

Leicester City Council have also developed plans and are currently working towards developing a technical infrastructure between Liquid Logic and the NHS SPINE in order to make available Personal Demographic Data to social care front line staff. This second phase is anticipated to be complete around January 2015.

Role based access control will be in place as part of deployment and relevant staff will be trained to use the NHS number. The NHS number being used as the primary identifier is anticipated to become standard procedure by January 2015.
All future information sharing agreements between the Council and health partners will include the NHS number as a specific piece of data that is required.

### ii) Please explain your approach for adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Leicester City Council is firmly committed to adopting systems that are based upon Open APIs and Open Standards (i.e. secure email standards, interoperability standards (ITK)). Any new systems that are procured for health and social care will have this as a core requirement. This will allow greater interoperability between systems and allow for greater electronic sharing of information.

The first step in the process has been to procure a new social care system (Liquid Logic). Liquid Logic has the ability to communicate and interoperate with health's IT systems. Once installed, the Council will work with health partners to ensure that information flows

between health and social care are carried out electronically, securely and safely by using national standards.

The Council is currently a member of the NHS LLR IM&T Strategy Board. A key objective of this Board is to look at opportunities of sharing and using information better between various organisational systems to improve patient care. Open APIs, Open Standards and ITKs are reviewed as part of any new solution that the Board take forward.

**Please explain your approach for ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practice and in particular requirements set out in Caldicott 2.**

Leicester City Council, Leicestershire Partnership NHS Trust and Leicester's Hospitals are signed up to the Leicestershire information sharing protocol which sets out the minimum standards expected from secure transfer of personal data (e.g. secure email, encryption, pass worded documents, registered post, secure FTP transfer). Newly formed health organisations such as the CCG and Greater East Midlands Commissioning Support Unit (GEM) are currently being invited to sign up.

Where data sharing takes place between these organisations written information sharing agreements are put in place. The county-wide Leicestershire Strategic Information Management Group are currently producing security standards for all partners in the county to adhere to when sharing information based on these standards.

We can confirm that we are committed to ensuring that the appropriate IG Controls will be in place. The existing county-wide information sharing protocol already introduced robust information governance standards across the county and followed Caldicott principles where health data was involved.

An information sharing protocol has been drafted between partners to cover all aspects of information sharing as part of the Better Care Fund. Individual information sharing agreements will be implemented for data sharing relating to the Better Care Fund.

All partners are committed to reviewing their relevant IG policies and fair processing notices to reflect the Caldicott 2 recommendations, and future information sharing agreements will reflect this. Leicester City Council has obtained level 2 of the NHS IG Toolkit for both Public Health and Social Care.

Leicester City Council last year introduced mandatory online data protection training for all staff and with the support of management in social care, annual refreshers will be implemented in 2014.

The Council has a named Caldicott Guardian within the organisation. The Guardian plays a key role in ensuring that the Council with social services responsibilities and partner organisations satisfy the highest practical standards for handling patient identifiable information. The Guardian actively supports work to enable information sharing where it is appropriate to share, and advises on options for lawful and ethical processing of information.

**How will the BCF interventions enable the NHS to be the primary identifier?**

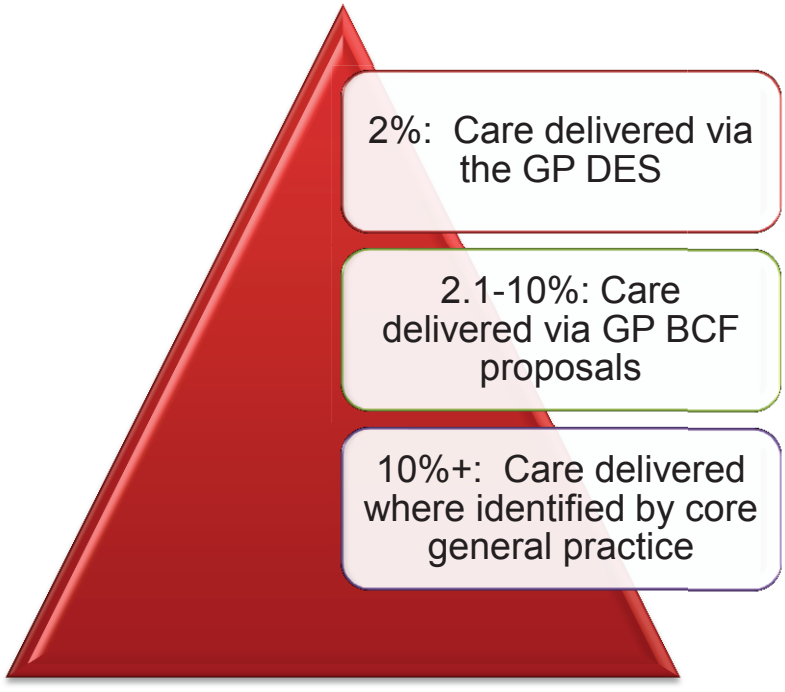
| BCF Intervention | Impact on IT services |
|---|---|
| IT integration | Will enable the use of the NHS number as a primary identifier |

**c) Joint assessment and accountable lead professional for high risk populations**

**i) Please specify what proportion of the adult population are identified as at high risk of hospital admission, and what approach to risk stratification was used to identify them**

**Proportion of high risk patients**

As outlined in the case for change above, using the Adjusted Clinical Groups (ACG) risk predictive software, this is approximately 7,200 people or 2% of the 370,000 residents of the city. We are working with our practices to implement proactive, holistic and responsive services for those patients identified using our RS model, using the following model of care:




The new DES that came into effect in 2014/15 and is focused upon providing targeted support for the top 2% of at risk patients.

Using our local population definition of those aged 60+ or 18-59 with three of more comorbidities, a further modelling exercise took place in July 2014. This resulted in a

targeted cohort of patients (next 2.1-10% at risk) identified as high risk of admission with specific services available to support these patients.

In partnership with our general practices, our 'Planned Intervention Team' will be key to managing both the health related aspects of care required by these patient but also the social care required to manage the patient care in the community and to keep the patient independent. A care navigation team are also in place to support the clinical lead in identifying the most appropriate service elements for their patient.

**ii) Please describe the joint process in place to assess risk, plan care and allocate a lead professional for this population**

Leicester City CCG has a running programme for the provision of high quality, personalised care planning, based upon a SystMone template.

As described above, we have worked with general practice to apply the risk stratification system to their population and provide multi-disciplinary assessment and care for those patients identified as being at highest risk, specifically focussing upon the top 10% of high risk patients in the first instance.

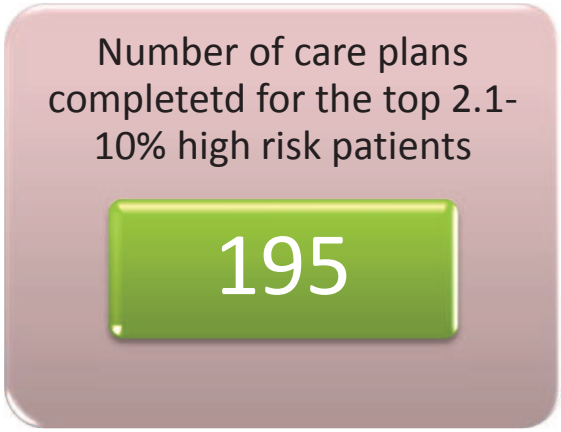
As part of our CCG Operating Plan 2014-2016, we have a commitment to ensuring that all patients over 75 registered in Leicester City have a named GP and those at high risk within this cohort will have a joint health and social care plan to enable proactive care management, integrated around the patient. This is described in detail below.

We will also apply the same methodology to our target cohort of patients (over 60 years and 18-59 with 3 or more comorbidities); this will involve prioritising our high risk patients from this cohort and provision of a personalised care plan where required. This is a longer term strategic commitment, delivered on a phased basis and driven by the risk predictive scores of the population.

**iii) Please state what proportion of individuals at high risk already have a joint care plan in place**

Each practice has an agreed risk stratified BCF cohort on which to focus on, with an agreed template to coproduce with their patient/Multi-disciplinary Team.

As at August 31st 2014:


Patients in the 2% cohort will benefit from the interventions detailed in the '*Avoiding unplanned admissions Enhanced service: proactive case finding and care review for Vulnerable people'* document (April 2014).

All 62 practices in the city have signed up to delivery of this DES which requires practices to identify patients who are at high risk of unplanned admission and manage them appropriately with the aid of risk stratification tools, a case management register, personalised care plans and improved same day telephone access. In addition, the practice is also required to provide timely telephone access to relevant providers to support decisions relating to hospital transfers or admissions in order to reduce avoidable hospital admissions or ED attendances and to have a named GP accountable for their care.

In addition to this, an additional £1.6m has been invested into primary care in the city, to deliver targeted services to a further cohort of vulnerable patients. Patients in the 2.1-10% highest risk cohort are not only provided with care plans but a whole suite of interventions, to include:

- Undertake routine assessments of patients with long term conditions in their home. This helps people with such conditions to better manage their own health and avoid unnecessary visits to hospital.
- Increase population-based interventions e.g. access to vaccinations, reducing social isolation, increasing access to third-sector and Local Authority services.
- Improve, for selected high-risk individuals, chronic disease management, medicines related safety and concordance.
- Improve self-care and self-management skills; reiterating Choose Better campaign messages where appropriate.
- Promote use of personal health budgets.
- Provide both proactive and reactive care
- Assess carers health needs; enhancing the resilience of the carer population.

- Prescribe and administer medications within the remit of local PGD, where appropriate, and undertake medication reviews across the cohort.

- Take a holistic approach to patient care, bringing together their medical, social and psychological needs – both for patients and carers.

- Refer patients to alternative health and/or social services through appropriate signposting and guidelines, linking with the wider BCF services and supporting patients in their own homes.

- Ensure high quality, detailed care plans are in place and up to date/reviewed.

SMART objectives have been agreed by at practice and locality levels to ensure delivery of targets and these form part of the Leicester City Integrated Care Dashboard as referenced in Section 7.

**d) How will the BCF interventions enable a joint assessment and an accountable lead professional for high risk populations?**

| BCF Intervention | Impact on joint assessment and accountable lead professional for high risk populations |
|---|---|
| Risk stratification | Will enable the 0.1-2% and 2.1-10% cohorts to be identified |
| General practice scheme (2.1-10%) | Will deliver targeted care planning function to high risk populations |
| Unscheduled Care Team | Will enable joint assessments of populations, with accountable care professionals coordinating care for high risk patients |
| Planned Care Team | Will enable joint assessments of populations, with accountable care professionals coordinating care for high risk patients |

# 8) ENGAGEMENT

### a) Patient, service user and public engagement

Please describe how patients, service users and the public have been involved in the development of this plan to date and will be involved in the future

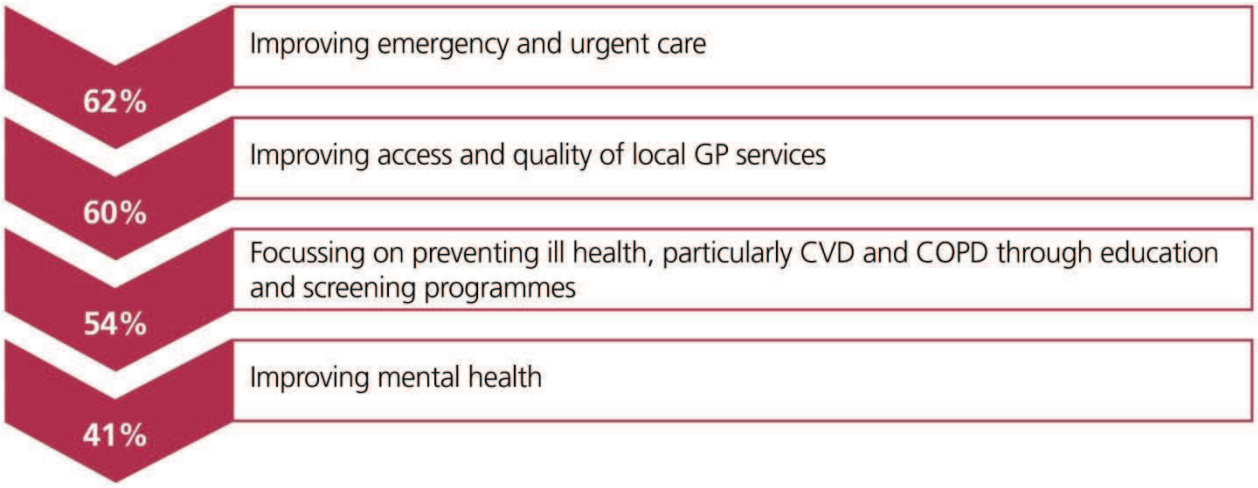
In developing priorities for the city, public views on the priorities for the city were sought at the start of our integrated care journey in 2013/14. This was done via a number of methods, including a survey (standard and easy read formats), visits to local organisations, community groups and service users and via a public workshop.

These methods were selected to offer stakeholders a wide range of ways to get involved, and to ensure we had both quantitative and qualitative feedback.

Public views on the city priorities were sought via a broad survey sent to all city stakeholders including partners, organisations, community groups, patients, carers and members of the public.

The survey asked what the main healthcare priorities for the city should be, by offering a number of options as a prompt. Respondents also had the opportunity to offer their own suggestions. A number of additional questions broadly asked for comments on the local NHS for input into future consultations.

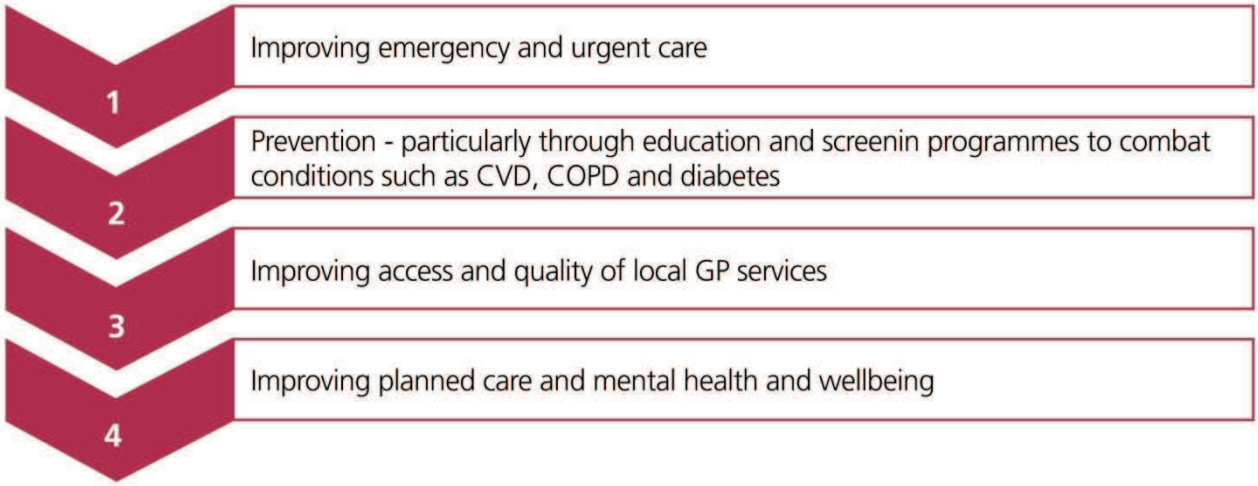
From the survey, four clear priority areas were identified by the public and stakeholders. These were:




Briefings were arranged with key community groups and organisations to ensure the engagement on healthcare priorities was widely sought and to encourage key stakeholders and hard to reach group to give their views. A number of these briefings included meetings with service users as well as directors and executives. These organisations covered each of the equality strands.

In addition, stakeholders across the city were invited to attend a public workshop. Those invited included statutory organisations, NHS Leicester City public members, voluntary sector and community groups, and members of the public. All local MPs and the city council's Overview and Scrutiny Committee were briefed and invited to attend. In total 50 stakeholders participated in the workshop.

From the discussions that took place at the individual briefings and public workshop key priority areas were identified and ranked. These were:




Given the alignment of these priorities to the evidence base presented earlier in this plan, the outputs from this engagement have been used as a basis for development for the interventions in our Better Care Fund:

| Priority area identified | BCF intervention |
|---|---|
| Improving urgent and emergency care | Clinical Response Team |
| | Unscheduled Care Team |
| | System Integration Coordinator |
| | Intensive Community Support service |
| | IT integration |
| Prevention (CVD, COPD, diabetes) | Lifestyle Hub |
| Improving access and quality of local GP services | Risk stratification |
| | General Practice scheme (2.1-10%) |
| | Planned Care Team |
| Improving planned care and mental health and wellbeing | Mental health discharge team |
| | Integrated Mental health step down service |

Further engagement has taken place since 2013 and into 2014 around our aims for systemic transformation, and we first introduced the concept of the Better Care Fund at our joint Call to Action event on 3 December 2013.

The event, which was aimed at stakeholders, patients, carers and members of the public from across the city, presented an outline of the Better Care Fund, its national goals and objectives and tasked attendees with identifying and sharing areas for improvement in health and social care.

The key themes that emerged from the engagement are the importance of carrying out a full assessment of all of a patient's needs, including health, social care and mental health; integrating care into community settings and putting the wishes of the patient at the centre of decision making; all of which have directly influenced the initiatives in this plan.

To commence moving our plan into implementation, a further workshop event took place in March 2014, seeking to validate the priorities identified and explore how we should measure and pay for 'good' and 'excellent' health and social care through our emerging model of Outcomes-Based Commissioning rather than traditional contracting methods. This was a 3 hour session attended by 30 local people. The outputs have informed the CCG's potential move towards outcomes based commissioning as a model of contracting in the future.


In October/November 2014, further engagement is planned with patients and service users to outline progress to date on the BCF and to gain an understanding of views for the next phase of our programme.

*Alignment to engagement in other programmes of work*

The Leicester, Leicestershire and Rutland Patient and Public Involvement Group, which is currently chaired by a member of Leicester City Healthwatch, has been set up to provide citizens' scrutiny of the five-year strategy that is being developed across LLR. Throughout February and March 2014, a series of workshops were held for the LLR five year strategy and this opportunity was used to further engage on the Leicester City BCF priorities and plan.

Significant engagement will be carried out to support the implementation of the five year strategy, which will also be relevant to the Better Care Fund. Representatives of Leicester City patients will continue to be part of this group and will ensure that the wider population have the opportunity to have their say.

## b) Service provider engagement

Please describe how the following groups of providers have been engaged in the development of the plan and the extent to which it is aligned with their operational plans

There is a strong, substantial and successful history of collaborative working across health and social care in Leicester, enabled by robust clinical and political support. This culture of meaningful and effective collaboration has already enabled partners in Leicester to make a real difference, notably through the development of a number of schemes and initiatives aimed at reducing health inequalities in the city.

The leaders of the Leicester, Leicestershire and Rutland health and social care economy have developed an overarching vision setting out the changes needed in the local health and social care system over the next five years. This work involves all partners including providers and culminated in the LLR Better Care Together Five Year Strategy in June 2014.

We have worked closely as one health and social care community on both Two and Five Year plans, aiming for systemic change that provides the right level of care at every step of the patient pathway. Full and open engagement with partner organisations has greatly informed the specific schemes detailed in this paper.

i) NHS Foundation Trusts and NHS Trusts
ii) Primary care providers
iii) Social care and providers from the voluntary and community sector

Organisations we have included in the development of our plan include general practitioners across Leicester City, Leicester City Council, Leicestershire Partnership NHS Trust (LPT), East Midlands Ambulance Services NHS Trust (EMAS), University Hospitals of Leicester NHS Trust (Leicester's Hospitals), Central Nottingham Community Services (CNCS) our GP Out Of Hours provider and Voluntary Action Leicester (on behalf of the VCS).

Our 2 biggest providers of health services, UHL and LPT, have been involved in shaping this programme from the outset and are represented throughout the Governance arrangements for this programme of work, from the strategic oversight of the plan, through to BCF Implementation group and specific task and finish groups. Sustained engagement will continue as we implement these plans.

On September 9th 2014, the final plan was presented to the UHL Executive Team, with agreement regarding the direction of travel of the plan and explicit agreement to continue the successful collaborative working across the system. Equally, on September 15th 2014, the final plan was presented to the Heads of Service at LPT, again, with ongoing support confirmed.

Our Plan has also been presented to 'Protected Learning Time' events for general practitioners and their staff, both clinical and managerial every month since the introduction of the BCF. Individual engagement has taken place at each of Leicester City's four general practice localities to further understand the impact of the BCF on

primary care and to develop supporting plans for additional funding made available to general practice to support the implementation of the BCF.

Local Authority representatives, including elected members and teams from adult social care services have been integral to the development of this plan and Healthwatch have been a vital partner in our planning so far. Both the Adult Social Care and Health Scrutiny Commissions have also had input into the plan, with briefings held on March 6th 2014 and April 1st 2014 respectively.

The voluntary sector across Leicester City has also been engaged, with workshop sessions held specifically with local agencies to identify how this sector could strengthen our plans, with workshops held on March 11th 2014 and again on June 10th 2014.

Implications of BCF delivery have been reflected in the operational plans of all partner organisations (specifically UHL and LPT) and will be managed and monitored through the BCF Implementation Group where required.

### c) Implications for acute providers

Please clearly quantify the impact on NHS acute service delivery targets. The details of this response must be developed with the relevant NHS providers, and include:

- What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?
- Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

The long-term strategic direction of travel for the Leicester, Leicestershire and Rutland health and social care economy has been agreed collectively at the five year strategy Programme Board. The membership of this includes Chief Executives and Lead Clinicians of all agencies across Leicester, Leicestershire and Rutland to ensure that individual organisations' plans, geographically aligned change programmes and all other plans strategically fit together.

The Leicester City Better Care Fund programme will regularly report into this programme to ensure that any modelling, in terms of activity reductions or increases, is explicitly understood by all organisations at an executive level as well via individual work streams at ground level.

There is an already established understanding that to achieve the shift of activity from an acute setting into the community will need significant investment in pre-hospital services, in both primary and community care. The Leicester, Leicestershire and Rutland *Better Care Together* five year strategic plan, due to be completed in draft form by June 2014, will set out our vision for this.

