Date: MONDAY, 6 JUNE 2016

Time: 10:00 am

Location: MEETING ROOM G.01, GROUND FLOOR, CITY HALL, 115 CHARLES STREET, LEICESTER, LE1 1FZ

HEALTH AND WELLBEING BOARD

Councillors:

Councillor Rory Palmer, Deputy City Mayor (Chair)

Councillor Adam Clarke, Assistant City Mayor

Councillor Abdul Osman, Assistant City Mayor

Councillor Sarah Russell, Assistant City Mayor

City Council Officers:

Frances Craven, Strategic Director Children's Services

Andy Keeling, Chief Operating Officer

Ruth Tennant, Director Public Health

Steven Forbes, Strategic Director of Adult Social Care

NHS Representatives:

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

Sue Lock, Managing Director, Leicester City Clinical Commissioning Group

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

Trish Thompson, Locality Director Central NHS England – Midlands & East (Central England)

Healthwatch / Other Representatives:

Karen Chouhan, Healthwatch Leicester

Chief Superintendent, Sally Healy, Head of Local Policing Directorate, Leicestershire Police

Professor Martin Tobin, Professor of Genetic Epidemiology and Public Health and MRC Senior Clinical Fellow, University of Leicester.

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

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

G. J. Carey

For Monitoring Officer

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

Information for members of the public

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

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

Further information

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

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

PUBLIC SESSION

AGENDA

NOTE:

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

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

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

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

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If the emergency alarm sounds, you must evacuate the building immediately by the nearest available fire exit and proceed to area outside the Ramada Encore Hotel on Charles Street as directed by Democratic Services staff. Further instructions will then be given.

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

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

3. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair to invite questions from members of the public.

4. MEMBERSHIP OF THE BOARD

To note the membership of the Board for 2016/17 approved by the Council on 19 May 2016:-

City Councillors
Councillor Rory Palmer - Deputy City Mayor – Chair
Councillor Adam Clarke – Assistant City Mayor – Energy and Sustainability
Councillor Abdul Osman – Assistant City Mayor - Public Health
Councillor Sarah Russell – Assistant City Mayor – Children, Young People and Schools

NHS Representatives

Professor Azhar Farooqi – Co-Chair of the Leicester City Clinical Commissioning Group
Sue Lock, Managing Director - Leicester City Clinical Commissioning Group
Trish Thompson - Director of Operations and Delivery, Leicestershire and Lincolnshire NHS England
Dr Avi Prasad - Co-Chair of the Leicester City Clinical Commissioning Group

City Council Officers

Andy Keeling - Chief Operating Officer
Frances Craven - Strategic Director – Children's Services
Stephen Forbes - Strategic Director - Adult Social Care.
Ruth Tennant - Director of Public Health

Local Healthwatch and Other Representatives

Karen Chouhan - Chair, Healthwatch Leicester
Chief Supt Sally Healy - Head of Local Policing Directorate
Professor Martin Tobin - Professor of Genetic Epidemiology and Public Health

5. TERMS OF REFERENCE

Appendix A
Page 1

To note the Board's Terms of Reference approved by the Council on 19 May 2016.

6. MINUTES OF THE PREVIOUS MEETING

Appendix B
Page 7

The Minutes of the previous meeting of the Board held on 2 February 2016 are attached and the Board is asked to confirm them as a correct record.

7. BETTER CARE TOGETHER

Appendix C
Page 19

To receive a report from the Programme Director Better Care Together (BCT) that provides an update on the progress of the BCT health and social care change programme for Leicestershire, Leicester and Rutland.

A copy of a presentation from the Programme Director Better Care Together giving an overview of the programme is also attached at Appendix C1. **(Page 21)**

8. SUSTAINABILITY AND TRANSFORMATION PLAN

Appendix D
Page 31

To receive a report from Sarah Prema, Director Strategy and Implementation, Leicester City Clinical Commissioning Group providing information on the development of the Sustainability and Transformation Plan (STP) for Leicester, Leicestershire and Rutland.

A presentation on the Sustainability and Transformation Plan Checkpoint Submission is also attached at Appendix D1. **(Page 33)**

9. BETTER CARE FUND

Appendix E
Page 41

To receive a report from the Managing Director, Leicester City CCG on the Leicester City Better Care Fund 2016/17.

10. PREVENTION

The Board to begin discussions on developing a new approach to prevention for Leicester's health and care system.

11. DATES OF FUTURE MEETINGS

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

Monday 1st August 2016– 2.00pm
Monday 10th October 2016 – 3.00pm
Thursday 15th December 2016 – 5.00pm
Monday 6th February 2017 – 3.00pm
Monday 3rd April 2017 – 2.00pm

Meetings of the Board are scheduled to be held in Meeting Room G01 at City Hall unless stated otherwise on the agenda for the meeting.

Appendix A

Leicester City Health and Wellbeing Board

Terms of Reference

(As amended at the Leicester City Council meeting on 18 June 2015)

Introduction

In line with the Health and Social Care Act 2012, the Health & Wellbeing Board is established as a Committee of Leicester City Council.

The Health & Wellbeing Board has operated in shadow form since August 2011. In April 2013, the Board became a formally constituted Committee of the Council with statutory functions.

1 Aim

To achieve better health, wellbeing and social care outcomes for Leicester City's population and a better quality of care for patients and other people using health and social services.

2 Objectives

2.1 To provide strong local leadership for the improvement of the health and wellbeing of Leicester's population and in work to reduce health inequalities.

2.2 To lead on improving the strategic coordination of commissioning across NHS, adult social care, children's services and public health services.

2.3 To maximise opportunities for joint working and integration of services using existing opportunities and processes and prevent duplication or omission.

2.4 To provide a key forum for public accountability of NHS, public health, social care for adults and children and other commissioned services that the Health &Wellbeing Board agrees are directly related to health and wellbeing.

3 Responsibilities

3.1 Working jointly, to identify current and future health and wellbeing needs across Leicester City through revising the Joint Strategic Needs Assessment (JSNA) as and when required. Preparing the JSNA is a statutory duty of Leicester City Council and Leicester City Clinical Commissioning Group.

3.2 Develop and agree the priorities for improving the health and wellbeing of the people of Leicester and tackling health inequalities.

3.3 Prepare and publish a Joint Health and Wellbeing Strategy (JHWS) that is evidence based through the work of the Joint Strategic Needs Assessment (JSNA) and supported by all stakeholders. This will set out strategic objectives, ambitions for achievement and how we will be jointly held to account for delivery. Preparing the JHWS is a statutory duty of Leicester City Council and Leicester City Clinical Commissioning Group.

3.4 Save in relation to agreeing the JSNA, JHWS and any other function delegated to it from time to time, the Board will discharge its responsibilities by means of recommendation to the relevant partner organisations, who will act in accordance with their respective powers and duties

3.5 Ensure that all commissioners of services relevant to health and wellbeing take appropriate account of the findings of the Joint Strategic Needs Assessment and demonstrate strategic alignment between the JHWS and each organisation's commissioning plans.

3.6 Ensure that all commissioners of services relevant to health and wellbeing demonstrate how the JHWS has been implemented in their commissioning decisions.

3.7 To monitor, evaluate and annually report on the Leicester City Clinical Commissioning Group performance as part of the Clinical Commissioning Groups annual assessment by the national Commissioning Board.

3.8 Review performance against key outcome indicators and be collectively accountable for outcomes and targets specific to performance frameworks within the NHS, Local Authority and Public Health.

3.9 Ensure that the work of the Board is aligned with policy developments both locally and nationally.

3.10 Provide an annual report from the Health and Wellbeing Board to the Leicester City Council Executive and to the Board of Leicester City Clinical Commissioning Group to ensure that the Board is publically accountable for delivery.

3.11 Oversee progress against the Health and Wellbeing Strategy and other supporting plans and ensure action is taken to improve outcomes

3.12 The Board will not exercise scrutiny duties around health and adult social care directly. This will remain the role of the relevant Scrutiny Commissions of Leicester City Council. Decisions taken and work progressed by the Health & Wellbeing Board will be subject to scrutiny by relevant Scrutiny Commissions of Leicester City Council.

3.13 The Board will need to be satisfied that all commissioning plans demonstrate compliance with the Equality Act 2010, improving health and social care

services for groups within the population with protected characteristics and reducing health inequalities.

3.14 The Board will agree Better Care Fund submissions and have strategic oversight of the delivery of agreed programmes.

4 Membership

Members:

Up to four Elected Members of Leicester City Council (4)

- The Executive Lead Member for Health & Wellbeing (1)
- An Elected Member nominated by the City Mayor (1)
- An Elected Member nominated by the City Mayor (1)
- An Elected Member nominated by the City Mayor (1)

Up to four representatives of the NHS (4)

- The Co -Chair of the Leicester City Clinical Commissioning Group (1)
- A further GP representative of the Leicester City Clinical Commissioning Group (1)
- The Managing Director of the Leicester City Clinical Commissioning Group (1)
- The Director of the Leicestershire and Lincolnshire Area Team, NHS England (1)

Up to four Officers of Leicester City Council (4)

- The Strategic Director of Adult Social Care (Leicester City Council) (1)
- The Strategic Director Children (Leicester City Council) (1)
- The Director of Public Health (Leicester City Council) (1)
- The Chief Operating Officer of Leicester City Council (1)

Up to four further representatives including Healthwatch Leicester/Other Representatives (4)

- One representative of the Local Healthwatch organisation for Leicester City (1)
- Leicester City Basic Command Unit Commander, Leicestershire Police (1)
- Two other people that the local authority thinks appropriate, after consultation with the Health and Wellbeing Board (2)

5 Quorum & Chair

5.1 For a meeting to take place there must be at least six members of the Board present and at least one representative from each of the membership sections:

- Leicester City Council (Elected member)
- Leicester City Clinical Commissioning Group or NHS England

- One senior officer member from Leicester City Council
- Local Healthwatch/Other Representatives

5.2 Where a meeting is inquorate those members in attendance may meet informally but any decisions shall require appropriate ratification at the next quorate meeting of the Board.

5.3 Where any member of the Board proposes to send a substitute to a meeting, that substitute's name shall be properly nominated by the relevant 'parent' person/body, and submitted to the Chair in advance of the meeting. The substitute shall abide by the Code of Conduct.

5.4 The City Council has nominated the Executive Lead for Health & Wellbeing to Chair the Board. Where the Executive Lead for Health & Wellbeing is unable to chair the meeting, then one of the other Elected Members shall chair (noting that at least one other Elected Member must be present in order for the meeting to be declared quorate)

6 Voting

6.1 Officer members of Leicester City Council shall not have a vote. All other members will have an equal vote

6.2 Decision-making will be achieved through consensus reached amongst those members present. Where a vote is require decisions will be reached through a majority vote of voting members; where the outcome of a vote is impasse the chair will have the casting vote.

7 Code of conduct and member responsibilities

All voting members are required to comply with Leicester City Council's Code of Conduct, including submitting a Register of Interests.

In addition all members of the Board will commit to the following roles, responsibilities and expectations:

7.1 Commit to attending the majority of meetings

7.2 Uphold and support Board decisions and be prepared to follow though actions and decisions obtaining the necessary financial approval from their organisation for the Board proposals and declaring any conflict of interest

7.3 Be prepared to represent the Board at stakeholder events and support the agreed consensus view of the Board when speaking on behalf of the Board to other parties. Champion the work of the Board in their wider networks and in community engagement activities.

7.4 To participate in Board discussion to reflect views of their partner organisations, being sufficiently briefed to be able to make recommendations about future policy developments and service delivery

7.5 To ensure that are communication mechanisms in place within the partner organisations to enable information about the priorities and recommendation of the Board to be effectively disseminated

8 Agenda and Meetings

8.1 Administration support will be provided by Leicester City Council.

8.2 There will be standing items on each agenda to include:

- Declarations of Interest
- Minutes of the Previous Meeting
- Matters Arising
- Updates from each of the working subgroups of the Health & Wellbeing Board.

