Leicester
City Council

MEETING OF THE ADULT SOCIAL CARE SCRUTINY COMMISSION

DATE: THURSDAY, 6 MARCH 2014
TIME: 5:30 pm
PLACE: THE OAK ROOM - GROUND FLOOR, TOWN HALL, TOWN HALL SQUARE, LEICESTER

Members of the Committee

Councillor Dr Moore (Chair)
Councillor Chaplin (Vice-Chair)

Councillors Alfonso, Fonseca, Joshi, Wann and Willmott

Standing Invitee (Non-voting)

Representative of Healthwatch Leicester

Members of the Commission are invited to attend the above meeting to consider the items of business listed overleaf.

Elaine Baker

for the Monitoring Officer

Officer contacts:
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PUBLIC SESSION

AGENDA

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

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

3. MINUTES OF PREVIOUS MEETING

The Commission is asked to confirm the minutes of its meeting held on 12 February 2014 as a correct record.

4. PETITIONS

The Monitoring Officer to report on any petitions received.

5. QUESTIONS, REPRESENTATIONS AND STATEMENTS OF CASE

The Monitoring Officer to report on any questions, representations or statements of case received.

6. DOMICILIARY CARE REVIEW **Appendix A**

a) An update on the information requested at the meeting held on 9 January 2014 is attached, along with the relevant minute of that meeting. (**Appendices A1 and A2**)

Members are reminded that the information requested in resolutions 2(a) and 2(b) of minute 85, "Domiciliary Care", was circulated previously

b) The Chair will provide a verbal update on her visits to care providers.

7. BLUE BADGE SCHEME **Appendix B**

The Director of Adult Social Care and Safeguarding submits a report informing Members of the operation of the Blue Badge Scheme for parking. The Commission is recommended to note the report and comment as appropriate.

8. BETTER CARE FUND **Appendix C**

The Director of Adult Social Care and Safeguarding submits a report informing Members of the Better Care fund and the local plan through which this funding can be accessed. The Commission is recommended to note the report and

comment as appropriate.

Members are asked to note that the detail of the proposal for the draft local plan is in the Plan Template. Due to the short period for submitting the plan, there will be on-going discussions between all parties involved in submitting the plan and NHS England over coming months and the Plan will continue to develop and evolve.

9. REPLACEMENT OF THE ADULT SOCIAL CARE AND CHILDREN'S IT APPLICATION **Appendix D**

The Director for Care Services and Commissioning (Adult Social Care) submits a report updating the Commission on the implementation of the new Liquidlogic and ControCC IT applications, which replace the existing CareFirst IT system. The Commission is recommended to note the work in progress to implement the new IT system and comment as appropriate.

10. ELDERLY PERSONS' HOMES **Appendix E**

a) A verbal update will be given on the development of an Intermediate Care facility. The Commission is recommended to receive this update and comment as appropriate.

b) The Director for Care Services and Commissioning (Adult Social Care) submits a report outlining progress with individual residents' moves to alternative accommodation, where their current homes are to be closed in phase 1, (attached at Appendix E). The Commission is recommended to note the report and comment as appropriate.

c) A verbal update will be provided on progress in establishing an Older Persons' Commission. The Commission is recommended to receive this update and comment as appropriate.

11. WORK PROGRAMME **Appendix F**

The draft work programme for the Commission is attached. The Commission is asked to consider this and make comments and/or amendments as it considers necessary.

12. ANY OTHER URGENT BUSINESS

Appendix A1

Leicester
City Council

Minutes of the Meeting of the
ADULT SOCIAL CARE SCRUTINY COMMISSION

Held: THURSDAY, 9 JANUARY 2014 at 5.30 pm

P R E S E N T :

Councillor Dr Moore – Chair
Councillor Chaplin – Vice Chair

Councillor Alfonso
Councillor Fonseca
Councillor Joshi
Councillor Willmott

In Attendance

Councillor Rita Patel – Assistant City Mayor (Adult Social Care)

* * * * * * * *

76. APOLOGIES FOR ABSENCE

There were no apologies for absence.

77. DECLARATIONS OF INTEREST

Councillor Chaplin declared an Other Disclosable Interest in agenda item 6, "Elderly Persons' Homes", in that she had attended a birthday party for three residents at Herrick Lodge on 3 January 2014 in a private capacity.

Councillor Joshi declared an Other Disclosable Interest in the general business of the meeting in that his wife worked for the City Council's Reablement service. He also declared an Other Disclosable Interest in the general business of the meeting in that he worked in the voluntary sector with people with mental health problems.

As a standing invitee to Commission meetings Philip Parkinson, Interim Chair of Healthwatch Leicester, declared an Other Disclosable Interest in the general business of the meeting in that his mother-in-law was in receipt of services from the City Council's Adult Social Care and Safeguarding division.

Although not a member of the Commission, Councillor Rita Patel declared an Other Disclosable Interest in the general business of the meeting in that her sister worked for the City Council's Adult Social Care and Safeguarding

division. She also declared an Other Disclosable Interest in the general business of the meeting in that in the last few weeks her mother had started to receive a package of services from the City Council's Adult Social Care and Safeguarding division.

In accordance with the Council's Code of Conduct, these interests were not considered so significant that they were likely to prejudice the respective people's judgement of the public interest. They were not, therefore, required to withdraw from the meeting.

85. DOMICILIARY CARE

The Director for Care Services and Commissioning (Adult Social Care) submitted a report providing further information as part of the Domiciliary Care Scrutiny Review. This also addressed questions raised at the Commission's meeting held on 5 December 2013, (minute 69 referred).

Members were reminded that the Council's Communications team would be asked to make an appeal for users of domiciliary care to provide information on their experiences of that care, both positive and negative. In addition, arrangements were being made to enable the Chair to accompany a care worker for a day, to get a better understanding of their work. Appropriate arrangements would be made to ensure that confidentiality and privacy were maintained at all times.

In response to a question from the Commission, the Director of Adult Social Care and Safeguarding explained that, under direct payments, people received a personal budget as a cash payment. The recipient then became responsible for meeting the costs of the services they received.

In reply to further questions from the Commission, the Commissioning Manager (Care Services and Commissioning Division) explained that, during the last week, approximately 22,000 hours of care were provided. The standard of this care was carefully monitored. For example, providers' self-assessments were used and some providers came under the Care Quality Commission. Officers carefully analysed the data and graded providers on their standard of care. For example, an assessment is made of whether the minimum level of care was being provided, or whether there was a higher level of provision.

The contracts had been operating for two months. Their operation had been relatively stable, even during a period of high pressure regarding hospital stays over the Christmas period. However, starting on 27 January 2014, a consultation would be undertaken with users of Home Care. This would be done via the telephone.

It was recognised that people recently had been consulted on various services, (for example, mobile meals and elderly persons' homes), so it was possible that this could result in some "consultation fatigue", but there were no proposals to change the method of consultation at this stage. The consultation would be undertaken through the Contracts and Assurance team. A stratified

sample would be used, but the actual number of people to be consulted was not known at this time.

The Commission welcomed the consultation, but queried whether allowance had been made for the reasoning abilities of some service users. In addition, as the Council was not the service provider, it needed to be made very clear that information provided would be confidential and that individual users would not be identified in the data compiled. The Commissioning Manager assured Members that these factors had been taken in to account in preparing for the consultation. For example, support packages would be checked before anyone was telephoned to make sure they were capable of taking part in the consultation and that, where possible, they could be consulted in their first language.

Members noted that some service users had more than one provider through choice. These people would move to a single provider as soon as possible. Information on the number of people affected by this could be provided, although the reasons for each individual choosing more than one provider would not be available.

The following points were then made during discussion on this item:-

- At some authorities, trades unions had negotiated an agreement that zero contract hours contracts would not be allowed. This included external providers;

- The move away from 15 minute calls was very welcome;

- Currently, the only in-house care service was the Re-ablement service and that team did not use 15 minute calls;

- Consideration needed to be given to whether there should be a sole provider at Danbury Gardens, as there were concerns that to have this would limit choice; and

- In the ASRA scheme the care provider had started a company and so promoted the use of that company to residents in the scheme. This was in direct contrast to the situation at Danbury Gardens and there was concern that it could create problems when people who already had identified their own providers moved in to that facility.
  Amendment made at following meeting (12 February 2014):
  Post-meeting note: Since the meeting, it has been clarified that the company providing care in the ASRA scheme has provided domiciliary care since before the scheme started. The company was not started for the ASRA scheme. ASRA residents can use this company, but are not obliged to do so, as other providers are available if preferred.

Particular concern was expressed about the number of people employed by care providers. It was recognised that care workers tended to be a transient work force, but the Commission was assured that the contracts being operated

were not block contracts. Each new care package was offered through a mini tendering exercise, so each package would state the minimum number of staff required for that particular element. The Care Quality Commission did not set minimum numbers of staff required.

At the pre-qualification stage of letting the contracts a full financial assessment was undertaken. This provided reassurance that provider would only take on the number of care packages they could provide. Although it was very unlikely to disrupt care if a large number of staff left a particular provider, there was provision in the contract about the action that would be taken if a large number left or were ill simultaneously. There also was provision in the contract for the Council to suspend a provider from the framework or terminate a package of care, but in practice this would be very unlikely to happen, as contract monitoring would enable action to be taken before it reached this stage.

RESOLVED:

1) That the Director for Care Services and Commissioning (Adult Social Care) be asked to provide information at the next meeting of the Commission on the number of people to be surveyed during the consultation of users of Home Care services, the questions they would be asked, the expected length of time of each interview and whether the same person would do all of the interviews;

2) That the Director of Adult Social Care and Safeguarding be asked to provide information at the next meeting of the Commission on the following matters:-

   a) the number of people who currently use more than one service provider; and

   b) whether the use of zero hours contracts was permitted; and

3) That consideration be given to reviewing the different methods of providing care at Danbury Gardens and the ASRA housing scheme.

Appendix A2

Leicester City Council Scrutiny Review

'Domiciliary Care'

Service User Consultation Outcome Briefing

Quality Assurance Framework

Scrutiny Briefing

Background

In the Autumn of 2013 Adult Social Care, Contracts and Assurance Service implemented a Quality Assurance Framework (QAF) that requires all domiciliary care contracted providers to undergo an annual assessment of contract compliance linked to ensuring that the outcomes of people who receives those services are at the forefront of the assessment.

The QAF process starts with a self-assessment tool which requires the Provider to submit data / evidence in relation to 6 standards, being;

- Business Management
- Personalised Care Treatment and Support
- Safeguarding and Safety
- Employment and Staffing Practices
- Quality and Management
- Voice Choice and Control

Part of the quality assurance framework (QAF) and, as an outcome of reviewing the Human Rights Commission Report (2013), there is an emphasis on direct contact with those people who receive domiciliary care services. In order to achieve this a telephone survey is undertaken with service users for who we have a recorded telephone number. This telephone survey is time based which means only a limited number of service users can be contracted per individual QAF process. In addition to this the Provider is given a Service User questionnaire which they are asked to pass on to all Service Users together with a stamped addressed envelope for the return of the questionnaire. The questionnaire is produced in two different formats to be inclusive for those people who require easy read and / or pictorial versions.

Officers from the Contracts and Assurance Service then receives and reviews all of the documentation and will undertake a visit with the Provider to verify the information and assess contractual compliance. In areas of non-compliance the Provider is issued with an action plan and given clear timescales for the completion of those actions.

Service User Engagement

Whilst the QAF process for individual Providers is an annual assessment due to resources available in January 2014 there was capacity within the Contracts and Assurance Service to undertake a QAF telephone survey to over 600 service users who are currently receiving services from 11 contracted providers. Officers were each given the survey questions and a list of Service Users to contact, taken from the CareFirst database.

The service user survey asks 11 questions that relate to how they feel about the service they receive and includes questions that relate to the six standards detailed above.

Service users from the following 11 domiciliary care providers were contacted:

Always There, Amicare, Care UK, Carewatch Leicester, Direct Health, Domiciliary Care Services, Help at Home, Housing 21, Mears Care Ltd, Sevacare UK Ltd, Westminster Homecare.

During this survey 688 service users were contacted and invited to participate. The survey questions are detailed in table 1. below.

Table 1. Collated Service User Survey results

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Summary of Telephone Survey - Autumn 2013 to early 2014 (continued)

		No	Sometimes	Most of Times	Always	Total responses
Q1	Do you feel listened to and that what you have to say is important and acted upon?	23	11	53	589	676
		3%	2%	8%	87%	100%
Q2	Do you feel that you can speak up and have choice and control over day to day decision?	24	10	57	556	647
		4%	2%	9%	86%	100%
Q3	Do you feel supported to keep good relationships with you family, friends, staff and other people?	21	19	55	572	667
		3%	3%	8%	86%	100%
Q4	Do you feel supported to do the things that are important to you?	26	14	53	580	673
		4%	2%	8%	86%	100%
Q5	Are your care needs, wishes, preferences and personal goals recorded in your personal plan?	31	15	46	557	649
		5%	2%	7%	86%	100%
Q6	Do you think that where you live is as comfortable and homely as possible?	22	9	55	590	676
		3%	1%	8%	87%	100%
Q7	Do you feel safe, free from fear of abuse, falling or other physical harm?	19	11	50	598	678
		3%	2%	7%	88%	100%
Q8	Are you getting enough food and drink, is it what you like and can you eat when it suits you?	17	9	45	601	672
		3%	1%	7%	89%	100%
Q9	Do you feel that staff are respectful and treat you with dignity and care?	20	18	54	586	678
		3%	3%	8%	86%	100%
Q10	Do you feel confident and know what to do if you are unhappy about the service you receive?	26	10	57	583	676
		4%	1%	8%	86%	100%
Q11	Does the Service and its staff make you feel important, confident and happy?	17	13	49	600	679
		3%	2%	7%	88%	100%

The responses show that for each question between 86% and 89% of responses were “Always” compared with only 3% to 5% responding “No”. The mid-range showed a variance between 1% and 3% for “sometimes” and between 7% and 9% for “Most of Times”.

Whilst percentages are quoted above it is recognised that these relate to individual people and even though percentage wise it appears that Service User satisfaction is high this information has to be used to drive up quality for all Service Users. It was necessary for Officers to recommend that some Service Users contact their Social Workers over specific issues relating to the services that they receive.

Next Steps

The Contracts and Assurance Service has this information broken down by Provider and this information will be fed into the each individual QAF assessment together with the returned service user questionnaires.

Where elements have been identified as a concern these are being picked up with Providers in the regular meetings that are held and through the monthly performance data checks.

Author; Tanya Sheehan, Head of Service; Ext, 372321
Ian Cooper, Contracts and Assurance Manager; Ext; 37 2366

Appendix B

Report to Scrutiny Commission

Adult Social Care Scrutiny Commission

Date of Commission meeting: 6th March 2014

Blue Badge Scheme

Report of the Director of Adult Social Care and Safeguarding

Leicester City Council

Useful Information:

- Ward(s) affected: All
- Report author: Hital Lakhani, Admin & Business Support Team Leader
- Author contact details 0116 454 5602 Hital.Lakhani@leicester.gov.uk

1. Report

The Scheme

1.1. The Blue Badge Scheme helps over 2.5 million people in England retain their independence by enabling them to park close to jobs, services and facilities. Within Leicester 12,717 Blue Badge permits are currently on issue. The scheme is administered for Leicester City Council by a small team of admin staff, working within the Adult Social Care Business Support Section.

1.2. In January 2012 following a review by the Department for Transport (DfT), a number of changes were made in the way the scheme is administered. Central to the changes made was the introduction of the Blue Badge Improvement System (BBIS) which is a national database of Blue Badge holders.

1.3. From January 2012 the DfT also transferred funds, previously held by Local Primary Care Trusts for Blue Badge assessments, to Local Authorities. This change was designed to enable Local Authorities to move away from the system of GP making assessments for eligibility, and instead implement an independent assessment of mobility. We currently hold mobility assessment clinics four days a week, inviting applicants to have their mobility assessed.

1.4. Other changes included the introduction of a standardised national application form and the amendment of legislation to enable Local Authorities to raise the maximum charge for the permit to £10. The increase is designed to assist Local Authorities to cover administration costs associated with processing applications under the new arrangements.

Administration & Assessment
(Appendix 1 - Blue Badge Team Process)

1.5. Applications fall into two distinct categories. The first is "automatic" applications where people have automatic entitlement to a Blue Badge based on specified criteria:

- receipt of Higher rate Mobility component of Disability Living Allowance currently in the transition of being replaced by Personal Independent Payment (PIP);
- being registered blind;
- receipt of War pensioner's mobility Supplement; or
- receipt of Tariffs 1-8 from The Service Personnel's and Veteran's Agency;

The second category is "discretionary" applications where entitlement is judged on a medical assessment of eligibility.

1.6. Automatic applications are received via post, online, or in person. Applications received via the post or online are dealt with to completion by the Blue Badge Admin team. Eligibility and the validity of all required documentation are checked before processing on the BBIS and Adult Social Care (ASC) Carefirst client database.

1.7. Automatic applications received face to face continue to be dealt with by Customer Services staff who are trained to complete application forms, check documentation and process automatic applications on the BBIS. Once they have processed the application they forward all paperwork to the Blue Badge team to record the contact on the Adult Social Care system and file the application.

1.8. Discretionary applications are received via the post, online, or in person. All discretionary applications are forwarded to the Blue Badge team, who carry out a desk top assessment for each application.

1.9. Desk top assessment involves the Blue Badge admin team collating information with regards to an applicant's level of mobility from the application form, from the Adult Social Care client database and from any medical information provided by the applicant. This is then assessed using the guidance provided by the DfT to assess eligibility. *(Appendix 2 - Desk top Assessment form)*. Any applications which is not clear are invited for a mobility assessment.