This may include:

- increasing the community footprint for Leicester, Leicestershire and Rutland;
- improved provision and access to primary care services, including an upskilling of GPs in Leicester City to provide more complex care in the community;
- downsizing the acute footprint for Leicester, Leicestershire and Rutland.

Leicester's Hospitals are currently consulting with their clinical base to assess options for a strategic outline case, looking at options available for the UHL footprint. Leicester, Leicestershire and Rutland CCGs have been an active part of this process and continue to support UHL in this objective.

The schemes detailed in this paper will support any downsizing by significantly reducing activity flowing into Leicester's Hospitals and increasing faster activity flows out. The schemes also enable the requirement set out in the NHS Planning Guidance 2014/15-2018/19 to reduce emergency hospital activity by 15%.

Clinical engagement from Leicester's Hospitals, Leicestershire Partnership Trust and East Midlands Ambulance Service for these schemes has been ongoing through the life of the Better Care Fund and will continue throughout to ensure that the ambitions set out in this paper are owned by the health and social care economy as a whole.

UHL clinical and strategic leads have been part of the BCF design process since Nov 2013, with senior clinicians (Dr's Simon Conroy and Richard Wong and Kate Shields, Director of Strategy) engaged at design stage. Representatives from UHL sit on the bi-weekly BCF Implementation Group (Head of Strategic Change, UHL) and senior UHL clinicians sit on each of the key sub-groups. The model of care has been presented to, and supported by, the UHL Executive Team (Sept 9th 2014) and has been supported by the UHL Clinical Director for Emergency Medicine.

At the time of this submission, an additional re-admission avoidance scheme is in the process of being developed with University Hospitals of Leicester which will be targeted to cardio/respiratory patients.

What is the impact of the proposed BCF schemes on activity, income and spending for local acute providers?

Significant activity shifts are expected as a result of the BCF. These have been mapped at an LLR level in order to quantify the total impact on the activity and income assumptions made at Provider level through the LLR five year strategic plan.

The schemes propose a 3.5% reduction in emergency admissions, resulting in 1013 reduction in emergency admissions. 2014/15 activity and subsequent financial impact has already been contracted with UHL. 2015/16 will be subject to annual contract negotiation but a trajectory for reductions in emergency admissions will continue in line with the LLR five year Plan.

These assumptions take into account CCG QIPP schemes and therefore there is no duplication in BCF assumptions.

Are local providers' plans for 2015/16 consistent with the BCF plan set out here?

Since the beginning of 2013/14 UHL have been operating at a financial deficit, which is expected to reach £39.8m by the end of the financial year. UHL has struggled with an unsustainable underlying financial deficit for a number of years, which has been compounded by an escalation in its spending during 2013/14 and some assumptions made by the Trust about income from CCGs and elsewhere which had not been agreed.

Much of UHL's deficit has however been driven by an inability to recruit medical and nursing staff ensuring that this level of support is now at c. £4m per month. Accordingly a reduction in emergency activity at least initially should be mutually beneficial with reductions in income at UHL more than offset by reductions in agency and locum costs and therefore contributes positively to the underlying UHL deficit.

There will inevitably be a point at which further removal of acute work will require UHL to start to reduce resources including physical and human. The scope and pace of this will require further detailed analysis and it is our expectation that there will potentially be a need for transitional support from the 1% transformation fund for UHL during this period.

There has been an increase in interventions aimed at mental health service users and therefore no negative impact on the level and quality of mental health services will be seen.

Please note that CCGs are asked to share their non-elective admissions planned figures (general and acute only) from two operational year plans with local acute providers. Each local acute provider is then asked to complete a template providing their commentary – see Annex 2 – Provider Commentary.

## Health and Wellbeing Board Details

ROCR approval applied for
Version 3

Please select Health and Wellbeing Board:

**Leicester**

Please provide:

| |
|---|
| Sarah Ferrin |
| Sarah.Ferrin3@Leicestercityccg.nhs.uk |

# Health and Wellbeing Board Payment for Performance

There is no need to enter any data on this sheet. All values will be populated from entries elsewhere in the template

## Leicester

**1. Reduction in non elective activity**

| | |
|---|---|
| Baseline of Non Elective Activity (Q4 13/14 - Q3 14/15) | 28,931 |
| Change in Non Elective Activity | -1,013 |
| % Change in Non Elective Activity | -3.5% |

**2. Calculation of Performance and NHS Commissioned Ringfenced Funds**

Figures in £

| | |
|---|---|
| Financial Value of Non Elective Saving/ Performance Fund | 1,509,370 |
| Combined total of Performance and Ringfenced Funds | 6,180,347 |
| Ringfenced Fund | 4,670,977 |
| Value of NHS Commissioned Services | 7,257,000 |
| Shortfall of Contribution to NHS Commissioned Services | 0 |

**2015/16 Quarterly Breakdown of P4P**

| | Q4 14/15 | Q1 15/16 | Q2 15/16 | Q3 15/16 |
|---|---|---|---|---|
| Cumulative Quarterly Baseline of Non Elective Activity | 8,276 | 14,905 | 21,955 | 28,931 |
| Cumulative Change in Non Elective Activity | -290 | -522 | -769 | -1,013 |
| Cumulative % Change in Non Elective Activity | -1.0% | -1.8% | -2.7% | -3.5% |
| Financial Value of Non Elective Saving/ Performance Fund (£) | 432,100 | 345,680 | 368,030 | 363,560 |

## Health and Wellbeing Funding Sources

### Leicester

*Please complete white cells*

| | Gross Contribution (£000) | |
|---|---|---|
| | 2014/15 | 2015/16 |
| Local Authority Social Services | | |
| Leicester | 12,336 | 1,877 |
| <Please select Local Authority> | | |
| <Please select Local Authority> | | |
| <Please select Local Authority> | | |
| <Please select Local Authority> | | |
| <Please select Local Authority> | | |
| <Please select Local Authority> | | |
| **Total Local Authority Contribution** | **12,336** | **1,877** |
| | | |
| CCG Minimum Contribution | | |
| NHS Leicester City CCG | | 21,384 |
| - | | - |
| - | | - |
| - | | - |
| - | | - |
| - | | - |
| - | | - |
| **Total Minimum CCG Contribution** | **-** | **21,384** |
| | | |
| Additional CCG Contribution | | |
| NHS Leicester City CCG | **2,600** | |
| <Please Select CCG> | | |
| <Please Select CCG> | | |
| <Please Select CCG> | | |
| <Please Select CCG> | | |
| <Please Select CCG> | | |
| <Please Select CCG> | | |
| **Total Additional CCG Contribution** | **2,600** | **-** |
| | | |
| **Total Contribution** | **14,936** | **23,261** |

## Summary of Health and Wellbeing Board Schemes

**Leicester**

*Please complete white cells*

## Summary of Total BCF Expenditure

Figures in £000

| | From 3. HWB Expenditure Plan | | Please confirm the amount allocated for the protection of adult social care | | If different to the figure in cell D18, please indicate the total amount from the BCF that has been allocated for the protection of adult social care services |
|---|---|---|---|---|---|
| | 2014/15 | 2015/16 | 2014/15 | 2015/16 | |
| Acute | - | - | | | |
| Mental Health | - | - | | | |
| Community Health | 3,463 | 4,261 | | | |
| Continuing Care | - | - | | | |
| Primary Care | 1,419 | 2,419 | | | |
| Social Care | 10,156 | 15,008 | 10,000 | 14,904 | nal funding for schemes to contribute to the overall delivery of Integrate |
| Other | (102) | 1,573 | | | |
| **Total** | **14,936** | **23,261** | | **14,904** | |

## Summary of NHS Commissioned out of hospital services spend from MINIMUM BCF Pool

Figures in £000

| | From 3. HWB Expenditure | |
|---|---|---|
| | | 2015/16 |
| Mental Health | | - |
| Community Health | | 3,265 |
| Continuing Care | | - |
| Primary Care | | 2,419 |
| Social Care | | - |
| Other | | 1,573 |
| **Total** | | **7,257** |

## Summary of Benefits

Figures in £000

| | From 4. HWB Benefits | | From 5.HWB P4P metric |
|---|---|---|---|
| | 2014/15 | 2015/16 | 2015/16 |
| Reduction in permanent residential admissions | (16) | (31) | |
| Increased effectiveness of reablement | (19) | (26) | |
| Reduction in delayed transfers of care | (164) | (114) | |
| Reduction in non-elective (general + acute only) | (1,126) | (1,496) | 1,509 |
| Other | - | - | |
| **Total** | **(1,326)** | **(1,668)** | **1,509** |

Cell D44 is based on financial year 15/16 and E44 based on calendar year 2015

## Health and Wellbeing Board Expenditure Plan

**Leicester**

*Please complete white cells (for as many rows as required):*

| | Expenditure | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Scheme Name** | **Area of Spend** | **Please specify if Other** | **Commissioner** | **if Joint % NHS** | **if Joint % LA** | **Provider** | **Source of Funding** | **2014/15 (£000)** | **2015/16 (£000)** |
| Reablement - Leicestershire Partnership | Community Health | | CCG | | | NHS Community Provider | Additional CCG Contribution | 1,125 | |
| Reablement - Leicster City Council | Social Care | | Local Authority | | | Local Authority | Additional CCG Contribution | 825 | |
| Carer's Funding | Social Care | | Local Authority | | | Local Authority | Additional CCG Contribution | 650 | |
| Risk Stratification | Primary Care | | CCG | | | Private Sector | Local Authority Social Services | 54 | |
| CRT | Primary Care | | CCG | | | Private Sector | Local Authority Social Services | 1,365 | |
| Unscheduled Care | Community Health | | CCG | | | NHS Community Provider | Local Authority Social Services | 315 | |
| Unscheduled Care | Community Health | | Local Authority | | | NHS Community Provider | Local Authority Social Services | 676 | |
| Planned Care | Community Health | | Local Authority | | | NHS Community Provider | Local Authority Social Services | 250 | |
| Planned Care | Community Health | | CCG | | | NHS Community Provider | Local Authority Social Services | 132 | |
| ICS | Community Health | | CCG | | | NHS Community Provider | Local Authority Social Services | 710 | |
| Integrated Mental health step down service | Community Health | | CCG | | | NHS Community Provider | Local Authority Social Services | 150 | |
| System Integration Post (7/7) | Community Health | | CCG | | | CCG | Local Authority Social Services | 63 | |
| Lifestyle Hub | Social Care | | Local Authority | | | Private Sector | Local Authority Social Services | 60 | |
| IT system integration | Social Care | | Local Authority | | | Private Sector | Local Authority Social Services | 96 | |
| Mental health discharge liaison Team | Community Health | | CCG | | | NHS Community Provider | Local Authority Social Services | 42 | |
| Existing ASC Transfer | Social Care | | Local Authority | | | Local Authority | Local Authority Social Services | 5,902 | |
| ASC Capital Grants | Social Care | | Local Authority | | | Local Authority | Local Authority Social Services | 2,623 | |
| Reablement - Leicestershire Partnership Trust | Community Health | | CCG | | | NHS Community Provider | CCG Minimum Contribution | | 1,125 |
| Reablement - Leicster City Council | Social Care | | Local Authority | | | Local Authority | CCG Minimum Contribution | | 825 |
| Carer's Funding | Social Care | | Local Authority | | | Local Authority | CCG Minimum Contribution | | 650 |
| Risk Stratification | Primary Care | | CCG | | | Private Sector | CCG Minimum Contribution | | 54 |
| CRT | Primary Care | | CCG | | | Private Sector | CCG Minimum Contribution | | 1,365 |
| Unscheduled Care | Community Health | | CCG | | | NHS Community Provider | CCG Minimum Contribution | | 479 |
| Unscheduled Care | Community Health | | Local Authority | | | NHS Community Provider | CCG Minimum Contribution | | 996 |
| Planned Care | Community Health | | CCG | | | NHS Community Provider | CCG Minimum Contribution | | 382 |
| ICS | Community Health | | CCG | | | NHS Community Provider | CCG Minimum Contribution | | 874 |
| Integrated Mental health step down service | Community Health | | CCG | | | NHS Community Provider | CCG Minimum Contribution | | 300 |
| System Integration Post (7/7) | Community Health | | CCG | | | CCG | CCG Minimum Contribution | | 63 |
| Lifestyle Hub | Social Care | | Local Authority | | | Private Sector | CCG Minimum Contribution | | 100 |
| IT system integration | Social Care | | Local Authority | | | Private Sector | CCG Minimum Contribution | | 4 |
| Mental health discharge liaison Team | Community Health | | CCG | | | NHS Community Provider | CCG Minimum Contribution | | 42 |
| Existing ASC Transfer | Social Care | | Local Authority | | | Local Authority | CCG Minimum Contribution | | 5,902 |
| 2015/16 ASC Increased Tfr | Social Care | | Local Authority | | | Local Authority | CCG Minimum Contribution | | 5,650 |
| Contingency Funding | Other | Contingency Funds | CCG | | | CCG | CCG Minimum Contribution | | 1,573 |
| GP Schemes | Primary Care | | CCG | | | Private Sector | CCG Minimum Contribution | | 1,000 |
| ASC Capital Grants | Social Care | | Local Authority | | | Local Authority | Local Authority Social Services | | 876 |
| Disabled Facilities Grant | Social Care | | Local Authority | | | Local Authority | Local Authority Social Services | | 1,001 |
| Over commitment | Other | Will be managed by slippage in year | CCG | | | CCG | Local Authority Social Services | (102) | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| **Total** | | | | | | | | **14,936** | **23,261** |

## Health and Wellbeing Board Financial Benefits Plan

**Leicester**

If you would prefer to provide aggregated figures for the savings (columns F-J), for a group of schemes related to one benefit type (e.g. delaye transfers of care), rather than filling in figures against each of your individual schemes, then you may do so.

If so, please do this as a separate row entitled "Aggregated benefit of schemes for X", completing columns D, F, G, I and J for that row. But please make sure you do not enter values against both the individual schemes you have listed, and the "aggregated benefit" line. This is to avoid double counting the benefits.

However, if the aggregated benefits fall to different organisations (e.g. some to the CCG and some to the local authority) then you will need to provide one row for the aggregated benefits to each type of organisation (identifying the type of organisation in column D) with values entered in columns F-J.

### 2014/15

*Please complete white cells (for as many rows as required):*

| | | | | 2014/15 | | | | |
|---|---|---|---|---|---|---|---|---|
| **Benefit achieved from** | **If other please specifiy** | **Scheme Name** | **Organisation to Benefit** | **Change in activity measure** | **Unit Price (£)** | **Total (Saving) (£)** | **How was the saving value calculated?** | **How will the savings against plan be monitored?** |
| Reduction in permanent residential admissions | | Clinical Response Team | Local Authority | (0) | 3,146 | (1,210) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in permanent residential admissions | | Unscheduled Care Team | Local Authority | (1) | 3,146 | (3,630) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in permanent residential admissions | | Intensive Community Support service | Local Authority | (1) | 3,146 | (3,630) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in permanent residential admissions | | Risk stratification | Local Authority | (1) | 3,146 | (2,420) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in permanent residential admissions | | General Practice scheme (3-10%) | Local Authority | (1) | 3,146 | (2,420) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in permanent residential admissions | | Planned Care Team | Local Authority | (0) | 3,146 | (1,210) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in permanent residential admissions | | Mental health discharge team | Local Authority | (0) | 3,146 | (1,210) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Increased effectiveness of reablement | | Unscheduled Care Team | Local Authority | (4) | 1,245 | (4,825) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Increased effectiveness of reablement | | System Integration Coordinator | Local Authority | (2) | 1,245 | (2,412) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Increased effectiveness of reablement | | Intensive Community Support service | Local Authority | (2) | 1,245 | (2,412) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Increased effectiveness of reablement | | Risk stratification | Local Authority | (2) | 1,245 | (2,412) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Increased effectiveness of reablement | | General Practice scheme (3-10%) | Local Authority | (2) | 1,245 | (2,412) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Increased effectiveness of reablement | | Planned Care Team | Local Authority | (4) | 1,245 | (4,825) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in delayed transfers of care | | Unscheduled Care Team | NHS Provider | (68) | 300 | (20,513) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in delayed transfers of care | | Mental health community crisis team | NHS Provider | (103) | 300 | (30,769) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in delayed transfers of care | | System Integration Coordinator | NHS Provider | (103) | 300 | (30,769) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in delayed transfers of care | | Intensive Community Support service | NHS Provider | (103) | 300 | (30,769) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in delayed transfers of care | | IT integration | NHS Provider | (34) | 300 | (10,256) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in delayed transfers of care | | Planned Care Team | NHS Provider | (34) | 300 | (10,256) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in delayed transfers of care | | Mental health discharge team | NHS Provider | (103) | 300 | (30,769) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in non-elective (general + acute only) | | Clinical Response Team | NHS Commissioner | (99) | 1,490 | (146,927) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in non-elective (general + acute only) | | Unscheduled Care Team | NHS Commissioner | (99) | 1,490 | (146,927) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in non-elective (general + acute only) | | Mental health community crisis team | NHS Commissioner | (66) | 1,490 | (97,951) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in non-elective (general + acute only) | | System Integration Coordinator | NHS Commissioner | (66) | 1,490 | (97,951) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in non-elective (general + acute only) | | Intensive Community Support service | NHS Commissioner | (66) | 1,490 | (97,951) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in non-elective (general + acute only) | | IT integration | NHS Commissioner | (33) | 1,490 | (48,976) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in non-elective (general + acute only) | | Risk stratification | NHS Commissioner | (99) | 1,490 | (146,927) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in non-elective (general + acute only) | | Lifestyle Hub | NHS Commissioner | (33) | 1,490 | (48,976) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in non-elective (general + acute only) | | General Practice scheme (3-10%) | NHS Commissioner | (99) | 1,490 | (146,927) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in non-elective (general + acute only) | | Planned Care Team | NHS Commissioner | (66) | 1,490 | (97,951) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in non-elective (general + acute only) | | Mental health discharge team | NHS Commissioner | (33) | 1,490 | (48,976) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| | | | | | | - | | |
| | | | | | | - | | |
| | | | | | | - | | |
| | | | | | | - | | |
| | | | | | | - | | |
| | | | | | | - | | |
| | | | | | | - | | |
| | | | | | | - | | |
| | | | | | | - | | |
| | | | | | | - | | |
| | | | | | | - | | |
| | | | | | | - | | |
| | | | | | | - | | |
| | | | | | | - | | |
| | | | | | | - | | |
| **Total** | | | | | | **(1,325,569)** | | |

### 2015/16

| | | | | 2015/16 | | | | |
|---|---|---|---|---|---|---|---|---|
| **Benefit achieved from** | | **Scheme Name** | **Organisation to Benefit** | **Change in activity measure** | **Unit Price (£)** | **Total (Saving) (£)** | **How was the saving value calculated?** | **How will the savings against plan be monitored?** |
| Reduction in permanent residential admissions | | Clinical Response Team | Local Authority | (1) | 3,146 | (2,420) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in permanent residential admissions | | Unscheduled Care Team | Local Authority | (2) | 3,146 | (7,260) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in permanent residential admissions | | Intensive Community Support service | Local Authority | (2) | 3,146 | (7,260) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in permanent residential admissions | | Risk stratification | Local Authority | (2) | 3,146 | (4,840) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in permanent residential admissions | | General Practice scheme (3-10%) | Local Authority | (2) | 3,146 | (4,840) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in permanent residential admissions | | Planned Care Team | Local Authority | (1) | 3,146 | (2,420) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in permanent residential admissions | | Mental health discharge team | Local Authority | (1) | 3,146 | (2,420) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Increased effectiveness of reablement | | Unscheduled Care Team | Local Authority | (5) | 1,245 | (6,537) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Increased effectiveness of reablement | | System Integration Coordinator | Local Authority | (3) | 1,245 | (3,268) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Increased effectiveness of reablement | | Intensive Community Support service | Local Authority | (3) | 1,245 | (3,268) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Increased effectiveness of reablement | | Risk stratification | Local Authority | (3) | 1,245 | (3,268) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Increased effectiveness of reablement | | General Practice scheme (3-10%) | Local Authority | (3) | 1,245 | (3,268) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Increased effectiveness of reablement | | Planned Care Team | Local Authority | (5) | 1,245 | (6,537) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in delayed transfers of care | | Unscheduled Care Team | NHS Provider | (48) | 300 | (14,288) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in delayed transfers of care | | Mental health community crisis team | NHS Provider | (71) | 300 | (21,431) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in delayed transfers of care | | System Integration Coordinator | NHS Provider | (71) | 300 | (21,431) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in delayed transfers of care | | Intensive Community Support service | NHS Provider | (71) | 300 | (21,431) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in delayed transfers of care | | IT integration | NHS Provider | (24) | 300 | (7,144) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in delayed transfers of care | | Planned Care Team | NHS Provider | (24) | 300 | (7,144) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in delayed transfers of care | | Mental health discharge team | NHS Provider | (71) | 300 | (21,431) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in non-elective (general + acute only) | | Clinical Response Team | NHS Commissioner | (131) | 1,490 | (195,125) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in non-elective (general + acute only) | | Unscheduled Care Team | NHS Commissioner | (131) | 1,490 | (195,125) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in non-elective (general + acute only) | | Mental health community crisis team | NHS Commissioner | (87) | 1,490 | (130,083) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in non-elective (general + acute only) | | System Integration Coordinator | NHS Commissioner | (87) | 1,490 | (130,083) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in non-elective (general + acute only) | | Intensive Community Support service | NHS Commissioner | (87) | 1,490 | (130,083) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in non-elective (general + acute only) | | IT integration | NHS Commissioner | (44) | 1,490 | (65,042) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in non-elective (general + acute only) | | Risk stratification | NHS Commissioner | (131) | 1,490 | (195,125) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in non-elective (general + acute only) | | Lifestyle Hub | NHS Commissioner | (44) | 1,490 | (65,042) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in non-elective (general + acute only) | | General Practice scheme (3-10%) | NHS Commissioner | (131) | 1,490 | (195,125) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in non-elective (general + acute only) | | Planned Care Team | NHS Commissioner | (87) | 1,490 | (130,083) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| Reduction in non-elective (general + acute only) | | Mental health discharge team | NHS Commissioner | (44) | 1,490 | (65,042) | Using the metrics model attached | Via Integrated Care dashboard (appendix X) |
| | | | | | | - | | |
| | | | | | | - | | |
| | | | | | | - | | |
| | | | | | | - | | |
| | | | | | | - | | |
| | | | | | | - | | |
| | | | | | | - | | |
| | | | | | | - | | |
| | | | | | | - | | |
| | | | | | | - | | |
| | | | | | | - | | |
| | | | | | | - | | |
| | | | | | | - | | |
| | | | | | | - | | |
| | | | | | | - | | |
| **Total** | | | | | | **(1,667,868)** | | |