8.3 Meetings will be held six times a year and the Board will meet in public and comply with the Access to Information procedures as outlined in Part 4b of the Council's Constitution

8.4 The first meeting of the Health and Wellbeing Board was on 11 April 2013

Version 9.2
As amended at Council on 18 June 2015

Appendix B

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: TUESDAY, 2 FEBRUARY 2016 at 2.00pm

Present:

Councillor Rory Palmer (Chair)	–	Deputy City Mayor, Leicester City Council.
Karen Chouhan	–	Chair, Healthwatch Leicester.
Councillor Adam Clarke	–	Assistant City Mayor, Public Health, Leicester City Council.
Frances Craven		Strategic Director, Children's Services, Leicester City Council.
Professor Azhar Farooqi	–	Co-Chair, Leicester City Clinical Commissioning Group.
Steven Forbes	–	Strategic Director of Adult Social Care, Leicester City Council.
Wendy Hoult	–	BCF Implementation Manager, NHS England – Midlands and East (Central Midlands).
Sue Lock	–	Managing Director Leicester City Clinical Commissioning Group.
Supt Mark Newcombe	–	Local Policing Directorate, Leicestershire Police.
Councillor Abdul Osman	–	Assistant City Mayor, Public Health, Leicester City Council.
Ruth Tennant	–	Director of Public Health, Leicester City Council.
Professor Martin Tobin	–	Professor of Genetic Epidemiology and Public Health and MRC Senior Clinical Fellow, University of Leicester.

In attendance

Graham Carey	–	Democratic Services, Leicester City Council.

Sue Cavill – Head of Customer Communications and Engagement NHS Arden and Greater East Midlands Commissioning Support Unit.

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26. APOLOGIES FOR ABSENCE

Apologies for absence were received from Chief Supt Sally Healy (Head of Local Policing Directorate, Leicestershire Police), Andy Keeling, Chief Operating Officer, Leicester City Council, Dr Avi Prasad (Co-Chair, Leicester City Clinical Commissioning Group), Councillor Sarah Russell (Assistant City Mayor), Trish Thompson, Locality Director Central NHS England – Midlands & East (Central Midlands).

27. DECLARATIONS OF INTEREST

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

28. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

That the Minutes of the previous meeting of the Board held on 27 October 2015 be confirmed as a correct record subject to Councillor Adam Clarke, Assistant City Mayor being added to the list of those present.

29. QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions submitted by members of the public.

30. UNIVERSITY HOSPITALS LEICESTER NHS TRUST - STRATEGIC PRIORITIES

Kate Shields, Director of Strategy, University Hospitals of Leicester NHS Trust (UHL) gave a presentation on the Trust's strategic priorities and current challenges. A copy of the presentation had been previously circulated with the agenda for the meeting.

During the presentation the following comments were noted in relation to the Trust's plans for the future and the challenges being faced in the current economic climate:-

a) UHL was the last large acute NHS Trust operating from 3 sites which needed to be addressed as part of the Trusts' 5 Year Operational Plan, the vision for which was set out in the presentation.

b) The Trust was a local, regional and national provider of health care

services and a third of the Trust's income came from providing tertiary specialist services. The Trust was working hard to ensure that hospitals referring patients to the LRI were fully supported so that the Trust could concentrate on providing the specialist tertiary services.

c) The Trust had made positive changes in a short time to change 'behavioural issues' in both staff and patients to drive forward the changes required. The Trust's beliefs and values fully underpinned the work to support behavioural change.

d) The Trust's Quality Commitment was refreshed each year. Currently the strategic aims were to reduce preventable mortality, to reduce the risk of error and adverse incidents and to improve patients' and their carers' experience of care.

e) The Life Study funding had recently been withdrawn.

f) The Estates Reconfiguration Plan would look to reduce inefficiencies of the use of sites over the next 5 years. The Trust were committing £320m of investment over the next 5 years to provide the Emergency Floor and reconfigure the estate to allow vascular services to move from the LRI to the Glenfield site, and to provide a better co-ordinated approach to general surgery to reduce the number of planned operations being cancelled due to emergency operations. Also, the Children's Hospital must be established at the LRI site by 2020 if the Trust was to retain children's congenital heart surgery.

g) The Trust had received £10m capital funding for the Emergency Floor this year which was to be welcomed. However there were increasing pressures on the capital funding nationally as it had been cut by 25% to fund revenue deficits in the NHS.

h) The Trust's current budget deficit was reducing and the Trust was confident that it would reduce in future years in accordance with the Trust's financial plan. The Trust still spent too much on agency and locum staff and efforts were being directed to making 'bank nursing' more attractive to staff in order to reduce the reliance on more expensive agency staff. The Electric Patient Record, when fully introduced, could be the biggest change to improving efficiencies within the hospital; as it would allow the full patient history to be available from primary care records and would enable faster decision making, better care and avoid duplication of recording patients' details.

Following questions from Members the responses below were noted:-

a) Work was progressing with improving integrated care. Better Care Together was helping to improve integration. Glenfield Hospital was working with GPs and Public Health Consultants to see how better access could be provided to the Clinical Decisions Unit. This was similar to the work at the LRI for single streamlining into UHL.

b) The Better Care Programme was also providing an opportunity to improve the long term conditions of patients and the Trust were looking to see how respiratory and cardiology consultants could provide treatment to patients in community hospital and neighbourhood hub settings. Although there had been considerable discussions in relation to working together, further work was still needed to achieve full integration or working practices.

c) Dealing with the frail and elderly remained one of the major challenges. Space could still be used better at the LRI site and if more beds were provided they would face more pressure from the frail and elderly than surgical cases.

d) It was not always necessary to increase facilities to manage larger demands. Medical staff were keen to change service delivery and moving to 23 hour hospital stays was an effective way of increasing patients numbers for a number of minor surgical interventions using the same number of beds.

e) Using the Intermediate Care System beds provided by LPT to the maximum effect would be crucial to future service delivery, particularly under Better Care Together.

f) Although the results of staff satisfaction and patients recommending others to use the hospitals was disappointing, particularly at the LRI site, a great deal of work was being undertaken by the recently appointed Director of Human Resources to change staff perceptions and promote positive achievements such as the moving the cardio-vascular service to Glenfield, building the new emergency floor and creating the children's hospital.

g) The Trust was the 9th largest teaching hospital in the country but struggled to retain students after qualification. Students were being actively involved in shaping future services and business cases for making change. The Trust recognised that part of the solution was having an offer for students that involved LLR and not just UHL.

h) UHL were working to deliver eye casualty services in a more dynamic modern hospital setting, as it was currently considered to be outdated in its current form.

i) UHL were having discussions with NHS England in relation to orthodontic services, which had been poorly commissioned and funded nationally for many years. The Trust had the largest number of ophthalmic outpatients in the country but not the largest local population.

j) The 25% reduction in the national capital programme was of concern but it was considered that the Trust would still receive support for reducing the number of sites from 3 to 2 and the Trust had regularly briefed the

Minister on current issues and priorities. However, if capital funding was prioritised, the Women's Hospital and the Ambulatory Care Hub would be delayed as there were other projects with greater priority involving higher clinical safety issues.

The Chair thanked Director of Strategy for her presentation. He felt that both the UHL and LPT had clarity in their planning with specific deliverables and milestones and for delivery. He was less confident that this was currently in place for the BCT planning; the delivery of which was crucial to all those in the local health and social care economy.

Finally the Chair wished the Director of Strategy best future wishes in her new employment.

31. BETTER CARE FUND

The Board received a report on the Better Care Fund (BCF) from Sue Lock, Managing Director, Leicester City Clinical Commissioning Group.

The Board were requested to approve the draft BCF 2016/17 template for submission on February 8th 2016 and to delegate approval of draft narrative plans to the Chair of the JICB and the Strategic Director for Adult Social Care also for submission on February 8th 2016.

It was noted that the format of the template was not an ideal way of presenting the information but it was a prescribed national format. The template required approval each year as it was a joint plan. The submission was in two parts, one is the template currently being considered and the second part is a narrative plan which sets out how the joint partners will achieve the trajectories. This could not been completed until national guidance had been received.

Part 1 of the template showed Better Care Fund expenditure of approximately £22m and represented, at service line level, what the CCG and the Council believed would be the most effective way to integrate services aimed at preventing emergency admissions. This was based upon the successes of the previous year with an element of expansion in some of those.

There was a high level classification of whether elements were Integrated Care Teams, Support for Carers or Reablement Services etc. with expected expenditure against each one. There was approximately £190k of recurrent expenditure that would be re-prioritised through the year. In addition there was a £1m none recurrent carry forward and proposals had been invited for this.

In response to a question on the £1.9m expenditure on the Performance Fund, it was noted that this was an amount of the fund that was payable based upon the performance to reduce none elective emergency admissions. It was a retrospective payment at the year end. If the performance did not achieve the intended reductions, the payment went to the acute trust. If the performance was achieved and the reduced admissions targets were achieved; then the payment was paid into the Better Care Fund in the following year.

It was noted that in putting forward the current proposals, horizon scanning had been carried out to evaluate what had been carried out elsewhere in the country. Experience of local and national events showed evidence that local practice was effective and robust and this had been mirrored in feedback at national level. Furthermore, the City's BCF had been cited as an example of good practice to other bodies including a presentation at the House of Lords.

The Director of Public Health commented that the risk stratification work undertaken for the BCF had potential to be used to great effect outside of the BCF context to consider the benefits that could be achieved through limited resources in preventative initiatives.

The East Midlands Better Care Fund Implementation Manager, NHS England, commented that the City's BCF was considerably further advanced with its financial information than other Health and Wellbeing Board areas covered by her post. It had been confirmed that the narrative plan would only be considered at a regional level rather than national level as in previous years. There was no prescribed template for the plan and it would focus on looking at what had worked well in the previous year, what hadn't and what had steps had been taken as a result. It was noted that the lack of national guidance had impacted upon the timetable in relation for the requirement to produce the narrative plan. However, no changes were expected to the current guidance except for changes in relation to the delayed transfer of care and non-elective admissions. The provision of the Performance Fund in the current draft BCF was commended as recognising these as issues.

The BCF Implementation Manager also stated that she could share a dashboard indicator of the 10 Health and Wellbeing Board areas within her remit which confirmed that the City was currently performing the best.

The Chair welcomed the offer of sharing the dashboard indicators with the Board. He felt that whilst the current draft had been commended for its planning, it was important to avoid being complacent in view of the fragility of future spending and budget allocations especially in relation to forthcoming spending reviews.

RESOLVED:

1) That the draft BCF 2016/17 template for submission on February 8th 2016 be approved and that approval of draft narrative plans also for submission on February 8th 2016 be delegated to the Chair of the JICB and the Strategic Director for Adult Social Care.

2) That NHS England and the Department of Health be made aware of the Board's views that:-

    a) the current presentation of information in the template was not helpful to people who had an

interest in the topic but did not have a heath background.

b) a number of schemes and interventions related to more than one scheme type and the true picture was distorted because of the inflexibility of having to badge each scheme and intervention against only one scheme type.

32. NHS PLANNING GUIDANCE - IMPLICATIONS FOR LEICESTER

The Board received and noted the NHS publication 'Delivering the Forward View: NHS planning guidance 2016/17 – 20120/21 that would have implications for the work of the Board. Sue Lock, Managing Director, Leicester City Clinical Commissioning Group introduced the key elements of the guidance.

The guidance supported the Government's NHS Spending Review in England in implementing the 5 year forward view, addressing financial sustainability and increasing the quality of service delivery.

The planning guidance required the production of a local one year Operational Plan to identify what would be done to meet the statutory guidance targets and constitutional standards and how the improved standards would be achieved.

The guidance also required the production of a Sustainability and Transformation Plan (STP) for 2016-2021 written as an overarching place based plan for the local population in relation to the health and social care economy as a whole. The Plan is required to be submitted by June 2016 and would be formally assessed in July. It had been agreed that the placed based element would cover the Leicester Leicestershire and Rutland footprint. In essence, the plan was similar to the Better Care Together but with additional strands covering specialised services, primary care services and a prevention plan element to the STP.

It was very different to the pre consultation business case developed for the Better Care Together Plan, although the identification of best practice and the relationships formed across the health and social care community for BCT had all helped to put LLR on a good footing for preparing the STP.