1.10. We currently have an assessment room set up where our assessors carry out mobility assessments. The assessors follow the guidance set by the DfT to complete an assessment which involves observing the applicant walk a measured distance from an allocated parking space to our assessment room along with a set discussion regarding the applicant's mobility. *(Appendix 3 - Blue Badge Guidance Feb 2012 (via weblink) and Appendix 4 - Blue Badge Mobility Assessment Questions).*

1.11. We have an appeals process which allows any applicant to appeal a decision within 28 days of refusal. Appeals are dealt with initially by the Team Leader who, at the first stage will verify the original decision and reassess the application taking into account any additional information provided by the applicant. At this stage if the applicant has not already attended a mobility assessment they may be invited to be assessed and if required we may also contact medical professionals to obtain further information. If the outcome is still unsatisfactory to the applicant they can request a second independent reassessment where the application is passed to an Independent Manager for review. Any complaints received are dealt with by following the corporate Complaints Policy.

1.12. The Blue Badge team are required to maintain both paper and electronic records. This involves the recording of all returned badges, recording all deceased applicants and requesting the return of badges. We are also required to take part in the National Fraud Initiative (NFI) every two years.

Statistics & Finances

	2012	2013	Total
Badges issued	4318	4803	9121
New	1391	2025	3416
Renewal	2869	2714	5610

(Appendix 5 - Blue Badge Statistics)

	2012	2013
Expenditure		
Cost of Badges - BBIS (£4.60 per badge)	£16,837	£22,926
Badge Pack Production (VAL)	£263.50	£210.80
Staffing		
Team Leader	£28,514.62	£30,032.15
Admin Officer (B) F.T.E.	£23,713.68	£24,069.73
Admin Officer (C) F.T.E.	£20,765.64	£21,075.99
Admin Officer (D) 0.8 F.T.E.	£15,585.97	£17,541.62
Mobility Assessor (SPOC) 0.4 F.T.E.	£11,634	£11,910
Mobility Assessor (Agency) PT 0.4 F.T.E.	-	£9,028.92
Interpreting	£150	£270
Income		
Fee (£10 per badge)	-£43,229	-£48,172
Total	£74,235	£88,893

Northgate IT solutions charge Local Authorities £4.60per badge for badge production and standard delivery. This cost is covered by the £10 fee charged to all applicants.

Adult Business Support sustains the stationery, equipment, printing, postage and any other ad-hoc costs incurred in delivering our service.

Misuse & Enforcement

1.13. The Blue Badge team is also required to deal with replacing any lost, stolen and damaged badges, ensuring relevant checks are made on each application to ensure any fraudulent applications are identified. It is also the Blue Badge team's responsibility to deal with all reported misuse of badges liaising with Local Authority parking teams the police and private car parks. In 2013 we received over 40 reports of badge misuse where we attempted to investigate and take action. We are unable to investigate many of the misuse reports received due to the limited information provided.

1.14. The DfT have recognised that legislation around Blue Badge enforcement has made tackling misuse very difficult for authorities for many years. In October 2013 the DfT announced some changes to the scheme the most relevant being to allow Enforcement Officers to inspect and seize badge's,

previously Police were required to seize a badge. *(Appendix 6 - DfT Enforcement changes circular – Oct 2013)*

Future Developments

1.15. Our aim is to work with Occupational Therapy staff to further develop our mobility assessment process utilising their expertise and resources.

1.16. We plan to recruit a second part time assessor to the Blue Badge assessment role as the demand cannot be met within the current resources.

1.17. We are currently working with Northgate who are developing the BBIS system to allow applicants to upload evidence and photos on-line.

1.18. We are also working with Northgate to promote the use of the assisted interview module within BBIS; this will allow Blue Badge team and Customer Service staff to complete an application directly onto the BBIS system uploading all relevant documents rather that completing a paper application form when an applicant comes to apply in person.

1.19. We are working closely with Leicester City Council Parking Enforcement team to develop the use of the BBIS system to allow enforcement officers to access the system on street using handheld devices to check badge validity. We aim to continue to work closely with Leicester City Council Parking Enforcement team and promote on street enforcement exercises

2. Recommendation(s) to scrutiny

2. None

3. Supporting Information

- *Appendix 1* - Blue Badge Team Process
- *Appendix 2* - Blue Badge Desk Top Assessment Form
- *Appendix 3* - Blue Badge Guidance Feb 2012: Link provided due to document size https://www.gov.uk/government/publications/the-blue-badge-scheme-local-authority-guidance-england

- *Appendix 4* - Blue Badge Mobility Assessment Questions
- *Appendix 5* - Blue Badge Annual Statistics
- Appendix 6 - DfT Enforcement changes circular – Oct 2013

4. Financial, legal and other implications

4.1 Financial implications

4.1.1 There are no direct financial implications, as the report is concerned with providing details of the processes and how the scheme works.

4.1.2 However, the service is currently funded from a combination of the income generated and other team budgets (ASC Admin Team) within the department.

4.1.3 The above table (1.12) shows the financial costs of administrating the scheme.

Yogesh Patel – Accountant (Adults Social Care)

4.2 Legal implications

4.2 "No direct legal implications"

Kamal Adatia - City Barrister & Head of Standards

4.3. Climate Change implications

4.3 There is no climate change implications associated with this report.

Chloe Hardisty, Senior Environmental Consultant (Climate Change)

4.4 Equality Impact Assessment

4.4 The Blue Badge Scheme is targeted for those with disability as their protected characteristic. However, the scheme is quite specific as to which disabled people would receive this benefit based on their need for mobility support. Some are automatically entitled to receive the Blue Badge as a result of their meeting national criteria, others must be assessed by the council to determine whether their needs are in keeping with the scheme's aims.

The main positive impact of the Blue Badge Scheme is that it enables people with mobility problems who have personal transport, to access activities and facilities that would otherwise not be readily available to them, by using specially designated disabled parking bays and being able to park on single or double yellow lines for up to three hours. This enables them to participate in community life, engage in social activities, take part in economic or educational activities, and maintain their identity and self-respect.

The fact that the scheme does not support all disabled people can be considered to be a negative impact. If people do not meet the automatic entitlement criteria, they are able to apply for the discretionary element of the scheme which sets out its criteria aimed at achieving the intended outcomes of the scheme. There is an appeals process in place which enables applicants to

seek recourse as mitigation for their unsuccessful application for a Blue Badge.

Irene Kszyk, Corporate Equalities Lead

4.5 Other Implications

(You will have considered other implications in preparing this report. Please indicate any which apply?)

None

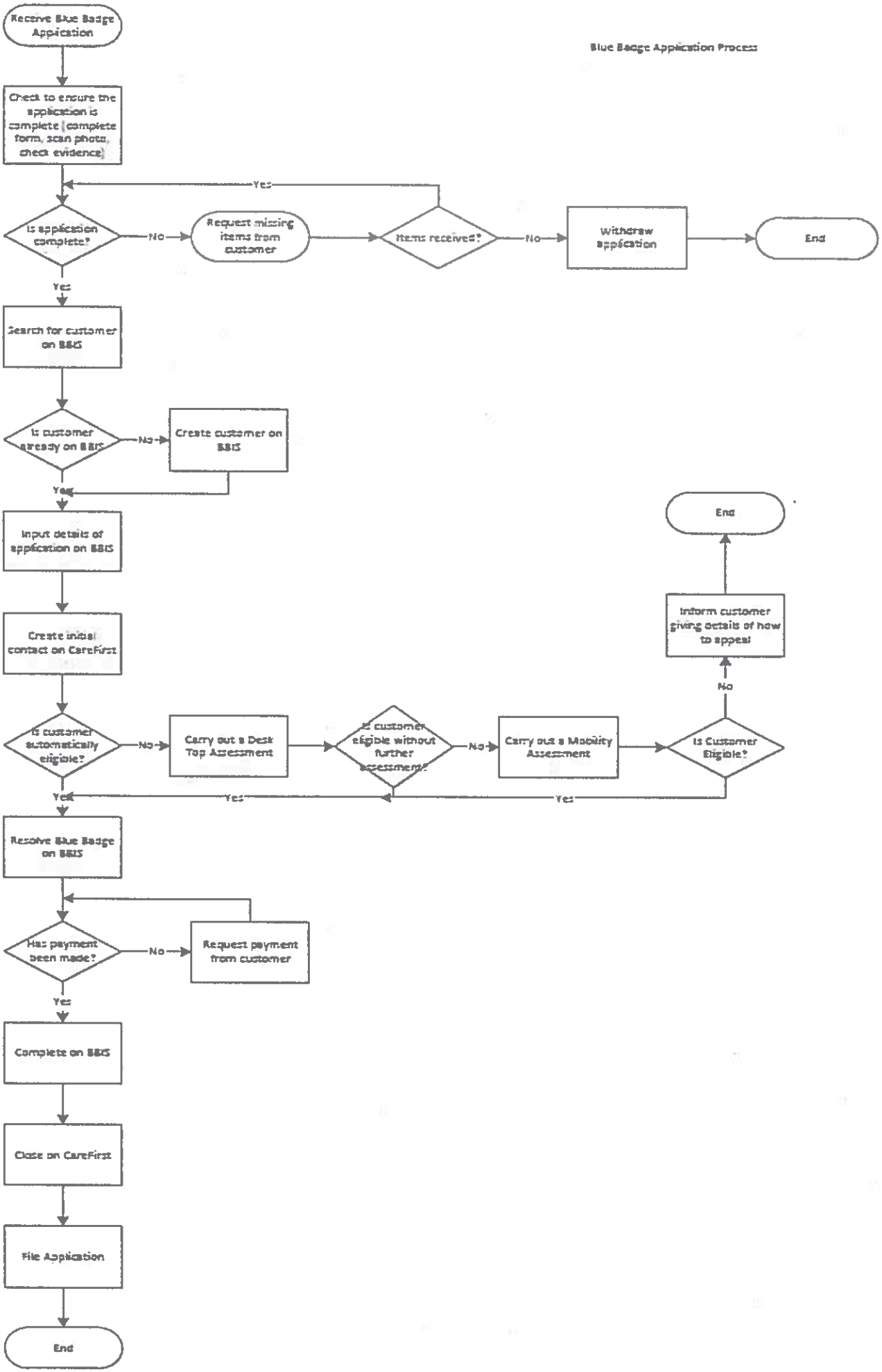
5. Background information and other papers:

6. Summary of appendices:

7. Is this a private report ? No

(If so, please indicate the reasons and state why it is not in the public interest to be dealt with publicly)

Appendix 1


Blue Badge Application Process
Receive Blue Badge Application
Check to ensure the application is complete (complete form, scan photo, check evidence)
Is application complete?
No
Request missing items from customer
Items received?
No
Withdraw application
End
Yes
Yes
Search for customer on BBIS
Is customer already on BBIS
No
Create customer on BBIS
Yes
Input details of application on BBIS
Create initial contact on CareFirst
Is customer automatically eligible?
No
Carry out a Desk Top Assessment
Is customer eligible without further assessment?
No
Carry out a Mobility Assessment
Is Customer Eligible?
No
Inform customer giving details of how to appeal
End
Yes
Yes
Yes
Resolve Blue Badge on BBIS
Has payment been made?
No
Request payment from customer
Yes
Complete on BBIS
Close on CareFirst
File Application
End

Int needed? Language: *Booked* ☐	*Appointment*	

BLUE BADGE ASSESSMENT LOG *Circle as you go version*

NAME:(*Mr/Mrs/Miss/Ms)*	CAREFIRST NO.

PERMANENT MOBILITY ISSUE: *YES NO Not answered AGE:*

Arthritis	***Breathing***	***Heart***	***Neurological***	***Walking Ability***
Knee(s) /hips /spine	*COPD*	*Angina/ AF/ IHD*	*Dementia/Alzheimer's*	*Only walk few paces/*
TKR Right/Left/Both	*SOB*	*Heart Failure/P'maker*	*Parkinson's*	*metres/ steps*
OA of _____	*Emphysema*	*Stroke /CABG*	*Debility/ frailty*	*Restricted walking*
Osteoporosis/ RA	*Asthma*	*Claudication*	*Balance/Vertigo*	*Cannot walk at all*
Back pain/ Sciatica		*Diabetes HBP*	*MS*	

Other/Applicant's comments:

Does Supermarket(with trolley/support)	*Painful to walk*	*Recuperating from surgery*
Public transport (sometimes)	*Struggles distances/hills*	*Awaiting surgery/treatment*

DISTANCE: *states can walk metres in mins.= approx. m per sec*
Can continue after short rest: YES / NO Able to walk >5mins in total: YES / NO walks in total mins):

SPEED . *Normal/Moderate Slow Very slow*

WALKING AID *W/Stick Rollator Tri-Wheeler Elbow Crutches W/Chair W/Frame Scooter Support from person None*

PROVIDED BY: *Self. Healthcare Professional SSD Hospital Red Cross*

GAIT: *Normal Adequate Poor Ext.Poor*

BREATHLESSNESS:

after walking for more than a few mins	*YES / NO*	*YES to ALL*
when hurrying on level ground/up slight hill	*YES / NO*	
with people own age on level ground	*YES / NO*	
have to stop for breath at own pace on level ground	*YES / NO*	*NO to ALL*
too breathless to leave home, or after dressing	*YES / NO*	

L.C.C INFO: Known to: Blue Badge PIU Reablement OT Red Cross OPAS
Prev BB Holder? Yes / No. Prev BB info: Permanent. Pain > Severe /moderate /none Distance (metres). <50m /50-100/< 100
Pace> Slow/v slow. Great/ Increased effort. Poor gait/ unsteady/walking aid

CF info:

EDRMS:

tick if any CF print-outs attached ☐ prescription attached ☐ Letter sent for Med info? ☐

MEDICAL PROFESSIONAL INFO: tick if any medical info attached ☐

DECISION: ISSUE DECLINE **MADE BY:** Desk Top assessment Mobility Assessment ( )
Does the applicant have a permanent and substantial disability which causes inability to walk or very considerable difficulty in walking? YES/NO

Reason:

Further assessment required if applies again? **Yes** ☐ **No** ☐

Signed off: ____Date: _______________________________

Blue Badge Mobility Assessment

Leicester City Council

Form Details	
Form Start Date:	**Worker Name:**

Person Details	
Name:	**CareFirst ID:**
DoB / EDD:	**Gender:**
Address:	**Tel No:**

Information Obtained During Assessment	
Medical Diagosis / Description of Disability	
Has the disability been medically diagnosed as permanent?	
If Other, please give details.	
Has any evidence been provided by the applicant?	
Are you having or due to have any of the following in connection with improving your mobility?	
If 'Other' please specify	
Why have you applied for a Blue Badge?	
Are you able to travel independently?	
If NO, why is assiatance needed?	
Do you, or would you be able to use:	
Are you normally a passenger or a driver?	
If a passenger, who would normally drive you?	

Blue Badge Mobility Assessment

Name:	CareFirst ID:

How did you get here today?

Therapist to note the distance walked by applicant by observing them

Distance Walked

How long did it take?

Were there any stops?

How long were the stops?

Is Today a Good Day?

How far can you normally walk?

Where do you normally mobilise?

Is your pace today typical of your normal pace?

How long does it normally take you to walk the distances you are managing?

Does your ability to walk vary?

What proportion of Good / Bad Days do you have in a week?

Assessors Observations / Applicants Report

Blue Badge Mobility Assessment

Name:	CareFirst ID:

ASSESORS OBSERVATIONS / APPLICANTS REPORT

Gait (Type and Severity)

Further details, Gait

Walking Speed

Further details, Walking Speed

Support Needed (Walking aid, other person)

Further details, Support needed

Further details, Stops required

Duration of stops

Further details, duration of stops

Breathlessness and breathlessness recovery

Further details, Breathlessness

Distance Covered before difficulty

Pain experienced

Pain relief taken, if any

Blue Badge Mobility Assessment

Name:	CareFirst ID:

Other medication taken

Recommendation of assessor - badge to be issued?

Reasons for decision

Should the applicant be re-assessed at Renewal?	