**Leicester**

*Red triangles indicate comments*

*Please complete the five white cells in the Non-Elective admissions table. Other white cells can be completed/revised as appropriate.*

*Planned deterioration on baseline (or validity issue)*
*Planned improvement on baseline of less than 3.5%*
*Planned improvement on baseline of 3.5% or more*

## Non - Elective admissions (general and acute)

| Metric | | Baseline (14-15 figures are CCG plans) | | | | Pay for performance period | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Q4 (Jan 14 - Mar 14) | Q1 (Apr 14 - Jun 14) | Q2 (Jul 14 - Sep 14) | Q3 (Oct 14 - Dec 14) | Q4 (Jan 15 - Mar 15) | Q1 (Apr 15 - Jun 15) | Q2 (Jul 15 - Sep 15) | Q3 (Oct 15 - Dec 15) | Q4 (Jan 16 - Mar 16) |
| **Total non-elective admissions in to hospital (general & acute), all-age, per 100,000 population** | *Quarterly rate* | **2,465** | **1,975** | **2,100** | **2,078** | **2,365** | **1,894** | **2,014** | **1,993** | **2,267** |
| | *Numerator* | 8,276 | 6,629 | 7,050 | 6,976 | 7,986 | 6,397 | 6,803 | 6,732 | 7,706 |
| | *Denominator* | 335,700 | 335,700 | 335,700 | 335,700 | 337,740 | 337,740 | 337,740 | 337,740 | 339,933 |

*Rationale for red/amber ratings*

*P4P annual change in admissions* -1013
*P4P annual change in admissions (%)* -3.5%
*P4P annual saving* £1,509,370

Please enter the average cost of a non-elective admission[1]: **£1,490**

Rationale for change from £1,490

*The figures above are mapped from the following CCG operational plans. If any CCG plans are updated then the white cells can be revised:*

| Contributing CCGs | CCG baseline activity (14-15 figures are CCG plans) | | | | % CCG registered population that has resident population in Leicester | % Leicester resident population that is in CCG registered population | Contributing CCG activity | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Q4 (Jan 14 - Mar 14) | Q1 (Apr 14 - Jun 14) | Q2 (Jul 14 - Sep 14) | Q3 (Oct 14 - Dec 14) | | | Q4 (Jan 14 - Mar 14) | Q1 (Apr 14 - Jun 14) | Q2 (Jul 14 - Sep 14) | Q3 (Oct 14 - Dec 14) |
| NHS East Leicestershire and Rutland CCG | 7,028 | 6,017 | 6,384 | 6,326 | 2.7% | 2.3% | 187 | 160 | 170 | 168 |
| NHS Leicester City CCG | 8,515 | 6,796 | 7,229 | 7,152 | 92.5% | 95.0% | 7,877 | 6,287 | 6,687 | 6,616 |
| NHS West Leicestershire CCG | 8,087 | 6,944 | 7,349 | 7,288 | 2.6% | 2.7% | 213 | 183 | 193 | 192 |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| *Total* | | | | | | **100%** | **8,276** | **6,629** | **7,050** | **6,976** |

**References**

[1] The default figure of £1,490 in the template is based on the average reported cost of a non-elective inpatient episode (excluding excess bed days), taken from the latest (2012/13) Reference Costs. Alternatively the average reported spell cost of a non-elective inpatient admission (including excess bed days) from the same source is £2,118. To note, these average figures do not account for the 30% marginal rate rule and may not reflect costs variations to a locality such as MFF or cohort pricing. In recognition of these variations the average cost can be revised in the template although a rationale for any change should be provided.

**Leicester**

*Please complete all white cells in tables. Other white cells should be completed/revised as appropriate.*

*Red triangles indicate comments*

*Planned deterioration on baseline (or validity issue)*

*Planned improvement on baseline*

## Residential admissions

| Metric | | Baseline (2013/14) | Planned 14/15 | Planned 15/16 |
|---|---|---|---|---|
| Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population | *Annual rate* | 764.2 | 710.0 | 671.4 |
| | *Numerator* | 290 | 280 | 270 |
| | *Denominator* | 38,080 | 39,438 | 40,216 |
| | *Annual change in admissions* | | -10 | -10 |
| | *Annual change in admissions %* | | -3.4% | -3.6% |

*Rationale for red rating*

## Reablement

| Metric | | Baseline (2013/14) | Planned 14/15 | Planned 15/16 |
|---|---|---|---|---|
| Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services | *Annual %* | 87.0 | 88.8 | 90.0 |
| | *Numerator* | 200 | 231 | 252 |
| | *Denominator* | 230 | 260 | 280 |
| | *Annual change in proportion* | | 1.8 | 1.2 |
| | *Annual change in proportion %* | | 2.1% | 1.3% |

*Rationale for red rating*

## Delayed transfers of care

| Metric | | 13-14 Baseline | | | | 14/15 plans | | | | 15-16 plans | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Q1 (Apr 13 - Jun 13) | Q2 (Jul 13 - Sep 13) | Q3 (Oct 13 - Dec 13) | Q4 (Jan 14 - Mar 14) | Q1 (Apr 14 - Jun 14) | Q2 (Jul 14 - Sep 14) | Q3 (Oct 14 - Dec 14) | Q4 (Jan 15 - Mar 15) | Q1 (Apr 15 - Jun 15) | Q2 (Jul 15 - Sep 15) | Q3 (Oct 15 - Dec 15) | Q4 (Jan 16 - Mar 16) |
| Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+). | *Quarterly rate* | 1,391.1 | 1,469.4 | 1,178.4 | 1,348.5 | 1,211.1 | 1,364.9 | 1,094.6 | 1,253.3 | 1,167.6 | 1,314.9 | 1,054.5 | 1,208.1 |
| | *Numerator* | 3,538 | 3,737 | 2,997 | 3,454 | 3,102 | 3,496 | 2,804 | 3,231 | 3,010 | 3,390 | 2,718 | 3,133 |
| | *Denominator* | 254,324 | 254,324 | 254,324 | 256,128 | 256,128 | 256,128 | 256,128 | 257,793 | 257,793 | 257,793 | 257,793 | 259,335 |
| | | | | | | | | *Annual change in admissions* | *-1094* | | | *Annual change in admissions* | *-381* |
| | | | | | | | | *Annual change in admissions %* | *-8.0%* | | | *Annual change in admissions %* | *-3.0%* |

*Rationale for red ratings*

## Patient / Service User Experience Metric

| Metric | | Baseline 2013 | Planned 14/15 (if available) | Planned 15/16 |
|---|---|---|---|---|
| Taken from GP Survey<br>(For respondents with a long-standing health condition) | *Metric Value* | 61.7 | 62.7 | 63.7 |
| Q32. In the last 6 months, have you had enough support from local services or organisations to help you to manage your long-term health condition(s)? Please think about all services and organisations, not just health | *Numerator* | 1,456 | 1,505 | 1,593 |
| (Total positive responses/total response) | *Denominator* | 2,357 | 2,400 | 2,500 |
| *Improvement indicated by:* | Increase | | | |

## Local Metric

| Metric | | Baseline Sep-13 | Planned 14/15 (if available) | Planned 15/16 |
|---|---|---|---|---|
| Number of patients on dementia registers as % of the estimated dementia prevalence (national indicator) | *Metric Value* | 0.6 | 0.6 | 0.7 |
| | *Numerator* | 1,831 | 2,194 | 2,285 |
| | *Denominator* | 3,323 | 3,376 | 3,410 |
| *Improvement indicated by:* | Increase | | | |

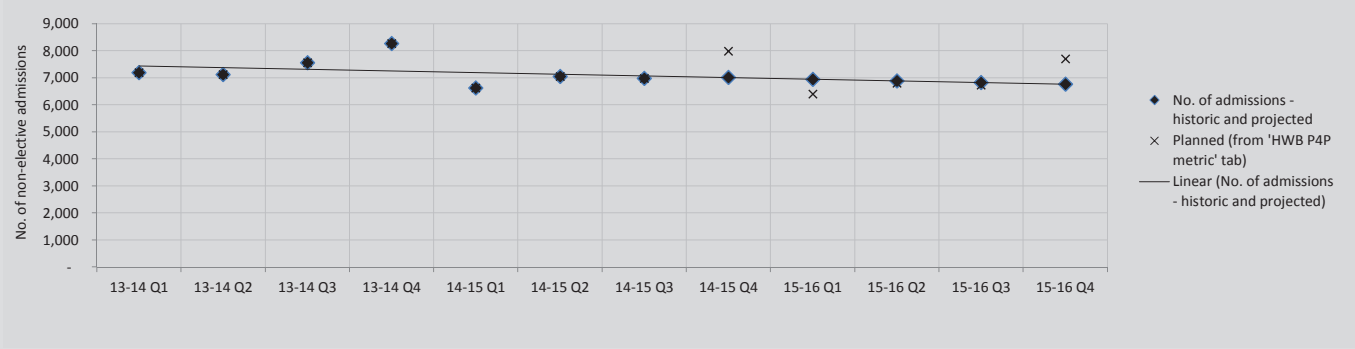
## Leicester

To support finalisation of plans, we have provided *estimates* of future performance, based on a simple 'straight line' projection of historic data for each metric. We recognise that these are crude methodologies, but it may be useful to consider when setting your plans for each of the national metrics in 2014/15 and 2015/16. As part of the assurance process centrally we will be looking at plans compared to the counterfactual (what the performance might have been if there was no BCF).

*No cells need to be completed in this tab. However, 2014-15 and 2015-16 projected counts for each metric can be overwritten (white cells) if areas wish to set their own projections.*

### Non-elective admissions (general and acute)

| Metric | | Historic | | | Baseline | | | | Projection | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 13-14 Q1 | 13-14 Q2 | 13-14 Q3 | 13-14 Q4 | 14-15 Q1 | 14-15 Q2 | 14-15 Q3 | 14-15 Q4 | 15-16 Q1 | 15-16 Q2 | 15-16 Q3 | 15-16 Q4 |
| **Total non-elective admissions (general & acute), all-age** | *No. of admissions - historic and projected* | 7,194 | 7,126 | 7,557 | 8,276 | 6,629 | 7,050 | 6,976 | 7,011 | 6,949 | 6,887 | 6,825 | 6,763 |

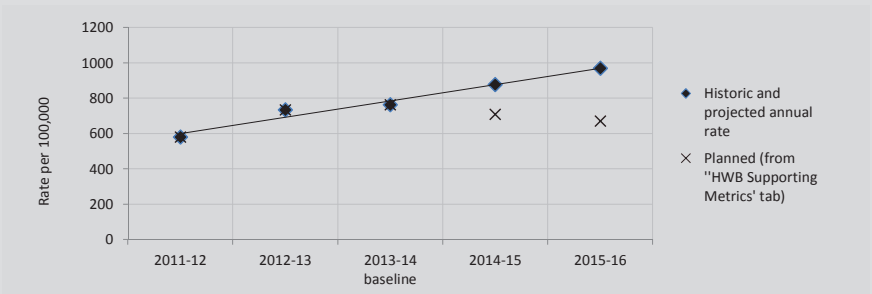



| Metric | | Projected | | | | |
|---|---|---|---|---|---|---|
| | | 2014 -2015 Q4 | 2015-16 Q1 | 2015-16 Q2 | 2015-16 Q3 | 2015-16 Q4 |
| **Total non-elective admissions (general & acute), all-age** | *Quarterly rate* | *2,088.4* | *2,057.4* | *2,039.1* | *2,020.7* | *1,989.4* |
| | *Numerator* | *7,011* | *6,949* | *6,887* | *6,825* | *6,763* |
| | *Denominator* | *335,700* | *337,740* | *337,740* | *337,740* | *339,933* |

* The projected rates are based on annual population projections and therefore will not change linearly

### Residential admissions

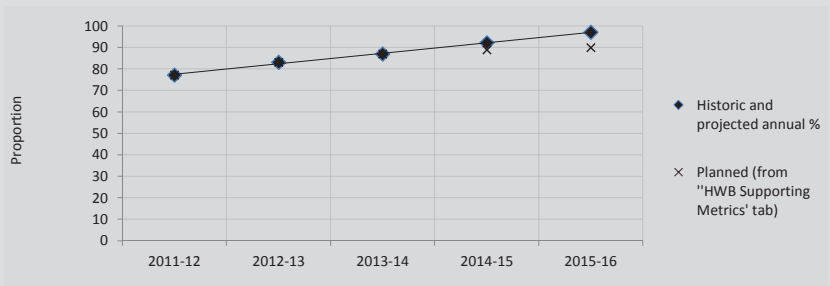
| Metric | | 2011-12 Historic | 2012-13 historic | 2013-14 baseline | 2014-15 Projected | 2015-16 Projected |
|---|---|---|---|---|---|---|
| **Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population** | *Historic and projected annual rate* | 580 | 735 | 764 | *877* | *969* |
| | *Numerator* | 215 | 280 | 290 | *346* | *390* |
| | *Denominator* | 37,395 | 38,080 | 38,080 | *39,438* | *40,216* |




This is based on a simple projection of the metric proportion.

### Reablement

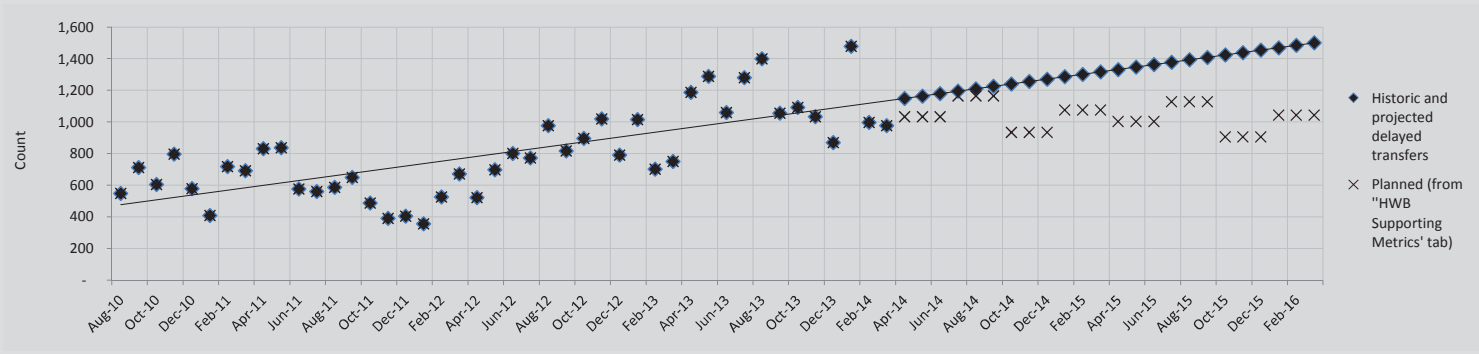
| Metric | | 2011-12 Historic | 2012-13 Historic | 2013-14 Baseline | 2014-15 Projected | 2015-16 Projected |
|---|---|---|---|---|---|---|
| **Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services** | *Historic and projected annual %* | 77.2 | 83.1 | 87 | *92.2* | *97.1* |
| | *Numerator* | 155 | 180 | 200 | *212* | *223* |
| | *Denominator* | 200 | 220 | 230 | *230* | *230* |




This is based on a simple projection of the metric proportion, and an unchanging denominator (number of people offered reablement)

### Delayed transfers

| Metric | | Historic | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Aug-10 | Sep-10 | Oct-10 | Nov-10 | Dec-10 | Jan-11 | Feb-11 | Mar-11 | Apr-11 | May-11 | Jun-11 | Jul-11 |
| **Delayed transfers of care (delayed days) from hospital** | *Historic and projected delayed transfers* | 549 | 713 | 606 | 797 | 579 | 410 | 719 | 693 | 831 | 837 | 576 | 560 |




| Metric | | Projected rates* | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | 2014-15 Q1 | Q2 | Q3 | Q4 | 2015-16 Q1 | Q2 | Q3 | Q4 |
| **Delayed transfers of care (delayed days) from hospital per 100,000 population (aged 18+).** | *Quarterly rate* | *1,363.8* | *1,417.4* | *1,471.1* | *1,514.9* | *1,568.2* | *1,621.5* | *1,674.9* | *1,717.9* |
| | *Numerator* | *3,493* | *3,630* | *3,768* | *3,905* | *4,043* | *4,180* | *4,318* | *4,455* |
| | *Denominator* | *256,128* | *256,128* | *256,128* | *257,793* | *257,793* | *257,793* | *257,793* | *259,335* |

* The projected rates are based on annual population projections and therefore will not change linearly

## HWB Financial Plan

| Date | Sheet | Cells | Description |
|---|---|---|---|
| 28/07/14 | Payment for Performance | B23 | formula modified to *=IF(B21-B19<0,0,B21-B19)* |
| 28/07/14 | 1. HWB Funding Sources | C27 | formula modified to *=SUM(C20:C26)* |
| 28/07/14 | HWB ID | J2 | Changed to Version 2 |
| 28/07/14 | a | Various | Data mapped correctly for Bournemouth & Poole |
| 29/07/14 | a | AP1:AP348 | Allocation updated for changes |
| 28/07/14 | All sheets | Columns | Allowed to modify column width if required |
| 30/07/14 | 8. Non elective admissions - CCG | | Updated CCG plans for Wolverhampton, Ashford and Canterbury CCGs |
| 30/07/14 | 6. HWB supporting metrics | D18 | Updated conditional formatting to not show green if baseline is 0 |
| 30/07/14 | 6. HWB supporting metrics | D19 | Comment added |
| 30/07/14 | 7. Metric trends | K11:O11, G43:H43,G66:H66 | Updated forecast formulas |
| 30/07/14 | Data | Various | Changed a couple of 'dashes' to zeros |
| 30/07/14 | 5. HWB P4P metric | H14 | Removed rounding |
| 31/07/14 | 1. HWB Funding Sources | A48:C54 | Unprotect cells and allow entry |
| 01/08/14 | 5. HWB P4P metric | G10:K10 | Updated conditional formatting |
| 01/08/14 | 5. HWB P4P metric | H13 | formula modified to *=IF(OR(G10<0,H10<0,I10<0,J10<0),"",IF(OR(ISTEXT(G10),ISTEXT(H10),ISTEXT(I10),ISTEXT(J10)),"",IF(SUM(G10:J10)=0,"",(SUM(G10:J10)/SUM(C10:F10))-1)))* |
| 01/08/14 | 5. HWB P4P metric | H13 | Apply conditional formatting |
| 01/08/14 | 5. HWB P4P metric | H14 | formula modified to *=if(H13="","",-H12*J14)* |
| 01/08/14 | 4. HWB Benefits Plan | J69:J118 | Remove formula |
| 01/08/14 | 4. HWB Benefits Plan | B11:B60, B69:B118 | Texted modified |
| **Version 2** | | | |
| 13/08/14 | 4. HWB Benefits Plan | I61, I119, J61, J119 | Delete formula |
| 13/08/14 | 4. HWB Benefits Plan | rows 119:168 | Additional 50 rows added to 14-15 table for orgaanisations that need it. Please unhide to use |
| 13/08/14 | 4. HWB Benefits Plan | rows 59:108 | Additional 50 rows added to 15-16 table for orgaanisations that need it. Please unhide to use |
| 13/08/14 | 3. HWB Expenditure Plan | rows 59:108 | Additional 50 rows added to table for orgaanisations that need it. Please unhide to use |
| 13/08/14 | a | M8 | Add Primary Care to drop down list in column I on sheet '*3. HWB Expenditure Plan*' |
| 13/08/14 | HWB ID | J2 | Changed to Version 3 |
| 13/08/14 | 6. HWB supporting metrics | C11, I32, M32 | Change text to *'Annual change in admissions'* |
| 13/08/14 | 6. HWB supporting metrics | C12, I33, M33 | Change text to *'Annual change in admissions %'* |
| 13/08/14 | 6. HWB supporting metrics | C21 | Change text to *'Annual change in proportion'* |
| 13/08/14 | 6. HWB supporting metrics | C22 | Change text to *'Annual change in proportion %'* |
| 13/08/14 | 6. HWB supporting metrics | D21 | Change formula to *=if(D19=0,0,D 18 -C 18 )* |
| 13/08/14 | 6. HWB supporting metrics | D21 | Change format to 1.dec. place |
| 13/08/14 | 6. HWB supporting metrics | E21 | Change formula to *= if(E19=0,0,E 18 -D 18 )* |
| 13/08/14 | 6. HWB supporting metrics | E21 | Change format to 1.dec. place |
| 13/08/14 | 6. HWB supporting metrics | D22 | Change formula to *=if(D19=0,0,D 18 /C 18 -1)* |
| 13/08/14 | 6. HWB supporting metrics | E22 | Change formula to *=if(E19=0,0,E 18 /D 18 -1)* |
| 13/08/14 | 5. HWB P4P metric | J14 | Cell can now be modified - £1,490 in as a placeholder |
| 13/08/14 | 5. HWB P4P metric | N9:AL9 | Test box for an explanation of why different to £1,490 if it is. |
| 13/08/14 | 4. HWB Benefits Plan | H11:H110, H119:H218 | Change formula to eg. *=H11*G11* |
| 13/08/14 | 2. Summary | G44:M44 | Test box for an explanation for the difference between the calculated NEL saving on the metrics tab and the benefits tab |

# ANNEX 1 – Detailed Scheme Descriptions

Detailed scheme descriptions have been completed for the following schemes:

| Ref no. | Scheme |
|---|---|
| **Priority 1:** Prevention, early detection and improvement of health-related quality of life | |
| BCF1 | Risk stratification |
| BCF 2 | Lifestyle Hub |
| BCF 3 | General Practice scheme (2.1-10%) |
| **Priority 2:** Reducing the time spent in hospital avoidably | |
| BCF 4 | Clinical Response Team |
| BCF 5 | Unscheduled Care Team |
| BCF 6 | System Coordinator |
| BCF 7 | Intensive Community Support service |
| BCF 8 | IT integration |
| **Priority 3:** Enabling independence following hospital care | |
| BCF 9 | Planned Care Team |
| BCF 10 | Mental health discharge team |
| BCF 11 | Integrated Mental health step down service |


| **Scheme ref no.** |
|---|
| BCF 1 |
| **Scheme name** |
| Risk Stratification |
| **What is the strategic objective of this scheme?** |
| Link to Vision:<br><br>• Develop a new model of primary care that provides a more proactive, holistic and responsive community service across physical and mental health, increasing capacity where required<br><br>Response to case for change through delivery of:<br><br>(a) Reduction in the numbers of patients requiring admission to permanent residential care<br>(b) Increase in the numbers of patients still at home 91 days after discharge from hospital<br>(c) Increase in the number of patients recorded as living with dementia<br>(d) Systematic proactive intervention with moderate to high risk patients identified through risk stratification to enhance self-care and links to wider community support<br>(e) To be a platform to ensure that specialist community services such as Community Matrons Heart Failure and Respiratory Specialist nursing, and Care Navigators caseloads are populated with the right kind of patients – i.e. those with high – very high risk of adverse outcomes where specialist input is likely to have the greatest chance of altering the clinical trajectory. |
| **Overview of the scheme**<br>Please provide a brief description of what you are proposing to do including:<br>- What is the model of care and support?<br>- Which patient cohorts are being targeted? |
| The risk stratification of each GP practice's entire population with a monthly refresh of this information is a key platform for the effective functioning of a whole range of BCF services and pathways. The CCG has been working in partnership with Greater East Midlands CSU, Johns Hopkins University and a working party of GPs, Practice Managers, and Practice Nurses since November 2012 to develop a suite of risk stratification reports based on the outputs of the Adjusted Clinical Groups (ACG) |

risk stratification tool.