It was noted that:-

a) The funding in 2017/18 would be dependent upon the quality of the STP and the clarity of defining what will be done in the future and this would influence how quickly funds could be accessed. Further details were awaited on this process.

b) The Operational Plan had a requirement for 9 'must dos' for 2016/17 and would need to show in detail how the activity and finance would work together to achieve the objectives.

c) The CCG had received definite allocations for the next 3 years and indicative allocations for the following 2 years. Although there was an uplift in allocations received, this did not represent any additional purchasing power in real terms as the cost of purchasing services had also risen. The CCG had received approximately £12m extra funding but to standstill and buy the same activity would cost approximately £11.8m.

d) All CCG's were being encouraged to create stability within providers and £1.8b nationally had been allocated to provide flexibility to providers and to allow the CCGs to work with providers to get some transformation for the following year. The challenge was to reduce deficit, improve access and progress the transformation.

e) The CCG had met with the Chief Executives of UH, and LPT to see what the challenges were for the future, what the improvement trajectories would look like and how to take the process forward within the financial settlements received.

f) Although the CCG had received an extra allocation for Primary Care Contracts, the core allocation now included a number of areas of expenditure where previously non-recurrent allocations had been received; such as GP IT systems. The net impact was less than had been hoped for.

g) The New Assessment Framework for CCGs had been received recently and was currently out for consultation. A copy would be forwarded to the Chair for information. The CCG's Director of Strategy and Implementation was co-ordinating the production of the plan across LLR and representatives of local authorities had been asked to link in with this process. There would be a focus towards the constitutional targets, which would be A&E, cancer, EMAS handovers and waiting times for elective surgery.

h) There had been discussions on whether there should be a local work-stream in BCT on prevention but it was felt that this should be driven at a strategic level by the Board.

RESOLVED

1) The approach being taken be noted and endorsed.

2) That the suggestion that prevention should be led by the Board at a strategic level be endorsed and that any non-recurrent Better Care Fund money be targeted at preventative measures.

33. MENTAL HEALTH JOINT COMMISSIONING STRATEGY

The Board received a report from the Lead Commissioner – Mental Health &

Learning Disabilities on a Mental Health Joint Commissioning Strategy developed by Leicester City Council and the Leicester City Clinical Commissioning Group; which outlined the commissioning intentions for the period 2015-2019.

The strategy has been developed in full consultation with stakeholders, including people with mental health problems and carers of people experiencing poor mental health.

The Board were requested to endorse the Mental Health Joint Commissioning Strategy as part of the sign off process prior to publication.

It was noted that:-

a) The strategy had been developed in consultation with stakeholders, including people with mental health problems and carers of people experiencing poor mental health.

b) The strategy was focused on prevention and early help for individuals to avoid them reaching crisis point before engaging with services. The strategy also aimed to build capacity in the community.

c) A dashboard had been developed to measure the strategy's impact on individuals and carers over the life span of the strategy.

d) The Mental Health Partnership Board would oversee the 2 year delivery plan for the strategy.

e) The strategy would also be reviewed and updated on an annual basis to take account of changing circumstances or guidance.

Members of the Board commented that:

a) There were a range of mechanisms within Children's and Young Peoples Services which should be used to seek the views of children and young people.

b) The work of Adult Education Centre in providing courses, qualifications and achievements had been shown to have positive benefits for peoples' mental health and this should be recognised in the strategy.

c) There was evidence that employers and the Department of Works and Pensions appeared to lack confidence in engaging people with learning difficulties.

d) That the strategy should deliver real improvements and changes to service users.

The Chair commented that he had held discussions with the Chair of the Leicester and Leicestershire Enterprise Partnership to encourage employers,

as part of their initiatives, to support people with mental health and learning difficulties through employment opportunities. He was also looking at supporting people in the community through the work of the Adult Social Care services provided by the Council.

RESOLVED:

1) That the Mental Health Joint Commissioning Strategy be endorsed.

2) That the Mental Health Partnership Board monitors the implementation and performance of the strategy and notifies the Board of any issues which they feel should be brought to its attention. These issues could be either concerns or items of positive feedback and outcomes.

34. PRIMARY CARE WORKFORCE PLANNING

The Chair requested an update following the concerns that had been expressed around the two recent closures of GP practices at Marples Surgery and Queens Road Surgery.

Professor Farooqi commented that both practices had been single GP practices and both GPs had submitted their notices to resign from their contracts. Once it became clear to the CCG that the Marples Surgery premises would not be available for future use as a surgery; the only option available was to disperse patients to other GP practices in the area. The decision of the GP to resign from his contract at the Queens Road Surgery was unexpected and the patients registered at that practice came from all parts of the City and the county. There were approximately 2,000 patients involved and these were being dispersed amongst other GP practices within the City.

It was generally acknowledged that there were significant pressures on GP practices; particularly as recent changes in the national funding formula had resulted in practices in the City receiving less funding. The CCG were working collaboratively with practices in the City to promote forming federations and offering ‘golden hello schemes’ in an attempt to address issues of recruitment and retention.

It was suggested that a 6 month period of notice would be useful to allow more time to make alternative arrangements for patients affected by the closure of a practice. In response, Professor Farooqi stated that the CCG contract with GPs had a 6 month period of notice. However, GPs general contracts were negotiated nationally and were subject to a 3 month notice period and could not be changed without further national negotiation and agreement. However, the CCG would be prepared to explore whether a voluntary agreement could be negotiated locally with single handed GP practices in order to help future planning of services to patients. This would enable more time to consider alternative options for the continued care of patients, especially in instances where there was a cumulative effect arising from more than one practice

closing in the same area of the City within a short time span.

A further suggestion was made to undertake a survey/audit of GP practices to identify any plans to assist future planning provision for GP services; particularly if this was conducted on an annual or biannual basis. It was also noted that the number of single handed GP practices in the City was gradually diminishing through the promotion of initiatives such as co-operation and federation working.

The Chair of the Council's Health and Wellbeing Scrutiny Commission stated that the Commission was currently undertaking a Task Group Review of Primary Care Workforce Planning which included both GP and practice nurses recruitment and retention.

RESOLVED:

1) That the update be noted.

2) That the CCG's willingness to explore a voluntary local extension to single handed GPs giving more than the national 3 months' notice period to resign be welcomed.

3) That the suggestion to undertake an general audit/survey of GPs to better inform future planning provision of services be supported.

35. ANY OTHER URGENT BUSINESS

There were no items to be considered.

36. CLOSE OF MEETING

The Chair declared the meeting closed at 3.50pm.

LEICESTER CITY HEALTH AND WELLBEING BOARD

6 June 2016

Title of the report:	Update on Better Care Together (BCT); a health and social care change programme for Leicestershire, Leicester and Rutland
Author:	Mary Barber Programme Director BCT
Presenter:	Mary Barber Programme Director BCT

Purpose of report:

This paper provides an update on the progress of the BCT health and social care change programme for Leicestershire, Leicester and Rutland

Background:

1. In 2014 the NHS Clinical Commissioning Groups (CCGs), major NHS service providers and Local Authorities of Leicestershire, Leicester and Rutland (LLR) agreed to form a partnership to drive forward improvements to quality of care and system sustainability across LLR.

2. BCT is entering its third year and has started to deliver change and has considered how some of the sustainability challenges that have existed within the LLR health system for over 10 years could be resolved.

3. The major sustainability challenges include the need for a more streamline acute hospital if the hospital is to be sustainable in the future, being clear on the capacity and type of provision required in community hospital and local communities, to provide the most sustainable quality service and the sustainability of the maternity service.

4. BCT operates via a matrix of projects and programmes embedded in the partner organisations and delivery is managed via cross organisational groups known as Work-streams. This model drives the change process to be embedded in the operational organisations, an essential learning from previous LLR change programmes.

5. BCT covers a wide range of CCG and NHS England commissioned activity including some specialised services and primary medical care. In addition it considers better integration with local authority services, including but not limited to prevention and social care. It therefore provides the basis for the development of the LLR STP and contributes to

    - Improved Health and Wellbeing
    - Improved care and quality
    - Ensuring financial sustainability.

6. During years one and two the programme has delivered improvements to mental health services, started to increase the level of planned care delivered in the community hospitals and initiated the implementation of a number of initiatives to better

support patients with Long Term Conditions

7. However much of the work of years one and two has been development of plans to be initiated from year three (this year) and preparing to consult the public on proposals to reconfigure acute, community and maternity services.

8. 2016/17 is therefore a critical year for the programme where the work-streams and partners will need to demonstrate that their plans can be implemented and can deliver both the quality and sustainability that will be described in the STP.

9. Delivering the proposed changes is a significant challenge for LLR health and social care partners.

Recommendations

NOTE the progress to date

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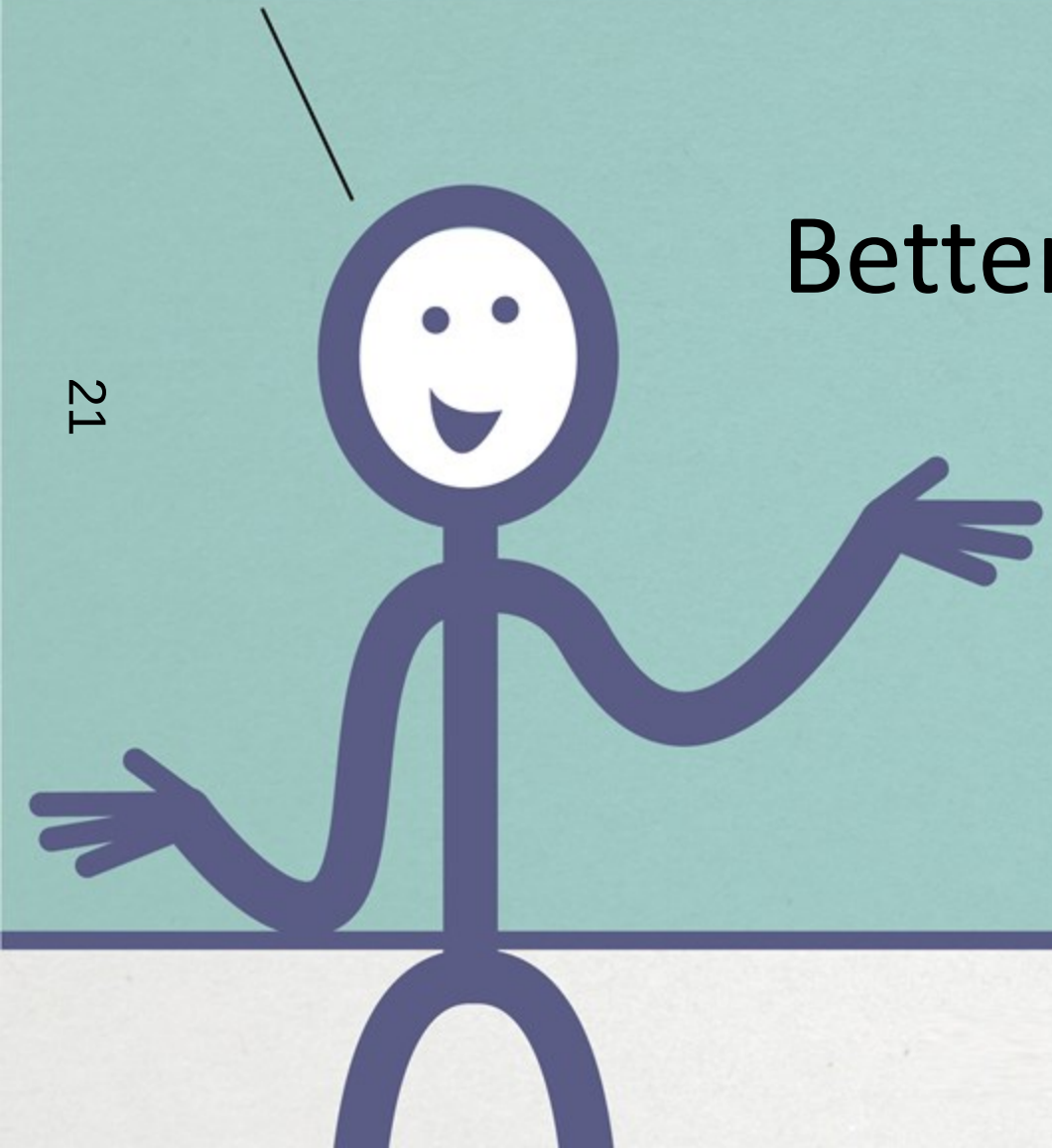

Better care together

Programme Overview

Leicester City H&WB

June 2016

Appendix C 1

Rutland County Council

Leicester City Council

Leicestershire County Council

NHS

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BCT Partners and Governance

- BCT is a major change programme involving all of the major NHS and social care organisations across Leicestershire, Leicester and Rutland
- It brings together the three healthcare providers for the region, the three CCG's and the three local authorities who are known as the "Partners"
- The Partners govern the programme via a Partnership Board which has a lay chair
- The operational delivery of the programme is run via leaders from each of the Partner organisations and working groups are made up of team members from a mixture of the Partner organisations which drives integration. These groups are known as Work-streams
- Clinical leaders from all Partners come together as a Clinical Leadership Group
- A small Programme Management Office supports the process of change

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BCT Strategic Objectives

The Better care together (BCT) programme was launched in January 2014 with the aim over five years to;

- Deliver high quality, citizen-centred, integrated care pathways, delivered in the appropriate place and at the appropriate time by the appropriate person, supported by staff/citizens, resulting in a reduction in the time spent avoidably in hospital;
- To reduce inequalities in care (both physical and mental) across and within communities in Leicester, Leicestershire and Rutland (LLR) Local Health and Social Care Economy;
- To increase the number of those citizens with mental, physical health and social care needs reporting a positive experience of care across all health and social care settings;
- To optimise both the opportunities for integration and the use of physical assets across the health and social care economy, ensuring care is provided in appropriate cost effective settings, reducing duplication and eliminating waste in the system;
- All health and social care organisations in LLR to achieve financial sustainability, by adapting the resource profile where appropriate;
- To improve the utilisation of workforce and the development of new capacity and capabilities where appropriate, in the people and the technology used.