If YES note points to check

Completion and Authorisation

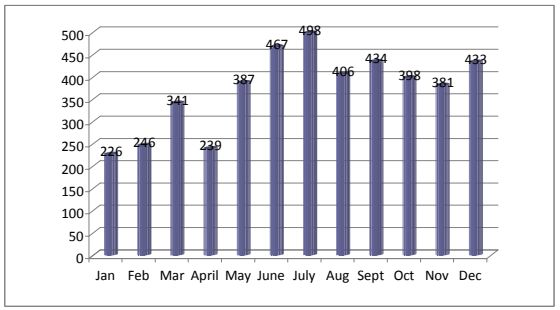
Completed By: Worker: Tel: Address:	Date:

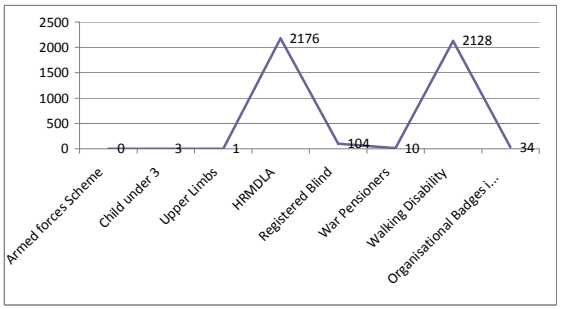
Authorisation Comment:

Appendix 5

2012	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
Applications received													N/A
Badges Issued	226	246	341	239	387	467	498	406	434	398	381	433	**4456**
Armed forces Scheme	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Child under 3	1	0	0	0	0	0	0	0	0	0	1	1	**3**
Upper Limbs	0	0	0	0	0	0	0	0	1	0	0	0	**1**
HRMDLA	145	112	183	132	216	235	220	190	198	165	175	205	**2176**
Registered Blind	5	12	12	8	10	9	10	5	9	11	6	7	**104**
War Pensioners	1	1	1	1	1	1	1	0	1	2	0	0	**10**
Walking Disability	74	119	142	95	160	217	261	211	223	213	199	214	**2128**
Organisational Badges issued	0	2	3	3	0	5	6	0	2	7	0	6	**34**
Badges refused	0	3	26	21	21	7	23	30	32	7	10	19	**199**

2012	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
Mobility Assessments	**1**	**25**	**28**	**28**	**48**	**28**	**42**	**50**	**41**	**56**	**16**	**33**	**396**
													0
Issued	1	18	19	20	36	22	34	32	31	46	11	23	**293**
													0
Refused	0	6	8	7	11	6	5	16	8	9	4	3	**83**
No Decision Made												6	**6**
Withdrawn	0	1	1	1	1	0	3	2	2	1	1	1	**14**
	1	25	28	28	48	28	42	50	41	56	16	33	**390**

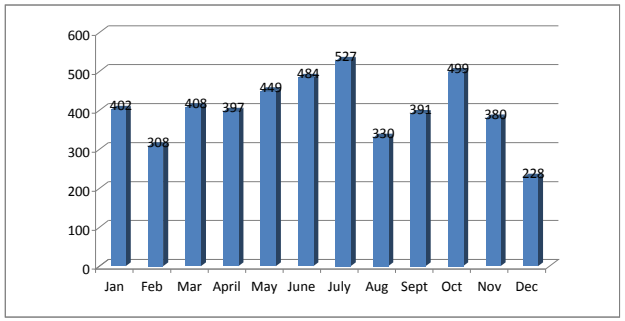


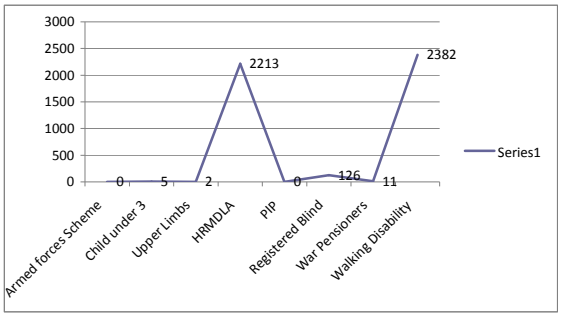


Appendix 5

2013	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
Applications received	**348**	**415**	**376**	**474**	**483**	**472**	**479**	**371**	**406**	**399**	**303**	**233**	4759
Badges Issued	402	308	408	397	449	484	527	330	391	499	380	228	**4803**
Armed forces Scheme													**0**
Child under 3		1		1			1			1		1	**5**
Upper Limbs	1										1		**2**
HRMDLA	193	166	204	183	197	245	234	156	176	190	159	110	**2213**
PIP													**0**
Registered Blind	8	11	9	7	12	14	15	8	8	19	11	4	**126**
War Pensioners	1	4	1	2			2				1		**11**
Walking Disability	196	121	190	194	230	219	273	157	205	287	205	105	**2382**
Organisational Badges issued	3	5	4	10	10	6	2	9	2	2	3	8	**64**
Badges refused	12	15	17	18	11	19	7	14	15	19	14	19	180

2013	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Yearly Total
Mobility Assessments Booked	45	29	43	40	54	50	53	45	73	64	62	39	**597**
Issued	35	23	33	34	45	42	43	39	60	53	53	32	**492**
Refused	10	6	10	6	9	8	10	6	13	11	9	7	**105**
No Decision Made Yet	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Monthly Subtotals	45	29	43	40	54	50	53	45	73	64	62	39	**597**





DEPARTMENT FOR TRANSPORT

DfT Circular 03/2013
Department for Transport
Great Minster House, 33 Horseferry Road, London SW1P 4DR

8 October 2013

THE BLUE BADGE SCHEME: ENFORCEMENT CHANGES

CONTENTS

INTRODUCTION

1. This circular provides information on changes to section 21 of the Chronically Sick and Disabled Persons Act 1970; section 117 of the Road Traffic Regulation Act 1984; and the Disabled Persons (Badges for Motor Vehicles) (England) Regulations 2000, as a consequence of the commencement of the Disabled Persons' Parking Badges Act 2013 and the introduction of the Disabled Persons (Badges for Motor Vehicles) (England) (Amendment) Regulations 2013.

2. The Circular only focuses on the changes brought about by the new legislation which are likely to affect local authorities in their day-to-day administration and enforcement of the Blue Badge scheme.

3. The changes affect:

    - the inspection and seizure of badges by local authorities;
    - the cancellation of badges by local authorities in certain circumstances;
    - the offence of using a badge that is no longer valid; and
    - the law relating to one badge per person

4. These changes come into force on 8 October 2013.

INSPECTION AND RETENTION OF BADGES

5. Until now, constables or enforcement officers could inspect badges under powers in the Chronically Sick and Disabled Persons Act 1970 ("the 1970 Act") but only the police could seize badges. With the widespread adoption of civil parking enforcement by local authorities, however, this situation is outdated. It is often impractical for local authorities to engage a police presence to assist in Blue Badge enforcement. Consequently, whilst many authorities will issue parking tickets to vehicles for parking infringements involving the misuse of a Blue Badge, they will often stop short of inspecting the badge and taking it away from the user in cases where the badge is not valid, or where a valid badge is being used by someone other than the holder.

6. However, commencement of the Disabled Persons' Parking Badges Act 2013 ("the 2013 Act) will enable enforcement officers to inspect and retain a badge without police presence if they have reasonable grounds for believing that the badge:

    (a) is a fake

    (b) has already been cancelled e.g. because it was reported lost or stolen (see section 2 below), or

    (c) should have been returned to the issuing authority (e.g. because it has expired, the holder has died, the holder is no longer disabled, a

replacement has been issued, the badge has become damaged/faded, the authority has written to the holder requesting return of the badge either following a relevant conviction for misuse or because it was obtained by false representation), or

(d) was being misused (including by someone other than the holder when the genuine holder is not involved in the journey).

7. There is no obligation on local authorities to use this power but many have indicated that they will do so. In using the power, we would expect enforcement officers to take appropriate steps to establish "reasonable grounds" for retaining the badge. Local authorities will wish to establish suitable procedures for their enforcement officers to follow but they could include checking the BBIS database; telephoning their local authority to establish further details of the badge/badge holder; or interviewing the person using the badge at the roadside.

8. Of particular interest is the power to retain a badge that is being used (misused) by someone other than the genuine badge holder. In using this power we would expect enforcement officers to establish that the disabled badge holder is not part of the journey. Even if they are not present, the badge holder may have been dropped at that place or may be being picked up from that place. Very often the person using the badge will admit on questioning that the holder is not involved in the journey; some local authorities telephone the holder to establish their whereabouts.

9. When a badge is retained in scenarios (a)-(c) above we expect the local authority will destroy it in due course, as it would no longer be valid (if the authority recovering the badge is not also the badge-issuing authority, we would suggest they liaise with the issuing authority in this respect). However, when a valid badge is retained under (d) above it should normally be returned to the holder. That is because the power to retain a badge is not the same thing as a power to permanently withdraw/confiscate a badge. Indeed, the badge holder may not know the third party is using the badge. A badge can only be permanently withdrawn from use if a relevant conviction for misuse has been obtained under regulation 9(2) of the Disabled Persons (Badges for Motor Vehicles) (England) Regulations 2000 or if it was obtained by false representation. To reinforce this, we are amending those regulations to explicitly require that a valid badge retained because it is being misused is returned as soon as reasonably practicable to the holder (provided that the authority does not have pre-existing grounds, under the regulations, for withdrawing the badge). In practice this is likely to mean that the badge is returned first to the issuing authority by the enforcing authority and then to the holder. The issuing authority may wish to warn the holder about the seriousness of misuse when returning the badge. The act of returning the badge does not preclude the relevant authority from prosecuting any offence that has been committed, if desired.

10. It should also be noted that the new legislation does not empower the local authority to use force when attempting to retain a badge. If an enforcement officer encounters any form of resistance we would advise that they take no further action without police support.

11. Each local authority will wish to consider its own training and procedures for enforcement officers employing the new powers.

New definition of enforcement officer

12. Where a badge is displayed on a motor vehicle, section 21 of the 1970 Act provides a power for constables or enforcement officers to require any person who is in the vehicle, or appears to have been in, or to be about to get into, the vehicle, to produce the badge for inspection. Until now, the definition of "enforcement officer" has been restricted to traffic wardens, civil enforcement officers and parking attendants. The definition of these officers also includes the wearing of a uniform when exercising their powers.

13. However, the 2013 Act adds to the definition of enforcement officer a person who is employed by a local authority or with whom the authority have made arrangements for the purpose of inspecting and retaining badges. This could include a direct employee of the local authority or a contractor. Furthermore, this new category of "enforcement officer" does not need to be in uniform but they do need to be authorised in writing by the authority to carry out badge inspections and retentions. They should also produce appropriate evidence of authority when exercising their powers, otherwise there is no obligation on an individual to hand their badge to the enforcement officer. In practice, the local authority should hold written documentary evidence of authorised officers and should ensure that all officers carry some form of identification authorising them to carry out inspections/badge retention.

14. The new powers therefore pave the way for the wider use of specialist Blue badge fraud teams operating in plain-clothes, and without the requirement for police presence.

CANCELLATION OF BADGES

15. There is a duty on badge holders to return their badge to the issuing authority immediately if: it has expired; the holder ceases to be disabled; a replacement has been issued; the badge is damaged/faded; or because it is no longer required. In all such cases the badge would be deemed to be no longer valid and could be flagged as such on the BBIS system; similarly when a badge holder dies.

16. However, legislation has not addressed the situation where a badge has been lost or stolen. Although in practice a local authority would 'cancel' the original and issue a replacement, there was no explicit power to do this and the legal status of the original badge was not clear. The 2013 Act amends the 1970 Act to legally permit a local authority to cancel a badge which the holder notifies as lost or stolen. This will ensure that the legal status of all badges on the

BBIS system will be beyond doubt, although it is unlikely to alter the day-to-day practices of most local authorities.

17. The amendment also enables a local authority to cancel a badge, after notifying the holder, in any other case where it has become apparent to the authority that the holder no longer has possession of the badge.

USE OF BADGES THAT ARE NO LONGER VALID

18. Section 117 of the Road Traffic Regulation Act 1984 ("the 1984 Act") and section 21 (4B) of the 1970 Act make wrongful use of a Blue Badge an offence. It has always been the Department's view that wrongful use includes the continued use of a badge that should have been returned. However, this was not explicitly clear in the wording of the legislation. The 2013 Act therefore amends the 1970 Act and the 1984 Act so that wrongful use of a badge includes (but is not limited to) when a person displays a badge that should have been returned or has been cancelled.

CLARIFICATION OF LAW RELATING TO ONE BADGE PER PERSON

19. Legislation states that "a" badge (i.e. one) may be issued to a disabled person. The scheme has always worked on a one badge per person basis as the badge may be used in any vehicle and in any local authority area. This keeps the number of badges in circulation down and prevents further opportunities for abuse. Regulations reinforce this by enabling an authority to refuse to issue a badge in circumstances in which the applicant already holds another valid badge, or to recover a badge if another valid badge is (inadvertently) issued to the holder by another issuing authority.

20. This principle is not changing but we have taken the opportunity to clarify that these provisions apply to badges issued not just in England, but also Scotland, Wales and Northern Ireland. So, for example, if a local authority in England is aware that an applicant already has a valid badge issued in Scotland, Wales or Northern Ireland, they should not issue another badge. Similarly, the authority should seek to recover a badge that they have issued if they become aware that the holder has subsequently been issued with another valid badge by another UK issuing authority.

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Great Minster House
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Telephone 0300 330 3000
General email enquiries FAX9643@dft.gsi.gov.uk
Website www.gov.uk/dft

Appendix C

Report to Scrutiny Commission

Adult Social Care Scrutiny Commission

Date of Commission meeting: 6th March 2014

Better Care Fund

Report of the Director of Adult Social Care and Safeguarding

Leicester City Council

Useful Information:

- Ward(s) affected: All
- Report author: Ruth Lake
- Author contact details 454 5551
- Date of Exec meeting N/A

1. Summary

The Integration Transformation Fund was announced in June 2013 as part of the government's spending round. This has subsequently been renamed as the Better Care Fund (BCF).

The BCF will be a national pooled budget of £3.8bn from 2015 /16, in part top-sliced from NHS budgets, to be spent on health and social care. It aims to drive closer integration, efficiencies and to improve outcomes for patients and service users.

This level of national funding translates as a total of £23.261m for Leicester and consists of a combination of new and existing funding streams. This is recurrent revenue and capital funding, rather than a one off allocation.

In order to access this funding, all areas have been required to produce and agree a draft local plan by 14th February 2014, detailing how local services will change across health and social care. A condition for access to the funding is that the Clinical Commissioning Group and the Local Authority must jointly agree the plan and it must be signed off by the Health and Wellbeing Board. The Health and Wellbeing Board supported this plan on 30th January 2014.

The detailed draft BCF plan is attached as appendix 1 (including excel sheet, appendix 1a). The guidance notes that explain what the plan must include are attached at appendix 2.

It should be noted that the plan has been produced to a tight timescale and further work will continue, in dialogue with NHS England, to refine the detail.

A final draft will be submitted on 3rd April 2014.

2. Recommendation(s) to scrutiny

Scrutiny is recommended to note the draft plan.

3. Supporting Information

Developing Plans for the Better Care Fund: Guidance annexe to the NHS planning Framework (Appendix 2)

4. Financial, legal and other implications

4.1 Financial implications

The first full year for the Better Care Fund is 2015/16. The total value of the fund in this year will be £23.261m which is a mixture of new and existing funding. The value of the 'new' funding from the NHS Clinical Commissioning Group is £11.571m. The rest of the funding is a mix of funding streams already being received from the NHS and Disabled Facilities and Social Care Capital Grants paid to the local authority and then transferred to the BCF.

In 2014/15 Leicester will receive £1.311m, subject to the submission of a satisfactory plan, to prepare for the implementation of pooled budgets in 2015/16.

The use to which the Better Care Fund is put will have a very significant impact on the financial position of both Adult Social Care (and therefore Leicester City Council as a whole) and the NHS.

There are a number of risks around the BCF which are described in Appendix 1. Foremost amongst these is the extent to which a significant element of the funding could be dependent on performance. However, there are recent indications that ministers have re-considered their position on this.

Rod Pearson, Head of Finance, Health& Wellbeing.

4.2 Legal implications

The closer integration of health and social care teams may involve the making of changes to staffing conditions. These proposals will have to be developed in accordance with the Council's HR policies and procedures.

Kamal Adatia
City Barrister & Head of Standards

4.3. Climate Change implications

Not applicable at this stage

4.4 Equality Impact Assessment

None noted at this stage but EIAs may be developed as part of the implementation planning process

4.5 Other Implications

Winter Care Plan
This report is wholly focussed on improving the experience of people using health and social care services, with a direct intention to reduce emergency admissions / acute hospital use. In this respect, the report sets out a positive opportunity to improve winter capacity and planning for vulnerable individuals.

5. Background information and other papers:
N/A

6. Summary of appendices:
Appendix 1 and 1a – Better Care Fund draft submission and excel finance / performance template
Appendix 2 – Better Care Fund guidance summary

7. Is this a private report ?

No

Better Care Fund planning template – Part 1

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

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	Leicester City Council
Clinical Commissioning Group	Leicester City CCG
Boundary Differences	None
Date agreed at Health and Well-Being Board:	30th January 2014
Date submitted:	14th February 2014

Minimum required value of ITF pooled budget: 2014/15	£14,983,000 (TBC)
2015/16	£23,261,000 (TBC)
Total agreed value of pooled budget: 2014/15	£14,983,000 (TBC)
2015/16	23,261,000 (TBC)

b) Authorisation and signoff

Signed on behalf of NHS Leicester City CCG	
By	Dr Simon Freeman
Position	Managing Director
Date	January 30th 2014
Signed on behalf of Leicester City Council	
By	Andy Keeling
Position	Chief Operating Officer
Date	January 30th 2014
Signed on behalf of the Leicester City Health and Wellbeing Board	
By Chair of Health and Wellbeing Board	Rory Palmer
Position	Deputy City Mayor and Chair of Leicester City Health & Wellbeing Board
Date	January 30th 2014

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

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 clear plan presented in this draft builds upon this existing spirit of collaboration and are part of a wider transformation of the services provided to our population. This links directly into the areas we have identified as priorities for improvement, which are:

- Effective, high-quality pre-hospital pathways
- Clinically sound and evidence-based hospital pathways
- Efficient, safe post-hospital pathways.

We have worked closely as one health and social care community on these programmes of work, 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. The plan has also had significant input from other stakeholders, members of the public, patients and carers.

Other organisations we have included in the development of our plan, include East Leicestershire and Rutland CCG, West Leicestershire CCG, Leicestershire Partnership NHS Trust (LPT), East Midlands Ambulance Services NHS Trust (EMAS), University Hospitals of Leicester NHS Trust (Leicester's Hospitals) and Central Nottingham Community Services (CNCS) our GP Out Of Hours provider. We also ensured we involved Local Authority representatives and teams from adult social care services, and Healthwatch has been a vital partner in our planning so far. As we progress our plan, we also aim to engage with the voluntary sector across Leicester City in respect of specific items of delivery.