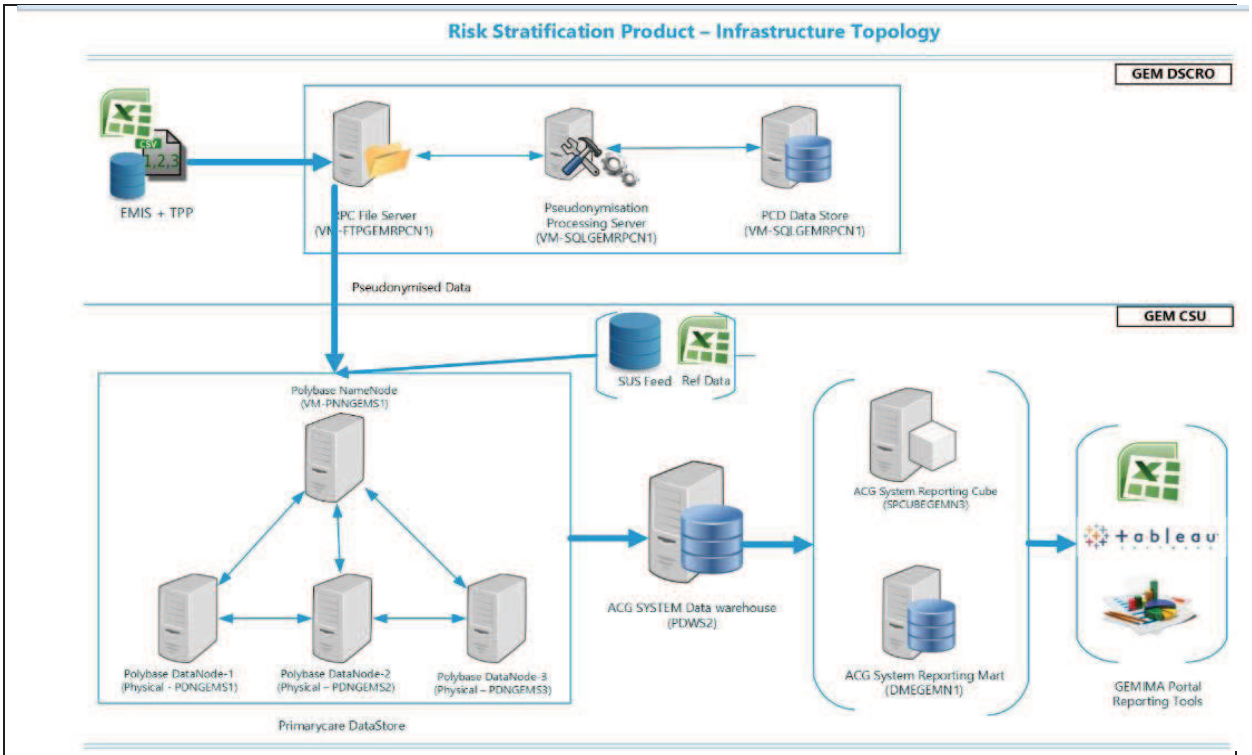
**The model of care:**
The ACG System considers the total disease experience of each patient, including the implications of co-occurring disease. The ACG System encourages a holistic view of the patient rather than the management of specific diseases or episodes. A disease-based focus may miss important implications of associated co-morbidities. Episodic approaches often focus on acute exacerbations or flare-ups, which potentially represent failures in care management.

The ACG risk stratification scores in the version of the system used in Leicester (Version 9 of the Dx PMx model) are derived from three main data sources:

1. All the patient's diagnoses – major and minor (i.e. not just QOF diagnoses and including mental health diagnoses and any coded symptoms for which there is not, as yet a confirmed diagnosis)) over the last 12 months – and in the case of long term conditions; going back to the patient's date of birth. The read codes will capture the diagnosis regardless of where the patient was first diagnosed – primary care, ED OPD etc.
2. Prescribing data
3. Secondary Care data diagnoses and procedure codes.

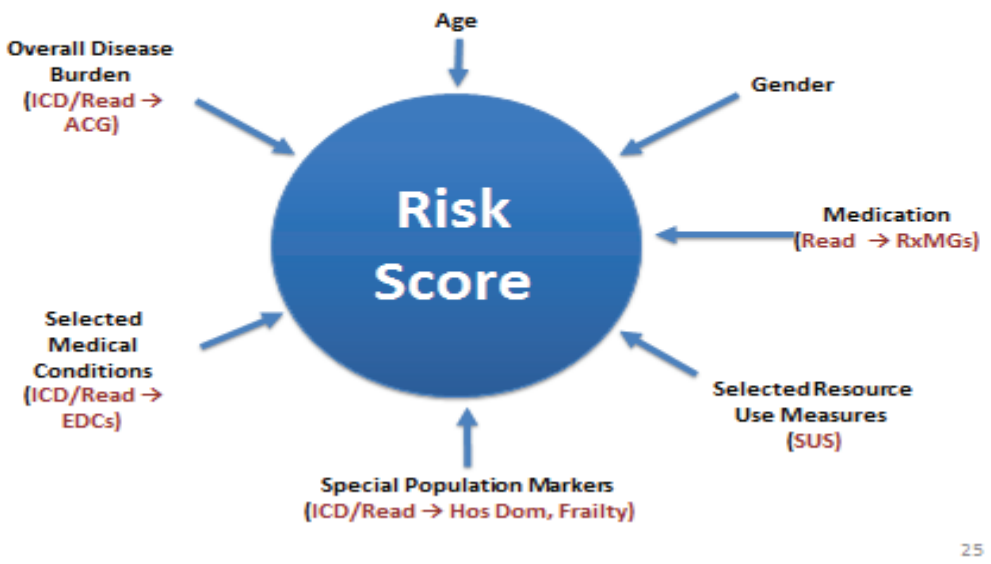
We have undertaken an extensive period of consultation with the LMC, BMA Law, GPC and NHS England back in 2012-13 to ensure that our data processing was in conformity with the guidelines and was acceptable to GPs as the data controllers. This led to a very narrow Information Sharing Agreement (ISA) which gave permission for processing to provide risk stratification reports to GPs only and for no aggregation of data. In 2014 GPs signed an addendum to the original ISA which gave permission for some aggregation of data. There is now increasing demand from GPs and others to have a refreshed ISA which will allow for further processing of these data to create more sophisticated reporting at practice, locality and CCG level for a variety of clinical and business planning purposes

The illustration below shoes how the 'pseudonymised' data is currently processed in the Accredited Safe Haven (ASH).




In addition to the diagnosis and prescribing data above, the risk scores are derived from risk markers unique to the ACG system:

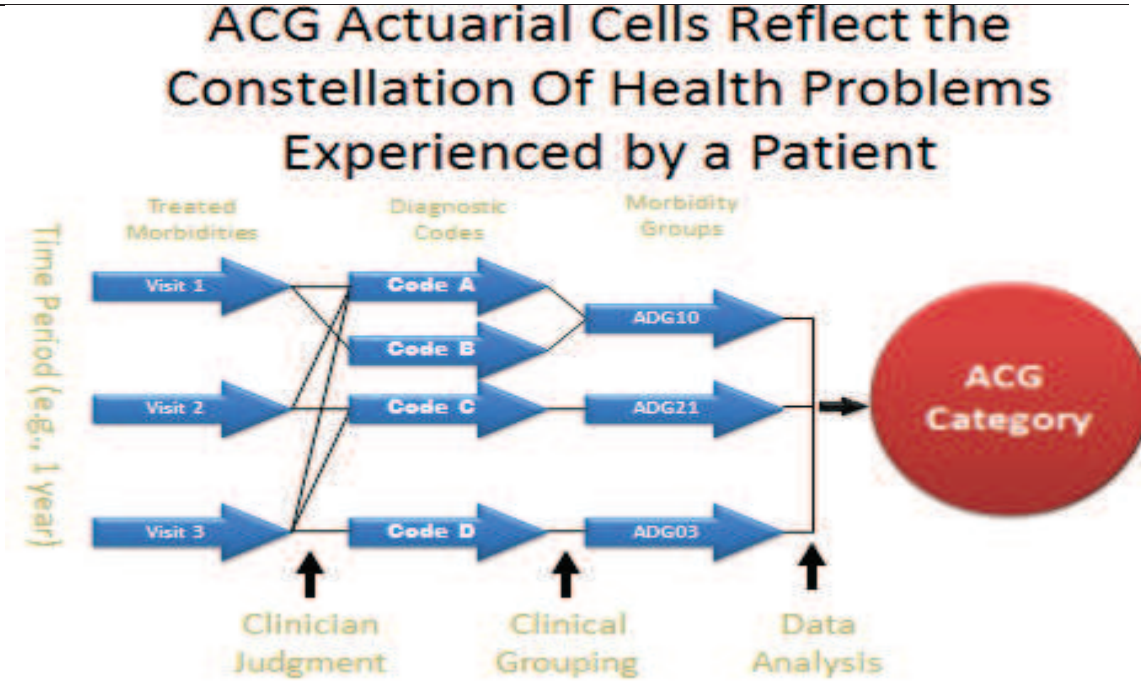
- **Frailty Flag** ( a binary flag which is appended to a patient in the presence of one or more of 12 diagnoses strongly associated with significant functional deficit).and
- **Hospital Dominant Condition count** (a Hospital Dominant Condition is one associated with a 50%+ chance of emergency admission over a 12 month period). The illustration below summarises the basic elements used to calculate risk in the logistical regression model.




The Grouper looks at each diagnosis under five domains:

- Duration
  - ✓ Acute, chronic or recurrent
- Severity
  - ✓ Minor/stable versus major/unstable
- Diagnostic certainty
  - ✓ Symptoms versus disease
- Etiology
  - ✓ Infectious, injury or other
- Specialty care involvement

In order to map each diagnosis in to an Aggregated Diagnosis Group (ADG) and finally a number of ADGs can map to only one Adjusted Clinical Group.
An illustration showing how someone who attends their GP on three occasions in a year and is given four different diagnoses is shown below




The suite of reports is refreshed each month and consists of reports aimed at helping primary care identify specific cohorts at the click of a button – Unplanned Admissions DES population and complex diabetes population – and a larger report where the practice can use a series of filters to define for their practice a population of interest. For example a practice might want to identify a segment of their population. An example of this might be if the practice wanted to identify all those women with diabetes who are in risk bands 3 and 4 as a means of selecting patients who would benefit from accessing the DESMOND training for self-management.

At the moment reports predict two discrete but related outcomes:

1. The probability of the patient being admitted as an emergency in the next 12 months
2. The probability of the patient being in the top 5% highest costing group pf patients across LLR next year

A series of training sessions for GPs, practice managers and practice nurses has been conducted over the last 18 months –both as one-to-one and as group sessions. This teaches staff about the ACG system, how to create searches to identify segments of the practice population and how to deploy a suite of evidence based interventions for patients at moderate to very high risk.

A guide has been produced for practices as to what kinds of interventions they might consider for at-risk patients and which of the range of community based health and social care services to consider referring patients to for further assessment. (see Appendix 9)

We have engaged GPs, practice managers, practice nurses, public health consultants and commissioners in identifying further developments to the current

reports. The following developments have been requested are expected to be in place by January 2015:

- Installation of version 10 of the ACG system
- Incorporating the RAV UK regression changes to the model (based on revalidation work described below in evidence)
- Addition of filters to allow segmentation of care home population and identification of all those taking 6+ medications
- Development of case-mix adjusted population reports for each practice
- Creation of suite of public health reports focusing on multi-morbidity associated with key local LTCs such as diabetes and mental health
- Building from scratch a local cost model based on pharmacy costs, secondary care costs and reference costs for primary care
- Creation of filter menu to allow tracking of interventions associated with the Unplanned Admission DES and the BCF primary care work – status markers to show care plan completed, membership of target group, need for review of care plan etc.

We will be working closely with our LMC and IG colleagues to develop an updated ISA which will be the framework for some key elements of the above reporting.

All 62 Leicester City GP practices have signed the ISA for risk stratification and receive a monthly refreshed series of reports. As explained in the vision section of this plan, the reports are used to support work to

- Identify the top 2% highest risk adults and children
- Identify the following 2.1 – 10% highest risk patients in their population
- Identify complex diabetes patients
- Identify patients at high risk of adverse outcomes from poly-pharmacy
- Identify the high risk segment of the over 75 population for referral to the Care Navigator Service.

**What patient cohorts are being targeted?**

In terms of the outputs of the risk stratification system, there are currently five target cohorts for the BCF pathway:

1. Those aged 18-59 years with three or more long term conditions (LTCs) in risk bands 3, 4 and 5
2. Those aged 60+ with one or more LTCs in risk bands 3,4,5
3. Those with dementia
4. Those with a positive frailty flag not already on the end of life or dementia register
5. Those with one or more hospital dominant conditions

**The delivery chain**

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

**Commissioners :**

Leicester City CCG.

Leicester City CCG pays the licence fee to the Johns Hopkins University for the use of the ACG system by Leicester city practices and pays GEM CSU for the processing of the data required to produce the risk stratification reports for each practice.

**Providers:**

- **Johns Hopkins University, Baltimore, Maryland, USA –** providers of the software for the ACG system.

- **Greater East Midlands Clinical Support Unit –** providers of the data processing required to create the risk stratification reports for each practice.

**The evidence base**

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

**Lewis L, Curry N et al Choosing a predictive risk model: a guide for commissioners in England. Nuffield trust (2011)**

**Thompson A, Morris C. Risk Stratification: Recalibration of the ACG System Predictive Models Central and Southern CSU 2014 (presented at Nuffield Trust Risk Stratification Conference )** this briefing summarises the work carried out by Johns Hopkins University in partnership with Central and Southern CSU to revalidate the statistical performance of the ACG predictive model in a large (523,000 individuals) UK population in November 2013 The new UK model actually performs better as a predictor of emergency admission in the UK than does the US model.

**Ham C, Imison C, et al. Avoiding Hospital Admissions; Lessons from Evidence and Experience King's Fund (2010)**

"The greatest opportunity to reduce hospital admissions and bed days lies in the proactive management of people with long-term conditions, especially people with multiple conditions. Integrated working between health and social care can result in lower than expected emergency admissions and reduced use of beds, as evidenced by the achievements of Torbay."

**Tian Y, Dixon A, Emergency Admissions for Ambulatory care sensitive conditions: Identifying the potential for reductions. King's fund (2012)**

- Influenza and pneumonia account for the highest proportion of all emergency admissions (EAs) for ambulatory care sensitive conditions (ACSCs) - 13% – much of this activity is preventable by vaccine administration.
- Those over 75 account for 40% of the total EAs for ACSC
- COPD/CHF/Flu/Pneumonia/Dehydration and gastritis account for 53% of costs associated with EAs for ACSCs.

**Oliver D, Foot C et al. Making our Health and care systems fit for an aging population The King's Fund (2014)**

Amongst a range of recommendations this paper highlights:

(a) rapid support close to home in times of crisis and (b) integration to provide person-centred co-ordinated care

**Roland M, Abel G Reducing Emergency Admissions: Are we on the right Track? BMJ 2012; 345 e6017**
Sets out the various segments of risk within the UK population and the proportion of the total amount of emergency admissions accrued by each segment. Highlights the important of not restricting interventions to the highest risk patients and the need to address patients from at least the top quintile of risk within the population.

**Salisbury C, Johnson L, Purdy S, Valderas JM, Montgomery AA. (2011) Epidemiology and impact of multi-morbidity in primary care: a retrospective cohort study. Br J Gen Practice 61:e12-e21.** Used the ACG system to characterise the distribution of clinical risk and multi morbidity in UK General practice and linked costs to various risk cohorts.

**Sylvia ML, Griswold M, Dunbar L, Boyd CM, Park M, Boult C. (2008) Guided care: cost and utilization outcomes in a pilot study. Disease Management 11:29-36.**
Demonstrates how use of risk stratification can support case management of those with LTCs to reduce hospitalisation.

**Naylor C. et al Long Term Conditions and Mental Health: The cost of Co-morbidities. King's Fund and Centre for Mental Health (2012)**

"…by interacting with and exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least 45 per cent for each person with a long-term condition and co-morbid mental health problem." One of the benefits of the ACG system is that it includes all mental health diagnoses in calculating risk of adverse outcomes and on an individual patient level allows practitioners to see the role of the interaction of physical and mental health in deriving a global morbidity score which takes into account the interaction between mental and physical health. This paper underpins our decision to invest in increasing access for older people with LTCs to the CMHT

**Leicester City CCG population segmenting and analysis by GEM CSU and LCC Public Health Department**

| **Investment requirements**<br>Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan |
|---|
| 2014/15: £54,000<br>2015/16: £54,000 |
| **Impact of scheme**<br>Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan<br>Please provide any further information about anticipated outcomes that is not captured in headline metrics below |
| Using the benefits analysis model developed with PA Consulting, we have attributed an impact on the following metrics: |

| |
|---|
| BCF National Metric 1: Less people going into nursing and residential care |
| BCF National Metric 4: A reduction in total hospital admissions |

BCF Local Metric: More people being identified as living with Dementia

Please see tab 4 of template 2 for further detail

In addition to the national metrics, we have set up a dashboard to monitor outcomes and activity under the following themes:

- **System performance against national BCF metrics**. Risk stratification in primary care as a platform for the activity described above will impact on:
- Emergency admissions and attendances
- Numbers still at home 91 days post discharge
- Numbers entering permanent residential care

**Ensuring that patients experience integrated planned community care to prevent deterioration of LTC and promote self-care**

- Numbers of patients seen each month by CMHTs, Community Planned Care Health team will go up.
- Number of contact and domiciliary assessments by SPoC will go up.

**Increase in evidence based interventions for those identified by the risk stratification system:**

- Number of pneumococcal and seasonal flu vaccines
- Number of care plans agreed with patients at risk of hospitalisation
- Number of those with a confirmed diagnosis of dementia
- Number of medicines reviews

**Feedback loop**
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

*Strategic level – Monthly reporting to the JICB and CCG Performance Exec*

At a strategic level, an overarching system dashboard is being formulated, covering the 5 + 1 national metrics as well as other relevant metrics to manage flow at a system level.

*Operational Level – Bi-weekly reporting to the BCF Implementation Group*

Underneath this, sits a comprehensive Integrated Care Performance Dashboard, specially produced to support the performance management function for the BCF Programme.

*Practice level – Weekly reporting*

Finally, GP practice level monitoring has been added to monitor progress against practice level targets for interventions aligned to the BCF, such as care planning, access to preventative services and overall acute care usage by practice.

In totality, this provides a comprehensive view of both the health and social care

| |
|---|
| system as a whole and tracks performance of the Integrated Care model.<br><br>All draft dashboards are provided as Appendix 7. |
| **What are the key success factors for implementation of this scheme?** |
| • Complete sign up of Leicester City CCG practices to sharing the required data to risk stratify each practice's complete population. This has been achieved<br>• Sign up to a new Information Sharing Agreement to allow more extensive reporting – especially of aggregated data and practice specific financial modelling. Engagement plan in place.<br>• Completion of the planned developments of the system – see above.<br>• Continued engagement with GP practices around the future direction of developments of the reports. |

| **Scheme ref no.** |
| --- |
| BCF 2 |
| **Scheme name** |
| Lifestyle referral hub |
| **What is the strategic objective of this scheme?** |

Link to Vision:

- Empower our population to be both better informed and better manage their own health and wellbeing using a range of traditional and digital media and technology

Response to case for change through delivery of:

(a) Reduction in the numbers of patients requiring admission to permanent residential care
(b) Increase in the numbers of patients still at home 91 days after discharge from hospital
(c) Reduction in the total numbers of emergency admissions
(d) Increase in the number of patients recorded as living with dementia

Link to wider strategic objectives:

Supporting the community of Leicester to live well and reduce unhealthy behaviours will reduce the number of people who develop non-communicable diseases e.g. CVD, COPD.