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BCT Outcomes

The combined outputs from the BCT work-streams drive a set of improved outcomes for patients and the public

- We will ensure the very best start in life
- We will help people stay well in mind and body
- We will provide faster access shorter waits and more services
- We will be there when it matters and especially in a crisis
- We will know peoples History and plan for their needs
- We will care for the most vulnerable and frail
- We will provide better support when life comes to an end

BCT Outcomes

Only by combining the outputs of the work-streams can the outcomes be achieved – the partnership approach.

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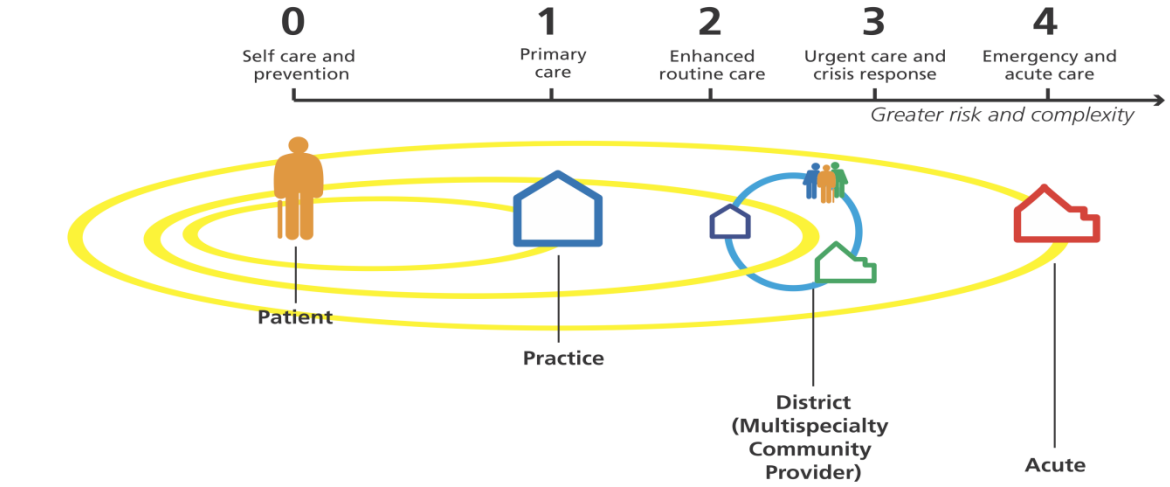
The Journey: Prevent, Avoid, Reduce



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Prevent: Primary prevention, early detection, treatment

Avoid: Enhance crisis response or ambulatory pathways to prevent avoidable admission to hospital

Reduce: When hospital admission is required, length of stay is as short as possible and long term health and wellbeing is optimised

The work-stream approach

The BCT Programme operates via work-streams, each considering a specific area for improvement in quality of care and sustainability

Clinical work-streams

- Children's, Maternity & Neonates
- Learning Disability
- Mental Health
- Planned Care
- Long Term Conditions
- Urgent Care
- Fraiil Older People & Dementia
- End of Life and learning lessons to improve care

Enabling work-streams and Service reconfiguration

- Workforce
- Estates & Facilities
- Information Management & Technology
- Communications & Engagement
- Commissioning & Contracting
- Prevention
- Service reconfiguration
- Adult social care
- Primary Care

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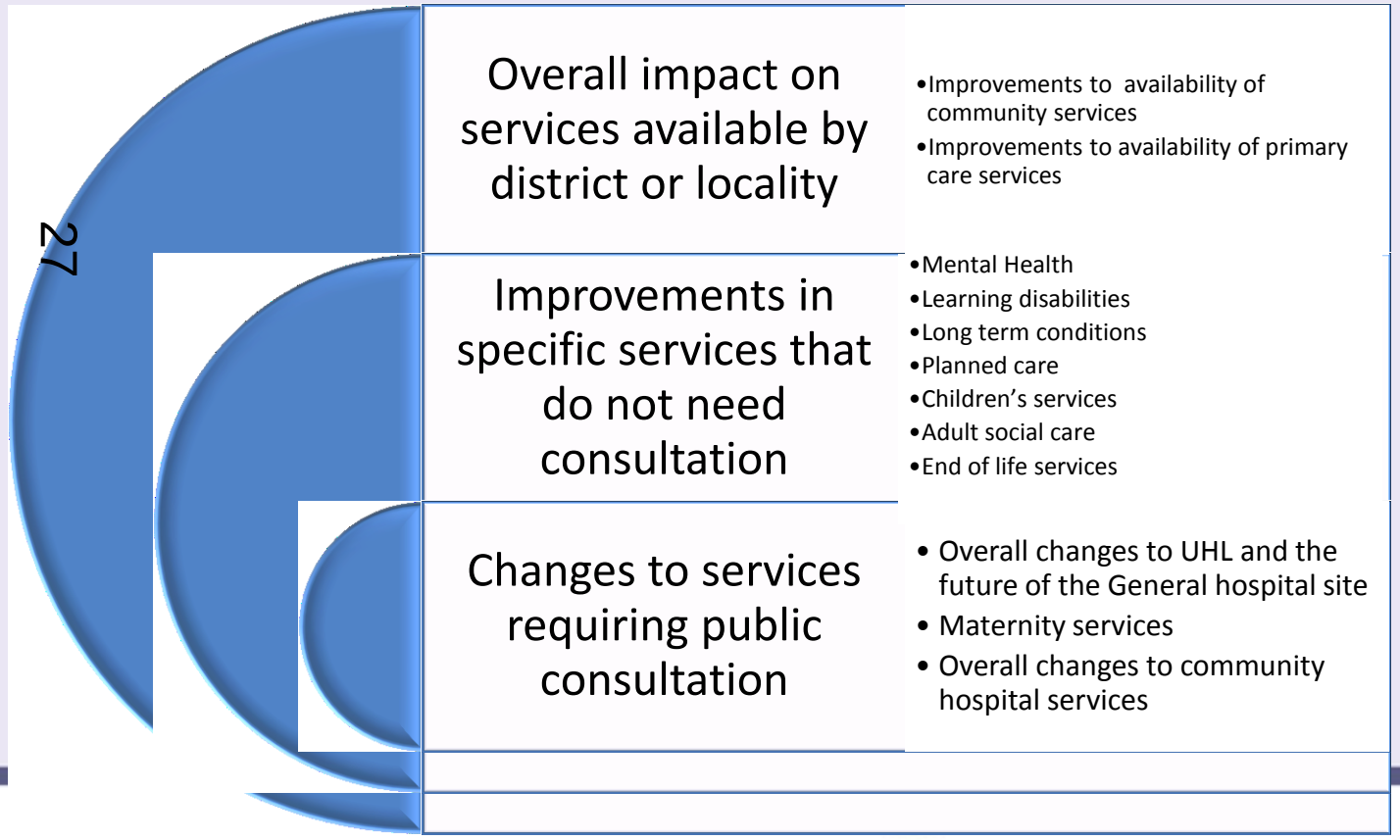
Services will change and some change requires public consultation

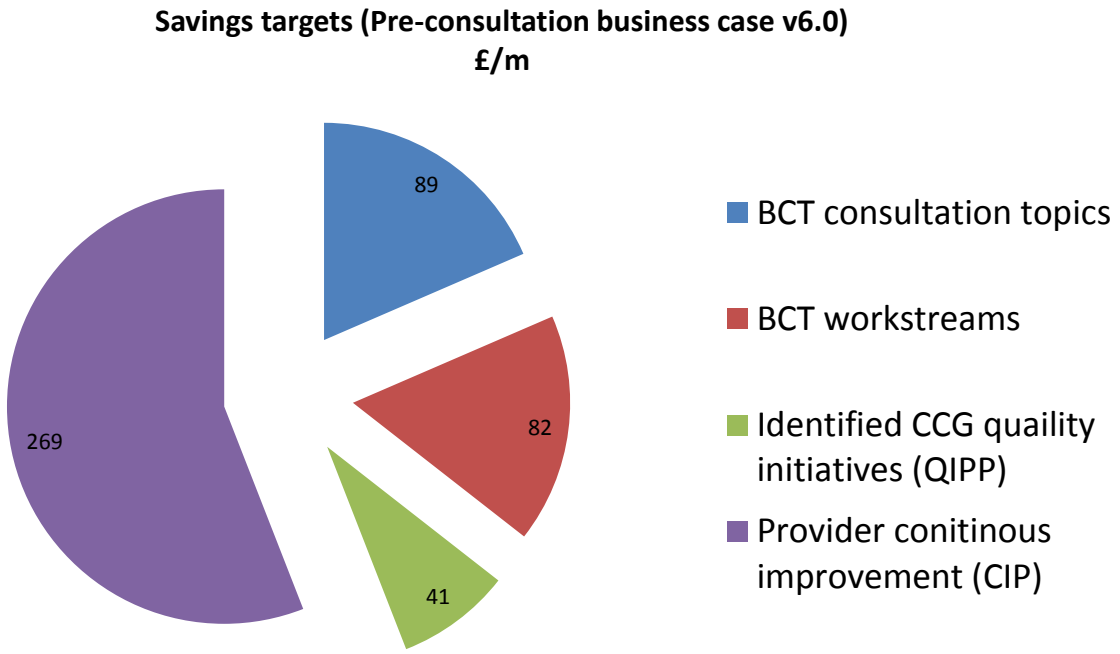


Public consultation will be structured to cover:

- Services requiring consultation
- Other service improvements
- What it means by district or locality

Rutland County Council
Leicester City Council
Leicestershire County Council
NHS

How sustainability is projected to be achieved



Finances are being reviewed following 206/17 spending review and the relative split may change.

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Changes of interest to City patients

- Additional “Hospital at home” beds, more patients rehabilitate in own home
- Reconfiguration of Leicester General Hospital (LGH) site, acute services moved to Leicester Royal Infirmary (LRI) and Glenfield hospital
- Maternity services on LGH site moved to LRI and potentially a Midwife led unit created at LGH
- Diabetes centre of excellence, Evington centre and stroke rehabilitation remain at LGH site
- New women’s hospital at LRI
- New look for children’s hospital at LRI
- New planned care hub at Glenfield site
- City CCG investigating potential for primary care hubs

LEICESTER CITY HEALTH AND WELLBEING BOARD

6 June 2016

Title of the report:	Development of the Sustainability and Transformation Plan for Leicester, Leicestershire and Rutland
Author:	Sarah Prema, Director Strategy and Implementation, Leicester City Clinical Commissioning Group
Presenter:	Sarah Prema, Director Strategy and Implementation, Leicester City Clinical Commissioning Group

Purpose of report:

This paper provides information on the development of the Sustainability and Transformation Plan (STP) for Leicester, Leicestershire and Rutland.

Background:

1. In the Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21 all areas were requested to develop a place based local blueprint for accelerating its implementation of the Five Year Forward View, known as a Sustainability and Transformation Plan (STP).

2. The STP needs to cover all areas of CCG and NHS England commissioned activity including specialised services and primary medical care. In addition it should address better integration with local authority services, including but not limited to prevention and social care. In developing a plan areas must show how they are going to ensure sustainability in the following three areas:

    - Health and Wellbeing
    - Improving care and quality
    - Ensuring financial sustainability.

3. The Spending Review provided additional dedicated funding streams for transformational change, building up over the next five years. Access to this funding from 2017/18 will be determined through the STP process.