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

Our vision for an effective, high-quality, patient-centred system has been formulated alongside detailed engagement with our local population which has informed the solution from inception through development to completion.

Significant engagement has taken place throughout 2013 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, General Practitioners, 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. These responses have been used as a basis to inform all Better Care Fund work streams.

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 draft plan.

To commence moving our plan into implementation, a further workshop event is taking place in February 2014. This event will seek 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.

As part of our longer-term strategic view, Leicester City patients and public representatives also form part of a Leicester, Leicestershire and Rutland Patient and Public Involvement Group, which is currently chaired by a member of Leicester City Healthwatch. This group has been set up to provide citizens' scrutiny of the five-year strategy plan that is being developed for the Leicester, Leicestershire and Rutland Unit of Planning, known locally as *Better Care Together*, and will carry out a similar role for this plan. We will ensure continuing engagement and active involvement with this group as our plans progress.

e) Related documentation

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

The following list is synopsis of some of the key source documents that have informed this submission.

Document or information title	Synopsis and links
Better Care Together – vision/strategy	The Leicester, Leicestershire and Rutland *Better Care Together* five-year strategic plan, due to be completed by the end of 2013-14, will set out our vision for the form and function of the health and social care economy across Leicester, Leicestershire & Rutland. ***To follow***
Joint Strategic Needs Assessment (JSNA)	Joint local authority and CCG assessments of the health needs of a local population in order to improve the physical and mental health and wellbeing of individuals and communities.

	http://www.leicester.gov.uk/your-council-services/social-care-health/jsna/jsna-reports/
Joint Health & Wellbeing Strategy (JHWS)	The Joint Health and Wellbeing Strategy sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out in the period 2013 to 2016 for Leicester City. http://www.leicester.gov.uk/your-council-services/health-and-wellbeing/health-and-wellbeing-board/joint-health-and-wellbeing-strategy/
Draft CCG Operational Strategy 2014-2016	The Operating Plan sets out the Leicester City Clinical Commissioning Group plan for health care commissioning in 2014/15 and 2015/16. It describes our vision and priorities based upon analysis of public health information and listening to our partners and local people. *To follow*

VISION AND SCHEMES

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

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

Our core vision

Our core vision, set out in Leicester's Health and Wellbeing Strategy, 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 integrated, 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.

At the core of our vision remains a thorough understanding of our population and the health inequalities it faces, which we will achieve better outcomes in the short and medium term.

Context

Life expectancy for Leicester is below the national average, and the health gap between affluent and more deprived areas within the city is significant. Across areas of the city there can be a difference of more than nine years' life expectancy for men and five years for women. Leicester has a high level of poverty and is ranked 25th worst for deprivation out of 326 local authorities in England in the most recent Index of Deprivation (2010). More than two fifths (41%) of Leicester's population live in the most deprived 20% of areas in England and a further 34% live in the 20-40% most deprived areas.

Although the city has a relatively young population, people suffer both physical and mental ill health and die much younger than the national average. This can be directly linked to the impact of the city's deprivation and made worse by health-related lifestyle factors. The main contributors to early death and the gap in life expectancy in the city are Cardiovascular Disease and Chronic Obstructive Pulmonary Disease. Cancer is also a major cause of death in the city but contributes less to the gap in life expectancy between Leicester and England.

Too often the levels of ill health in the city and the current healthcare model results in an over-reliance on acute care. Long-term conditions are detected late, while primary, community care and social care services are not used to their full potential and services are based around the organisation that is providing the service rather than the needs of the individual patient and their carer(s).

With so many factors influencing the health of the city, such as housing, lifestyle factors

and the environment around us, we recognise the need to shape a new collaborative approach to service delivery which puts the patient and their carer(s) at the centre. We want to deliver seamless services that break down the institutional divide between physical and mental health, primary and secondary care, and health and social care. This approach will be built on strong partnerships between local health and social care agencies and the citizens of Leicester, drawing on all expertise, experience and ideas from across the city.

This means that the drivers of use of acute care in Leicester are complex, related as they are both to frail older people (accepting that we have a relatively lower elderly population relative to total population size) and younger people with multiple morbidities. Our approach and plan therefore by necessity covers both of these issues.

Our approach to the development of our core vision

As part of our application to be an Integration Pioneer, a draft vision was developed and agreed for health and social care services in Leicester as part of the Joint Expression of Interest submitted in June 2013 by Leicester City Council and Leicester City CCG.

As this had been jointly agreed, we have chosen this as the basis for our joint work on the Better Care Fund plan. This has taken into account the recent NHS Planning Guidance (*Everyone Counts: Planning for Patients 2014/15 – 2018/19*) as well as what our population has been telling us is most important to them through our engagement events.

Underpinning our core vision are the five categories of outcomes, as set out in the NHS Outcomes Framework. We will use the Better Care Fund as an enabler towards achieving the outcomes in each domain:

Figure 1: The five categories of outcomes in the NHS Outcomes Framework

Across each of these five categories, the NHS Planning Guidance sets out a further set of 10 specific ambitions. Our Better Care Fund plan is designed to enable us to make

measurable improvement towards these ambitions for the citizens of Leicester City. These are described in Table 1.

Changes in the pattern and configuration of services over the next five years

We recognise that this is simply the start of our collective journey. Over the next five years we will continue to work together through the enablement of the Better Care Fund to build a resilient, efficient and wholly integrated system.

Our vision for integrated care and support in Leicester City is built around the definition of integrated care developed by National Voices:

"I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me"

Our early citizen participation strategy has informed the principles that underpin our vision for integrated care. These principles form the basis of our Better Care Fund model and will enable improvements towards the ambitions set out in the NHS Planning Guidance. We have aligned the priority areas of our focus to both the national ambitions and our local principles to ensure that the maximum value is gained from the application of our Better Care Fund. This is summarised in the table below:

Table 1: Priority areas, national ambitions and local principles

10 National Ambitions	Local principle	Local Priority area
Improving health – working together with the Health and Wellbeing Board to ensure the key elements of commissioning for prevention are delivered	Access to preventative services is essential to prevent ill health, avoid deterioration in overall wellbeing and achieve greater independence	Prevention, early detection and improvement of health-related quality of life
Increasing the proportion of older people living independently at home following discharge from hospital	Care should be provided in an integrated way with services organised around the patient and the needs for their carer(s)	Enabling independence following hospital care
Parity of esteem – ensuring patients with mental health problems don't suffer inequalities	People should have early diagnosis and timely access to services, particularly when in crisis	Prevention, early detection and improvement of health-related quality of life

Securing additional years of life for the people of England with treatable mental and physical health conditions	Services that proactively support people to maintain their health, wellbeing and independence for as long as possible should be provided, receiving care in their home and local community wherever possible	Prevention, early detection and improvement of health-related quality of life	
Improving the health-related quality of life of the 15 million+ people with one or more long-term conditions, including mental health conditions		Prevention, early detection and improvement of health-related quality of life	
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	Acute hospital emergency admissions to be regarded as an exception by all parts of the system	Reducing the time spent in hospital avoidably	
Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care		Reducing the time spent in hospital avoidably	
Reducing health inequalities – ensuring the most vulnerable in our society get better care and better services through integration, in order to get better health outcomes	Tackling the wider or social determinants of health is integral to an approach which puts the patient at the centre of care	Prevention, early detection and improvement of health-related quality of life	
Increasing the number of people with mental and physical health conditions having a positive experience of hospital care	Integration will deliver better outcomes for patients and their carer(s), improves care and patient experience	Reducing the time spent in hospital avoidably	
Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community	Services that proactively support people to maintain their health, wellbeing and independence for as long as possible should be provided, receiving care in their home and local	Prevention, early detection and improvement of health-related quality of life	

community wherever possible

On the basis of these national ambitions and our local principles, our model for integrated care is based on a menu of services for different scenarios in a patient's life, which will provide support from prevention through to end-of-life care. These have been mapped into priority areas for the Better Care Fund, ensuring pathways of care are changed across our whole system:

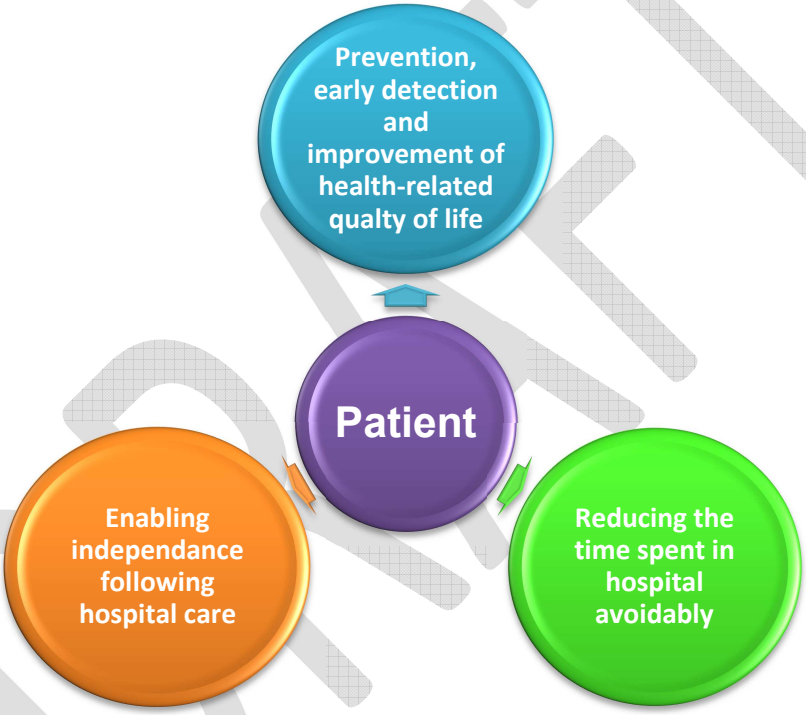

Figure 2: The Leicester City model of integrated care

Schemes under each of these priorities are detailed further in the plan.

In order to ensure the best use of resources, our system integration will be focused on those patient groups likely to derive the most benefit. Data mining has informed this population stratification and fits broadly with what our population has told us, which is:

- 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).

For this population, we propose to implement specific services in the following areas:

- Prevention, early detection and improvement of health-related quality of life; services such as risk stratification will target patients at risk of deterioration and

hospital admission.

- Services designed to reduce the amount of time people spent avoidably in hospital will prevent those patients in crisis being admitted to hospital; instead they will be treated in their own homes using a better, more integrated community approach, delivered in a holistic fashion.
- Services designed to enable independence following hospital care, such as support to keep patients independent as well as to prevent further avoidable time in hospital where possible.

All three facets of this model are effectively 'wrapped around' the patient in the following manner:

Figure 3: The Leicester City pre- and post-hospital pathway 2014-2016

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.

Key enablers of our vision

In practice, our vision for 2015/16 will be enabled by the delivery of the national conditions set out in the Better Care Fund guidance starting in 2014/15. These are described in more detail later in this plan.

We will achieve this improvement through the mobilisation of four transformative work streams, set up as our joint response to the Call to Action issued by NHS England. These will also cover the national conditions underpinning the Better Care Fund:

Table 2: Better Care Fund workstreams

	Work stream	Sub-groups	National condition
1	Citizen participation and empowerment	Listening to patient views	Plans to be jointly agreed
		Delivering better care through the digital revolution	
		Transparency and data sharing	Information sharing/NHS number
2	Wider primary care, provided at scale	Transforming primary care services	
3	A modern model of Integrated Care	Ensuring tailored care for vulnerable and older people	Lead accountable professional
		Care integrated around the patient	Protection of social care
4	Access to the highest quality urgent and emergency care		Seven-day working Implications for the acute sector

Detailed schemes under each of these work streams are described later in the plan.

The national conditions will span a number of work streams above. It is recognised that work stream leads will be required to work collaboratively to achieve the measures of success outlined. Expected outputs from the national conditions are explained fully in the section 'National Conditions'.

What will be different in five years?

This programme is purposely aligned with longer-term strategic change 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 form a part of the Leicester, Leicestershire & Rutland 5 year Strategic Plan. The Strategic Plan will set out the medium term direction for the models of health, care and support services that will need to apply in five years' time across Leicester, Leicestershire and Rutland (the LLR 'unit of planning' footprint) and the steps needed to

realise that vision.

At a local level, by joining up our services from the bottom up, as described in later sections of this plan, we will make a fundamental change in both culture and delivery mechanisms within our local health and social care economy.

There will be 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.

What difference will this make to our patients and their outcomes?

We recognise that our current model of care provides unaffordable and variable quality of care, placing a high demand on the acute sector. Our resources are concentrated on crisis and statutory services, rather than services designed to keep people independent and there is too large a variation in health outcomes across the city.

Typically, our services are not coordinated in a manner which serves our population. There is confusion about when to use services and access is further hampered by a lack of information sharing between and within organisations. This leads to duplication of effort across agencies and leads to a lack of confidence across the system for citizens and professionals working within the system.

This programme will form part of a wider transformative strategy for Leicester City, delivered through both the CCG and the local authority programmes of change and for the Leicester, Leicestershire and Rutland health and social care economy, delivered through the *Better Care Together* programme. However, our Better Care Fund is the key to begin making a difference and improving outcomes for our patients over the next two years.

This programme will move us towards a long-term, high-quality and affordable model of patient care. It will enable our citizens to remain independent for longer, reduce the time spent in hospital avoidably and enable the health-related quality of life for our citizens to be improved.

The commitment detailed in this plan towards transparency and data sharing will enable better health outcomes and improved patient experience by enhancing access to joint records across organisations. This includes access to personalised health care plans for patients at the end of their life or those with long-term conditions.

We will deliver better care through the digital revolution by harnessing technology and applying it to better the services we offer. This includes a truly single point of access for professionals working within our system, an electronic single assessment process to eliminate duplication and use of telehealth to keep our citizens at home and independent.

We will work with our citizens to ensure access to information and guidance through a digital front door, empowering our citizens to self-manage or access the right service at the right time.

We will assume joint responsibility for this programme by co-designing these pathways with all partners within our system. This will both maximise the potential for change and the success in transforming the system.

Inevitably all of these changes will need to see a significantly changed role for General Practice as co-ordinators and potentially integrators of enhanced community services. This role will need to be defined more accurately as implementation of the model proceeds.

b) Aims and objectives

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

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

The aims and objectives of our integrated system

Our model is focussed on the cohort of people most likely to derive a benefit from integrated ways of working, which we have identified as older people and those with long-term conditions. Our local definition focuses our programme on those aged 60+ and those aged 18-59 with three or more comorbidities.

We will use the Better Care Fund to achieve our aims:

- To design and commission services centred on our patients, public and carers, with our patients, public and carers.
- To 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.
- To develop a new model of primary care that provides a more proactive, holistic and responsive community service across physical and mental health.
- To provide a modern model of integrated care with a senior clinician taking responsibility for coordination of care.
- To reduce the amount of time spent in hospital avoidably by our citizens.
- To ensure that people are kept independent for as long as possible following hospital care.
- To provide safe, transparent and open data sharing across our system, enabling proactive coordination of care for our citizens.

We have started our journey towards these aims and have committed to achieving our objectives through the following programme of work:

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 using available technology and patient education programmes, reducing avoidable hospital stays.
- 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.

Priority 2: Reducing the time spent in hospital avoidably
We will achieve this by:

- Ensuring every person in the cohort experiences coordinated unplanned and planned care from an integrated team which responds in a coordinated way to ensure care is delivered in the community and around the individual.
- Reducing the number of avoidable hospital admissions through the provision of rapid community responses, instead of a 999 response. This will focus primarily on those over 60 years of age.

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.
- Increasing the number of patients able to live independently following a hospital stay.

We will achieve these aims and objectives by utilising the resources of the Better Care Fund and harnessing the will of the organisations involved to mobilise the schemes detailed further in this plan.

Each priority will be delivered through the work streams described earlier in this plan, which are summarised below:

Objectives:	**Priority 1:** Prevention, early detection & improvement of health related quality of life			**Priority 2:** Reducing the time spent in hospital avoidably		**Priority 3:** Enabling independence following hospital care	
	To increase the numbers of people identified as 'at risk' and ensure they are better able to manage their conditions	To deliver 'great' experience and patient focussed condition control using available technology, reducing avoidable hospital stays;	To enable the use of the NHS number as a primary identifier, linked to high quality care plans for our patients with long term conditions	To reduce the number of avoidable hospital admissions through the provision of rapid community responses;	To ensure every person in the cohort experiences coordinated and planned care from an integrated team which responds in a coordinated way to ensure care is delivered in the community and around the individual;	To ensure timely hospital discharge via the provision of in reach (pull) teams to swiftly repatriate people to community based services and maintain independence	To increase the number of patients able to live independently following a hospital stay
Workstream 1: Citizen Participation and empowerment	Increase our offer of assistive technologies						
	Integrating health and social care systems and data around the NHS number						
	Upscale our routine and service user satisfaction surveys						
	Implement traditional and digitally delivered patient education programmes						
			Integrating our community health 'single point of access' and our local authority 'single point of contact'.				
	Improve our ability to manage and track outcomes for our population						
	Review all existing services provided under our Integrated Commissioning Programme (including those in Section 256 agreements)						

Workstream 2: Wider primary care, provided at scale	Proactive care plans will be drawn up for our target population, specifically focussing on the 60+ and 18-59 with 3 or more comorbidities						
	Invest in preventative services, such as our new Leicester City Lifestyle Hub						
Workstream 3: A modern model of Integrated Care				Commission a Non-Elective team (NET), comprising of traditionally separate teams of health and social care, as one team, providing one service, 24/7.			
					Increase the capacity of the NET team above to be able increase the offer to support patients being discharged home, 7 days a week		
					Create a network of 10 new joint integrated teams covering all of Leicester City		
					Increase the number of these virtual beds through the life of the Better Care Fund, but commission them specifically for our patients in acute mental health services so that they may step down into community facilities		
				Review and then strengthen our reablement offer across both health and social care providers			
Workstream 4: Access to the highest quality urgent and emergency care				Commission one virtual team of 6 local GPs who will respond to 999 calls deemed clinically appropriate 7 days a week between 8am and 10pm			
				Commission community geriatric support for the whole pre-hospital pathway (covering GP team, Non-Elective Team and Planned Intervention Team as described above)			

Measures of success for these aims and objectives

These aims and objectives will be evaluated by metrics to capture the key measures of the Better Care Fund:

- Reducing delayed transfers of care
- Reducing emergency admissions
- Improving the effectiveness of reablement services
- Reduce admissions to residential and nursing care homes
- Improving patient and experience.