Cardiovascular disease accounts for 33% of all deaths in Leicester and 28% of all deaths under 75 years of age. It is the major contributory factor to the gap in life expectancy between Leicester and England, 39% for males and 31% for females. More than half of CVD-related deaths are from coronary heart disease (CHD), and a quarter from stroke. Outcomes for CVD within the city are significantly worse than the rest of the East Midlands, and about 50% higher than the national average. CHD mortality is significantly higher in the most deprived areas of the city, and 13 wards show a significantly higher rate of premature CVD deaths than the England average.

It is estimated that 86% of the risk factors associated with CVD are potentially reversible and include lifestyle issues such as smoking, obesity, poor diet and lack of physical activity, in addition to socio-economic factors such as low income and poor housing.

High blood pressure, raised sugar levels and high blood fats are also predisposing conditions to CVD.

However, timely detection and treatment of these conditions can help reduce prevalence and premature mortality rates from CVD.

The premature CVD mortality rate in Leicester has reduced over the last 10 years but not at the same rate as it has for England. The gap between Leicester and

England has almost doubled over the last 10 years (from 27% in 1998-2000 to 53% in 2008- 2010).

Mortality rates for COPD in 2008-10 are significantly higher in Leicester overall and in Leicester males than England, in both all ages and under-75s.

There has been a gradual downward trend in COPD mortality rates in England over the past 10 years. In Leicester the rate is more variable due in the main to relatively small numbers. However, the rates are generally higher for both males and females with male mortality rates significantly higher than in England in a number of years.

Higher rates of respiratory disease mortality are generally found in the west of Leicester and similar patterns are seen for high COPD mortality (with the exception of Thurncourt and Coleman wards). Higher mortality reflects areas of higher deprivation and high smoking prevalence.

Unhealthy behaviours such as smoking, physical inactivity, poor diet and alcohol consumption are major risk factors for all the main causes of mortality in Leicester (cardiovascular disease, diabetes, cancers and respiratory conditions). Supporting people to make and sustain changes in these behaviours will ultimately reduce morbidity and mortality, improving wellbeing and saving public sector money.

Therefore, the service will help meet the following objectives:

- CCG Outcomes Indicator 1 Preventing people from dying prematurely – reducing under 75 mortality from CVD and respiratory disease

- CCG outcomes Indicator 2 Enhancing quality of life for people with long-term conditions – ensuring people feel supported to manage their condition

- CCG Clinical commissioning strategic objective – CVD – design and implement patient education programme and improve the prevalence rates

- CCG Clinical commissioning strategic objective – COPD – design and implement patient education programme.

- Health & Well-being board Strategic priority 2: Reduce premature mortality
    - Reduce smoking and tobacco use
    - Increase physical activity and healthy weight
    - Improve the identification and management of cardiovascular disease, respiratory disease and cancer

The establishment of the Healthy Lifestyles Hub has been endorsed by the Health and Wellbeing Board as part of Leicester's Joint Health and Wellbeing Strategy.

**Overview of the scheme**
Please provide a brief description of what you are proposing to do including:
What is the model of care and support?
Which patient cohorts are being targeted?

The Lifestyle Referral Hub will:

- Provide a simple, effective and reliable “one stop” referral service for GPs and other health care professionals
- Look beyond single issues and undertake a holistic assessment of clients’ needs, state of readiness to change, and identify any barriers to change that may need addressing before the client can engage with services e.g. debt, housing problems
- Support clients to access appropriate lifestyle services such as Food & Activity Buddies, DHAL, Active Lifestyle, walking groups, cycle training, Heart smart group and smoking cessation, and build emotional resilience and self confidence
- Motivate clients to make and sustain behavioural changes to reduce their risk factors
- Work with individual GP practices to maximise appropriate referrals
- Monitor the progress of clients and ensure appropriate feedback is provided to GPs

The Lifestyle Referral Hub is an integrated approach to supporting people to attain and maintain good health. This involves building personal resilience, connecting people to local resources and increasing motivation and confidence to make and sustain changes in lifestyle behaviours.

As well as providing a solution to streamline referrals, the hub will deliver added benefit through the holistic assessment of clients, and an awareness of the wide range of services and activities available within the city.

The assessment will enable a better understanding of clients’ lifestyle risk factors, which factors they feel ready to address (many people have more than one risk factor), their state of readiness to change and what the barriers to achieving and sustaining behaviour change might be. For example concerns about debt or housing problems can prevent clients from being able to address their lifestyle risk. If this is the case, the referral hub can signpost clients to advice services to get support to address these issues at the same time as being referred to lifestyle support services. In this way clients will be better prepared and able to engage successfully with health improvement services, thus making more effective use of those services. Many people who are referred to lifestyle support services currently don’t engage fully. This situation can be improved by understanding the social context of clients’ health behaviours.

All practices in the city have signed up to the NHS Health Check programme whereby all patients aged 40-74 will be invited into their GP practice to have a health check. This is an ideal opportunity for those patients that are inactive, overweight or in need of other support to be referred into appropriate lifestyle services.

GPs report the main reason that they do not currently refer patients is due to confusion about the number of services/ initiatives available in the city and how to access them. It is considered, therefore, that a single point of access into these services would increase referrals and subsequently improve the health of patients.

A telephone based referral hub will manage the referral of adults to relevant lifestyle services. Individuals in need of support to address lifestyle risk factors (e.g. smoking, poor diet, inactivity, obesity etc) will be referred to the Lifestyle Referral Hub by GPs and other health professionals in primary care. In the longer term it is proposed to expand the hub to allow clients to self-refer.

The provider will initially contact the referred client by phone. Trained staff will then introduce the service, assess the needs of the client (including lifestyle risk factors and willingness to change), provide client-centred motivational support, identify lifestyle services appropriate to the client's needs and preferences and obtain and document the consent of the client to transfer details to other service providers. Clients will then be followed up after 4-6 weeks to assess whether further support is required. Clients will also be followed up 6 months after the final contact to assess progress and maintenance of behaviour change, provide additional motivational support as required and refer to other relevant services as appropriate. Clients may also be signposted to unstructured activities such as volunteering opportunities, parks and active transport initiatives depending on their needs.

If it is apparent during the initial contact that the client requires additional support and is eligible for the full health trainer service (i.e. lives in an area of high deprivation), one to one support with a health trainer will be offered. This gives clients the opportunity to work with a health trainer for a maximum of 12 months to develop a Personal Health Plan (PHP) and work towards achieving sustainable behaviour change.

**The delivery chain**
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Leicester GPs, Nurses or other health care professionals refer into the lifestyle hub commissioned by Public Health within Leicester City Council and provided by Parkwood Healthcare.

The provider contacts the patient and may refer them to anyone of a number of voluntary and community groups or professional organisations commissioned across Leicester's health and social care community.

The provider may also, if the criteria are met, make an appointment for the patient to see a Tier 2 Health trainer service. The health trainers are employed by the provider

A contract variation with Parkwood Healthcare (current provider of the pilot scheme and health trainer service) will be needed to expand the lifestyle referral hub for the duration of the current contract (i.e. until end March 2015).

30 practices to have access to the hub from April 2014 and all practices to have access from April 2015.

**The evidence base**

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The need for a Lifestyle Referral Hub has been demonstrated by the lack of referrals into lifestyle services (e.g. FAB weight management/ Active Lifestyle Scheme/ Health Trainers etc) by GP practices in Leicester.

Nottingham City experienced a similar problem regarding lack of referrals into lifestyle services from GPs. They commissioned a lifestyle referral hub and saw a significant increase in referrals within a short space of time (over 4,000 referrals in the first year). By 2012/13 5,480 patients were referred (including self-referral) into the hub in Nottingham.

A pilot of the lifestyle referral hub in Leicester has been running with 7 city practices since February 2013 and a further 6 practices have recently been recruited. The existing health trainer service is providing the referral hub pilot and non recurrent funding was provided to employ an additional health trainer to take on this role. Referrals into the hub started slowly but have gradually increased in these 7 practices. Data from the pilot scheme to the end of October 2013 suggest there would be 5,000 referrals annually if all practices had access

Providing motivational support, advice and referral to appropriate services can help individuals to reduce their risk factors for non-communicable disease. This is evidenced from the evaluation of a similar service in Nottingham which shows statistically significant improvements in a range of factors including BMI, physical activity and diet. The Nottingham evaluation also found clients' general health and wellbeing improved. The Nottingham service operates a slightly different model to that being proposed in Leicester but the extract from their evaluation is included as an indication of what can be achieved.

| Risk Factor | n | Start of Coaching Period (mean & 95% CI) | End of Coaching period (mean & 95% CI) | Mean Difference | P value* |
|---|---|---|---|---|---|
| BMI (kg/m$^2$) | 2273 | 35.9 (35.7-36.2) | 33.5 (33.2-33.8) | 2.4 | p<0.01 |
| Moderate Physical Activity (days/week) | 976 | 2.9 (2.7-3.0) | 3.2 (3.0-3.4) | 0.3 | p<0.01 |
| Fruit and vegetable (portions/day) | 2896 | 3.8 (3.7-3.9) | 4.76 (4.7-4.9) | 0.9 | P<0.01 |
| Alcohol (units/week) | 650 | 8.2 (7.1-9.3) | 7.4 (6.3-8.5) | 0.8 | P<0.01 |
| Smokers | 512 | 512 | 479 | 33 | p<0.01 |

*paired t-test for continuous data/ chi-squared test for smoking.

| Wellbeing measure | n | Start of Coaching Period | End of Coaching period | Mean Difference | P value* |
|---|---|---|---|---|---|
| WHO five wellbeing (score) | 1195 | 53.4 | 62.5 | 9.1 | p<0.01 |
| General Health score | 1190 | 57.2 | 67.6 | 10.4 | p<0.01 |

**Investment requirements**
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15: £60,000
2015/16: £100,000

**Impact of scheme**
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Using the benefits analysis model developed with PA Consulting, we have attributed an impact on the following metrics:

| |
|---|
| BCF National Metric 1: Less people going into nursing and residential care |
| BCF National Metric 2: More people receiving help to recover at home |
| BCF National Metric 4: A reduction in total hospital admissions |
| BCF National Metric 5: Improved patient/service user experience |

Please see tab 4 of template 2 for further detail

In addition to the national metrics, we have set up a dashboard to monitor outcomes and activity under the following themes, linking into the overarching Leicester City integrated care dashboard, attached as Appendix 7.

| | |
|---|---|
| Reduction in health inequalities | Lifestyle risk factors are socially patterned and more prevalent in deprived communities. Addressing lifestyle risk factors will benefit deprived communities proportionately more. |
| | The target is for 80% of health trainers to be recruited from the most economically deprived areas in Leicester. |
| Reduction in barriers to access | The target is for 50% of new client registrations to be from BME communities |
| | The target is for 50% of new client registrations to be men (men are currently under represented in clients accessing health improvement service) |
| Achievement of Personal Health Plans | Target 60% partial achievement, 45% full achievement |
| % weight loss for clients with weight loss as a goal within their personal health plan | Target average of at least 3% |
| Increased fruit and vegetable consumption for clients with diet improvement as a goal within their personal health plan | Target average of at least 1.5 portions/day |
| Increased sessions of moderate/vigorous intensity activity for clients with physical activity as a goal within their personal health plan | Target average of at least 2 sessions/week |
| Proportion of clients achieving 4 week quit where smoking cessation is a goal within their personal health plan | Target 50% |
| Proportion of clients not exceeding guidelines for safe | Target 70% |

| | |
|---|---|
| drinking levels where alcohol consumption is a goal within their personal health plan | |

| Output | Target Number | Supporting Evidence |
|---|---|---|
| Percentage of all clients referred to the Healthy Lifestyles Hub contacted within 5 working days | 85% | Contract minimum data set |
| Number of initial assessments undertaken | No target set | Contract minimum data set |
| Breakdown of primary risk factors (i.e. diet/exercise/ smoking/alcohol etc.) | Not applicable | Contract minimum data set |
| Number of clients signposted/referred to health improvement services | 80% | Contract minimum data set |
| Number of clients who attend first appointment with health improvement service | 70% | Contract minimum data set |
| Breakdown of health improvement services signposted/referred to | Not applicable | Contract minimum data set |
| Number of 6 weeks follow up calls successfully completed | 80% | Contract minimum data set |
| Number of successful calls to clients who have 'dropped out' of health improvement services | 70% | Contract minimum data set |

**Feedback loop**
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The service will be commissioned by Public Health within Leicester City Council.

A steering group will be set up to oversee the project, chaired by public health and including representation from the provider (currently Parkwood Healthcare), the CCG, IT (HIS) and representation from other lifestyle services such as FAB and the Active Lifestyle Scheme.

A group already meets to oversee the pilot; this will be expanded to report into the Better Care Fund Implementation Group

**What are the key success factors for implementation of this scheme?**

KSF's identified with processes in place to manage them:

1. Successful use of the LRH by GP's and other health professionals
2. Successful uptake of the services by the referred population

3. Successful tendering process in place and securing of a suitable provider to deliver the service

| **Scheme ref no.** |
|---|
| BCF 3 |
| **Scheme name** |
| General Practice scheme (2.1-10%) |
| **What is the strategic objective of this scheme?** |
| Link to Vision:<br><br>• Develop a new model of primary care that provides a more proactive, holistic and responsive community service across physical and mental health, increasing capacity where required<br><br>Response to case for change through delivery of:<br><br>(a) Reduction in the numbers of patients requiring admission to permanent residential care<br>(b) Increase in the numbers of patients still at home 91 days after discharge from hospital<br>(c) Reduction in total emergency admissions<br>(d) Increase in the number of patients recorded as living with dementia<br>**(e)** Increase in patient and service user satisfaction |
| **Overview of the scheme**<br>Please provide a brief description of what you are proposing to do including:<br>What is the model of care and support?<br>Which patient cohorts are being targeted? |
| To support the BCF identified cohort , LCC will aim to address their top 0 – 2% high risk patients via the Unplanned Admission DES, allowing them to maximise the BCF funding on the 2.1 -10% high risk population, which will include the BCF cohort:<br>• 60 + years<br>• 18- 59 with 3 or more co- morbidities<br>• Including dementia<br><br>By concentrating the work on this cohort of patients, the CCG will be maximising the impact on the workload in avoiding unnecessary emergency admissions.<br><br>This proposal will ensure the identification of patients who are in need of better care and provide experienced clinical time to:<br>• Undertake routine assessments of patients with long term conditions in their home. This helps people with such conditions to better manage their own health and avoid unnecessary visits to hospital<br>• increase population-based interventions e.g. access to vaccinations, reducing social isolation, increasing access to third-sector and Local Authority services<br>• improve, for selected high-risk individuals, chronic disease management, medicines-related safety and concordance<br>• improve self-care and self-management skills; reiterating Choose Better campaign messages where appropriate |

- promote use of personal health budgets
- provide both proactive and reactive care
- assess carers health needs; enhancing the resilience of the carer population
- prescribe and administer medications within the remit of local PGD, where appropriate, and undertake medication reviews across the cohort
- take a holistic approach to patient care, bringing together their medical, social and psychological needs – both for patients and Carers
- refer patients to alternative health and/or social services through appropriate signposting and guidelines, linking with the wider BCF services and supporting patients in their own homes
- Ensure high quality, detailed care plans are in place and up to date/reviewed.

There are a number of benefits for following this mixed economy of increasing capacity within the primary care setting, including:

- ability for collaborative working for those practices that are seeking to share resources e.g. for sickness cover etc
- more responsive and flexible solution, providing greater continuity of care
- minimal, if any, additional management support will be required (e.g. recruitment costs; referral management processes)
- most appropriate skill mix to best meet needs of individual practices with different requirements e.g. Flexibility for individual practices to choose where to focus their staffing needs
- best use of scarce human resources
- some staffing mainly sourced through existing staffing levels, no recruitment issues
- little set up time; ability to start the work on 1st August 2014
- introduction of shared learning through peer review at locality meetings and PLT

**The delivery chain**
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

General Practice commissioned by Leicester City CCG.

**The evidence base**
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

As set out in the earlier sections of this plan, we know that citizens in Leicester City already suffer reduced life expectancy and more ill health than the national average. Moreover, analysis of specific diseases which are amenable to early intervention and preventative strategies shows equally adverse outcomes; therefore it is even more important for Leicester City to invest in the right interventions for these groups of patients, especially in light of the health inequalities seen across the City. The Marmot Review called for a strengthening in the role and impact of ill-health

prevention, through prevention and early detection of the key long term conditions related to health inequalities.

Many long term conditions are preventable and have common behavioural risk factors, amenable to public health intervention. Even when someone may have been identified as having one of these conditions there may still be opportunities, through appropriate health and social intervention, to prevent or delay the onset of complications and extend disability-free life. However, managing these conditions appropriately can be complex and challenging. The Better Care Fund programme provides major opportunity to improve services and their organisation locally, for the effective management of people with LTC.

Prevention and effective management of conditions in the community is also likely to be more cost effective than waiting for patients to turn up sick at the doors of our GP surgeries or hospitals. Of more than 250 studies on prevention published in 2008, almost half showed a cost of under £6,400 per quality-adjusted life year and almost 80% cost less than the £30,000 threshold used by NICE. And although some interventions take many years to pay-off, others do not - for example, effective management of atrial fibrillation or hypertension can show results within a couple of years. Smoking cessation programmes can have an impact over the short term when targeted on Chronic Obstructive Pulmonary Disease patients at risk of acute admission, (NHS call to action, Nov 2013).

**Investment requirements**
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2015/16: £1,000,000

**Impact of scheme**
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Using the benefits analysis model developed with PA Consulting, we have attributed an impact on the following metrics:

| |
|---|
| BCF National Metric 1: Less people going into nursing and residential care |
| BCF National Metric 2: More people receiving help to recover at home |
| BCF National Metric 3: A reduction in hospital bed days due to discharge being delayed |
| BCF National Metric 4: A reduction in total hospital admissions |
| BCF National Metric 5: Improved patient/service user experience |

BCF Local Metric: More people being identified as living with Dementia

Please see tab 4 of template 2 for further detail

In addition to the national metrics, we have set up a dashboard to monitor outcomes and activity under the following themes:

There are a number of KPI's which the individual practices, and the locality as a whole, will be monitored on. These include:

- QIPP reductions in activity at UHL, both in expenditure and activity; across Out Patients; A&E and Emergency Admissions – this will be monitored through existing reporting mechanisms (% practice/locality target)
- A&E reductions in activity at UHL, both in expenditure and activity (% practice/locality target)
- Reductions in emergency admissions from Care Homes (Actual - practice/locality target)
- Increased number of care plans in place for the 2.1-10% high risk cohort (Actual practice/locality target)
- Recording of patient contacts for the patient cohort (Actual - practice/locality target)
- Additional hours/appointments (Actual - practice/locality target)
- Ensure appropriate usage of wider BCF services through increased reported usage (% practice/locality target)
- Increase in number of seasonal flu/pneumococcal vaccinations undertaken (% practice/locality target)
- Increase in recording of Residential Institute (RI) codes on patient records (Actual - practice/locality target)
- Increase in the number of people on the dementia registers (Actual - practice/locality target)
- Evidence of collaborative working through peer review meetings
- Confirmation of the practice direct phone line to care homes where they have registered patients
- Increase in the number of MURs undertaken (Medicine Usage Reviews) (Actual - practice/locality target)
- Evidence of increased referrals to the following self-care services:
    - DESMOND/DAFNE for diabetic patients
    - Pulmonary Rehabilitation
    - Heart Failure Nurse Specialist
    - SPRINT for COPD patients
    - STOP for smokers
    - Lifestyle hub
    - Care Navigator for 75+ patients

**Feedback loop**
What is your approach to measuring the outcomes of this scheme, in order to

understand what is and is not working in terms of integrated care in your area?

*Strategic level – Monthly reporting to the JICB and CCG Performance Exec*

At a strategic level, an overarching system dashboard is being formulated, covering the 5 + 1 national metrics as well as other relevant metrics to manage flow at a system level.

*Operational Level – Bi-weekly reporting to the BCF Implementation Group*

Underneath this, sits a comprehensive Integrated Care Performance Dashboard, specially produced to support the performance management function for the BCF Programme.

*Practice level – Weekly reporting*

Finally, GP practice level monitoring has been added to monitor progress against practice level targets for interventions aligned to the BCF, such as care planning, access to preventative services and overall acute care usage by practice.

In totality, this provides a comprehensive view of both the health and social care system as a whole and tracks performance of the Integrated Care model.

All draft dashboards are provided as Appendix 7.

**What are the key success factors for implementation of this scheme?**

- UHL contract at the 14/15 year end delivered to planned levels.
- UHL contract at the 14/15 year end is £500k (or more) below plan.


| **Scheme ref no.** |
|---|
| BCF 4 |
| **Scheme name** |
| Clinical Response Team |
| **What is the strategic objective of this scheme?** |

Link to Vision:

- Reduce the amount of time spent in hospital avoidably by our citizens, by focussing on health and social care pathways and services such as housing

Response to case for change through delivery of:

(a) Reduction in the numbers of patients requiring admission to permanent residential care
(b) Increase in the numbers of patients still at home 91 days after discharge from hospital
(c) Reduction in the total numbers of emergency admissions
(d) Reduction in the number of delayed transfers of care
(e) Increase in the number of patients recorded as living with dementia

Link to wider strategic objectives:

This service is part of this wider transformative change within the health and social care economy in Leicester City. At a local level, by joining up our services from the bottom up, we will make a fundamental change in both culture and delivery mechanisms within our local health and social care economy, linking particularly into our priority areas for improvement;

1. Effective, high quality pre-hospital pathways
2. Clinically sound and evidence based hospital pathways
3. Efficient, safe post-hospital pathways

In accordance with Work stream 4: Access to the highest quality urgent and emergency care, EMAS will be able to respond more efficiently to the most appropriate calls, whilst the lower acuity calls are managed within an appropriate non-acute setting. This will allow timely referrals to be made to those services necessary within the whole range of community services. Also to allow immediate treatment as required followed by a holistic assessment to ensure that suitable, effective and manageable care planning is made to facilitate the patient to remain at home and feel more confident to manage any ongoing health needs. Details of

interventions will be communicated to all relevant parties to ensure that follow ups are made.