4. Each STP area has a nominated footprint lead, for Leicester, Leicestershire and Rutland this is Toby Sanders, Managing Director, West Leicestershire Clinical Commissioning Group.

5. The Better Care Together Programme is a good foundation on which to develop the STP. As an area we have set out our plans through the Better Care Together Programme to improve a number of clinical pathways which will improve health and wellbeing; care and quality; and contribute to financial sustainability. But the STP asks us to go further than this.

6. Areas were asked to complete a summary of progress for 15th April 2016, which is attached. It sets out where we think LLR can go further on each of the three areas outlined in paragraph 2 and identifies emerging priorities for the STP. Feedback from NHS England has been positive and further work is ongoing to develop this further for submission of the STP on 30th June 2016. This will be based on both the BCT Programme and the STP emerging priorities.

7. The emerging priorities, on page 8 of the attached, have been developed through engagement with all partners during early April 2016. The Health and Wellbeing Board is asked to consider these emerging priorities.

8. The governance arrangements for the development of the STP is through the Better Care Together Programme with the addition of a time limited Task and Finish Group.

Recommendations

NOTE the development of the Sustainability and Transformation Plan for Leicester, Leicestershire and Rutland.

CONSIDER the emerging priorities.

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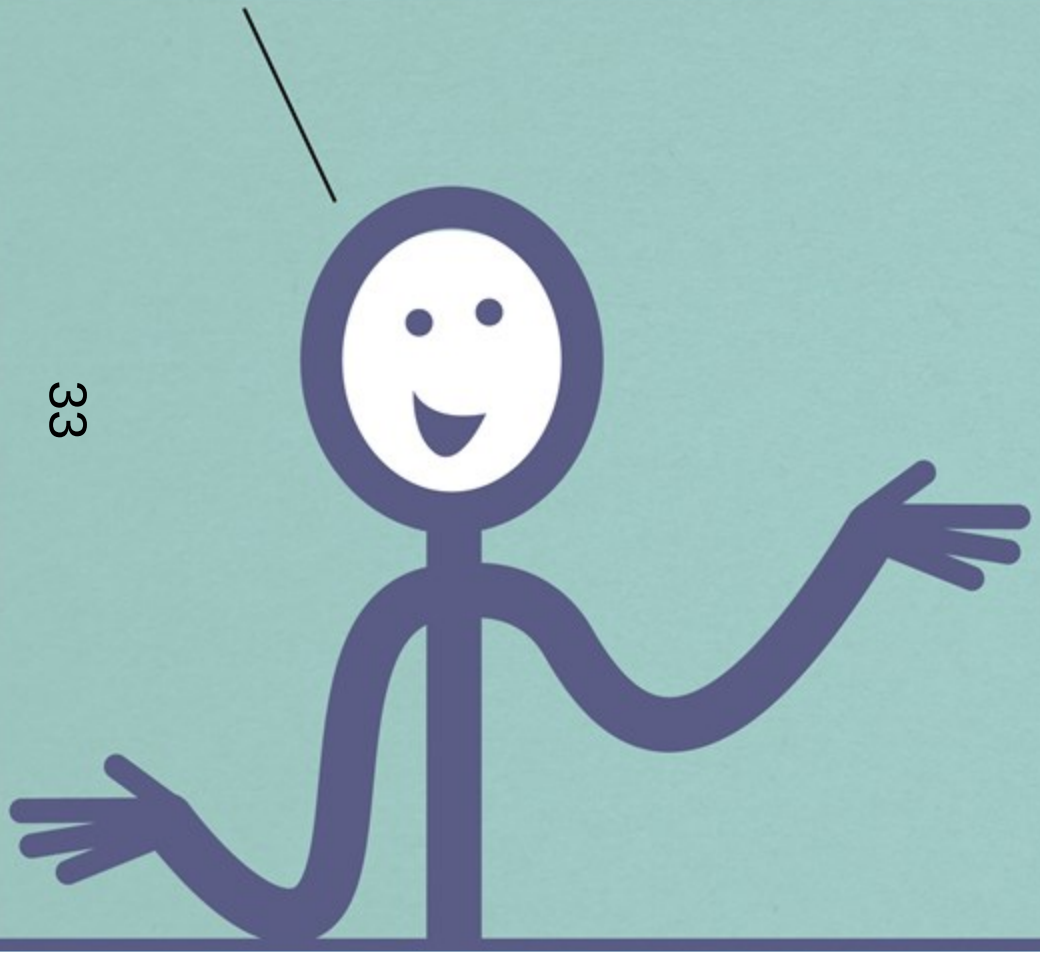

STP Footprint:

Leicester, Leicestershire & Rutland (No.15)

Region: Midlands & East

Nominated Footprint Lead:
Toby Sanders, Chief Officer, NHS West Leicestershire CCG

Contact details:
toby.sanders@westleicestershireccg.nhs.uk
Tel: 01509 567740

Organisations within footprint:

University Hospitals of Leicester NHS Trust
Leicestershire County Council
Leicester Partnership NHS Trust
NHS East Leicestershire and Rutland Clinical Commissioning Group
NHS Leicester City Clinical Commissioning Group
NHS West Leicestershire Clinical Commissioning Group
East Midlands Ambulance Service NHS Trust
Rutland County Council
Leicester City Council

LLR context

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- Leicester, Leicestershire and Rutland has a well established whole system strategic transformation programme in place called Better Care Together (BCT)
- This health and care programme was stimulated by the nationally supported Challenged Health Economy work in 2014 and is now in its third year
- LLR has been externally recognised as having made huge progress over recent years in strengthening relationships and system leadership
- On 10 March senior representatives from the BCT partners came together to review progress to date and identify next step areas of focus:

✓ Strong partner support
✓ Clear work streams with clinical & patient involvement
✓ Good early delivery in some areas (e.g. BCF & reducing DTOC)
✓ Clear proposals for acute reconfiguration
✓ And difficult choices re number and configuration of community hospital inpatient wards
✓ Aiming for formal public consultation summer 2016

× Some early implementation not having anticipated impact (e.g. LRI UEC)
× Some work stream plans not clear (e.g. older people) or ambitious enough (e.g. shared records/care plans)
× Decision making and governance complicated
× Pace of implementation generally too slow, impacted on by organisational position and funding
× Some issues not adequately addressed (e.g. model of general practice)
× Some opportunities not fully exploited (e.g. public sector estate)

- Strong local consensus that the BCT programme is already addressing some of our systems underlying and long standing issues (e.g. acute hospital configuration) but that there is much more to do and the scale of the challenge has increased given the public sector financial climate
- Therefore collective agreement to approach STP development as BCT 'Phase II'

1. Leadership, Governance and Engagement

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Leicester, Leicestershire & Rutland health and social care

Collaborative leadership and decision making:

- The LLR STP is being developed through our existing BCT leadership and decision making arrangements. These include:
  - An overarching Partnership Board, independently Chaired, and including senior clinical, patient, managerial and lay/NED input from all partner (NHS, LA and Healthwatch) organisations
  - A Clinical Leadership Group which brings together senior medical and nursing leads to shape clinical service models
  - A Chief Officers Group with executive authority for managing development of the programme
- Our STP lead is supported by a nominated CCG strategy exec lead (Sarah Prema), the BCT Programme Director (Mary Barber) and PMO. Wider partner support is provided through a new fortnightly STP Task Group comprising senior managerial input from all organisations
- Decision making arrangements are being strengthened by moving the Commissioning Collaborative Board to being a formal Joint Committee of each of the 3 LLR CCGs with delegated authority to enable decisions to be taken post consultation

An inclusive process:

- The initial shape of our emerging STP has been developed through an open and inclusive conversation across the system
- Individual STP discussions, focused on identifying the key local challenges that the STP needs to address, have been held during April with Board/exec teams/strategy groups of NHS and LA partners
- STP development will build on existing patient and wider community involvement mechanisms including an active Patient Involvement Group, Equalities Group and voluntary sector forum
- Initial areas of focus have been shaped by recent Healthwatch intelligence (e.g. 'Your Voice Matters' survey)

Local government involvement:

- The three upper tier local authorities in LLR are all active partners in the BCT programme and governance
- All 3 LAs have been involved during April in the initial thinking around the shape and areas of focus of our STP
- HWB Chairs are Partnership Board members and we have agreed that wider formal member engagement will be through the 3 HWBs supplemented by using scheduled informal member and political briefings
- Health is not currently a main focus of local devolution proposals for Leicester and Leicestershire but there is the potential for this to broaden through the STP process (see section 4)

Engaging clinicians and NHS staff:

- The BCT work streams are clinically led and have input from a range of acute, community and primary care health and care professionals
- STP thinking around new models of care was the focus of a major local Kings Fund supported event on 6 April attended by c.200 clinicians, patients, lay members and managers

2a. Improving health and wellbeing

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Leicester, Leicestershire & Rutland health and social care

Issues

- Variation in health outcomes, deprivation levels and health inequalities across the system
- CVD, Cancer and Respiratory disease are the main causes of death and premature mortality
- More than 50% of the burden of strokes, 65% of CHD; 70% of COPD; and 80% lung cancer are due to behavioural risk
- Variation in the early detection rates for cancer across the system and tumour sites
- Variation in the prevalence rates of diseases compared to expectation
- Infant mortality rates in the city are significantly higher than the national average
- Limited exploration of community assets and social prescribing to support prevention, self-care and resilience
- Not exploiting the strength of the NHS workforce in being advocates for healthier life styles

Getting it right in the NHS and social care:

- Develop and embed what we know works in primary and secondary prevention
- Support the NHS workforce to be healthy exemplars
- A step-change in patient activation and self-care including expansion of existing programmes such as Personal Health Budgets, Making Every Contact Count

Making the most of the local government contribution to prevention, building on the work of public health and the role of HWBs:

- Support local councils to build health into the local environment, making healthy behaviour the norm
- Clear pathways to local integrated lifestyle services (smoking, healthy weight, physical activity, mental well-being)
- Redesign public health commissioned services to provide better integration with primary care and community initiatives
- Build on existing services (e.g. 0-19 integrated children's public health service) renewed focus on 6 high impact areas & multi agency LLR programmes of work

Through the STP process develop plans to maximise the joint contribution of health and local government:

- Build local platforms to communicate effectively with the public, building on approaches such as PHE's Sugar Swap campaign
- Utilise risk profiling to target communities and places with the worst health to close the health gap & reduce health inequalities
- Harness the strength of communities to provide social support, through community asset based approaches, drawing together health and local government through integrated approaches to social prescribing
- Implementation of the Diabetes Prevention Programme (June 2016)

2b. Improving care & quality of services

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The Leicester, Leicestershire and Rutland health and social care system have identified the following as the key challenges that contribute to our care and quality 'gaps':

- Rising demand for all forms of health and social care, which is creating an imbalance between demand and capacity
- Sustainability of urgent and emergency care in the context of rising demand
- Focus is on individuals rather than pathways which leads to lack of service integration between health and social care for complex and frail older patients
- Clinically unsustainable acute service configuration e.g. maternity, children's, intensive care services
- Sustainability and funding of social care, particularly in the context of supporting people to remain independent and to help with hospital discharge
- Sustainability of primary care, particularly in the context of growing demand both from patients and service redesign, workforce issues and reduced share of NHS funding
- Inappropriate clinical variation across all sectors which impacts on outcomes for patients
- Improving the integration of mental health services with physical health
- Continued growth in demand for CHC services and impact of current model on recovery and re-ablement outcomes
- Transition between settings of care which often lead to patients telling their story more than once and poor outcomes
- Information sharing – being able to have access to information no matter what care setting a patient is presenting in
- Acute adult mental health pathway which results in too many patients being placed out-of-county
- Acute child and adolescent mental health care pathway requiring a better crisis response and improved local inpatient capacity
- Unsustainable community hospital inpatient configuration across eight county town and city sites
- Insufficient dementia capacity which will not secure a two thirds diagnosis rate for people with dementia, diagnosis within 6 weeks of referral, and improved post diagnosis treatment and support
- End of life services which offer limited patient choice of services and have insufficient capacity to enable people to choose to die at home
- The management of an increasing number of people who have long term conditions and co-morbidities
- Developing a workforce that can respond to the challenges faced in health and social care and the transfer of services from the hospital to community settings

2c. Improving productivity and closing the local financial gap

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Leicester, Leicestershire & Rutland health and social care