The sixth measure, required to be identified locally, is:

- Estimated diagnosis rate for people with dementia.

Template 2 of this submission details the baselines which have been agreed as part of this plan, with initial trajectories for improvement set. These will be subject to change until formal agreement at the Better Care Fund Programme Board.

Other measures of success

A further measure of success will be the joint use of patient data. This is expected to be live in June 2014 and will be used a marker of success.

In addition, we will be monitoring more detailed key performance indicators as markers of success. These may include, as examples:

- People in top 5% risk identified and managed via a care plan
- Cohort population with integrated care plan / lead professional
- Reduced unplanned admissions to mental health inpatient beds
- People diverted from statutory services
- Length of stay
- People in receipt of assistive technologies
- Falls reduction in the 65+ cohort
- Setting of death

These will be finalised as part of the mobilisation process with baselines and improvement trajectories agreed by 1 April 2014.

Measures of health gain

Long-term health gain measures will include increased life expectancy and healthy life expectancy. As a subset, having health management plans in place will result in reductions in premature mortality for our population.

c) Description of planned changes

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

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and local authority plan/s for social care

Within Leicester City we have agreed jointly to use the opportunities presented by the Better Care Fund to drive a clinically-led, patient-centred transformative change programme. This will harness the collective views, innovations and ideas of many experienced health and social care professionals as well as the views of our patients and carers. The programme is purposely aligned with longer-term strategic planned change in our acute sector, including the plans of Leicester, Leicestershire and Rutland *Better Care Together* programme.

Work stream 1: Citizen participation and empowerment

We will use the Better Care Fund to:

- Commit to integrating health and social care systems and data around the NHS number to ensure that all health and social care staff who need access to the data can access it to provide better holistic care to our population.
- Increase our offer of assistive technologies, particularly for falls and specific conditions such as COPD and hypertension, so that patients feel safe and remain independent and manage their own health proactively.
- Design and implement both traditional and digitally deliverable patient education programmes to empower our patients to manage their conditions better
- Extend our routine patient and service-user satisfaction surveys to include a wider range of services in health and social care to ensure that any service change we implement is increasing patient and service-user satisfaction.
- Begin the process of integrating our community health 'single point of access' and our local authority 'single point of contact'. In 2014/15, we will enable a warm transfer function to enable health and social professionals to easily access services across both health and social care with one phone call. We will review the potential of this virtual integration becoming a real integration during 2014/15.
- Improve our ability to manage and track outcomes for our population, ensuring that every pound spent on the services described above increase outcomes for our target population as well as returns the most value for our patients.

Work stream 2: Wider primary care, provided at scale

We will use the Better Care Fund to:

- Invest in GP services to ensure that our older population is cared for proactively by a named GP.
- Specific condition-management plans will be drawn up for our target population, ensuring that our patients know how to manage their conditions but

also know who to call when they feel the need for additional support, other than 999. This will start with our resident care home population and move onto prioritised population segments using our risk stratification model.

- Invest in preventative services, such as our new Leicester City Lifestyle Hub, empowering people in our target population to access services such as weight management, STOP smoking services, reduction of social isolation and exercise programmes. This will be directly linked to our hugely popular and successful NHS Health Check programme.

Work stream 3: A modern model of integrated care

We will use the Better Care Fund to:

- Commission a Non-Elective Team (NET), bringing together traditionally separate health and social care teams to provide one service, 24 hours a day, seven days a week. This builds on our successful Integrated Crisis Response Service which has recently been nominated for a Local Government Association award for integrated care. These teams will provide care for patients (and carers, where appropriate) in their own homes for up to 72 hours following a crisis call out with the aim of preventing admissions to hospital and promote independence at home. This will cover both physical and mental health.
- Increase the capacity of the Non-Elective Team to increase the offer to support patients being discharged home, seven days a week, preventing any delays in any of our hospitals. Ultimately, this will include mental health crisis services.
- Create a network of 10 new Joint Integrated Teams covering all of Leicester City. These teams will offer holistic planned interventions, keeping people independent at home as well as preventing both physical and mental health crises. These teams will refer into all core offers of health and social care services as well actively link with the voluntary sector services in the city.
- Review and then strengthen our reablement offer across both health and social care providers to patients to promote independence and reduce admissions to care homes.
- Invest in the current Intensive Community Support service which discharges patients home into one of 24 virtual beds. We will look to increase the number of these virtual beds through the life of the Better Care Fund, but commission them specifically for our patients in acute mental health services so that they may step down into community facilities.

Work stream 4: Access to the highest quality urgent and emergency care

We will use the Better Care Fund to:

- Commission one virtual team of six local GPs who will respond to 999 calls deemed clinically appropriate, seven days a week between 8am and 10pm. These GPs will assess and stabilise the patient and, where clinically appropriate, not-convey the patient the hospital but treat them in their own home. Basic diagnostic equipment will be part of the service, with access to on-call consultants at the acute site should further consultation be required. If more complex diagnostics are required, the patient will directly access the Emergency Frailty Unit at the Leicester Royal Infirmary and be discharged home, rather than via a base ward.
- Commission community geriatric support for the whole pre-hospital pathway

(covering the GP team, Non-Elective Team and Planned Intervention Team) to ensure that our patients are not admitted unnecessarily and equally, are admitted when clinically appropriate.

Other planned activity:

We plan to review all existing services provided under our Integrated Commissioning Programme (including those in Section 256 agreements) to ensure true value is being released by any investments. This includes services covered by:

- ASC Capital Grants
- Disabled Facilities Grant
- Carers Funding
- Reablement funds

In addition, we recognise that the introduction of the Care Bill will have implications for the Better Care Fund in Year 2, specifically concerning funding pressures resulting from care and support reform. As yet, these have not been quantified and will require further collaborative planning.

We will also strengthen the involvement of our vibrant voluntary sector in the City, ensuring that we harness the expertise within the organisations to enable us to achieve our objectives.

Application of Equality and Diversity principles

We are committed to ensuring that in developing schemes under the Better Care Fund, we will continue to engage with Leicester's diverse communities to design healthcare services that are appropriate and accessible to all. We will pay 'due regard to equality' when making decisions in line with the Equality Act 2010, but, go beyond simple compliance and work towards achieving the highest rating against NHS England's Equality Delivery System and effective delivery of the CCG and Local Authority equality and diversity strategies.

Indicative timeline

Due to the scale of system-wide change required, we have agreed that locally we will not wait until 2015/16 to mobilise. Many of the schemes listed below are happening as part of planned CCG or local authority work programmes during 2014/15 and 2015/16. We will use 2014/15 to test the proposed Better Care Fund models on a larger scale than would normally be enacted. Priorities will be agreed in consultation with our local health and social care partners according to feasibility and return on investment, and with our local population during planned engagement activity.

Actions completed to date:

Q3 2013-14

- Engagement process with our patients, service users and population to agree end-point outcomes began in October 2013.
- Governance structure to ensure all organisations are signed up to the ambition, scale and pace of the Fund was formulated in November 2013.
- Target population for interventions was identified and agreed in November 2013.
- Agreement reached with frontline staff across organisations about what and how to radically change to meet the aims and objectives for our Integrated Care

programme in November 2013.
- A high-impact shortlist was developed from qualitative and quantitative intelligence, and developed into outline cases for evaluation in November/December 2013.

Actions planned:

Q4 2013-2014
- Detailed activity, finance and workforce implications developed for every scheme under the Better Care Fund programme, including viability of mobilisation timescales and any procurement implications.
- Achieve sign off from all relevant bodies and begin mobilisation of priority schemes where appropriate.

Q1-Q2 2014-15
- Mobilise priority schemes.
- Continue patient and service-user engagement programme.
- Begin Integrated Care Whole Systems programme for data sharing across organisations as Liquid Logic, the new social care IT system, goes live.
- Continue assessment of Outcomes-Based Commissioning model; agree commissioning model and begin commissioning and procurement processes, including detailed system service specification.

Q3-Q4 2014-15
- Begin mobilisation of remaining schemes.

From April 2015
- All schemes to be live, with sufficient monitoring covering activity, outcomes and finance.
- Scope the next stage for the Leicester City Integrated Care pathway.

Our plans, though far-reaching and impactful, form an integral part of the *Better Care Together* programme and align with the overall five-year strategy for the Leicester, Leicestershire and Rutland health and social care economy. Through alignment with this programme, we will ensure no adverse impact is felt in the system as a whole as we implement our plans.

These timescales may change subject to any unforeseen circumstances. However, the risk of this will be limited by regular briefings to the *Better Care Together* Programme Board.

d) Implications for the acute sector

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

The long-term strategic direction of travel for the Leicester, Leicestershire and Rutland

health and social care economy is agreed collectively at the *Better Care Together* 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 the *Better Care Together* 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 by the end of 2013-14, 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. We are currently modelling the impact of our schemes in detail, including the impact on estate, workforce and finance across the system.

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 contribute 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.

e) Governance

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

Shared vision, shared leadership

The delivery of the Better Care Fund builds on a mix of strong existing partnership groups and a new strengthened oversight Programme Board.

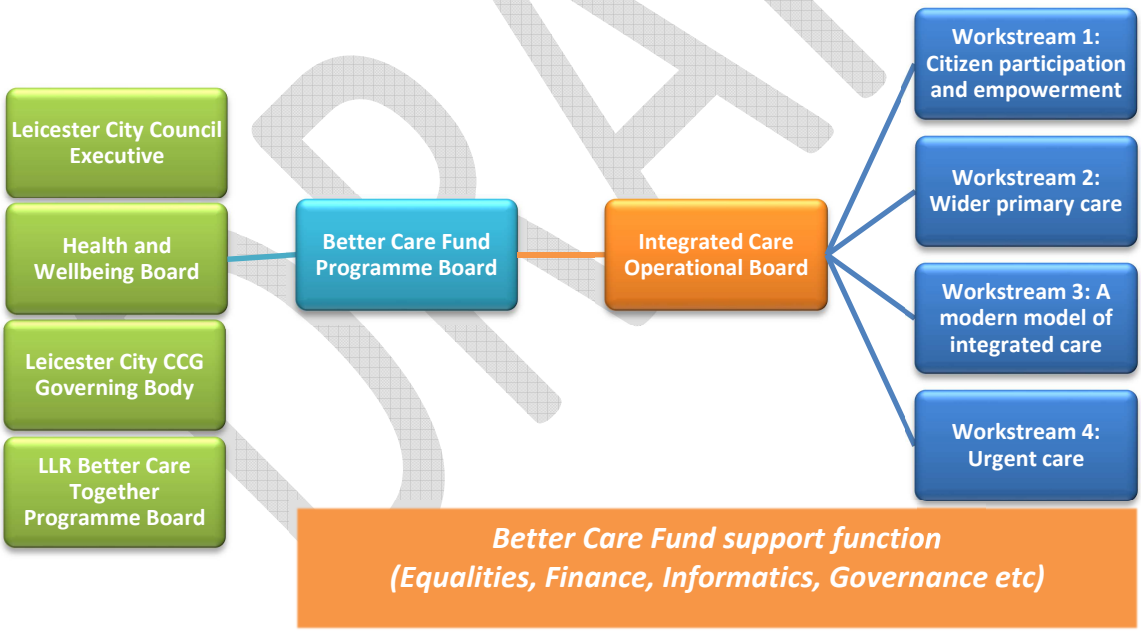

Figure 4: Better Care Fund Programme Structure

The Better Care Fund Programme Board consists of executive leaders from the health and social care economy, including the Managing Director of Leicester City CCG, 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 delivery of each work stream will be overseen by the Integrated Care Operational Board. This will run weekly and be co-chaired by the CCG Clinical Chair and the CCG

Managing Director. The Operational Board will be attended by heads of service at both the local authority and partner organisations, and involved teams from relevant functions across the organisations. This will report into the Better Care Fund Programme Board for oversight and rapid issue resolution.

Throughout the implementation of the programme, regular checkpoints have been arranged so that key CCG and partner organisation clinicians and elected members can confirm and challenge the overall programme of work. This will involve the active interrogation of the key measures of success outlined above.

In addition, regular progress reports are provided to the LLR *Better Care Together* Programme Board to ensure alignment with the overall strategic direction of travel of the LLR health and social care economy.

NATIONAL CONDITIONS

a) Protecting social care services
Please outline your agreed local definition of protecting adult social care services.

Protecting social care services in the Leicester means:

Ensuring 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.

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.

Please explain how local social care services will be protected within your plans.

Funding currently allocated 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 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.

On the Council side this has seen a projected annual increase in demand for social care against proposed budgets and the profile of cost-efficiency schemes within social care. On the CCG side this has involved an assessment of the numbers and cohorts being impacted in the community, the subsequent sizing of the community teams and therefore the investment needed.

A figure to support social care has now been agreed and will be recommended to the Council executive, CCG Governing Body and Leicester City Health & Wellbeing Board for approval.

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

What we have done so far
There is a local strategic commitment to seven-day working, through the Urgent Care Working Group, in response to the NHS Services Seven Days a Week Forum report. Partners are jointly developing and testing, through 'proof of concept' trials (locally known as 'super-weekends'), seven-day working models based on the recommendations in this report to enable our system to meet the clinical standards as recommended. The first test events ran in January 2014, with all partners across the health and social care system providing weekend service provision.

This builds on the existing enhanced service provision within community health and social care services to facilitate hospital discharge and/or admission avoidance. For example, 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. The test weekends described 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.

What we plan to do next
As part of our commitment to deliver seven-day services, we are in the process of agreeing a Service Development and Improvement Plan with our acute and community providers based on our 'proof of concept' trialling. This will be in partnership with the Leicester, Leicestershire and Rutland Urgent Care Working Group.

Our developing Better Care Fund plans include seven-day working (where applicable & feasible) as a standard expectation. For example, the schemes enabled by the Better Care Fund in our plan have all been modelled on a seven-day service expectation. Current mobilisation plans indicate that this will be fully live across the GP First, Non-Elective Team and the Planned Intervention Team in Q2 2014/15 but we expect that some services to expand to seven-day working in Q1 2014/15 where workforce allows across health and social care.

Alongside this, the super-weekends will allow assessment of need within the acute sector to support 7 day working.

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

This is currently not in place at Leicester City Council as normal procedure.

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

What we have done so far
The current IT systems used within social care do not allow for the NHS number to be used as a primary identifier. However, Leicester City Council is committed to doing this and has procured a new social care system to replace their existing systems called Liquid Logic. Liquid Logic will be used within the Council from April 2014 onwards.

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 will apply, as a commissioner, to the HSCIC for the NHS numbers in order to populate the new care system shortly after its live launch. Role based access control will be in place and all staff will be trained to use the NHS number. The NHS number as primary identifier is expected to become standard procedure by June 2014.

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.

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

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

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's public health team has attained level 2 of the NHS IG Toolkit.

Leicester City Council last year introduced mandatory online data protection training for all staff, and annual refreshers will be implemented in April 2014. This, combined with the newly procured social care system, will enable Leicester City Council to achieve NHS IG Toolkit Level 2 compliance in its adult's and children's social care services from April 2014 onwards.

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.

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

We can confirm that local people at high risk of hospital admission will have an agreed accountable lead professional and that health and social care will use a joint process to assess risk, plan care and allocate a lead professional.

The integrated community team model is the result of discussions with CCG GP leads who have discussed and identified what is required to improve the care delivered to those at most risk of admission. The proposal takes a number of disparate teams, including some non-recurrent pilots – and brings them together into an integrated model that deals with both step-up and step-down caseloads. The teams will be expanded where necessary and, based upon robust evaluation; the effective non-recurrent elements will be funded recurrently. Further discussions are taking place at locality meetings to engage with the wider practice membership. Clearly the central role of the practice as integrators of care will need to be discussed further and supported.

The approach to risk stratification we have used to identify patients at high risk of hospital admission

What we have done so far:

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.

What we will use the BCF to do next:

We are working with Greater East Midlands Clinical Support Unit and practices to complete this work by the end of April 2014. It is anticipated that by this time all 63 practices across Leicester City will be actively using the Risk Stratification tool to manage their high risk patients.

We have also committed to developing the functionality of this system further, specifically to areas such as medicines management, our care home population and in disease areas associated with frailty.

It is recognised that recorded disease prevalence in some areas is below expected prevalence. 98% of our practices use the SystMone clinical system. We have invested in a clinical system facilitator who supports practices in training, development and the design of clinical templates. This leads to a consistent approach to coding and is helping to increase accurately recorded disease prevalence across the City.

Proportion of the adult population identified as at high risk of hospital admission

What we have done so far:

Using the Adjusted Clinical Groups (ACG) risk predictive software, this is approximately 7,200 people or 2% of the 360,000 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.