**Overview of the scheme**

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

A skill mix of clinicians (GPs and ECPs) will support EMAS by responding to a pre-agreed referral criteria, either as a first response for lower category calls or as a secondary response from Paramedics on scene to provide appropriate safe and timely clinical treatment to maximise opportunities to avoid unnecessary ambulance dispatches, visits to A&E or short stay unplanned medical admissions when they could be looked after at home by a GP. The clinicians will assess, treat and stabilise the patient and, of appropriate, prevent the requirement for conveyance to the ED at the Acute site, preventing the ED attendance and preventing a potential admission into an acute bed. Referrals to community services will be utilised wherever possible to ensure an appropriate immediate intervention and a programme of ongoing care developed to try and prevent the need for unnecessary contact with emergency services in the future. In addition, it will help to educate the public around the range of community services available within the City.

A phased approach has been taken to the introduction of this Service, with the final phase to be implemented by November 2014. In addition to EMAS referrals, Leicester City care homes and GP practices will be permitted to refer appropriate patients directly into the Service. The Clinical Response Team is also being added to the Electronic Directly of Services, making it visible to NHS 111 for appropriate referrals also.

This variety of referral routes will permit anyone aged 60+, or aged 18-59 with pre-existing co-morbidities to be appropriately cared for within the community following initial contact with EMAS, care homes, GPs or 111.

**The delivery chain**

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

| | |
|---|---|
| Commissioner: | NHS Leicester City CCG |
| Service Provider: | SSAFA Care CIC |
| Working in partnership with: | EMAS (East Midlands Ambulance Service) |
| Community service providers: | Leicestershire Partnership Trust (health care)<br>Leicester City Council (social care)<br>Derbyshire Health United (NHS 111)<br>Central Nott's Clinical Services (Out of Hours)<br>Various care home providers within Leicester City |

**The evidence base**

Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Modelling has shown a potential pool of up to 20275 calls in 2013/14; this covers R2 – G4 999 calls and a selected number of chief complaints which are deemed as ambulatory. In 2014/15, this number is expected to increase with the full roll out of NHS 111 across the City.

Of this pool, 50% of these patients aged 60+ conveyed to UHL and once at UHL, the conversion rates for these patients is 65%. The chief complaints chosen for focus are those which are best treated in primary and community settings and therefore, this scheme is designed to reduce the conveyance of such patients (where clinically appropriate) to the acute site and instead support the patient at home.

In 2013/14, the CCG took part in a similar GP in a Car scheme which resulted in reductions in both ED attendance and ambulance conveyance. Learning from this scheme has been applied here.

**Investment requirements**
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15: £1,365,000
2015/16: £1,365,000

**Impact of scheme**
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Using the benefits analysis model developed with PA Consulting, we have attributed an impact on the following metrics:

| |
|---|
| BCF National Metric 1: Less people going into nursing and residential care |
| BCF National Metric 2: More people receiving help to recover at home |
| BCF National Metric 3: A reduction in hospital bed days due to discharge being delayed |
| BCF National Metric 4: A reduction in total hospital admissions |
| BCF National Metric 5: Improved patient/service user experience |
| BCF Local Metric: More people being identified as living with Dementia |

Please see tab 4 of template 2 for further detail

In addition to the national metrics, we have set up a dashboard to monitor outcomes as outlined below:

- A reduction in time spent avoidably in hospital
- An increase in EMAS call response times
- Improved clinical outcomes
- Improved patient satisfaction
- Simplified local access
- Eliminated duplication
- Improved clinical and cost effectiveness
- Better allocation of resource to genuine emergencies improving performance in these categories

**Feedback loop**
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

*Strategic level – Monthly reporting to the JICB and CCG Performance Exec*

At a strategic level, an overarching system dashboard is being formulated, covering the 5 + 1 national metrics as well as other relevant metrics to manage flow at a system level.

*Operational Level – Bi-weekly reporting to the BCF Implementation Group*

Underneath this, sits a comprehensive Integrated Care Performance Dashboard, specially produced to support the performance management function for the BCF Programme.

*Practice level – Weekly reporting*

Finally, GP practice level monitoring has been added to monitor progress against practice level targets for interventions aligned to the BCF, such as care planning, access to preventative services and overall acute care usage by practice.

In totality, this provides a comprehensive view of both the health and social care system as a whole and tracks performance of the Integrated Care model.

All draft dashboards are provided as Appendix 7.

**What are the key success factors for implementation of this scheme?**

The non-conveyance rate remains above the target of 70%, and the CRT clinicians are reporting back on excellent standards of care which have seen patients referred onto the Unscheduled and Planned Care teams for management within a community setting. In addition, there have been >25 referrals back to the registered GP practices for follow up, enabling the practices to make their own contact and provide appropriate support for both the patient and any carers.

No complaints or serious incidents have been reported and a patient experience survey is due to be carried out in September 2014.

| **Scheme ref no.** |
|---|
| BCF 5 |
| **Scheme name** |
| Unscheduled Care Team |
| **What is the strategic objective of this scheme?** |

Link to Vision:

- Provide a modern model of integrated care with a senior clinician taking responsibility for coordination of care
- Reduce the amount of time spent in hospital avoidably by our citizens, by focussing on health and social care pathways and services such as housing

Response to case for change through delivery of:

(a) Reduction in the numbers of patients requiring admission to permanent residential care
(b) Increase in the numbers of patients still at home 91 days after discharge from hospital
(c) Reduction in the total numbers of emergency admissions
(d) Reduction in the number of DTOC's
(e) Increase in the number of patients recorded as living with dementia

Link to wider strategic objectives:

The strategic intention of this scheme is to create a responsive integrated multidisciplinary health and social care team to be available seven days a week twenty four hours a day to respond to patients aged 18 and over who have called an ambulance/ activated their Leicester Care alarm/ or had an urgent GP consultation but whose conditions or needs can be treated and cared for at home provided the right community support is provided.

**Overview of the scheme**

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

A substantial left-shift in activity to have many more patients with long term conditions managed at home requires the right level of community support to be available on a seven day basis. Patients are quite often admitted to hospital by ambulance service/social care staff and GPs because there is a perceived lack of reliable community services to provide further assessment and provision of monitoring and care – and so hospital is often seen as the only safe option. This Integrated Unscheduled community service will provide a solution to this problem by establishing a robust and reliable integrated community health and social care service available 24/7. The service will support primary care, Clinical Response Team (CRT) and Out of Hours (OOH) GPs and ambulance crews who want to initiate rapid response and high intensity care in a community setting as a safe

alternative to hospitalisation. Regardless of which location the patient is first seen in on an urgent basis (home/care home/GP surgery/community) the clinician or social care worker will be able to mobilise a rapid and comprehensive assessment and management response for the next 72 hours following the initial referral.

The BCF investment in this element – Unscheduled health and Social care - specifically targets the following elements of our model described below:

- Uplift and development of the capacity of the Unscheduled Integrated community health services team and development of integrated pathway for joint response with rapid response social care team (ICRS)
- Increase in the capacity in overnight nurse service – to work side by side with ICRS
- Increase in the capacity of Adult Social Care Rapid Response team (ICRS) – for both day and overnight rotas to work jointly with unscheduled health care team.
- Co-location of both health and social care Unscheduled care teams to develop integrated working, joint visiting and sharing of intelligence and skill sets.
- Increase in investment in Assistive Technology and Practical Help at Homes teams. Minor home adaptations and equipment and Assistive Technology devices can be key facilitators of independence and safety at home for older people

**The model of care: A patient –centred and holistic approach to bringing care closer to home over the whole 24/7 cycle through:**

(1) A Single Point of Access (SPA) for integrated Unscheduled Community Health and Social Care
(2) Physical co-location of Unscheduled health and social care staff to facilitate integrated response and to reduce duplication for the patient
(3) A maximum response time of 2 hours 7 days a week across the 24 hour cycle
(4) Holistic assessment of patients' health (including mental health)and social care needs in their home setting followed by:
(5) Rapid deployment of domiciliary care, nursing, therapy and equipment services with the aim of stabilising the patient and identifying ongoing care needs
(6) An increase in evening and overnight staffing in health and social care teams (including at weekends) to ensure that there is prompt response and continuity of care for frail older people in crisis
(7) A continuous cycle of reassessment and evaluation over the next 72 hours with close cooperation from the patient's primary care team leading to:
(8) Planned discharge from the Integrated Unscheduled into (a) Integrated Planned Community Care Services such as:
    - Reablement
    - Adult social care
    - Community Therapy
    - Community nursing services – including specialist heart failure and respiratory services where appropriate
    - Community mental health services

Or (b) into planned primary care follow up with or without personal budget commissioned social care support.

(9) Into some or all of the above with additional input from our voluntary and 3rd sector services (e.g. Age Concern "let's get moving together", Memory Cafes, Lifestyle Hub, IAPT, CLASP, Mental health charities).

(10) The discharge plan will address any outstanding interventions relating to environmental safety and safeguarding, health interventions such as missing vaccinations, medication-related issues and mental health or cognitive concerns with details of how these will be followed up.

**What patient cohorts are being targeted?**

There are three target cohorts for the BCF pathway:

2. Patients aged 18-59 years with three or more long term conditions (LTCs)
3. Patients aged 60+ with one or more LTCs
4. Patients with dementia

**The delivery chain**

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

**Commissioners :**

Leicester City CCG
Leicester City Council Adult Social Care Services

**Providers:**

Leicestershire Partnership Trust Community Health Services (LPT CHS) - Providers of **Unscheduled Integrated Community Health Services** including specialist nursing, district nursing, mental health practitioners, physiotherapy, health care assistants, and continence specialists for example.

Leicester City Council – Providers of

- **the Integrated Crisis Response Service** (Adult Social Care's 24 hour Rapid Response Service bringing to bear social care assessment/ Occupational Therapy assessment, provision of domiciliary care/help with nutrition and hydration, referral on to reablement and a wide variety of social inclusion opportunities.
- **Assistive Technology Service** (rapid assessment of patient needs and the installation of tailored suite of assistive Technology solutions such pendant alarms, electronic medication reminders, continence alarms, falls detectors, wandering alarms, gas detection alarms – all focused on reduction of risk and maintenance of independence in the home.
- **Practical Help At Home** – Home Handyman service which in the Unscheduled care setting aims to install grab rails, hand rails, lighting, minor floor repairs etc.in response to identified high risk situations. Works hand in hand with unscheduled health and social care services to ensure prompt response to prevent potential admission to hospital.

- Emergency duty Team – Adult Social Care out of hours duty team available from 5PM – 8AM to provide emergency assessment and safeguarding interventions.

**The evidence base**

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

**Ham C, Imison C, et al. Avoiding Hospital Admissions; Lessons from Evidence and Experience King's Fund (2010)**

"The greatest opportunity to reduce hospital admissions and bed days lies in the proactive management of people with long-term conditions, especially people with multiple conditions. Integrated working between health and social care can result in lower than expected emergency admissions and reduced use of beds, as evidenced by the achievements of Torbay."

**Purdy S. Avoiding Emergency Admissions: what does the evidence say? King's Fund (2010)**

Points to the potential of integration of Health and Social care responses in reducing admissions

**Tian Y, Dixon A, Emergency Admissions for Ambulatory care sensitive conditions: Identifying the potential for reductions. King's fund (2012)**

- Influenza and pneumonia account for the highest proportion of all emergency admissions (EAs) for ambulatory care sensitive conditions (ACSCs) - 13% – much of this activity is preventable by vaccine administration.
- Those over 75 account for 40% of the total EAs for ACSC
- COPD/CHF/Flu/Pneumonia/Dehydration and gastritis account for 53% of costs associated with EAs for ACSCs.

**Oliver D, Foot C et al. Making our Health and care systems fit for an aging population The King's Fund (2014)**

Amongst a range of recommendations this paper highlights:

(a) rapid support close to home in times of crisis and (b) integration to provide person-centred co-ordinated care

**Roland M, Abel G Reducing Emergency Admissions: Are we on the right Track? BMJ 2012; 345 e6017**

Sets out the various segments of risk within the UK population and the proportion of the total amount of emergency admissions accrued by each segment. Highlights the important of not restricting interventions to the highest risk patients and the need to address patients from at least the top quintile of risk within the population.

**Igual et al. Challenges, issues and trends in fall detection Systems BioMedical Engineering OnLine 2013, 12:66**

Highlights the importance of avoiding "long lie" for patients who have fallen and are unable to get themselves up. Assistive technology linked to rapid response teams can be vital in avoiding this adverse outcome.

**Leicester City CCG population segmenting and analysis by GEM CSU and LCC Public Health Department**

**Investment requirements**
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15: £926,000
2015/16 £1,475,000

**Impact of scheme**
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Using the benefits analysis model developed with PA Consulting, we have attributed an impact on the following metrics:

| |
|---|
| BCF National Metric 1: Less people going into nursing and residential care |
| BCF National Metric 2: More people receiving help to recover at home |
| BCF National Metric 3: A reduction in hospital bed days due to discharge being delayed |
| BCF National Metric 4: A reduction in total hospital admissions |
| BCF National Metric 5: Improved patient/service user experience |
| BCF Local Metric: More people being identified as living with Dementia |

Please see tab 4 of template 2 for further detail

In addition to the national metrics, we have set up a dashboard to monitor outcomes and activity under the following themes:

- Monthly discussion of anonymised individual case studies at BCF Implementation Group meeting
- Monthly BCF Operational Group meetings for providers to discuss any challenges/successes in implementing the pathway.
- Feedback of outcomes of cases to individual referring clinicians
- Quality report – reporting on any incidents/complaints issues – by exception based on quality schedule of main LPT CHS contract

**Feedback loop**
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

*Strategic level – Monthly reporting to the JICB and CCG Performance Exec*

At a strategic level, an overarching system dashboard is being formulated, covering the 5 + 1 national metrics as well as other relevant metrics to manage flow at a system level.

*Operational Level – Bi-weekly reporting to the BCF Implementation Group*

Underneath this, sits a comprehensive Integrated Care Performance Dashboard, specially produced to support the performance management function for the BCF Programme.

*Practice level – Weekly reporting*

Finally, GP practice level monitoring has been added to monitor progress against practice level targets for interventions aligned to the BCF, such as care planning, access to preventative services and overall acute care usage by practice.

In totality, this provides a comprehensive view of both the health and social care system as a whole and tracks performance of the Integrated Care model.

All draft dashboards are provided as Appendix 7.

**What are the key success factors for implementation of this scheme?**

- Co-production and co-ownership of the model and aims of the BCF pathway.
- Guarantee of rapid response for patients to those colleagues who will be referring in patients – primary care GPs, CRT GPs, OOH GPs, EMAS crews, Integrated Community Health Services, Locality Adult Social Care Staff ( Doing what we said we would do for front line staff in terms of increasing access to reliable support for patients to be safely managed at home).
- Engagement of front line clinical and social care staff to refer patients into the pathway
- Commitment by commissioners and providers to work together to implement the practical elements of the pathway – a two hour maximum response time day or night, a willingness to share information and work in a joined up fashion with patients with complex needs, good discharge planning to ensure effective transitions from the Unscheduled care team to the next phase of care within the community.
- Recruitment of staff to plan to ensure that the increased volume of patients being kept at home can be successfully managed within the community setting.
- Co-location of health and social care day and night staff
- Ability to regularly collect activity and relevant outcome and quality data from individual services

| **Scheme ref no.** |
|---|
| BCF 6 |
| **Scheme name** |
| System Coordinator |
| **What is the strategic objective of this scheme?** |

Link to vision:

- Provide a modern model of integrated care with a senior clinician taking responsibility for coordination of care
- Reduce the amount of time spent in hospital avoidably by our citizens, by focussing on health and social care pathways and services such as housing

Response to case for change through delivery of:

- Reduction in emergency admissions and especially readmissions to acute care
- Reduction in the numbers of patients requiring admission to permanent residential care
- Increase in the numbers of patients still at home 91 days after discharge from hospital
- To be a platform to ensure that specialist community services such as Community Matrons Heart Failure and Respiratory Specialist nursing, and Care Navigators caseloads are populated with the right kind of patients – i.e. those with high – very high risk of adverse outcomes where specialist input is likely to have the greatest chance of altering the clinical trajectory.

**Overview of the scheme**

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

As the city PCT and then CCG and Local Authority have been developing additional community based services and pathways over the last few years to try to facilitate a "left-shift" in care away from acute hospitals, a variety of both in-patient intermediate care type facilities and intensive domiciliary services have been commissioned. The challenge remains to ensure that the total available capacity in the community – in-patient and domiciliary, health and social care, NHS and independent sector – is used to optimum (not necessarily maximum) capacity throughout the year **and** throughout the 7 day cycle.

The role of the System Integrator is to act on behalf of the whole health and social care economy across the city – including our acute provider - to ensure that our entire community in-patient bed stock and our total resource for intensive and/ or urgent domiciliary support is being utilised in such a way as to:

(a) support flow through the system
(b) take pressure off the acute sector by facilitating discharge and reducing inappropriate admission
(c) Ensure that patients are managed in the least intensive setting consistent with their meeting their treatment and therapy goals safely

Skilled nurse leadership is fundamental to the achievement of integrated care and to

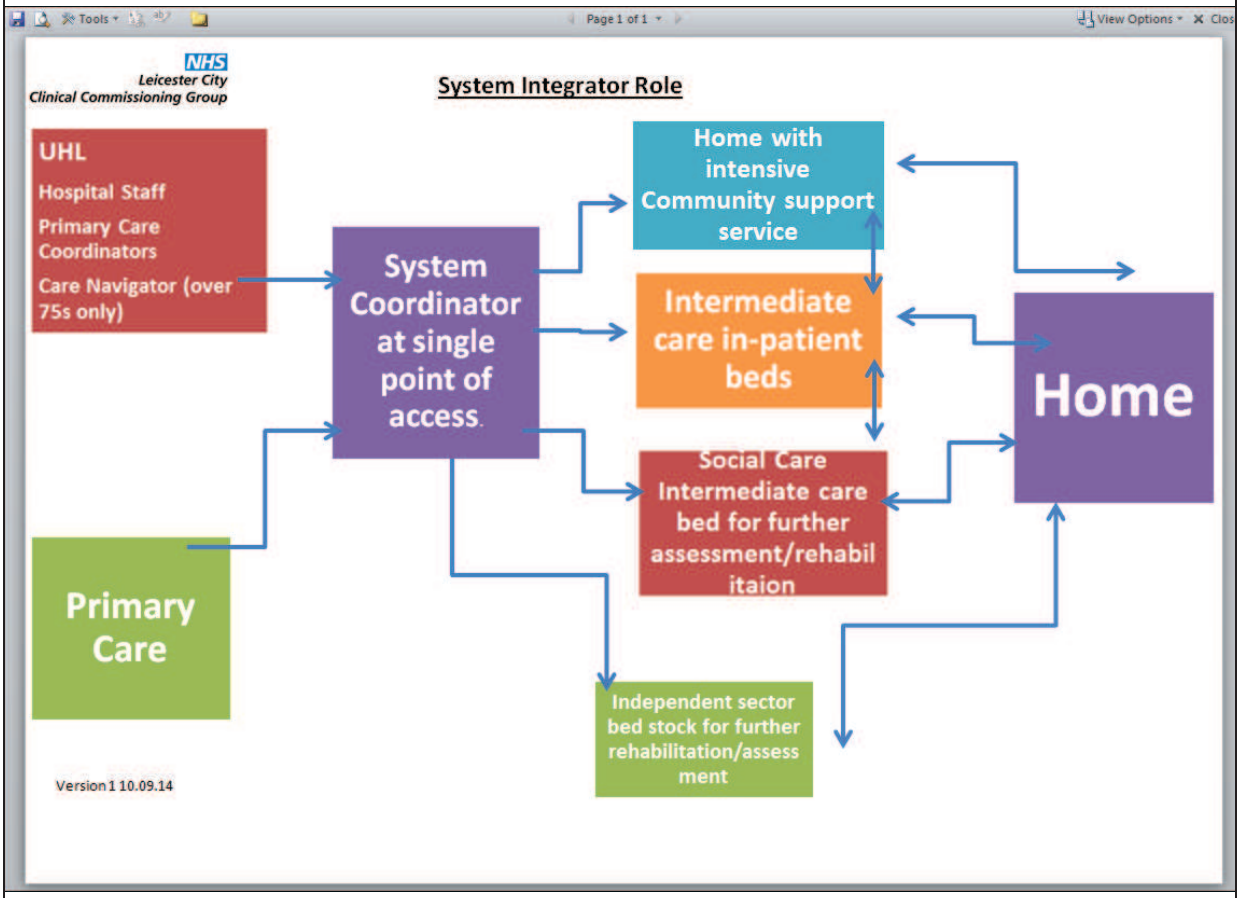
the optimal functioning of the total health and social care community based resource , The System Integrator (an experienced nurse situated in our Single Point of Access) will deliver optimum efficiency across all systems through:

1. Bed and other resource management at whole system level outside of UHL – and close liaison with UHL bed manager on twice daily or more frequent basis.
2. Providing input into decision-making processes (for example challenging decisions to keep patients in hospital where there is a lack of knowledge about what can be offered in the community setting)
3. Clinical leadership
4. Proactive communication with all partners. Providing patient care to ensure that resources are freed up in a timely manner and that where a chain of patient moves through several services is required to happen in order to ensure that each patient is treated in the right place at the right time; that such moves occur in a timely fashion.
5. To lead a twice daily conference call with UHL, LPT CHS and Adult Social Care to coordinate the discharge planning and movement between services from UHL into the community and between various community services.
6. To provide a series of ward based education opportunities over the course of the winter 2014-15 periods to UHL staff on base wards to educate them as to the capacity of community services to support patients with quite complex needs at home.