Financial challenges

- Previous modelling (2014 EY, updated 2015) developed an five year 'do nothing ' model for LLR which produced a financial gap of c.:
  - £0.5 billion for the NHS
  - £0.2 billion for Adult Social Care

  This is being updated post allocations and 16/17 contracts to inform the development of the STP
- Current 'structural deficit' at UHL supported in 16/17 through £23m national STF

Current financial solutions identified

Currently identified plans to deliver savings through:

- BCT system wide work: pathway redesign in eight clinical and six enabling work-streams and reconfiguration of acute services
- Organisational CIP and QIPP for example through primary care prescribing; theatre utilisation and length of stay improvements
- Local authority MTFS plans to achieve savings, including a 2% council tax precept for social care

Opportunities

- Reduce the need for and reliance on inpatient care by stemming admission growth by increasing the community and home offer and reducing length of stay
- Focus financial growth and investment in out of hospital and primary care services
- Developing new models of care that support integration and reduce duplication in the system
- Improve the utilisation and rationalise the public sector estate – "one public estate"
- Manage the growth in CHC
- Focus on prevention and promote a self-care culture to ensure longer term sustainability
- Work towards a place based control total
- Commissioner /Provider collaboration to reduce overheads
- IM&T solutions that improve care quality and efficiency
- Supporting carers to reduce reliance on social care services
- Improving access to information and advice, enabling people to help themselves
- Utilising support from families and the community before resorting to support from formal public services

Current plans that support sustainability – note some of these are subject to the outcome of formal public consultation

- Acute hospital footprint reduced from three to two sites
- Consolidation of community hospital estate and increased hospital at home services
- Reconfiguration of maternity services
- Improved support for people with Learning Disabilities to live in community settings and reduction in inpatient beds over time
- Improved mental health services for all focussing on prevention, resilience and improving crisis services
- Development of dementia services to improve quality of life
- Improve the quality and choice of end of life services
- Working with individuals to deliver cost effective, personalised care and maximise independence
- Working with local communities and providers to develop local community based support
- Develop an integrated housing offer, to support individuals in their own home

3a. Emerging thinking - areas of focus

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Major local challenges	3 'gaps'		
	Health and Wellbeing	Care and Quality	Finance and Productivity
Implementing BCT Phase 1	• Shift of all age mental health to prevention and resilience • Secondary prevention and primary care upskilling for LTC's	• Maternity consolidation • Increasing community support for people with learning disabilities • CAMHS transformational plan • Redesign integrate urgent care offer (Vanguard) • Configuration of intensive care	• Acute site consolidation (3:2) • Community hospital reconfiguration • Efficiencies and lowest cost settings for planned care
Current issues where plans are insufficient	• Cancer prevention and early detection • Services for frail older people • Physical and mental health integration • Self care support • Employers offer for staff health and wellbeing (public and large private sector employers)	• End of life services • Access to and variation in general practice • Variation in care home quality • Acute adult mental health pathway • Community response to mental health crisis • Shared records and care plans	• In balance between demand and capacity across all sectors • LRI Urgent Care service model • CHC model and demand • Reducing inappropriate clinical variation/duplication • Capacity in out of hospital services to absorb left shift in activity • Collective culture and approach to service improvement
Potentially unsustainable in 2020	• Public expectations and approaches to accessing health and care services	• Dementia capacity for treatment and support • Care home and domiciliary provider market • Workforce supply (capacity and skill mix) • Urgent and emergency care service 'designation'	• Viability of adult social care model/funding • Model and viability of general medical care services (workforce, finance , business model) • Configuration of specialised services
Potential opportunities to enable transformation	• Capitalising on community and voluntary sector assets to support primary prevention • Place based approach across public sector services and workforce	• Exploiting advances in technology, science and treatment to enable patients to remain well and support independence • New 'paramedic at home ' and wider EMAS clinical delivery model	• New models of care (integrated health and social care teams) • Acute provider networks • Placed based control total • Integration of commissioning between health and social care • Collaborative commissioning arrangements • IM&T interoperability and paperless (Digital Roadmap) • One public sector estate (utilisation and consolidation) • Carter review (productivity)

N.B. some of these 'propositions' will be subject to formal public consultation

3b. Emerging thinking – Top Priorities

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1. **BCT Phase I service reconfiguration** - acute and community hospitals
2. **Public sector efficiency** – within and across providers (Carter) and commissioner collaboration/integration
3. **Prevention** – community asset base, risk targeted and staff wellbeing
4. **Urgent and emergency care** – integrated urgent care, LRI services , designation and EMAS delivery model
5. **Mental health** – acute pathway, all age crisis and dementia
6. **Integrated place based community teams** - multi-specialty and health/care supporting LTCs and older people
7. **Primary medical care** – quality variation, workforce and business model/scale
8. **Digital technology** – shared records/care plans, patient monitoring and self care
9. **Public sector estate** – utilisation, co-location, consolidation and condition
10. **Health and care workforce** – supply, skill mix, flexibility and settings of care
11. **LLR place based system approach** – collective leadership, single control total, 'One LLR' OD/quality improvement way

Appendix E

LEICESTER CITY HEALTH AND WELLBEING BOARD
DATE

Subject:	Leicester City Better Care Fund 2016/17
Presented to the Health and Wellbeing Board by:	Sue Lock, Managing Director, Leicester City CCG
Author:	Rachna Vyas, Deputy Director of Strategy & Implementation, Leicester City CCG

EXECUTIVE SUMMARY:

1. The 2016/17 Better Care Fund approval process required each area to submit a 2 part plan – the first requirement was a planning template detailing activity, finance & a metrics plan and the second was a narrative plan providing a detailed description of plans for 2016/17. These are attached as Appendix 1 & 2.
2. Both components were co-produced between the CCG and the LA, with approval given by the Joint Integrated Commissioning Board (JICB) and the Chair of the HWB prior to submission.
3. These were submitted as per the deadlines mandated through the Regional Assurance and Support Process.
4. This process reviewed:
    a. area BCF funding plans
    b. 'Risk to Delivery risk assessment' to understand system and delivery challenges
    c. Implications for financial stability as per the national guidance and BCF assessment/risk template.
5. The panel found that the Leicester City BCF submission *"highlighted the ongoing commitment of your area to the BCF programme and the narrative descriptors gave confidence that plans were in place to deliver against the BCF outcomes in 2016/17".* The panel therefore, subject to national calibration, gave the Leicester City BCF planning submission a rating of Fully Approved.
6. Ongoing monitoring will be through the JICB, with reports to the HWB provided as required.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

APPROVE the 2 components of the Leicester City Better Care Fund plan 2016/17.

Leicester City Council

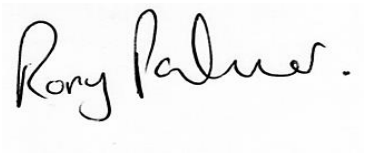
NHS
Leicester City
Clinical Commissioning Group

The Leicester City Better Care Fund

2016/17

Local Authority:	**Leicester City Council**
Clinical Commissioning Group:	**Leicester City Clinical Commissioning Group**
Boundary Differences:	**None**
Date agreed at Health and Wellbeing Board:	**Sign off under delegated authority on behalf of HWB: 30th March 2016** **Full Board will sit in May 2016**
Date submitted to DCO team:	**11th April 2016**
Minimum required value of BCF pooled budget:	**£21,861,473**
Total agreed value of pooled budget:	**£23,715,473**

a) Authorisation and signoff

Signed on behalf of NHS Leicester City CCG 	
By	Sue Lock
Position	Managing Director
Date	**30th March 2016**
Signed on behalf of Leicester City Council 	
By	Andy Keeling
Position	Chief Operating Officer
Date	**30th March 2016**
Signed on behalf of the Leicester City Health and Wellbeing Board 	
By Chair of Health and Wellbeing Board	Cllr Rory Palmer
Position	Deputy City Mayor and Chair of Leicester City Health & Wellbeing Board
Date	**30th March 2016**

Chapter 1: Our core vision for health and social care in Leicester City

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

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

Our vision for a healthier population goes much further than just ensuring people get the right care from individual services. We want to create a holistic service delivery mechanism so that every Leicester citizen benefits from a positive experience and better quality of care.

At the core of our vision remains a thorough understanding of our population (with a focus on the demographic and socio-economic breakdown across the City) and the health inequalities faced and what we need to do to achieve better outcomes in the short and medium term in line with our JSNA and Joint HWB strategy. A full contextual breakdown of these issues is provided in Appendix 1.

Using integration as a vehicle to delivering the Five Year Forward View

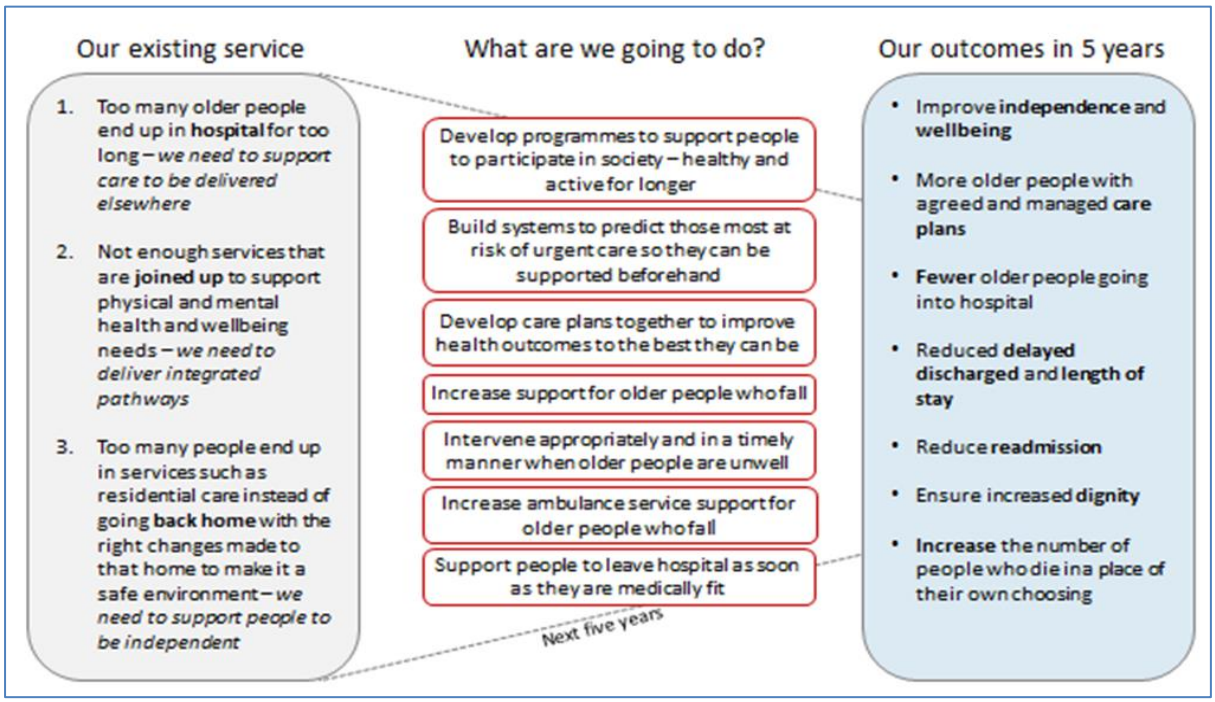
The recent NHS Five Year Forward View enables a far greater focus to be put onto ambitious and transformative change across the totality of the health and social care economy, through new models of care, driving change through relationships with communities and truly achieving parity of esteem for mental health services. We have aligned our BCF plans for 16/17 to enable the City to take a further step towards full achievement of these and the services described in this plan reflect those in our CCG Operational Plan, Adult Social Care Operating Plan and our emerging Sustainability and Transformation Plan, taking us closer to fully integrated health and social care services by 2020.

Experience-led Commissioning – Understanding the outcomes we need to deliver through listening to the experiences of our patients, service users, carers and the public

In 2015, we jointly launched a public engagement programme with all organisations in LLR (Experience-led Commissioning; Older People, 2015) to further ensure that our 16/17 programmes of work were designed with patient and public feedback at the heart of our delivery systems. One such engagement project was aimed specifically looking at older people and integrated care; 494 responses were gathered using a variety of engagement methods across LLR.

Key themes from this exercise included better communications between agencies, better access to services and better feedback to patients about their care – however, the majority of our patients want care to be provided in the best place possible for them based on their needs – whether this be at home or hospital. A summary of this engagement is available in Appendix 2.