What we will use the BCF to do next:

The BCF proposal is designed to complement the new DES that is coming into effect in 2014/15, which is focused upon the avoidance of unnecessary admissions in vulnerable people.

Using our local population definition of those aged 60+ or 18-59 with 3 of more comorbidities, a further modelling exercise will take place with practices in July 2014. This will result in a targeted cohort of patients 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 navigator will support the clinical lead in identifying the most appropriate service elements for their patient.

What proportions of individuals at risk have a joint care plan and accountable professional

What we have done so far:

Leicester City CCG has a running programme for the provision of high quality, personalised care planning, based upon a SystMone template.

We have, in partnership with NHS England, implemented a Direct Enhanced Service, which incentivises our General Practices 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.

We have prioritised our frail elderly population, recognising that these patients are at high risk of admission, committing to providing every care home resident in the City with a personalised care plan by March 2014 through a newly commissioned 'Emergency Response Service'. This is a team of GP's who construct care plans for this target population, in partnership with all agencies involved in the patient's care.

By the end of 2013/14, this will result in the following:

1. Approximately 562 personalised care plans for patients at the End of Life
2. Provision of a holistic health and social care assessment, including care planning where required for a further 2100 patients
3. GP led MDT assessment, including care planning where required for a further 800

patients

What we will use the BCF to do next:

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.

We will also aim to introduce 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.

2) RISKS

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

The table below provides an overview of some of the key risks identified through the co-design process to-date. A full risks and mitigations log is being produced in support of our finalised Better Care Fund submission.

Risk	Risk rating	Mitigating Actions
UHL are already in a deficit position; non-delivery of these schemes will effectively push all organisations into deficit	High	Explicit agreement will be made with UHL regarding the expected impact (activity and finance) of this programme.
Poor practice across the urgent care system will effectively render all efforts of this programme null as any activity/finance reductions made will simply be replaced with other activity or changes in coding practice	High	The Better Care Fund Programme Board will work in partnership with both *Better Care Together* and Urgent Care Working Group to ensure delivery of this programme. Much improvement has been seen in 2013-14 and we will commit to working together on further improvements from 2014 onwards.
The shift to integrated working will require a whole scale change in culture and process across numerous organisations. Implications of this shift will be significant for workforce, finance, operations, and clinical governance	High	Clinical and operational credibility will take time to build. Using a bottom-up process of staff engagement on a weekly basis, the initial phases of the schemes will be fluid and take staff feedback into account. As the project progresses, organisational implications will continue to be mitigated at the Programme Board.
The speed at which we are mobilising these new services and systems is rapid.	High	In order to realise the potential of this model in 15/16, it is imperative that this system gains credibility in 14/15 and therefore requires rapid mobilisation. Risks will be mitigated by a resilient Programme Board and delivery sub-structure along with both provider and commissioner organisations releasing staff to mobilise this system safely and
Clinical buy-in, especially from the acute sector, is imperative for success. Historically, this has been a block to success	High	CCG GP leads will form a clinical oversight group, with key clinicians from both acute and non-acute providers to ensure a clinically led process from the outset. The Integrated Care Operational Group will involve clinicians from all organisations from

		the outset to provide a clinically-credible model of care.
The introduction of the Care Bill, currently going through Parliament and expected to receive Royal Assent in 2014, will result in a significant increase in the cost of care provision from April 2016 onwards that is not fully quantifiable currently and will impact the sustainability of current social care funding and plans.	High	The Leicester City Better Care Fund Programme Board recognise this and will collaboratively work towards mitigation of this risk
Capacity within Primary Care, particularly in General Practice, is already stretched. This scheme must complement the schemes already in place.	High	The integrated care pathway for LC will effectively add capacity within primary and community care services. We will work with General Practice to ensure that the pathway agreed is clinically compatible with schemes running in General Practice.

Finance - Summary

For each contributing organisation, please list any spending on BCF schemes in 2014/15 and the minimum and actual contributions to the Better Care Fund pooled budget in 2015/16.

Organisation	Holds the pooled budget? (Y/N)	Spending on BCF schemes in 14/15	Minimum contribution (15/16)	Actual contribution (15/16)
Leicester City Council	Y	11.311	1.877	1.877
Leicester City CCG	Y	3.625	21.384	21.384
BCF Total		**14.983**	**23.261**	**23.261**

Approximately 25% of the BCF is paid for improving outcomes. If the planned improvements are not achieved, some of this funding may need to be used to alleviate the pressure on other services. Please outline your plan for maintaining services if planned improvements are not achieved.

Calculated as £5.815m. In line with planning guidance, if a local area achieves 70% or more of the levels of ambition set out in each of the indicators in its plan, it will be allowed to use the held-back portion of the performance pool to fund its agreed contingency plan as necessary. If an area fails to deliver 50% of the levels of ambition set out in its plan, it may be required to produce a recover plan. Non recurrent funds and contingency funds will be used to mitigate in year risks.

Contingency plan:		2015/16	Ongoing
Outcome 1	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		
Outcome 2	Planned savings (if targets fully achieved)		
	Maximum support needed for other services (if targets not achieved)		

Please list the individual schemes on which you plan to spend the Better Care Fund, including any investment in 2014/15. Please expand the table if necessary.

BCF Priority Area	BCF Investment	Lead provider	2014/15 spend		2014/15 benefits		2015/16 spend		2015/16 benefits	
			Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent	Recurrent	Non-recurrent
Prevention, Early Detection & condition management	- Risk stratification	CCG	£ 54,000.00	£ -	TBD	£ -	£ 54,000.00	£ -	TBD	£ -
	- Assistive technologies	LA	£ 229,000.00	£ -	TBD	£ -	£190,000.00	£ -	TBD	TBD
	Lifestyle Hub	LA	£ 60,000.00		TBD		£100,000.00		TBD	TBD
	- Supporting integration of LPT/LA community teams	LA		£ 195,350.00		TBD	£ 380,000.00	£ -		TBD
Preventing hospital admissions	- Ambulatory Care admission avoidance GP team	CCG	£ 1,365,000.00	£ -	-£ 4,186,500.00	£ -	£ 1,365,000.00	£ -	-£ 5,442,450.00	TBD
	- IT integration - EMAS	EMAS	£ -	£ 40,000.00		£ -		£ -		
	- Strengthening 7 day services for Non-Elective Team - LPT CHS	LPT	£ 450,000.00	£ -		£ -	£ 450,000.00	£ -		
	- Strengthening 7 day services for Non-Elective Team - LA	LA	£ 331,000.00	£ -			£ 570,000.00			
	- Strengthening 7 day services for Non-Elective Team - LPT MH	LPT	£ 192,326.00	£ -		£ -	£ 96,399.00	£ -		
	- Direct access to Community geriatric support	LPT	£ -	£ -		£ -	£ -	£ -		
	Enhanced night nursing	LPT	£ 80,000.00	£ -		£ -	£ 80,000.00	£ -		
Reducing DTOC and preventing admissions into long term care	- 12 integrated virtual beds	LPT	£ 300,000.00	£ -	TBD	TBD	£ 300,000.00	£ -	TBD	TBD
	- Mental health discharge liaison Team	LPT	£ 42,000.00	£ -			£ 42,420.00	£ -		
	- Integrated Mental health step down service	LPT	£ -	£ 150,000.00			£ 300,000.00	£ -		
	- Strengthening 7 day services for planned care teams - LPT CHS	LPT	£ -	£ -			Included in NET cost	£ -		
	Intensive Community Support Beds	LPT	£ 485,000.00				£ 485,000.00			
	- Strengthening 7 day services for planned care teams - LA	LA	£ 780,000.00	£ 92,000.00			£ 205,000.00	£ -		
	Reablement - LPT	LPT	£ 1,125,000.00	£ -			£ 1,125,000.00	£ -		
	Reablement - LA	LA	£ 24,500.00				£ 203,000.00			
Enabling workstreams	- Review of existing portfolio	CCG/LA	£ -	£ -		£ -	£ -	£ -	£ -	£ -
	- System Integration Post (7/7)	CCG	£ 63,178.00	£ -		£ -	£ 63,178.00	£ -	£ -	£ -
Existing transfers	ASC Capital Grants	LA	£ 2,623,000.00	£ -			£ 876,000.00			
	Existing ASC Transfer	LA	£ 5,633,000.00				£ 5,633,000.00			
	2015/16 ASC Increased Tfr						£ 5,650,000.00			
	Disabled Facilities Grant	LA	£ -	£ -			£ 1,001,000.00			
	Carers Funding	LA	£ 650,000.00	£ -			£ 650,000.00			
	Reablement funds	LA	£ 825,000.00	£ -			£ 825,000.00			
	Total Proposed BCF Schemes		£ 15,312,004.00	£ 477,350.00	-£ 4,186,500.00		£ 20,643,997.00		-£ 5,442,450.00	

Outcomes and metrics

For each metric other than patient experience, please provide details of the expected outcomes and benefits of the scheme and how these will be measured.

Each of the nationally defined metrics will follow national technical guidance. Every scheme in the Better Care Fund has been mapped to either one or more of the 5 national outcome measures or the sixth local measure. In addition, local metrics, attributed to each scheme, will be agreed through each project lead and are yet to be defined in detail.

For the patient experience metric, either existing or newly developed local metrics or a national metric (currently under development) can be used for October 2015 payment. Please see the technical guidance for further detail. If you are using a local metric please provide details of the expected outcomes and benefits and how these will be measured, and include the relevant details in the table below

It is anticipated that we will apply the national metric for the October 2015 payment. This will be assessed when the metric & associated technical guidance is released.

For each metric, please provide details of the assurance process underpinning the agreement of the performance plans

Each of the metrics listed below will be subject to a minimum of monthly monitoring at the Programme Board. Each scheme will have detailed metrics agreed prior to commencement and these will form a performance dashboard; this dashboard will be used to monitor progress against the outcomes expected from each scheme. For underpinning metrics, where weekly monitoring is available, this will be used at Project level.

In setting the performance plans, the achievability of each metric has been carefully considered given a background of an ageing population with extremely high levels of socio-economic deprivation and the need to turn the tide of increasing care home and emergency hospital admissions over a number of years, in a very short time-span for the monitoring periods below. The BCF statistical significance calculator has been used to help to assess the appropriate level of ambition on each metric.

Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population - monitored quarterly

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

Delayed transfers of care from hospital per 100,000 population - monitored daily and weekly at project level and monthly at Programme Board

Avoidable emergency admissions - monitored monthly. This is the composite level of emergency admissions; local data at HRG level will be monitored closely on a weekly basis at project lev

Patient / service user experience - Not yet defined

Estimated diagnosis rate for people with dementia - monitored monthly

If planning is being undertaken at multiple HWB level please include details of which HWBs this covers and submit a separate version of the metric template both for each HWB and for the multiple-HWB combined

Not Applicable

Metrics		Current Baseline (as at....)	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment	
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	737.7	N/A	665.1	
	Numerator	280		260	this is 85% sig level
	Denominator	37955		39094	
		(April 2012 - March 2013)		(April 2014 - March 2015)	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	*Metric Value*	85.7%	N/A	87%	? If same denominator in 14/15
	Numerator	712			this is 75% sig level
	Denominator	831			
		(April 2012 - March 2013)		(April 2014 - March 2015)	
Delayed transfers of care from hospital per 100,000 population (average per month)	*Metric Value*	2870	4230	2810	First target 85% sig level
	Numerator	7275	10758	7178	Second target 90% sig level
	Denominator	253460	254331	255403	
		April - September 2013	(April - December 2014)	(January - June 2015)	
Avoidable emergency admissions (composite measure)	*Metric Value*	1708	836	827	First target 85% sig level
	Numerator	5656	2796	2781	Second target 90% sig level
	Denominator	331096	334501	336188	
		April 2012 - March 2013	(April - September 2014)	(October 2014 - March 2015)	
Patient / service user experience (awaiting national definition)			N/A		
		(insert time period)		*(insert time period)*	
Number of patients on dementia registers as % of the estimated dementia prevalence (national indicator)	*Metric Value*	55.1%	65.0%	67.0%	First target >95% sig level
	Numerator	1831	2194	2285	Second target >95% sig level
	Denominator	3323	3376	3410	Trajectory in line with
		Sep-13	Dec-14	Jun-15	Everyone Counts Dec 2013

Annex to the NHS England Planning Guidance

Developing Plans for the Better Care Fund

(formerly the Integration Transformation Fund)

What is the Better Care Fund?

1. The Better Care Fund (previously referred to as the Integration Transformation Fund) was announced in June as part of the 2013 Spending Round. It provides an opportunity to transform local services so that people are provided with better integrated care and support. It encompasses a substantial level of funding to help local areas manage pressures and improve long term sustainability. The Fund will be an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change.

2. The Better Care Fund provides an opportunity to improve the lives of some of the most vulnerable people in our society, giving them control, placing them at the centre of their own care and support, and, in doing so, providing them with a better service and better quality of life.

3. The Fund will support the aim of providing people with the right care, in the right place, at the right time, including through a significant expansion of care in community settings. This will build on the work Clinical Commissioning Groups (CCGs) and councils are already doing, for example, as part of the integrated care “pioneers” initiative, through Community Budgets, through work with the Public Service Transformation Network, and on understanding the patient/service user experience.

What is included in the Better Care Fund and what does it cover?

4. The Fund provides for £3.8 billion worth of funding in 2015/16 to be spent locally on health and care to drive closer integration and improve outcomes for patients and service users and carers. In 2014/15, in addition to the £900m transfer already planned from the NHS to adult social care, a further £200m will transfer to enable localities to prepare for the Better Care Fund in 2015/16.

5. The tables below summarise the elements of the Spending Round announcement on the Fund:

The June 2013 Spending Round set out the following:	
2014/15	**2015/16**
A further £200m transfer from the NHS to adult social care, in addition to the £900m transfer already planned	£3.8bn to be deployed locally on health and social care through pooled budget arrangements

In 2015/16 the Fund will be created from:
£1.9bn of NHS funding
£1.9bn based on existing funding in 2014/15 that is allocated across the health and wider care system. This will comprise: • £130m Carers' Break funding • £300m CCG reablement funding • £354m capital funding (including £220m Disabled Facilities Grant) • £1.1bn existing transfer from health to adult social care.

6. For 2014/15 there are no additional conditions attached to the £900m transfer already announced, but NHS England will only pay out the additional £200m to councils that have jointly agreed and signed off two-year plans for the Better Care Fund.

7. In 2014/15 there are no new requirements for pooling of budgets. The requirements for the use of the funds transferred from the NHS to local authorities in 2014/15 remain consistent with the guidance[1] from the Department of Health (DH) to NHS England on 19 December 2012 on the funding transfer from NHS to social care in 2013/14. In line with this:

8. *"The funding must be used to support adult social care services in each local authority, which also has a health benefit. However, beyond this broad condition we want to provide flexibility for local areas to determine how this investment in social care services is best used.*

9. *A condition of the transfer is that the local authority agrees with its local health partners how the funding is best used within social care, and the outcomes expected from this investment. Health and wellbeing boards will be the natural place for discussions between NHS England, clinical commissioning groups and councils on how the funding should be spent, as part of their wider discussions on the use of their total health and care resources.*

10. *In line with our responsibilities under the Health and Social Care Act, an additional condition of the transfer is that councils and clinical commissioning groups have regard to the Joint Strategic Needs Assessment for their local population, and existing commissioning plans for both health and social care, in how the funding is used.*

11. *A further condition of the transfer is that local authorities councils and clinical commissioning groups demonstrate how the funding transfer will make a positive difference to social care services, and outcomes for service users, compared to service plans in the absence of the funding transfer"*

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

12. Councils should use the additional £200m to prepare for the implementation of pooled budgets in April 2015 and to make early progress against the national conditions and the performance measures set out in the locally agreed plan. This is important, since some of the performance-related money is linked to performance in 2014/15.

13. The £3.8bn Fund includes £130m of NHS funding for carers' breaks. Local plans should set out the level of resource that will be dedicated to carer-specific support, including carers' breaks, and identify how the chosen methods for supporting carers will help to meet key outcomes (e.g. reducing delayed transfers of care). The Fund also includes £300m of NHS funding for reablement services. Local plans will therefore need to demonstrate a continued focus on reablement

14. It was announced as part of the Spending Round that the Better Care Fund would include funding for costs to councils resulting from care and support reform. This money is not ring-fenced, but local plans should show how the new duties are being met.

    i. £50m of the capital funding has been earmarked for the capital costs (including IT) associated with transition to the capped cost system, which will be implemented in April 2016.

    ii. £135m of revenue funding is linked to a range of new duties that come in from April 2015 as a result of the Care Bill. Most of the cost results from new entitlements for carers and the introduction of a national minimum eligibility threshold, but there is also funding for better information and advice, advocacy, safeguarding and other measures in the Care Bill.

What will be the statutory framework for the Fund?

15. In 2015/16 the Fund will be allocated to local areas, where it will be put into pooled budgets under Section 75[2] joint governance arrangements between CCGs and councils. A condition of accessing the money in the Fund is that CCGs and councils must jointly agree plans for how the money will be spent, and these plans must meet certain requirements.

16. Funding will be routed through NHS England to protect the overall level of health spending and ensure a process that works coherently with wider NHS funding arrangements.

17. DH will use the Mandate for 2015/16 to instruct NHS England to ring-fence its contribution to the Fund and to ensure this is deployed in specified amounts at local level for use in pooled budgets by CCGs and local authorities.