Nursing expertise must be recognised and utilised to provide the “glue” and the drive to ensure that in the absence of true vertical integration of organisations, that patients reap the benefit of vertically integrated pathways between acute and community services. The ability of nursing staff to view whole care pathways and to take holistic perspectives that go beyond day-to-day clinical issues affords them a vital role in delivering optimum levels of bed occupancy, length of stay and outcomes from each of the linked services.

The slide below illustrates how the System Integrator based at the Single Point of Access will coordinate entry into and movement out of services

**The model of care:**




**What patient cohorts are being targeted?**

5. The System Integrator will be targeting all patients over the age of 18 who are being discharged from UHL who are not able initially to return to live **independently** at home.

**The delivery chain**

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

**Commissioners :**

Leicester City CCG.

Leicester City CCG will commission this post on behalf of all the BCF partners in the city

**Provider:**

Leicestershire Partnership Trust Community Health Services will provide a suitably experienced and credentialed staff member to fulfil this challenging role.

**The evidence base**

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme

- to drive assumptions about impact and outcomes

**Health and Social Care Act 2012** The act gives a duty to NHS England, clinical commissioning groups, Monitor and health and wellbeing boards to make it easier for health and social care services to work together. This will improve the quality of services and people's experiences of them.

**Ham C, Imison C, et al. "Avoiding Hospital Admissions; Lessons from Evidence and Experience" King's Fund (2010)**
"The greatest opportunity to reduce hospital admissions and bed days lies in the proactive management of people with long-term conditions, especially people with multiple conditions. Integrated working between health and social care can result in lower than expected emergency admissions and reduced use of beds, as evidenced by the achievements of Torbay."

**Humphries R Curry N "Integrating Health and Social Care. Where next?" King's Fund 2011**

**"The Integration of Health and Social Care" Health Policy and Economic Research Unit (2012)**

**Oliver D, Foot C et al. Making our Health and care systems fit for an aging population The King's Fund (2014)**
Amongst a range of recommendations this paper highlights:
(b) rapid support close to home in times of crisis and (b) integration to provide person-centred co-ordinated care

.

**Investment requirements**
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15: £63k
2015/16: £63k

**Impact of scheme**
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Using the benefits analysis model developed with PA Consulting, we have attributed an impact on the following metrics:

| BCF National Metric 1: Less people going into nursing and residential care |
|---|

| |
|---|
| BCF National Metric 2: More people receiving help to recover at home |
| BCF National Metric 3: A reduction in hospital bed days due to discharge being delayed |
| BCF National Metric 4: A reduction in total hospital admissions |
| BCF National Metric 5: Improved patient/service user experience |
| BCF Local Metric: More people being identified as living with Dementia |

Please see tab 4 of template 2 for further detail

As part of our overall dashboard we will be measuring the following metrics which will indicate the effectiveness of this investment:

1. Occupied bed days in Intensive Community Support service (ICS)
2. Number of episodes of care per month in ICS
3. Average LOS in ICS
4. Occupied bed days in Intermediate Care beds at Evington Centre
5. Monthly average LOS at Evington Centre
6. Occupied bed days at Local Authority Intermediate care in-patient facility at Brookside Court
7. Average monthly LOS at Brookside Court

**Feedback loop**
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

*Strategic level – Monthly reporting to the JICB and CCG Performance Exec*

At a strategic level, an overarching system dashboard is being formulated, covering the 5 + 1 national metrics as well as other relevant metrics to manage flow at a system level.

*Operational Level – Bi-weekly reporting to the BCF Implementation Group*

Underneath this, sits a comprehensive Integrated Care Performance Dashboard, specially produced to support the performance management function for the BCF Programme.

*Practice level – Weekly reporting*

Finally, GP practice level monitoring has been added to monitor progress against practice level targets for interventions aligned to the BCF, such as care planning, access to preventative services and overall acute care usage by practice.

In totality, this provides a comprehensive view of both the health and social care system as a whole and tracks performance of the Integrated Care model.

| |
|---|
| All draft dashboards are provided as Appendix 7. |
| **What are the key success factors for implementation of this scheme?** |
| • Ability to recruit candidate of sufficient experience and character to exert influence over system wide resources in context of multiple stakeholders and multiple pathways<br>• Ability to engage UHL staff in changing traditional patterns of care in order to fully utilise the available community capacity<br>• Capacity in ancillary services such as community equipment, Practical help at Home, Transport services etc. to support the decisions of the System Coordinator to move patients towards safely returning to home. |

| **Scheme ref no.** |
|---|
| BCF 7 |
| **Scheme name** |
| Intensive Community Support service |
| **What is the strategic objective of this scheme?** |
| Link to vision:<br><br>• Reduce the amount of time spent in hospital avoidably by our citizens, by focussing on health and social care pathways and services such as housing<br>• Ensure that people are kept independent for as long as possible following hospital care<br><br>The strategic objective of this scheme is to :<br>(a) Reduce delays to transfers to care from both secondary care and from the Intermediate care in-patient beds<br>(b) Increase the numbers of patients independent at home 91 days after discharge<br>(c) Reduce emergency admissions and readmissions to acute care<br>(d) Reduce the number of people admitted to permanent residential care<br>(e) Improve patient experience of care |
| **Overview of the scheme**<br>Please provide a brief description of what you are proposing to do including:<br>- What is the model of care and support?<br>- Which patient cohorts are being targeted? |
| A substantial left-shift in activity to have many more patients with long term conditions managed at home requires the right level of community support to be available on a seven day basis. The current pressures noted through the urgent and emergency care system are compounded by the lack of discharge capacity, specifically into discharge destinations relating to community services. These patients, often older vulnerable patients, occupy acute beds when they could be cared for in the community if more capacity was available. Moving these patients into appropriate community services will improve the quality of care for this cohort of patient whilst releasing valuable acute capacity.<br><br>Intensive Community Support is a model of care underpinned by the principles of comprehensive geriatric assessment (CGA), which has a strong evidence base for improving outcomes for older people. These include reduced mortality or functional decline, improved cognition, improved quality of life, reduced length of stay, reduced readmission rates and reduced rates of long term care use. CGA has also demonstrated that home and bed-based intermediate care schemes through adequately resourced community based services improve outcomes including reduced mortality, increased patient satisfaction and reduced costs.<br><br>The BCF investment in this element – Intensive Community Support service - specifically targets the following elements of our model described below: |

Commissioning of 30 “virtual Ward” beds which allow patients with complex health and social care needs and relatively high levels of dependency to be stabilised and re-abled at home.

**The model of care:**
A patient –centred and holistic approach to providing intensive integrated health and social care to patients with long term conditions and /or frailty syndrome through intensive community nursing , therapy and social care input to patients in their own homes

- The service will operate from 8 AM – 10 PM 7 days per week.
- Treatment and care will be delivered to the patient in their own home but on a more intensive and extended scale than is the case with routine community nursing care
- Patients will be able to receive up to 4 visits per day from health and social care staff
- For those patients with overnight monitoring or care needs care after 10PM will be provided by the increased Night nursing capacity commissioned via the BCF investment – working side by side with the night time ICRS team from Adult Social Care
- Patient are kept on with the ICS for up to 6 weeks
- Although the team will be led by an Advanced Nurse Practitioner, there will be access to the community consultant geriatrician in the Rapid Intervention Team for additional clinical input if required.
- The ethos of ICS care is rehabilitative where possible and therefore dedicated occupational and physiotherapy staff contribute to assessment and treatment of patients – working in partnership with domiciliary care staff to restore independence in activities of daily living
- The service may refer patients on to Reablement for further support towards achieving therapy goals
- Parity of esteem for mental health needs though Community Mental Health Practitioner team (CMHT). Extra emphasis on the importance of managing the mental health aspects of living with long term conditions and social isolation – through the commissioning of extra capacity in the CMHT. This team will work in close association with the ICS service to determine whether latent cognitive impairment or mental health issues are a part of the patient’s complexity of need.
- Robust reablement service which includes community health assessment as standard. Up to 6 weeks of free access to reablement services will be offered to all those ICS patients who might benefit.

**What patient cohorts are being targeted?**

There are three target cohorts for the BCF pathway:

6. Patients aged 18-59 years with three or more long term conditions (LTCs)
7. Patients aged 60+ with one or more LTCs
8. Patients with dementia

**The delivery chain**
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

**Commissioners :**
Leicester City CCG
Leicester City Council Adult Social Care Services

**Providers:**
**Leicestershire Partnership Trust Community Health Services (LPT CHS)** – Providers of the Community Geriatricians, Advanced Nurse Practitioner (ANPs), CMHTs and other specialist nurses Therapy and Health Care Assistant Staff that make up the **health component of the ICS**. The service will work very closely with other members of the planned and unscheduled teams.

**Leicester City Council** Adult **Social Care** – Providers of

- **Single Point of Contact (SpoC) –** this service provides ASC contact and domiciliary assessment for access under FACS criteria to Adult Social Care. Capacity in this team will be increased by 6.53 WTE under the BCF Investment in 2015-16. This additional support will enable prompt assessment and commissioning of care for patients requiring intensive social care support during their period with ICS.
- **Practical Help at Home (PHAH)** see description in Unscheduled Care annex. PHAH may have an input to ICS to provide some minor home adaptations to allow patients to remain at home safely.
- **Assistive Technology (AT) team** See the Unscheduled Care annex for details of this service. Installation of selected AT devices may be part of the support needed to complete the input from the ICS team for frailer patients in order to reduce future risk of readmission.
- **Reablement –** see above and annex on Planned Care for description of this service

**The evidence base**
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Evidence to support this approach can be found in the following papers:

- Ernst & Young. (2012) National Evaluation of the Department of Health's Integrated care Pilots: Rand Europe
- Laurant MJ, Harmsen M, Faber M, Wollersheim H, Sibbauld B, Grol R (2010). Revision of Professional Roles and Quality Improvement: A review of the evidence. London: The Health Foundation.
- Ellis G, Whitehead M, Robinson D, O'Neill D, Langhorne P (2011) Comprehensive geriatric assessment for older adults admitted to hospital:

meta-analysis of randomised controlled trials' British medical Journal, vol. 343, d6553.

**Purdy S. Avoiding Emergency Admissions: what does the evidence say? King's Fund (2010)**
Points to the potential of integration of Health and Social care responses in reducing admissions

**Oliver D, Foot C et al. Making our Health and care systems fit for an aging population The King's Fund (2014)**
Amongst a range of recommendations this paper highlights:
(c) rapid support close to home in times of crisis and (b) integration to provide person-centred co-ordinated care

**Salisbury C, Johnson L, Purdy S, Valderas JM, Montgomery AA. (2011) Epidemiology and impact of multi-morbidity in primary care: a retrospective cohort study. Br J Gen Practice 61:e12-e21.**

**Naylor C. et al Long Term Conditions and Mental Health: The cost of Co-morbidities. King's Fund and Centre for Mental Health (2012)**
"…by interacting with and exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least 45 per cent for each person with a long-term condition and co-morbid mental health problem." This paper underpins our decision to invest in increasing access for older people with LTCs to the CMHT

**Leicester City CCG population segmenting and analysis by GEM CSU and LCC Public Health Department**

**Investment requirements**
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15: £710,000
2015/16: 874,000

**Impact of scheme**
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Using the benefits analysis model developed with PA Consulting, we have attributed an impact on the following metrics:

| |
|---|
| BCF National Metric 1: Less people going into nursing and residential care |
| BCF National Metric 2: More people receiving help to recover at home |
| BCF National Metric 3: A reduction in hospital bed days due to discharge being delayed |
| BCF National Metric 4: A reduction in total hospital admissions |

BCF National Metric 5: Improved patient/service user experience

Please see tab 4 of template 2 for further detail

As part of our overall dashboard we will be measuring the following metrics which will indicate the effectiveness of this investment:

- Occupancy rate of ICS beds
- Occupied bed days
- Monthly completed episodes of care
- Monthly BCF Operational Group meetings for providers to discuss any challenges/successes in implementing the pathway.
- Feedback of outcomes of selected cases to individual referring clinicians
- Quality report at BCF Subgroup on Planned and Unscheduled care– reporting on any incidents/complaints issues – by exception based on quality schedule of main LPT CHS contract

**Feedback loop**
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

*Strategic level – Monthly reporting to the JICB and CCG Performance Exec*

At a strategic level, an overarching system dashboard is being formulated, covering the 5 + 1 national metrics as well as other relevant metrics to manage flow at a system level.

*Operational Level – Bi-weekly reporting to the BCF Implementation Group*

Underneath this, sits a comprehensive Integrated Care Performance Dashboard, specially produced to support the performance management function for the BCF Programme.

*Practice level – Weekly reporting*

Finally, GP practice level monitoring has been added to monitor progress against practice level targets for interventions aligned to the BCF, such as care planning, access to preventative services and overall acute care usage by practice.

In totality, this provides a comprehensive view of both the health and social care system as a whole and tracks performance of the Integrated Care model.

All draft dashboards are provided as Appendix 7.

**What are the key success factors for implementation of this scheme?**

- Co-production and co-ownership of the model and aims of the BCF pathway.

We have had input from GPs, LPT CHS management, Adult Social Care Management EMAS and UHL in the creation of this scheme.

- Engagement of front line clinical and social care staff to refer patients into the pathway. There has been extensive engagement with primary care and Adult Social Care in particular on the drive to adequately resource ICS to support patients with quite intensive needs at home – including those with overnight needs
- Recruitment of staff to plan to ensure that the increased volume of patients being kept at home can be successfully managed within the community setting.
- Integrated working between community geriatricians and the rest of the ICS staff
- Ability to regularly collect activity and relevant outcome and quality data from individual services – we have engaged with all providers to agree the relevant and available data items which can be collated to evaluate progress on this scheme.

| **Scheme ref no.** |
|---|
| BCF 8 |
| **Scheme name** |
| IT Integration Project |
| **What is the strategic objective of this scheme?** |
| The incorporation of the NHS number into the Social Care record has been identified as one of the main strategic priorities in relation to the BCF and is a national condition and one of the core metrics identified by the Better Care Fund Guidance<br><br>To develop the delivery of more seamless and integrated health and social care for those with complex needs a single unique identifier will be required where records are to be shared to improve communication across the local health and social care economy.<br><br>This scheme is fundamentally concerned with developing a technical and information governance infrastructure across health and social care in Leicester. The system integration project is aimed at meeting the national condition of data sharing through enabling the NHS number to be used as the primary identifier. It will also have the potential to support each of the key projects to integrate its business process and information sharing to an optimised level. This will bring capability for the generation of integrated management information to support strategic and operational decision making. |
| **Overview of the scheme**<br>Please provide a brief description of what you are proposing to do including:<br>- What is the model of care and support?<br>- Which patient cohorts are being targeted? |
| **Phase 1**<br><br>Phase 1 will firstly involve the development of an overarching information governance framework between the NHS Leicester City and Leicester City Council Adult Social Care. This will allow the sharing of information and the development of a set of associated Individual Information Sharing Agreements (ISA) to support particular functions/services as they integrate more closely in a phased way, in line with the wider programme.<br><br>Compliance with the IG toolkit is an activity in this phase and a key enabler to allow phase 2 to commence.<br><br>The establishment of NHS numbers through the Demographic Batch Service (DBS) for all customers known to Adult Social Care is a key milestone for this phase and is a key enabler in supporting; strategic and operational decision making, service |

redesign and understanding performance across functions of the integrated care pathway.

Indicative timescales for this phase of work are anticipated to be from April 2014 – November 2014.

**Phase 2**

This phase aims to build an integral link between NHS and Council information systems respectively. This will facilitate a long term solution to enable day to day transfer of the NHS number and other Personal Demographic data from the NHS SPINE to the Adult Social Care case management system namely Liquid Logic IAS. This link will involve dedicated technical work with the deployment of specialist software modules which are designed to support this type of integration.

Indicative timescales for this phase of work are anticipated to be from October 2014 – January 2015.

Having a means of linking health and social care records is a key step towards having shared records for patients in receipt of health and social care. A shared record is one of the mechanisms for ensuring that care is more joined up for patients and avoids patients having to retell their histories multiple times especially if they have episodes of care at different locations at different times.

Another critical strategic impact of this work will be to allow the local health and social care community to evaluate the impact of the new pathways integrating health and social care responses in the community. It is essential that we are able to gather the evidence of the impact on individual patients in terms of usage of the acute care system so that changes can be made to the pilot if necessary.

**The delivery chain**
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

**Below are brief details of those involved in the delivery of this scheme:**

Business Improvement Manager, Adult Social Care – This role provides overall project management and delivery of the scheme through coordinated and planned activity across partner organisations.

Head of Service, Adult Social Care – This role provides a senior management input to ensure that new technical capability is implemented with due consideration of operational business processes.

Strategy and Planning Manager, LCCCG – This provides commissioner input and supports the coordinated and planned activity across partner organisations through identification of data to be shared

Information Assurance, LCC – This role provides assurance that the necessary

information governance standards are being met at an organisational level such as compliance with the NHS toolkit level 2

Information Governance, LCC – This role represents social care and provides the information governance framework at local organisations level in order to support data sharing between various partners
Information Governance, (GEM CSU) – This role represent the health economy and provides the information governance framework at local organisations level in order to support data sharing between various partners

Senior IM&T Manager, (GEM CSU) – This role provides a view on technical requirement and best practice process to be undertaken in order to deliver the scheme

Application Support Manager, LCC – This role provides a view on technical requirements and best practice processes to be undertaken in order to deliver the scheme

RA service programme Manager (GEMSCU) – This role provides support and services in relation to the Registration Authority Service

Liquid Logic Project Manager – This role provides the technical resources and expertise in relation to the interface software between Liquid Logic and the NHS SPINE

**Partner organisations**

Leicester City Council – Joint commissioner of scheme and recipient of health data

Leicester City CCG – Joint commissioner of scheme

GEMCSU – Is the local approved ASH and is expected to provide the RA authority service to social care in order to ensure secure access to health systems

Liquid Logic (McKesson) – Is the supplier of Adult Social Care's Case Management system and provides capability to incorporate health data into social care records

Health and Social Care Information Centre (HSCIC) – Provides necessary authorisation and tools with which to undertake data matching at a local level

**The evidence base**
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Fundamentally, this scheme is about supporting integrated care across the health and social care economy. The real time capabilities and sharing of data across organisational boundaries through the implementation of identified technology and an associated culture change has proven to be a key enabler of integrated care.

Other areas such as Barnsley Council, whom we have been in contact with, have realised the benefits that can be achieved through joint information governance and information sharing to deliver more integrated health and social care.

**Investment requirements**
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15: 96k
2015/16: 4k

**Impact of scheme**
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

**Phase 1 Outline Benefits**

• Information governance framework in place covering Leicester City NHS and Leicester City Council Adult Social Care;

• Leicester City Council obtains compliance status in line with NHS IG toolkit which is a necessary precursor to any system integration activity;

• Will allow for the commencement of data modelling around potential co terminus arrangements.

**Phase 2 Outline Benefits**

• Will support systematic tracking of customer journey across Health and Social Care boundaries providing the platform for integrated management information which will support strategic decision making;

• Time saving for Adult Social Care staff through eliminating need to manually enter some key health related customer information. It will be possible to look up customer/patient information within the Patient Demographic Service (PDS) and imported;

• Adult Social Care staff will have the ability to validate, in real-time, a customer's individual NHS Number on their Liquid Logic record against their health care record;

• Adult Social Care staff will no longer have to ask customers for some of their personal details;

• Should increase speed of communications/referrals between integrated functions across the Health and Social Care economy;

• Ensures Adult Social Care staff and Health Professionals are talking about the same person across health and social care;

• Supports the Adult Social Care staff to have up to date customer details when they change and ensure that changes are reflected accurately;

• Prevention of duplication or inaccuracy across patient / customer records;

• Enhanced data integrity in Adult Social Care systems resulting in trusted information to inform decision making both strategically and operationally.

• Information sharing should facilitate seamless delivery of care across both Health and Social Care economies.

**Feedback loop**
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The outcomes and benefits are anticipated to be across the whole integrated pathway in Leicester. Whilst financial benefits are not directly anticipated to result from this scheme, intangible benefits such as the overall smoother journey for the customer and the elimination where possible of the customer having to tell their twice when working are expected. In addition, integrated management information to support the tracking of people across the health and social care is expected to be available.

The routine availability of integrated management information and an associated performance dashboard will support strategic and operational decision making to enable validation of what is and not working.

A further measure of the success of this scheme will be the tangible use of health data in social care as a matter of course in day to day activities including the mandatory requirement to input onto social care systems.