The key themes from this engagement have been used to formulate the outcomes roadmap below. This has formed the basis of our 5 year STP and is the blueprint for our local system design in 16/17:



Our local Delivery model – our steps towards a fully integrated system of care by 2020

A series of interwoven pilots were launched in 15/16 aligned with the vision above, which included models of care coordination, integrated crisis response services and enhanced care planning, all designed to reduce the time spent avoidably in hospital through provision of integrated community services. We have used these pilots as the key building blocks upon which our 16/17 BCF has been co-constructed and we will use the BCF to accelerate our progression towards our joint optimal delivery model, fully operational by 2020.

Our delivery model is based on 3 key priority areas, which have been designed to deliver one integrated, place-based model of care:

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

We will achieve this by implementing:

- Services for complex patients**:**
  - **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.**
- The Leicester City Lifestyle hub:
  - **Delivering 'great' experience and improving the quality of life of patients with long term conditions by expanding our use of available technology, patient education programmes and GP-led care planning, reducing avoidable hospital stays.**

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

We will achieve this by implementing:

- The Clinical Response team:
  - **Providing an ECP-led 2 hour response to patients at risk of hospital admission from GP's, care homes, 999 and 111.**
  - **Proving a proactive care home service to ensure our care home population receive high quality care in their usual place of residence**
- Our joint neighbourhood teams**:**
  - **One integrated physical and mental health team, ranging from health and social care to housing and financial services, which responds in a coordinated way to ensure care is delivered in the community and around the individual.**
- Interoperable IT systems & governance:
  - **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.**
- Our Intensive Community Support Service**:**
  - **Increasing community capacity to look after people in their own homes rather than in a hospital bed.**

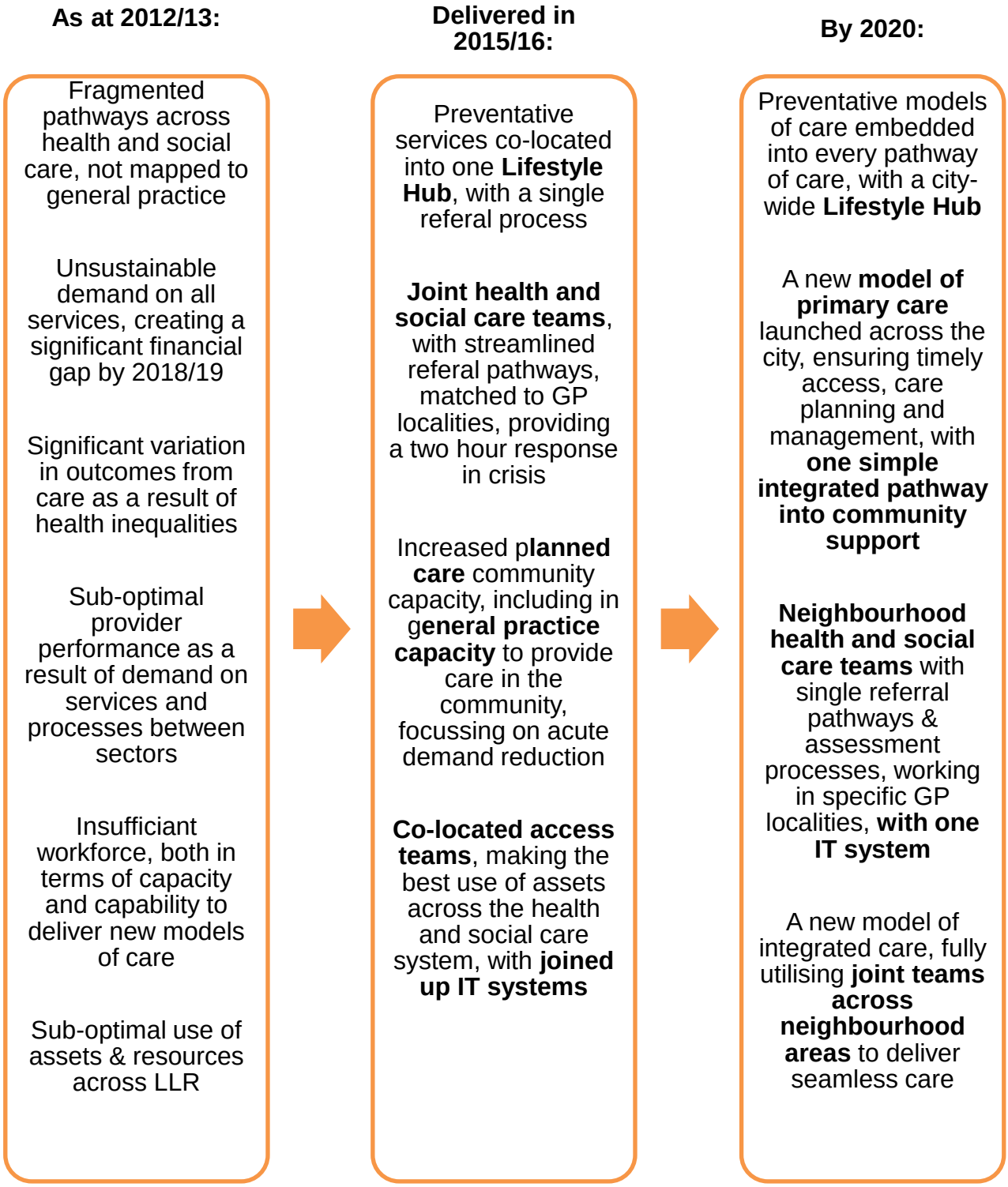
Priority 3: **Enabling independence following hospital care**

We will achieve this by implementing:

- Our nationally commended ICRS service:
  - **Ensuring timely hospital discharge via the provision of in-reach (pull) teams to swiftly repatriate people to community-based services and maintain independence across physical and mental health services. This service also has an admission avoidance function through partnership working with our GP's. Access to assistive technologies is also provided through ICRS.**
- Our holistic enablement & reablement services:
  - **Increasing the number of patients able to live independently following a hospital stay by helping them back to independence**
- Our Joint community mental health teams:
  - **Mobilising community-based capacity specifically targeting the discharge of patients in mental health care settings.**

The vast majority of these services are linked into one community pathway, ensuring that referral into one service produces a holistic health and social care assessment which addresses the patient's wider needs, rather than just the requirement that they were referred for.

The delivery model described will move us towards a fully integrated system by 2020 and takes into account other areas of development across our system, such as implementation of our primary care strategy and the ambitions of our Urgent and emergency care Vanguard programme:



16/17 Investments

Funding has increased in line with planning guidance released and contributions are outlined below:

	Gross Contribution
Total Local Authority Contribution	£1,854,000
Total Minimum CCG Contribution	£21,861,473
Total Additional CCG Contribution	£0
Total BCF pooled budget for 2016-17	**£23,715,473**

Aligned to the services above, the expenditure plan for the 16/17 BCF is as follows:

Scheme Name	Total 15-16 Expenditure (£) (if existing scheme)	2016/17 Expenditure (£)	New or Existing Scheme	Agreed at BCF joint confirm and challenge?	Impact on service
Risk Stratification	£54,000	£64,000	Existing	Yes	Expansion
Lifestyle Hub	£100,000	£100,000	Existing	Yes	None
IT	£4,000	£4,000	Existing	Yes	None
Clinical Response Team	£1,365,000	£1,380,015	Existing	Yes	None
Assistive Technology	£211,000	£213,321	Existing	Yes	None
LPT Unscheduled care team	£389,216	£469,216	Existing	Yes	Expansion
ICRS	£662,000	£835,000	Existing	Yes	Expansion
Night Nursing team	£90,000	£90,990	Existing	Yes	None
Services for complex patients	£1,220,000	£1,220,277	Existing	Yes	None
Mental Health Planned Care Team	£148,000	£232,025	Existing	Yes	Expansion
MH Housing team		£40,440	New	Yes	---
MH Discharge team	£42,000	£42,462	Existing	Yes	None
ICS (+)	£874,000	£883,614	Existing	Yes	None
Reablement - LPT	£1,125,000	£1,137,375	Existing	Yes	None
Existing ASC Transfer	£5,901,968	£5,901,968	Existing	Yes	None
Carers Funding	£650,000	£650,000	Existing	Yes	None
Reablement funds - LA	£825,000	£825,000	Existing	Yes	None
2016/17 ASC Increased Transfer	£5,650,000	£5,650,000	Existing	Yes	None
Performance Fund	£1,926,541	£1,926,540	Existing	Yes	None
Uncommitted		£194,757	New	Yes	---
DFG	£1,001,000	£1,854,000	Existing	Yes	---

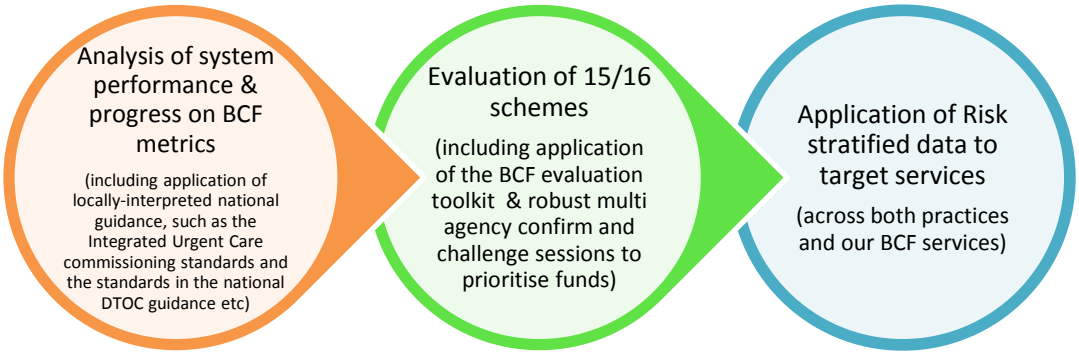
Chapter 2: Our evidence base

Our local evidence based planning process

The Leicester City BCF has been designed as part of a wider system-wide change across the LLR health and social care economy via our emerging STP. LLR is also an urgent and emergency care

Vanguard and the BCF services form a core part of testing out new models of care and new ways of delivering services within a wider footprint.

Our original BCF plan outlined our analysis of national and international literature regarding how various joint interventions have worked elsewhere (refreshed analysis available as Appendix 3). Following this, we have analysed three sets of data and collectively used this intelligence to design our place-based system locally;



We have then applied local knowledge and the analysis from our Risk stratification system to target our service delivery model to the right cohorts within our population.

Analysis of system performance

The LLR Emergency care system has been under sustained pressure for much of 2015/16, reflected in declining performance on a number of key indicators, particularly A&E waiting times and ambulance handover and turnaround times at LRI. Addressing performance issues is a key priority in 2016/2017 for both the BCF and the wider system. Our approach is to combine a collaborative, system wide improvement approach, led by the LLR System Resilience Group, with robust management as well as to manage urgent care contracts with providers.

Progress against BCF metrics in 15/16

Metric	Plan 15/16	Actual 15/16	Status
DTOC	1186.2 per quarter	593.4 per quarter	Achieved
Non elective admissions	32698	38214	Not Achieved
Residential Care	671.4	571.9	Achieved
Reablement	90%	87.9%	Not Achieved
Dementia prevalence	70%	82%	Achieved

As part of our planning process, we have analysed performance against each of these metrics in depth in order to target our 16/17 plans.

Non-elective admissions (General and Acute)

Performance in 15/16

Despite activity in every BCF scheme reaching capacity in 15/16, Leicester City did not meet the non-elective admissions target. Clinical audit of BCF schemes shows significant impact on the non-elective admission rate; however, the overall non-elective admission rate has continued to rise despite this.

Analysis of the data shows that this was largely due to a significant increase year on year (37%) in short stay admissions for younger age ranges (20-40 year olds). Despite such significant levels of growth in short stay activity, the variance to planned activity for 15/16 for Leicester City is forecast to be 8.2%. This also shows that the opportunity for ultra-short stay admission reduction is now significant for Leicester City CCG.

Excluding 0-6 hours admissions, Leicester City CCG has seen a -14.2% decline in activity against our 15/16 plan:

Commissioner (M09)	% Variance 2015/16 YTD to:	
	Baseline Plan (Contract)	**Aspirational Plan**
NHS LEICESTER CITY CCG	-14.2%	-9.7%

As this growth in short stays was not contracted for in 15/16, excluding the growth shows that the CCG would be on track to deliver ambitious QIPP targets set in 15/16. 'True' growth is therefore masked and year on year trends (such as those used in the IHAM model) are now no longer comparing like with like.