18. Legislation is needed to ring-fence NHS contributions to the Fund at national and local levels, to give NHS England powers to assure local plans and performance, and to ensure that local authorities not party to the pooled budget can be paid from it, through additional conditions in Section 31 of the Local

[2] Sec 75 of the NHS Act, 2006, provides for CCGs and local authorities to pool budgets.

Government Act 2003. This will ensure that the Disabled Facilities Grant (DFG) can be included in the Fund

19. The DFG has been included in the Fund so that the provision of adaptations can be incorporated in the strategic consideration and planning of investment to improve outcomes for service users. DFG will be paid to upper-tier authorities in 2015/16. However, the statutory duty on local housing authorities to provide DFG to those who qualify for it will remain. Therefore each area will have to allocate this funding to their respective housing authorities (district councils in two-tier areas) from the pooled budget to enable them to continue to meet their statutory duty to provide adaptations to the homes of disabled people, including in relation to young people aged 17 and under.

20. Special conditions will be added to the DFG Conditions of Grant Usage (under Section 31 of the Local Government Act 2003) which stipulate that, where relevant, upper-tier local authorities or CCGs must ensure they cascade the DFG allocation to district council level in a timely manner such that it can be spent within year. Further indicative minimum allocations for DFG have been provided for all upper-tier authorities, with further breakdowns for allocations at district council level as the holders of the Fund may decide that additional funding is appropriate to top up the minimum DFG funding levels.

21. DH and the Department for Communities and Local Government (DCLG) will also use Section 31 of the Local Government Act 2003 to ensure that DH Adult Social Care capital grants (£134m) will reach local areas as part of the Fund. Relevant conditions will be attached to these grants so that they are used in pooled budgets for the purposes of the Fund. DH, DCLG and the Treasury will work together in early 2014 to develop the terms and conditions of these grants.

How will local Fund allocations be determined?

22. Councils will receive their detailed funding allocations in the normal way. NHS allocations will be two-year allocations for 2014/15 and 2015/16 to enable more effective planning.

23. In 2014/15 the existing £900m s.256 transfer to councils for adult social care to benefit health, and the additional £200m, will continue to be distributed using the social care relative needs formula (RNF).

24. The formula for distribution of the full £3.8bn fund in 2015/16 will be based on a financial framework agreed by ministers. The current social care transfer of £1.1bn and the £134m of adult social care capital funding included in the Fund in 2015/16 will be allocated in the same way as in 2014/15. DFG will be allocated based on the same formula as 2014/15. The remainder of the Fund will be allocated on the basis of the CCG allocations formula. It will be for local areas to decide how to spend their allocations on health and social care services through their joint plan.

25. The announcement of the two-year CCG allocations, communicated to CCGs and councils alongside this planning guidance, includes the Fund allocations in 2015/16. In 2014/15, the additional £200m will be transferred directly from NHS

England to councils along with the rest of the adult social care transfer. The local authority and CCGs in each Health and Wellbeing Board area will receive a notification of their share of the pooled fund for 2014/15 and 2015/16 based on the aggregate of the allocation mechanisms. The allocation letter also specifies the amount that is included in the payment-for-performance element, and is therefore contingent in part on planning and performance in 2014/15 and in part on achieving specified goals in 2015/16.

26. Allocation letters will specify only the minimum amount of funds to be included in pooled budgets. CCGs and councils are free to extend the scope of their pooled budget to support better integration in line with their Joint Health and Wellbeing Strategy.

27. The wider powers to use Health Act flexibilities to pool funds, share information and staff are unaffected by the new Better Care Fund requirements, and will be helpful in taking this work forward.

How should councils and CCGs develop and agree a joint plan for the Fund?

28. Each statutory Health and Wellbeing Board will sign off the plan for its constituent councils and CCGs. The Fund plan must be developed as a fully integral part of a CCG's wider strategic and operational plan, but the Better Care Fund elements must be capable of being extracted to be seen as a stand-alone plan.

29. Where the unit of planning chosen by a CCG for its strategic and operational plan is not consistent with the boundaries of the Health and Wellbeing Board, or Boards, with which it works, it will be necessary for the CCG to reconcile the Better Care Fund element of its plan to the Health and Wellbeing Board level. NHS England will support CCGs in this position to ensure that plans are properly aligned.

30. The specific priorities and performance goals in the plan are clearly a matter for each locality but it will be valuable to be able to:

    - aggregate the ambitions set for the Fund across all Health and Wellbeing Boards;
    - assure that the national conditions have been achieved; and
    - understand the performance goals and payment regimes that have been agreed in each area.

31. To assist Health and Wellbeing Boards we have developed a template which we expect everyone to use in developing, agreeing and publishing their Better Care Plan. This is attached as a separate Word document and Excel spread sheet. The template sets out the key information and metrics that all Health and Wellbeing Boards will need to assure themselves that the plan addresses the conditions of the Fund.

32. As part of this template, local areas should provide an agreed shared risk register. This should include an agreed approach to risk sharing and mitigation covering, as a minimum, the impact on existing NHS and social care delivery and

the steps that will be taken if activity volumes do not change as planned (for example, if emergency admissions or nursing home admissions increase).

33. CCGs and councils must engage from the outset with all providers, both NHS and social care (and also providers of housing and other related services), likely to be affected by the use of the fund in order to achieve the best outcomes for local people. The plans must clearly set out how this engagement has taken place. Providers, CCGs and councils must develop a shared view of the future shape of services, the impact of the Fund on existing models of service delivery, and how the transition from these models to the future shape of services will be made. This should include an assessment of future capacity and workforce requirements across the system. It will be important to work closely with Local Education and Training Boards and the market shaping functions of councils, as well as with providers themselves, on the workforce implications to ensure that there is a consistent approach to workforce planning for both providers and commissioners.

34. CCGs and councils should also work with providers to help manage the transition to new patterns of provision including, for example, the use of non-recurrent funding to support disinvestment from services. It is also essential that the implications for all local providers are set out clearly for Health and Wellbeing Boards and that their agreement for the deployment of the Fund includes agreement to all the service change consequences.

What are the National Conditions?

35. The Spending Round established six national conditions for access to the Fund:

National Condition	Definition
Plans to be jointly agreed	The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Well Being Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

National Condition	Definition
Protection for social care services (not spending)	Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with the 2012 Department of Health guidance referred to in paragraphs 8 to 11, above.
As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends	Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.
Better data sharing between health and social care, based on the NHS number	The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care. Local areas should: • confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to; • confirm that they are pursuing open APIs (ie. systems that speak to each other); and • ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place. NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

National Condition	Definition
Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional	Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.
Agreement on the consequential impact of changes in the acute sector	Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

How will Councils and CCGs be rewarded for meeting goals?

36. The Spending Round indicated that £1bn of the £3.8bn would be linked to achieving outcomes. Ministers have agreed the basis on which this payment-for-performance element of the Fund will operate.

37. Half of the £1bn will be released in April 2015. £250m of this will depend on progress against four of the six national conditions and the other £250m will relate to performance against a number of national and locally determined metrics during 2014/15. The remainder (£500m) will be released in October 2015 and will relate to further progress against the national and locally determined metrics.

38. The performance payment arrangements are summarised in the table below:

When:	Payment for performance amount	Paid for:
April 2015	£250m	Progress against four of the national conditions: • protection for adult social care services • providing 7-day services to support patients being discharged and prevent unnecessary admissions at weekends • agreement on the consequential impact of changes in the acute sector; • ensuring that where funding is used for integrated packages of care there will be an accountable lead professional
	£250m	Progress against the local metric and two of the national metrics: • delayed transfers of care; • avoidable emergency admissions; and
October 2015	£500m	Further progress against all of the national and local metrics.

National and Local Metrics

39. Only a limited number of national measures can be used to demonstrate progress towards better integrated health and social care services in 2015/16, because of the need to establish a baseline of performance in 2014/15. National metrics for the Fund have therefore been based on a number of criteria, in particular the need for data to be available with sufficient regularity and rigour.

40. The national metrics underpinning the Fund will be:

- admissions to residential and care homes;
- effectiveness of reablement;
- delayed transfers of care;
- avoidable emergency admissions; and
- patient / service user experience.

41. The measures are the best available but do have shortcomings. Local plans will need to ensure that they are applied sensitively and do not adversely affect decisions on the care of individual patients and service users.

42. Further technical guidance will be provided on the national metrics, including the detailed definition, the source of the data underpinning the metric, the reporting schedule and advice on the statistical significance of ambitions for improvement.

43. Due to the varying time lags for the metrics, different time periods will underpin the two payments for the Fund as set out in the table below. Data for the first two

of these metrics, on admissions to residential and care homes and the effectiveness of reablement, are currently only available annually and so will not be available to be included in the first payment in April 2015.

Metric	April 2015 payment based on performance in	October 2015 payment based on performance in
Admissions to residential and care homes	N/A	Apr 2014 - Mar 2015
Effectiveness of reablement	N/A	Apr 2014 - Mar 2015
Delayed transfers of care	Apr – Dec 2014	Jan - Jun 2015
Avoidable emergency admissions	Apr – Sept 2014	Oct 2014 – Mar 2015
Patient / service user experience	N/A	Details TBC

44. For the metric on patient / service user experience, no single measure of the experience of integrated care is currently available, as opposed to quality of health care or social care alone. A new national measure is being developed, but will not be in place in time to measure improvements in 2015/16. In the meantime, further details will be provided shortly on how patient / service user experience should be measured specifically for the purpose of the Fund.

45. In addition to the five national metrics, local areas should choose one additional indicator that will contribute to the payment-for-performance element of the Fund. In choosing this indicator, it must be possible to establish a baseline of performance in 2014/15.

46. A menu of possible local metrics selected from the NHS, Adult Social Care and Public Health Outcomes Frameworks is set out in the table below:

NHS Outcomes Framework	
2.1	Proportion of people feeling supported to manage their (long term) condition
2.6i	Estimated diagnosis rate for people with dementia
3.5	Proportion of patients with fragility fractures recovering to their previous levels of mobility / walking ability at 30 / 120 days
Adult Social Care Outcomes Framework	
1A	Social care-related quality of life
1H	Proportion of adults in contact with secondary mental health services living independently with or without support
1D	Carer-reported quality of life

Public Health Outcomes Framework	
1.18i	Proportion of adult social care users who have as much social contact as they would like
2.13ii	Proportion of adults classified as “inactive”
2.24i	Injuries due to falls in people aged 65 and over

47. Local areas must either select one of the metrics from this menu, or agree a local alternative. Any alternative chosen must meet the following criteria:

- it has a clear, demonstrable link with the Joint Health and Wellbeing Strategy;
- data is robust and reliable with no major data quality issues (e.g. not subject to small numbers);
- it comes from an established, reliable (ideally published) source;
- timely data is available, in line with requirements for pay for performance;
- the achievement of the locally set level of ambition is suitably challenging; and
- it creates the right incentives.

48. Each metric will be of equal value for the payment for performance element of the Fund.

49. Local areas should set an appropriate level of ambition for improvement against each of the national indicators, and the locally determined indicator. In signing off local plans, Health and Wellbeing Boards should be mindful of the link to the levels of ambition on outcomes that CCGs have been asked to set as part of their wider strategic and operational plans. Both the effectiveness of reablement and avoidable emergency admissions outcomes metrics are consistent with national metrics for the Fund, and so Health and Wellbeing Boards will need to ensure consistency between the CCG levels of ambitions and the Fund plans.

50. In agreeing specific levels of ambition for the metrics, Health and Wellbeing Boards should be mindful of a number of factors, such as:

- having a clear baseline against which to compare future performance;
- understanding the long-run trend to ensure that the target does not purely reward improved performance consistent with trend increase;
- ensuring that any seasonality in the performance is taken in to account; and
- ensuring that the target is achievable, yet challenging enough to incentivise an improvement in integration and improved outcomes for users.

51. In agreeing levels of ambition, Health and Wellbeing Boards should also consider the level required for a statistically significant improvement. It would not be appropriate for the level of ambition to be set such that it rewards a small improvement that is purely an artefact of variation in the underlying dataset.

How will plans be assured?

52. Ministers, stakeholder organisations and people in local areas will wish to be assured that the Fund is being used for the intended purpose, and that the local plans credibly set out how improved outcomes and wellbeing for people will be

achieved, with effective protection of social care and integrated activity to reduce emergency and urgent health demand.

53. To maximise our collective capacity to achieve these outcomes and deliver sustainable services the NHS and local government will have a shared approach to supporting local areas and assuring plans.

54. The most important element of assurance for plans will be the requirement for them to be signed-off by the Health and Wellbeing Board. The Health and Wellbeing Board is best placed to decide whether the plans are the best for the locality, engaging with local people and bringing a sector-led approach to the process.

55. The plans will also go through an assurance process involving NHS England and the LGA to assure Ministers. The key elements of the overall assurance process are as follows:

- Plans are presented to the Health and Wellbeing Board, which considers whether the plans are sufficiently challenging and will deliver tangible benefits for the local population (linked to the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy).

- If the Health and Wellbeing Board is not satisfied, and the plan is still lacking after a process of progressive iteration, an element of local government and NHS peer challenge will be facilitated by NHS England and the LGA.

- NHS England's process for assuring CCG strategic and operational plans will include a specific focus on the element of the plan developed for the Fund. This will allow us to summarise, aggregate and rate all plans, against criteria agreed with government departments and the LGA, to provide an overview of Fund plans at national, regional and local level.

- This overview will be reviewed by a Departmental-led senior group comprised of DH, DCLG, HMT, NHS England and LGA officials, supported by external expertise from the NHS and local government. Where issues of serious concern are highlighted the group will consider how issues may be resolved, either through provision of additional support or escalation to Ministers.

- Where necessary, Ministers (supported by the senior group) will meet representatives from the relevant LAs and CCGs to account for why they have not been able to produce an acceptable plan and agree next steps to formulate such a plan.

- Ministers will give the final sign-off to plans and the release of performance related funds.

What will be the consequences of failure to achieve improvement?

56. Ministers have considered whether local areas which fail to achieve the levels of ambition set out in their plan should have their performance-related funding

withdrawn, to be reallocated elsewhere. However, given the scale and complexity of the challenge of developing plans for the first time, they have agreed that such a sanction will not be applied in 2015/16. Further consideration will be given to whether it should be introduced in subsequent years.

57. If a local area achieves 70% or more of the levels of ambition set out in each of the indicators in its plan, it will be allowed to use the held-back portion of the performance pool to fund its agreed contingency plan, as necessary.

58. If an area fails to deliver 70% of the levels of ambition set out in its plan, it may be required to produce a recovery plan. This will be developed with the support of a peer review process involving colleagues from NHS and local government organisations in neighbouring areas. The peer review process will be co-ordinated by NHS England, with the support of the LGA.

59. If the recovery plan is agreed by the Health and Wellbeing Board, NHS England and the local government peer reviewer, the held-back portion of the performance payment from the Fund will be made available to fund the recovery plan.

60. If a recovery plan cannot be agreed locally, and signed-off by the peer reviewers, NHS England will direct how the held-back performance related portion of the Fund should be used by the local organisations, subject to the money being used for the benefit of the health and care system in line with the aims and conditions of the Fund.

61. Ministers will have the opportunity to give the final sign-off to peer-reviewed recovery plans and to any directions given by NHS England on the use of funds in cases where it has not been possible to agree a recovery plan.

Support for BCF Planning

62. CCGs and councils can access additional support for Better Care Fund planning from the same routes as for NHS operational and strategic plans: local support via CSUs or external providers, workshops and webinars, and specific tools and resources. Links to these, and contact details can be found on NHS England and the LGA's websites.

When should plans be submitted?

63. Health and Wellbeing Boards should provide the first cut of their completed Better Care Plan template, as an integral part of the constituent CCGs' Strategic and Operational Plans by **14 February 2014**, so that we can aggregate them to provide a composite report, and identify any areas where it has proved challenging to agree plans for the Fund.

64. The revised version of the Better Care Plan should be submitted to NHS England, as an integral part of the constituent CCGs' Strategic and Operational Plans by **4 April 2014**.

Appendix D

Adult Social Care Scrutiny Commission

Date: 6th March 2014

Replacement of the Adult Social Care and Children's IT Application

Lead Director: Tracie Rees

City Mayor

Useful Information:

- Ward(s) affected: Insert Ward(s) or All
- Report author: Andrew Raynes, Programme Manager (Care Systems)
- Author contact details: 0116 4541141 Andrew.raynes@leicester.gov.uk
- Date of Exec meeting: 6th March 2014

1. Summary

1.1 The purpose of this report is to provide an update to the Adult Social Care Scrutiny Commission on the implementation of the new Liquidlogic and ControCC IT Applications, which replace the existing CareFirst IT system.

1.2 The new Liquidlogic IT Applications is a case management system and ControCC is a contracts and payments system for both Adults and Children's services.

1.3 The new applications will support over 1200 members of Social Care staff.

2. Recommendations

2.1 The Adult Social Care Scrutiny Commission is asked to note the work in progress to implement the new IT system.

3. Report

Background Information

3.1 Leicester City Council (LCC) is in the process of replacing the CareFirst IT Application, following a procurement exercise in 2013. The existing contract expires in December 2014 and work is in progress to implement the new systems by the end of April 2014.

3.2 The implementation of the new system is overseen by a Programme Board, which consist of senior officers from Adult Social Care and Children's services and progress is reported to the Council's Programme Monitoring Office.

3.3 A seven year framework contract was awarded to Liquidlogic on 1st February 2013 following a formal tendering exercise to replace CareFirst to meet the needs of Adults and Children's Social Care. The system includes a payments function called ContrOCC (from Oxford Computing Consultants), also to be implemented as part of the contract in April 2014.