**What are the key success factors for implementation of this scheme?**

There are a number of key success factors associated to the successful implementation of this scheme which are detailed below:

1) Joint partnership appetite at a strategic leadership and operational level to share and use data;

2) The development of a coherent and jointly agreed set of Information governance arrangements;

3) Joint staff communication and briefings on when and how to use shared data routinely as part of day to operational working;

4) Good inter organisational team working including the establishment of a joint multi-disciplinary system integration group consisting of representation of an array partner organisations;

5) A change in working culture between health and social operational teams;


| **Scheme ref no.** |
|---|
| BCF 9 |
| **Scheme name** |
| Planned Care Team |
| **What is the strategic objective of this scheme?** |

Link to Vision:

- Provide a modern model of integrated care with a senior clinician taking responsibility for coordination of care
- Reduce the amount of time spent in hospital avoidably by our citizens, by focussing on health and social care pathways and services such as housing
- Ensure that people are kept independent for as long as possible following hospital care

Response to case for change through delivery of:

(a) Reduction in the numbers of patients requiring admission to permanent residential care
(b) Increase in the numbers of patients still at home 91 days after discharge from hospital
(c) Reduction in the total numbers of emergency admissions
(d) Reduction in DTOCs
(e) Increase in patient satisfaction
(f) Increase in the number of patients recorded as living with dementia

**Overview of the scheme**

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

A substantial left-shift in activity to have many more patients with long term conditions managed at home requires the right level of community support to be available on a seven day basis. The BCF investment in this element – Community Planned Care Health and Social Care teams - specifically targets the following elements of our model described below:

- Uplift and development of the capacity of the Community Mental Health Practitioner team to proactively address the needs of older people's mental health in the community
- Establishment of a new Care Navigator Service – a team of Health and Social care coordinators to coordinate health and social care services for the frailest over 75s
- Increase in the capacity of Adult Social Care (ASC) Single Point of Contact (SPoC) to facilitate alignment of their working times of the Health Single Point of Access (SPA)
- Year long process of Organisational development by Leicester City Adult Social care Services to redesign their current Locality boundaries to align them to be co-terminous with the neighbourhood structure of Leicestershire Partnership Trust Community Health Services

**The model of care:**
A patient –centred and holistic approach to providing systematic integrated health and social care to patients with long term conditions and /or frailty syndrome through:

- **Systematic use of risk stratification software** to support primary care in identifying patients with moderate to high risk of emergency admission of the next twelve months (see separate annex)
- **Deployment at scale of proactive community interventions** to reduce risk of admission in those with LTCs (care planning and patient education) and to reduce incidence of preventable admission for ambulatory care sensitive conditions
- **A seamless pathway into on-going community support for those being discharged from unscheduled health and social care services.** We know that many patients who have entered integrate services as an emergency will require further monitoring and longer term intervention such as reablement. Planned care services will liaise with unscheduled services to plan the transition from unscheduled to planned care.
- **Parity of esteem for mental health needs though Community Mental Health Practitioner team** (CMHT) - Extra emphasis on the importance of managing the mental health aspects of living with long term conditions and social isolation – through the commissioning of extra capacity in the CMHT. This team will work in close association with primary care and with community health and social care colleagues in the rest of the planned care and unscheduled care teams
- **Care coordination for the most complex older people through our Care Navigator team** – targeted to coordinate the health and social care services deployed to the frailest cohort of the over 75s (identified via risk stratification tool and GP intuition). This team will have access to read and entry access to both the health and social care electronic record systems to facilitate joined up communication for the most vulnerable and complex patients. We have identified at least 18 different health and social care agencies and services that the Care Navigators can refer into on behalf of their patients.
- **Increased access to Adult Social Care services though the Single Point of Contact (SPoC)** Increased Adult Social Care Locality staff complement to

facilitate more community assessments and sign posting to Advice, Information and Guidance. The proactive identification of greater numbers of patients at potential risk of admission will require more capacity in ASC locality Teams to deliver timely responses to requests for non-urgent help.

- **Robust reablement service which includes community health assessment as standard and is accessible either on discharge from hospital or from community services. Up to 6 weeks of free access to reablement services will be offered to all those who might benefit. Reablement will aim to optimise the functional independence of older people at home by providing therapy and equipment as needed to promote achievement of agreed therapy goals. In addition** Part of the planned health care provision will include a community nurse assessment on entry into reablement as standard. We know from pilot work done in the CCG last winter that the addition of health monitoring improves outcomes of reablement and reduces readmission to hospital within 30 days.
- **Co-terminus health and social care neighbourhood boundaries** to facilitate more integrated working via multi-disciplinary team meetings hosted by primary care and greater continuity of care for those with complex health and social care needs

**What patient cohorts are being targeted?**

There are three target cohorts for the BCF pathway:

9. Patients aged 18-59 years with three or more long term conditions (LTCs)
10. Patients aged 60+ with one or more LTCs
11. Patients with dementia

**The delivery chain**

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

**Commissioners :**

Leicester City CCG
Leicester City Council Adult Social Care Services

**Providers:**

**Leicestershire Partnership Trust Community Health Services (LPT CHS)** - Providers of **Community Mental Health Practitioner Services**. These practitioners will support both primary care and community health and social care teams in the assessment and monitoring of older people with symptoms of mental ill-health. We know that the prevalence of mental health problems such as depression and anxiety are common amongst older people with LTC and can have a bearing on their use of emergency services. Specialist CMHTs can support improving access for such patients to the right assessments and treatments. The service will work very closely with other members of the planned and unscheduled teams.

**Providers of physiotherapy and education services for reablement** (in partnership with Leicester City Council Adult Social Care).

Leicester City Council – Providers of

- **Single Point of Contact (SPoC) –** this service provides both (a) call handling for sign posting to advice, information and guidance to a wide variety of statutory and non-statutory services and an assessment and (b) ASC contact and domiciliary assessment for access under FACS criteria to Adult Social Care. Capacity in this team will be increased by 6.53 WTE under the BCF Investment in 2015-16
- **Care Navigator (CN) Service**– 5 WTE Care Navigators have been recruited to support primary care in coordinating the care of patients over 75 with complex health and social care needs. These Navigators will work with the patients named GP to ensure optimal integrated of health, social care and voluntary sector service for these patients. The CNs focused on reduction of risk and maintenance of independence in the home.
- **Reablement – current CCG funding of reablement**.

**The evidence base**

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

**Ham C, Imison C, et al. Avoiding Hospital Admissions; Lessons from Evidence and Experience King's Fund (2010)**

"The greatest opportunity to reduce hospital admissions and bed days lies in the proactive management of people with long-term conditions, especially people with multiple conditions. Integrated working between health and social care can result in lower than expected emergency admissions and reduced use of beds, as evidenced by the achievements of Torbay."

**Purdy S. Avoiding Emergency Admissions: what does the evidence say? King's Fund (2010)**

Points to the potential of integration of Health and Social care responses in reducing admissions

**Tian Y, Dixon A, Emergency Admissions for Ambulatory care sensitive conditions: Identifying the potential for reductions. King's fund (2012)**

- Influenza and pneumonia account for the highest proportion of all emergency admissions (EAs) for ambulatory care sensitive conditions (ACSCs) - 13% – much of this activity is preventable by vaccine administration.
- Those over 75 account for 40% of the total EAs for ACSC
- COPD/CHF/Flu/Pneumonia/Dehydration and gastritis account for 53% of costs associated with EAs for ACSCs.

**Oliver D, Foot C et al. Making our Health and care systems fit for an aging population The King's Fund (2014)**

Amongst a range of recommendations this paper highlights:

(d) rapid support close to home in times of crisis and (b) integration to provide person-centred co-ordinated care

**Roland M, Abel G Reducing Emergency Admissions: Are we on the right Track? BMJ 2012; 345 e6017**

Sets out the various segments of risk within the UK population and the proportion of the total amount of emergency admissions accrued by each segment. Highlights the important of not restricting interventions to the highest risk patients and the need to address patients from at least the top quintile of risk within the population.

**Igual et al. Challenges, issues and trends in fall detection Systems BioMedical Engineering OnLine 2013, 12:66**
Highlights the importance of avoiding "long lie" for patients who have fallen and are unable to get themselves up. Assistive technology linked to rapid response teams can be vital in avoiding this adverse outcome.

**Salisbury C, Johnson L, Purdy S, Valderas JM, Montgomery AA. (2011) Epidemiology and impact of multi-morbidity in primary care: a retrospective cohort study. Br J Gen Practice 61:e12-e21.**

**Sylvia ML, Griswold M, Dunbar L, Boyd CM, Park M, Boult C. (2008) Guided care: cost and utilization outcomes in a pilot study. Disease Management 11:29-36.**
Demonstrates how use of risk stratification can support case management of those with LTCs to reduce hospitalisation.

**Naylor C. et al Long Term Conditions and Mental Health: The cost of Co-morbidities. King's Fund and Centre for Mental Health (2012)**

"…by interacting with and exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least 45 per cent for each person with a long-term condition and co-morbid mental health problem." This paper underpins our decision to invest in increasing access for older people with LTCs to the CMHT

**Leicester City CCG population segmenting and analysis by GEM CSU and LCC Public Health Department**

**Investment requirements**
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15: £382,000
2015/16: £382,000

**Impact of scheme**
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Using the benefits analysis model developed with PA Consulting, we have attributed an impact on the following metrics:

| |
|---|
| BCF National Metric 1: Less people going into nursing and residential care |
| BCF National Metric 2: More people receiving help to recover at home |
| BCF National Metric 3: A reduction in hospital bed days due to discharge |

| |
|---|
| being delayed |
| BCF National Metric 4: A reduction in total hospital admissions |
| BCF National Metric 5: Improved patient/service user experience |
| BCF Local Metric: More people being identified as living with Dementia |

Please see tab 4 of template 2 for further detail

In addition to the national metrics, we have set up a dashboard to monitor outcomes as outlined below:

- numbers of patients seen each month by CMHTs, Community Planned Care Health team,
- Number of contact and domiciliary assessments by SPoC
- Monthly performance management of targets for primary care BCF scheme at QED and Locality meetings
- Monthly discussion of anonymised individual case studies at BCF Implementation Group meeting
- Monthly BCF Operational Group meetings for providers to discuss any challenges/successes in implementing the pathway.
- Feedback of outcomes of cases to individual referring clinicians
- Quality report at BCF Subgroup on Planned and Unscheduled care– reporting on any incidents/complaints issues – by exception based on quality schedule of main LPT CHS contract

**Feedback loop**
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

*Strategic level – Monthly reporting to the JICB and CCG Performance Exec*

At a strategic level, an overarching system dashboard is being formulated, covering the 5 + 1 national metrics as well as other relevant metrics to manage flow at a system level.

*Operational Level – Bi-weekly reporting to the BCF Implementation Group*

Underneath this, sits a comprehensive Integrated Care Performance Dashboard, specially produced to support the performance management function for the BCF Programme.

*Practice level – Weekly reporting*

Finally, GP practice level monitoring has been added to monitor progress against practice level targets for interventions aligned to the BCF, such as care planning, access to preventative services and overall acute care usage by practice.

In totality, this provides a comprehensive view of both the health and social care

system as a whole and tracks performance of the Integrated Care model.

All draft dashboards are provided as Appendix 7.

**What are the key success factors for implementation of this scheme?**

- Co-production and co-ownership of the model and aims of the BCF pathway. We have had input from GPs, LPT CHS management, Adult Social Care Management EMAS and UHL in the creation of this scheme.
- Guarantee of a smooth entry into planned care for patients to those colleagues who will be referring in patients – primary care GPs, CRT GPs, Integrated Community Health Services, Locality Adult Social Care Staff (Doing what we said we would do for front line staff in terms of increasing access to reliable support for patients to be safely managed at home).
- Engagement of front line clinical and social care staff to refer patients into the pathway. There has been extensive engagement with primary care and Adult Social Care in particular on the drive to adequately resource community care to support more proactive intervention with patients identified via risk stratification.
- Recruitment of staff to plan to ensure that the increased volume of patients being kept at home can be successfully managed within the community setting.
- Alignment of health and social care neighbourhood boundaries to support continuity of care and greater integrated working on the front line.
- Ability to regularly collect activity and relevant outcome and quality data from individual services – we have engaged with all providers to agree the relevant and available data items which can be collated to evaluate progress on this scheme.

| **Scheme ref no.** |
|---|
| BCF 10 |
| **Scheme name** |
| **MH discharge team** |
| **What is the strategic objective of this scheme?** |

Link to vision:

- Provide a modern model of integrated care with a senior clinician taking responsibility for coordination of care
- Reduce the amount of time spent in hospital avoidably by our citizens, by focussing on health and social care pathways and services such as housing
- Ensure that people are kept independent for as long as possible following hospital care

Link to wider strategic objectives:

Strategic objectives are to enhance life chances and independence reducing inequalities in health status (Parity of Esteem) and associated costs.

Improving Mental Health service outcomes is a priority for both the CCG and local authority and a LLR Better Care Together priority. In particular the plans are to increase resilience in the population, earlier and more effective intervention, integrated local care delivery and proactive timely response to crisis and to managed demand for secondary care services.

Unnecessary stays in mental health units have a detrimental impact on patients. A study in 2010 showed that 27% of respondents rarely feel safe whilst in hospital and 51% of inpatients reported suffered some form of mistreatment, (Tansella, 2010). Local analysis of data has shown the majority of DTOC's on the mental health units are due to waits for assessments. In depth analysis has identified that demand is not matched to capacity, leading to excess waits for assessment.

**Overview of the scheme**

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

In order to meet the demand identified and to negate any detrimental impact on patients, this intervention will increase the capacity of the social work assessment team on 2 key units:

The Bennion ward (Mental health services for Older person)
The Bradgate Unit (Adult mental health)

It is envisaged that these posts will work in partnership with the Unscheduled and

planned care teams described earlier in this plan to ensure that holistic care is provided for these patients.

**The delivery chain**
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners Leicester City CCG
Post hosted by Leicester City Council adult social care.
Working with Leicestershire Partnership Trust (Mental Health) inpatient services provider.

**The evidence base**
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

A recent independent review of the LLR mental health pathway has evidenced that it is under significant pressure, with increasing delayed transfers of care, increasing length of stay, and people placed in out of county acute placements due to lack of local provision.

Benchmarking indicates bed capacity is within range of peer services but that community options are less developed leading to a higher LOS. Analysis shows:

1. In 2013/14 out of county (OOC) placements increased significantly. LLR spend on OOC placements in 2013/14 was £4m, with Leicester City CCG contribution of £1.9m towards this.
2. The average weekly cost of OOC placement was £3,600 per week, significantly higher than local provision.
3. City MH/LD DTOC has been increasing during 2013/14. It has been consistently higher per weighted population than county HWB areas, on average 4.5 higher per 100,000 population.

**Investment requirements**
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

**2014/15: £42000**
**2015/6: £42000**

**Impact of scheme**
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Using the benefits analysis model developed with PA Consulting, we have attributed an impact on the following metrics:

| |
|---|
| BCF National Metric 3: A reduction in hospital bed days due to discharge being delayed |
| BCF National Metric 4: A reduction in total hospital admissions |
| BCF National Metric 5: Improved patient/service user experience |

Please see tab 4 of template 2 for further detail

In addition to the national metrics, we have set up a dashboard to monitor outcomes as outlined below:

- Ongoing reduction in Mental Health Delayed transfer of care measured by- Delayed transfers of care (delayed days) from adult MH and MHSOP inpatient wards per 100,000 population (average per month).

- Supporting reduction in OOC placements

| | Quarter 1 14/15 | Quarter 2 14/15 | Quarter 3 14/15 | Quarter 14/15 |
|---|---|---|---|---|
| **Estimated average OoA placements** | 15 | 2 | 0 | 0 |
| **Estimated average OoA placements** | 19 | 6 | 1 | 0 |
| **Estimated average OoA placements** | 21 | 14 | 8 | 5 |

- Reduction in average LLR length of stay in a MH unit from 46.7 days in 2013/14 to the national mean of 30 days by April 2016.

**Feedback loop**
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

*Strategic level – Monthly reporting to the JICB and CCG Performance Exec*

At a strategic level, an overarching system dashboard is being formulated, covering the 5 + 1 national metrics as well as other relevant metrics to manage flow at a system level.

*Operational Level – Bi-weekly reporting to the BCF Implementation Group*

Underneath this, sits a comprehensive Integrated Care Performance Dashboard, specially produced to support the performance management function for the BCF Programme.

*Practice level – Weekly reporting*

Finally, GP practice level monitoring has been added to monitor progress against practice level targets for interventions aligned to the BCF, such as care planning, access to preventative services and overall acute care usage by practice.

In totality, this provides a comprehensive view of both the health and social care system as a whole and tracks performance of the Integrated Care model.

All draft dashboards are provided as Appendix 7.

**What are the key success factors for implementation of this scheme?**

- Co-production and co-ownership of the model and aims of the BCF pathway. We have had input from GPs, LPT MH management & Adult Social Care Management as well as patients
- Engagement of front line clinical and social care staff to refer patients into the pathway.
- Recruitment of staff to plan to ensure that the increased volume of patients being kept at home can be successfully managed within the community setting.
- Alignment of health and social care neighbourhood boundaries to support continuity of care and greater integrated working on the front line.
- Ability to regularly collect activity and relevant outcome and quality data from individual services – we have engaged with all providers to agree the relevant and available data items which can be collated to evaluate progress on this scheme.

| **Scheme ref no.** |
|---|
| BCF 11 |
| **Scheme name** |
| **Integrated Mental health step down service** |
| **What is the strategic objective of this scheme?** |
| Improving Mental Health service outcomes is a priority for both the CCG and local authority and a LLR Better Care Together priority. In particular the plans are to increase resilience in the population, earlier and more effective intervention, integrated local care delivery and proactive timely response to crisis and to managed demand for secondary care services.<br><br>Unnecessary stays in mental health units have a detrimental impact on patients. A study in 2010 showed that 27% of respondents rarely feel safe whilst in hospital and 51% of inpatients reported suffered some form of mistreatment, (Tansella, 2010). Local analysis of data has shown the majority of DTOC's on the mental health units are due to waits for assessments. In depth analysis has identified that demand is not matched to capacity, leading to excess waits for assessment. |
| **Overview of the scheme**<br>Please provide a brief description of what you are proposing to do including:<br>- What is the model of care and support?<br>- Which patient cohorts are being targeted? |
| Local Mental Health Trust ( NHS Leicestershire Partnership Trust) to commission a provision of semi-independent apartments for mental health service users stepping down from acute inpatient care<br><br>The service aims to:<br><br>• Provide a short term step down facility that promotes independence, inclusion and community engagement for service users, following an episode of acute<br>• mental illness<br>• Facilitate a successful and sustainable discharge from hospital, back in to the community for service users<br>• Facilitate reduced lengths of stay within LPT acute inpatient beds<br>• Provide a cost effective service that meets the needs of service users who no longer require the intensity of support provided within an acute ward |
| **The delivery chain**<br>Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved |
| **Commissioners**<br>Leicester City CCG/ West Leicestershire CCG/ East Leicestershire & Rutland CCG |

**Provider:**
Local Mental Health Trust provider (NHS Leicestershire Partnership Trust) funded to purchase service from independent sector Leicester City Council adult social care.

**The evidence base**
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

A recent independent review of the LLR mental health pathway has evidenced that it is under significant pressure, with increasing delayed transfers of care, increasing length of stay, and people placed in out of county acute placements due to lack of local provision.

Benchmarking indicates bed capacity is within range of peer services but that community options are less developed leading to a higher LOS. Analysis shows:

1. In 2013/14 out of county (OOC) placements increased significantly. LLR spend on OOC placements in 2013/14 was £4m, with Leicester City CCG contribution of £1.9m towards this.
2. The average weekly cost of OOC placement was £3,600 per week, significantly higher than local provision.
3. City MH/LD DTOC has been increasing during 2013/14. It has been consistently higher per weighted population than county HWB areas, on average 4.5 higher per 100,000 population.

**Investment requirements**
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

**2014/15: £150k**
**2015/16: £300k**

**Impact of scheme**
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Using the benefits analysis model developed with PA Consulting, we have attributed an impact on the following metrics:

| |
|---|
| BCF National Metric 3: A reduction in hospital bed days due to discharge being delayed |
| BCF National Metric 4: A reduction in total hospital admissions |
| BCF National Metric 5: Improved patient/service user experience |

Please see tab 4 of template 2 for further detail

In addition to the national metrics, we have set up a dashboard to monitor outcomes as outlined below:

- Ongoing reduction in Mental Health Delayed transfer of care measured by- Delayed transfers of care (delayed days) from adult MH and MHSOP inpatient wards per 100,000 population (average per month).
- Ongoing and sustainable reduction in OOC placements per quarter over 2014/15
- Reduction in average LLR length of stay in a MH unit from 46.7 days in 2013/14 to the national mean of 30 days by April 2016.

**Feedback loop**
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

*Strategic level – Monthly reporting to the JICB and CCG Performance Exec*

At a strategic level, an overarching system dashboard is being formulated, covering the 5 + 1 national metrics as well as other relevant metrics to manage flow at a system level.

*Operational Level – Bi-weekly reporting to the BCF Implementation Group*

Underneath this, sits a comprehensive Integrated Care Performance Dashboard, specially produced to support the performance management function for the BCF Programme.

*Practice level – Weekly reporting*

Finally, GP practice level monitoring has been added to monitor progress against practice level targets for interventions aligned to the BCF, such as care planning, access to preventative services and overall acute care usage by practice.

In totality, this provides a comprehensive view of both the health and social care system as a whole and tracks performance of the Integrated Care model.

All draft dashboards are provided as Appendix 7.

**What are the key success factors for implementation of this scheme?**

- Co-production and co-ownership of the model and aims of the BCF pathway. We have had input from GPs, LPT MH management & Adult Social Care Management as well as patients
- Engagement of front line clinical and social care staff to refer patients into the pathway.

- Recruitment of staff to plan to ensure that the increased volume of patients being kept at home can be successfully managed within the community setting.
- Alignment of health and social care neighbourhood boundaries to support continuity of care and greater integrated working on the front line.
- Ability to regularly collect activity and relevant outcome and quality data from individual services – we have engaged with all providers to agree the relevant and available data items which can be collated to evaluate progress on this scheme.

# ANNEX 2 – Provider commentary

For further detail on how to use this Annex to obtain commentary from local, acute providers, please refer to the Technical Guidance.

| | |
|---|---|
| **Name of Health & Wellbeing Board** | Leicester City |
| **Name of Provider organisation** | University Hospitals Leicester |
| **Name of Provider CEO** | John Adler |
| **Signature (electronic or typed)** |  |

**For HWB to populate:**

| | | |
|---|---|---|
| **Total number of non-elective FFCEs in general & acute** | **2013/14 Outturn** | 30077 |
| | **2014/15 Plan** | 28207 |
| | **2015/16 Plan** | 27010 |
| | **14/15 Change compared to 13/14 outturn** | -6.2% |
| | **15/16 Change compared to planned 14/15 outturn** | -4.2% |
| | **How many non-elective admissions is the BCF planned to prevent in 14-15?** | 1013 |
| | **How many non-elective admissions is the BCF planned to prevent in 15-16?** | 1013 |

**For Provider to populate:**

| | Question | Response |
|---|---|---|
| **1.** | **Do you agree with the data above relating to the impact of the BCF in terms of a reduction in non-elective (general and acute) admissions in 15/16 compared to planned 14/15 outturn?** | Yes |
| **2.** | **If you answered 'no' to Q.2 above, please explain why you do not agree with the projected impact?** | N/A |

| | | |
|---|---|---|
| **3.** | **Can you confirm that you have considered the resultant implications on services provided by your organisation?** | Yes |