Benefits

3.4 The benefits of the new Liquidlogic application will help future proof the organisation enabled through the advances of more modern intuitive technology which is both user friendly and can flex to support new initiatives and legislation, including the new Care Bill and integration agenda with Health. Benefits include:

- Safeguarding Clients and Service Users through more modern and user friendly technology enabling our social care teams to spend more of their valuable time where it's needed by reducing time spent at the computer.

- Meaningful Information through better reporting capability informing social care practice, managing resources and commissioning services.

- Improved Communication providing a more seamless service as we work more closely with other services such as Health.

Governance Arrangements

3.5 The project is being delivered by a Steering Group comprising of representation from; Adults and Children's services, Liquidlogic, ICT, Transformation, IT Application Support, and the Programme Management Team. The Steering Group reports to the Programme Board and an operational go-live team will ensure readiness for go-live.

3.6 The project so far has been delivered on time and to budget, including the successful implementation of the Electronic Rostering and Monitoring System, which supports the delivery of the Reablement Service.

3.7 There are a number of important challenges, which are being addressed:
Data migration
The Application Support Team has achieved 95% data quality through extensive work on this process work is in progress to complete the remaining 5% prior to go-live.

Financial payments
The payments system (ControCC) is still to be fully tested and some issues remain around 'fairer charging' and 'payment protection' which still require development by the supplier and LCC. Work continues with the supplier to ensure the issues are resolved prior to go-live.

Testing
The implementation of Liquidlogic includes four rounds of tests. This process enables LCC to localise the 'set-up' of the system ensuring it works as the Social Work Teams have configured the settings. Test round 4, still needs to be completed before go-live; to ensure the system and new processes work and will be reflected in the new system.

Implementation

3.8 The implementation of Liquidlogic and ContrOCC at LCC is due to be completed within the next six weeks for Children's services and eleven weeks for Adult Social Care.

3.9 Work has been in progress for a number of months to communicate the changes and benefits of the new system via a Communications and Information Plan, which includes demonstrations and presentations of the new Applications. A comprehensive Training Plan has also been developed to ensure that staff are trained to use the new system. This will be supported by floor walkers, suitable training material at both go live and post live and a help desk. Staff have also been involved in developing the functionality for the new Applications to ensure they have ownership of the systems that will deliver an improved case management system.

Future enhancements

3.10 With changes associated with the Care Bill, Capital bids have been made to enhance the Liquidlogic system further, such as a client portal for Adults Social Care and eCAF for early intervention (Children's) including support from the project team and supplier.

4. Financial Implications (Rohit Rughani)

4.1 The total project cost is approx. £2.8m of which £2.7m is secured and £0.1m is a bid to the Better Care Fund. This latter money would be used to improve joint working between Social Care and the NHS through better systems integration.

4.2 The table below shows the funding contributions of Adult Social Care, Children's Department and Corporate ICT. The capital funding is one-off and the revenue funding is ongoing.

Fig 1. Summary of CareFirst replacement funding contributions.

Capital Money		
1	Children's contributions	£650,000
2	Adults contributions	£650,000
3	eRMS (Adults)	£100,000
4	NHS/ASC Systems Integration	£100,000 – *to be confirmed*
5	Additional funds from Children	£238,330
6	Additional funds from Adults	£238,330
Revenue (recurring)		
7	Maintenance and Support (ICT)	£831,789

Total	**£2,808,449**

4.3 Further Capital bids have been submitted in 2014/15. If successful, these will support further developments to the system including a client portal for Adults, and various other enhancements such as eCAF for early intervention (Children's) including support from the project team and supplier. The bids total £1.27 million in 2014-15.

5 Legal Implications

5.1 Awaiting legal comments, although the procurement of the new systems was overseen by Legal Services.

Appendix E

Report to the Adult Social Care Scrutiny Commission

Date: 6th March 2014

Elderly Persons Homes Update

Lead Director: Tracie Rees

Useful Information:

- Ward(s) affected: New Parks, Western Park, Latimer, Eyres Monsell
- Author: Tracie Rees
- Author contact details Ext 2301

1. Summary

1.1 This report provides an indicative timetable for the actions needed to support existing residents living in the Council's Elderly Persons Homes that are due to be closed. See Appendix 1.

1.2 Appendix 2 provides an anonymised summary of the progress of individual residents to move to alternative accommodation, where the homes are to be closed in phase I (Herrick Lodge, Elizabeth House and Nuffield House). The provision of this information has been agreed by the Council's Information Governance service.

1.3 The information details progress against the 7 steps in the "My Moving Plan" process. 22 of the 33 residents are currently on Steps 4 or 5 of the process and their assessments have now been completed. 1 resident who has already moved and 1 is still at step 1 of the process the remaining 9 residents are at Stage 3 awaiting the completion of their assessments.

1.4 Of the 22 residents who have had a reassessment, 17 residents are currently in the process of identifying a home that they would like to move into (Step 4). 5 residents are in the planning stage of moving (Step 5) which means that a vacancy has been identified that meets their needs and they will be moving shortly.

Appendix 1

PHASE 1 REPROVISION PROGRESS – Report to ASC Scrutiny

DATE: 6th March 2014 (Data as at 24th February 2014)

Key:

Step 1	Deciding who needs to be involved in your moving plan
Step 2	Meeting to look at what is most important to you in a new home
Step 3	Your social worker carries out a new assessment of your needs
Step 4	Meeting to review your moving plan and agree what will happen next
Step 5	Planning your move
Step 6	The day you move
Step 7	After you move

RESIDENT NO	STATUS	STEP ON MOVING PLAN	NOTES AND TARGET MOVING DATE
1	Resident	**Step 3**	Assessment underway.
2	Resident	**N/A**	Deceased
3	Resident	**Step 5**	Assessment complete. Home of choice can meet needs and has vacancy.
4	Resident	**Step 3**	Need for nursing care confirmed Assessment currently being finalised.
5	Resident	**Step 4**	Assessment complete have identified a home they would like.
6	Resident	**Step 4**	Assessment complete. Needs nursing care.
7	Resident	**Step 7**	Resident has moved. Asked to be moved quickly and has moved to home of choice. Supported by LCC staff to visit prior to move. LCC staff still involved.
8	Resident	**Step 3**	Assessment still underway. Information from GP needed to finalise. Once complete family and social worker to look at homes together.
9	Resident	**Step 4**	Assessment complete family has seen a home they feel the

			resident might like, and a visit has been arranged.
10	Resident	**Step 4**	Assessment complete. In the process of visiting preferred home.
11	Resident	**Step 4**	Assessment complete. In the process of considering which homes to visit.
12	Resident	**Step 1**	Awaiting involvement from relative
13	Resident	**Step 4**	Assessment complete. In the process of considering which homes to visit.
14	Resident	**Step 4**	Assessment complete. In the process of considering which homes to visit.
15	Resident	**Step 3**	Assessment underway
16	Resident	**Step 4**	Assessment complete. In the process of consider
17	Resident	**Step 4**	Assessment considering which homes to visit.
18	Deceased	**n/a**	Deceased
19	Resident	**Step 4**	Assessment complete. Needs nursing care.
20	Resident	**Step 5**	Assessment complete. Home of choice can meet needs and has vacancy.
21	Resident	**Step 3**	Assessment underway awaiting input from health. Likely nursing needs.
22	Resident	**Step 3**	Assessment underway.
23	Resident	**Step 4**	Assessment completed .Needs nursing care.
24	Resident	**Step 4**	Assessment completed. Needs nursing care.
25	Resident	**Step 4**	Assessment underway awaiting confirmation that home of choice can meet needs.
26	Resident	**Step 5**	Assessment completed. Home of choice meets needs and has vacancy.
27	Resident	**Step 5**	Assessment completed. Home of choice meets needs and has vacancy.
28	Resident	**Step 4**	Assessment complete. Resident undertaking visits to home of choice.
29	Resident	**Step 4**	Assessment complete. Awaiting confirmation that home of choice

			can meet needs.
30	Resident	**Step 4**	Assessment completed awaiting further input from health.
31	Resident	**Step 3**	Assessment being finalised
32	Resident	**Step 3**	Assessment underway.
33	Resident	**Step 3**	Assessment underway
34	Resident	**Step 4**	Assessment complete. Resident looking at two homes they might like to move to.
35	Resident	**Step 5**	Assessment completed. Home of choice meets needs and has vacancy.

ADULT SOCIAL CARE SCRUTINY COMMISSION
DRAFT WORK PROGRAMME 2013/14

Work from 2012/13

Meeting	Meeting Items	Standing Items	Scrutiny Review	Key Actions Agreed
10th Jan	- ASC 2013/14 Budget	- Elderly Persons Homes		ASC 2013/14 Budget Officers asked to note comments of the commission and that they are kept informed of changes introduced as minuted, particularly proposals to integrate community services in residential packages.
Special Mtg 16th Jan			- Domiciliary Care	Domiciliary Care The Scoping document was agreed with minor amendments.
13th Feb	- Protecting Elderly People from Rogue Traders	- Elderly Persons Homes	- Domiciliary Care - Alternative Care for Elderly People	Protecting Elderly People from Rogue Traders It was agreed for information on what the current processes and actions are around financial abuse to come to the next meeting with the commission considering how it might be able to input into an awareness raising campaign.
7th Mar	- Healthwatch Leicester and ICAS - Protecting Elderly People from Rogue Traders	- Elderly Persons Homes	- Domiciliary Care - Alternative Care for Elderly People	Healthwatch and ICAS Members of the commission asked that a further report on the ICAS be given at a future meeting.
4th Apr	- Day Care for People with Mental Health Problems	- Elderly Persons Homes	- Domiciliary Care - Alternative Care for Elderly People	Elderly Persons Homes Cllr Patel mentioned that a letter to inform of the findings of her review into EPH will be circulated within the next week and a report will come to the next meeting of the commission. Day care for people with mental health problems It was agreed that findings of the consultation process would come back to a future meeting.
2nd May		- Elderly Persons Homes	- Domiciliary Care - Alternative Care for Elderly People	Elderly Persons Homes Agreed for consultation findings to come back to the commission before a decision is made.

Appendix F

ADULT SOCIAL CARE SCRUTINY COMMISSION
DRAFT WORK PROGRAMME 2013/14

2013/14 Work Programme

Meeting	Meeting Items	Review/Report	Actions Agreed
Thurs 13th June 2013 at 5.30pm	- Adult Social Care Portfolio Overview	- Presentation	
	- Elderly Persons Homes	- Review Item Report	Agreed to hold a special meeting and cover in the scheduled July meeting to gather evidence. Also agreed to circulate the report completed by scrutiny previously.
	- Corporate Procurement Plan 2013/14	- Report	
	- City Mayor's Delivery Plan	- Report	Comments were submitted to officers. Asked for a further update in 3/6 months' time.
	- Access for All Work Programme	- Report	
	- Work Programme	- Report	A number of future items were discussed and were to be added to the work programme.
Special Mtg – Mon 1st July 2013 at 5.30pm	- Elderly Persons Homes	- Review Item Report	Extra information requested with regards to the proposals. Members of the public will be allowed to give representation at the next meeting.
Thurs 11th July at 5.30pm	- Elderly Persons Homes	- Review Item Report	Further information still required but a report to be drafted up pending this information.
Thurs 5th Sept 2013 at 5.30pm	- Elderly Persons Homes	- Review Item Report	Agreed that a final report with the commission's comments be completed and sent to the Executive.
	- Older Persons Mental Health Day Care Services	- Report	The commission voted in favour of the option to close the day service of older people with mental health problems and move the existing users to alternative provision.
	- Enablement Pilot and the Community Inclusion Team	- Presentation	The commission to receive a further update at the next meeting.

ADULT SOCIAL CARE SCRUTINY COMMISSION
DRAFT WORK PROGRAMME 2013/14

Meeting	Meeting Items	Review/Report	Actions Agreed
Thurs 10th Oct 2013 at 5.30pm	- Community Inclusion Team	- Report	
	- Douglas Bader Day Centre	- Report	Trade unions will be invited to give representation at the next meeting. The results of the consultation to come back to the January meeting of the commission.
	- Current Consultations	- Verbal Update	The series of consultations announced to be added to the work programme
	- Personal Budgets and Direct Payments	- Presentation	A report that evaluates the effectiveness of the indicative personal budgets be brought back to the commission in 6 months' time.
	- Elderly Persons Homes	- Verbal Update	The final review report was ratified. The direction of travel and timescales to brought back to the next meeting. The commission asked to be kept informed about progress of proposals to set up a commission for vulnerable people.
	- Winter Care Plan	- Scoping Document	The scoping document was agreed.
Thurs 7th Nov 2013 at 5.30pm	- ASC Local Account	- Report	Feedback was given to the draft ASC Local Account.
	- Douglas Bader Day Centre	- Verbal	Representation was received from Unison union and their views were endorsed by the commission.
	- Elderly Persons Homes	- Verbal	The commission requested anonymised updates on the position of each resident at each stage of the process of moving them from their current EPH to their new one.
	- Domiciliary Care Review	- Review Item	Further information was requested for the next meeting.

ADULT SOCIAL CARE SCRUTINY COMMISSION
DRAFT WORK PROGRAMME 2013/14

Meeting	Meeting Items	Review/Report	Actions Agreed
Thurs 5th Dec 2013 at 6.00pm	- Mental Health Care (Dementia)	- Report	It was agreed to consider all the information provided and follow up at the next meeting.
	- Mobile Meals Service	- Report	The commission agreed that the Executive be recommended to consider the way that consultations are carried out in view of the Commission's concerns about this consultation. Also recommended the Executive adopt option 2, (expand the in-house service).
	- Housing Related Support Services	- Verbal	Representations were received from residents and staff at John Woolman House and Vernon House and also from Castle Ward Councillors.
	- Domiciliary Care Review	- Review Item	The commission agreed to look at communicating the review to carers and family members in order for them to give representation. Further information was requested for the next meeting.
	- Elderly Persons Homes	- Report	
Thurs 9th Jan 2014 at 5.30pm	- Elderly Persons Homes	- Report	The commission requested for a paper on the Intermediate Care facility be brought to the commission when available.
	- Mobile Meals Service	- Verbal	
	- Alternative Care for Elderly People	- Review Report	The final review report was agreed and the Executive were asked to consider the recommendations in the report.
	- Dementia Care for Elderly People	- Report	It was agreed to consider having a joint meeting with the Health scrutiny commission to consider an initial report or presentation on this area of work.
	- Domiciliary Care	- Review Item	Further information was requested.

ADULT SOCIAL CARE SCRUTINY COMMISSION
DRAFT WORK PROGRAMME 2013/14

Meeting	Meeting Items	Review/Report	Actions Agreed
Wed 12th Feb 2014 at 5.30pm	- Housing Related Support Services	- Report	The commission welcomed changes made to the proposals following previous scrutiny meetings. However the commission still felt that 15 hours of core support will not be sufficient to enable effective care to be given so requested that discussions are had with providers and Council officers as to what the correct level of support should be, and the appropriate mix of core and floating support that this should include. The commission also requested the service review housing alarm services being used across the city to see if more equitable costs can be achieved, this to include discussions with Leicestershire County Council to see if joint provision of one or more alarm systems will be advantageous. Pending the outcome of this the commission requested funding for alarm only provision is retained at its current level, this funding to be available to current and future users. The commission requested that all of this returns to the commission before a decision by the Executive is made.
	- Douglas Bader Day Centre	- Report	The Commission supported Option 2 for closure of the service and the provision of support to service users to source alternative provision. The commission requested regular general updates on how current users of the centre adapt to alternative services.
	- Elderly Persons Homes	- Report	
	- General Fund Budget 2014/15 to 2015/16	- Report	The commission wanted their concern acknowledged at OSC that the Adult Social Care budget is facing large cuts, despite the services within this portfolio working with some of the city's most vulnerable people.

ADULT SOCIAL CARE SCRUTINY COMMISSION
DRAFT WORK PROGRAMME 2013/14

Meeting	Meeting Items	Points to be considered	Review Items	
Agenda Meeting – Wednesday 19th February 2014 at 4.30pm				
Thurs 6th Mar 2014 at 5.30pm	- Enforcement of Blue Badge Scheme	• What is the current system? • How is it administered?	- Elderly Persons Homes	• Progress on individual residents
	- Better Care Fund	• Information on the transfer of funds from Dept. of Health to the Council • What does it involve? • How much will it be? • Draft plan submitted to Dept. of Health	- Domiciliary Care	• Update from Chair on visits to providers
	- Transformation programme and I.T systems	• What is the system and why do we have it and what's changing? • What money is being spent on it? • What is the provision of the new system? • Any identified problems and how they will be resolved?		
Special Meeting – Wed 19th March at 5.30pm	- Dementia Care for Elderly People	• What is dementia and what causes it? • Dementia services and related costs? • Summary of the local strategy • Specific issues facing older people		
Agenda Meeting – Wednesday 19th March 2014 at 4.30pm				
Thurs 3rd Apr 2014 at 5.30pm	- VCS Preventative Services	• Update on the findings of the consultation	- Elderly Persons Homes	• Progress on individual residents
	- Update on Personal Budgets	• Update report to evaluate the effectiveness of the indicative personal budgets	- Domiciliary Care Review	
	- Older Person's Commission	• Update on progress		
Thurs 1st May 2014 at 5.30pm	- Intermediate Care Facility	• Options for developing the facility	- Domiciliary Care	• Final Review Report
	-	•		
	-	•		

ADULT SOCIAL CARE SCRUTINY COMMISSION
DRAFT WORK PROGRAMME 2013/14

Future Items	Items to be considered
Internal Day Care for People with a Learning Disability Review (Later in 2014)	• An update of services • What is being changed and what will the review involve?