Opportunity analysis for 2016/17

Our 16/17 non-elective reduction ambitions are therefore ambitious – only schemes with specific cohorts of patients have been counted for admission reduction, both to prevent double count and to ensure that the scheme is measurable. Key schemes and the impact modelled are shown below:

Focus Cohort 1: EMAS G3 and G4 calls

The Clinical Response Team is a team of ECP's who respond to GP/111/care home calls for patients at risk of admission between 8am to 8pm, 7 days per week.

During 15-16, we have run PDSA type trials with the team which, for example, have taken 999 calls directly from the EMAS stack. Through the trial, of the calls diverted daily to our BCF pathway none were conveyed to hospital – previously these patients would have been taken straight into the acute site. In 16/17, we will focus this service on G3 and G4 category calls, ensuring patients are treated where clinically appropriate.

Scheme Name	Modelled impact on Short Stay (0-12hrs) admission activity (per day)	Annual reduction modelled	Service status (as at April 1st 2016?)
BCF – CRT **(EXPANSION OF CURRENT SCHEME – as above)**	▪ 8 calls from the EMAS STACK taken per day/2920 per year ▪ 40% non-conveyance from these calls = 1168 not conveyed = 1168 ED attends saved per year **3.2 ED attendances saved per day** ▪ Of those not conveyed, 58% admission rate applied = 677 admissions saved **1.9 admissions saved per day from ED + GP/Bed bureau**	-677 NEL	Yes

Focus Cohort 2: Care home patients

For our care home patients, we have put into place various schemes in 15/16 which will be integrated as one service in 16/17. This includes the CRT (as above), a proactive quality team who provide holistic interventions for patients in their own home and a care home pharmacy and nutrition service.

Results from the proactive team alone have shown that emergency admissions from targeted, high admitting care homes has halved in Q3 15/16 when compared to the same period last year as a result of our BCF-funded proactive care home model:

	Oct-Dec 14	Oct-Dec 15
Home 1	**15**	**8**
Home 2	**39**	**35**
Home 3	**10**	**6**
Home 4	**26**	**16**
Home 5	**5**	**3**
Home 6	**19**	**28**
Home 7	**22**	**6**
Home 8	**38**	**19**

Care home emergency admissions trend, Leicester City registered patients

We plan to upscale this project in from Q1 in 2016/17 with an additional practitioner and have QIPP monitoring arrangements in place.

Scheme Name	Modelled impact on Short Stay (0-12hrs) admission activity (per day)	Annual reduction modelled	Service status (as at April 1st 2016?)
BCF – CARE HOMES **(EXPANSION OF CURRENT SCHEME– as above)**	▪ Additional car = 8 calls per day/2920 per year ▪ 40% non-conveyance = 1152 ED attends per year ▪ 0.58 admission rate = 668 admissions **1.8 admissions per day from ED and GP/Bed bureau**	-668 NEL	Yes

Focus cohort 3: Multi-morbid, high risk populations

Based on the Slough model, utilisation of the ACG System within the population of Leicester City CCG demonstrated that there was a clear relationship between multi-morbidity and cost. People associated with the highest costs were those with 7 or more chronic conditions, with costs consistently high in pharmacy, unscheduled attendances and admissions.

Our GP's agree they can make a difference within the primary care setting for a cohort of people; multi-morbid patients with a base disease that was unstable in nature and prone to exacerbation. Each member of this cohort had one of four combinations of disease:

- CHF and CRF
- CHF and COPD
- Diabetes, CHF and CRF
- Diabetes, Ischaemic heart disease and CRF

These patients will be provided with a combination of interventions, including targeted longer GP appointments, case management and further education on condition management.

Based on slough modelling, (24% reduction in A&E activity in November 2015 compared with the same month in 2014 and a 17% reduction in non-elective admissions), the CCG has replicated both the model and associated QIPP.

Scheme Name	Modelled impact on Short Stay (0-12hrs) admission activity (per day)	Annual reduction modelled	Service status (as at April 1st 2016?)
BCF – PIC GP **(CHANGE IN CURRENT SCHEME– as above)**	▪ 15% admission reduction target based on Slough Right Care model ▪ 3100 cohort in city ▪ 775 ED attends per year **2.8 ED attendances saved per day** ▪ 0.15 x 3100 = 465 admissions per year ▪ 465/274 days (Impact expected Q2-4) **1.6 admissions per day from GP/Bed bureau**	-465 NEL	Cohort identified – impact modelled from Q2

To ensure alignment with CCG Operational Plans and commissioner/provider capacity plans, the same non-elective reduction target has been used.

This has been agreed by the CCG, LA and the HWB and is being agreed at provider level in March 2016.

Admissions to residential and care homes

Admissions to care have been closely monitored with new placements scrutinised by Quality Assurance Panel to ensure appropriate decision making. Placement directly from hospital into long term care does not happen routinely and the use of "home first" or intermediate care services are a primary discharge option. Appropriate use of interim placements are made to avoid DTOC but with

capacity in the community services prioritised for hospital discharge, this is only used in necessary cases where a bed is needed to meet patient needs, rather than to simply avoid DTOC.

Opportunity analysis 16/17

Previous performance has been improved in 2015/16 and the impact of BCF funded schemes, including ICRS and enhanced ICS are contributing factors in making responsive and step down facilitates available permanent admissions are minimised. These services are protected in 2016/17. It is understood that 2015/16 had minimal winter/seasonal challenges which may also be a contributory factory and targets for 2016/17 take account of this.

Effectiveness of reablement

Performance in 15/16

The target takes account of previous performance (including in-year data for 2015/16) which is indicating that our approach described below is proving effective. The impact of BCF initiatives has also been taken into account. There is emerging evidence to suggest that those initiatives supporting effective discharge/step-down pathways are providing complimentary and/or alternative approaches to maximising independent living.

Opportunity analysis 16/17

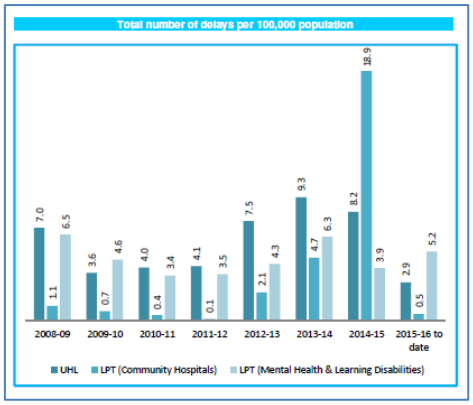
The target for 2016/17 reflects our ambition to ensure that those receiving reablement services are afforded the greatest chance of maximising independent living. As such, we have reflected the challenge of meeting this objective by maintaining a high target for the proportion of over 65's still at home 91 days after reablement, through a more targeted approach to referrals, resulting in a slightly smaller cohort receiving the reablement services (220 for the three month reporting period against 235 in 2014/15).

Delayed transfers of care

Performance in 15/16

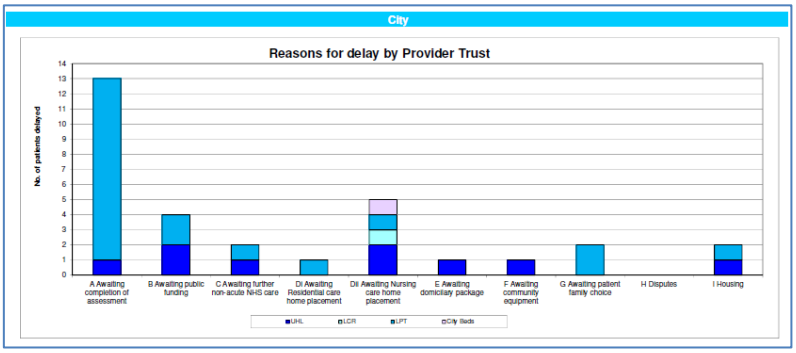
During 15/16, BCF teams worked closely across commissioner and provider to reduce DTOC rates. This involved analysis of the reasons for delay by site and subsequent plans enacted to deal with each reason for delay in a systematic fashion. As a result of this, our DTOC rate has reduced significantly as a result of the processes put into place via the BCF schemes and the wider system redesign under the aegis of the Urgent Care Board.

As seen in the charts below, performance in 2015/16 compared to 2014/15 is significantly better:



Total Number of days per 100,000 population: Leicester City CCG

Analysis of reasons for delay by provider shows that the highest reason by far in 15/16 for delays is the delay in assessment.

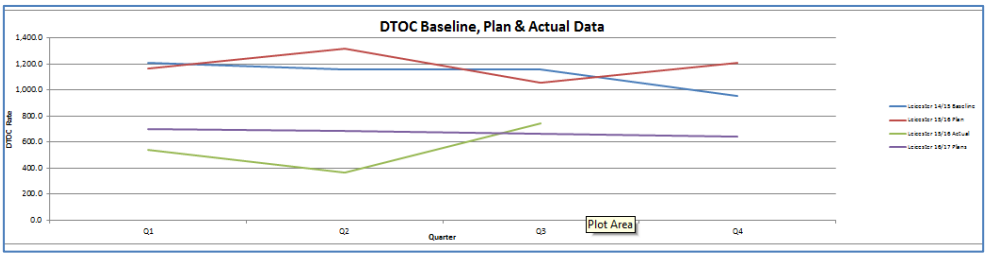


Reasons for delay by Provider Trust, Leicester City CCG, March 2016

This is a particular area of focus in our 16/17 plans and again aligns to wider system redesign work.

Opportunity analysis for 2016/17

Our DTOC trajectory is therefore set to reduce our rate further but then maintain the rate given the reduction achieved in 15/16:



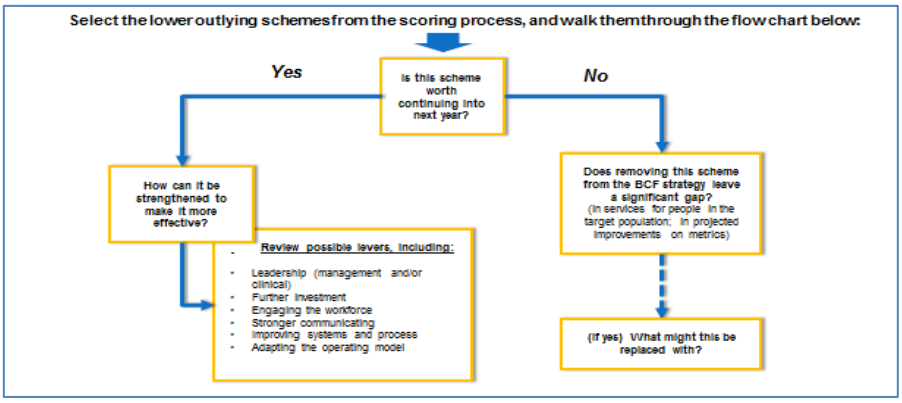
Leicester City DTOC BCF plan, Jan 2016

This has been agreed by the CCG, LA and the HWB and is being agreed at provider level in March 2016.

Evaluation of 15/16 schemes

We know we have made some progress in 2014/15 and 15/16 through the implementation of BCF schemes in the City; each intervention resourced in 15/16 has been evaluated using the BCF

evaluation toolkit. Services were scored based on the guidance in the toolkit and those which scored low were then taken through part b of the process to determine how best to proceed as described in the diagram below:



This process was chaired by an Independent Lay Member of the CCG Board and all decisions were ratified by the JICB.

As a result, each scheme has been either up scaled or re-focussed in readiness for 16/17. Key changes in 16/17 include expansion of our Clinical Response and Integrated Crisis Response Teams and better, targeted use of our ACG system (described below) to target our services to those patients who need them the most.

Usage of schemes in 2015/16

As the infographic below shows, the number of people being offered a much more integrated pathway of care has increased and that our patients are experiencing joint health and social care in their own homes where possible:

Leicester City Better Care Fund

Service usage

Care plans
15,000 care plans completed since inception

500 people per month accessing preventative services via **the Lifestyle hub**

Creation of one co-located health and social care team

100 patients per month treated by our **mental health planned care team**

3000 patients per month seen and treated by **2 hour, in home health and social care crisis teams**

2 City **Night nurses** are in place to prevent overnight admissions

Over 1000 at risk patients per month access the healthy homes programme

46 ICS beds have enabled flow across LPT and UHL sites

MH team on Bradgate & Bennion units has **halved LPT DTOC rate**

Our risk stratification programme – using Adjusted Clinical Groups to target our resources effectively

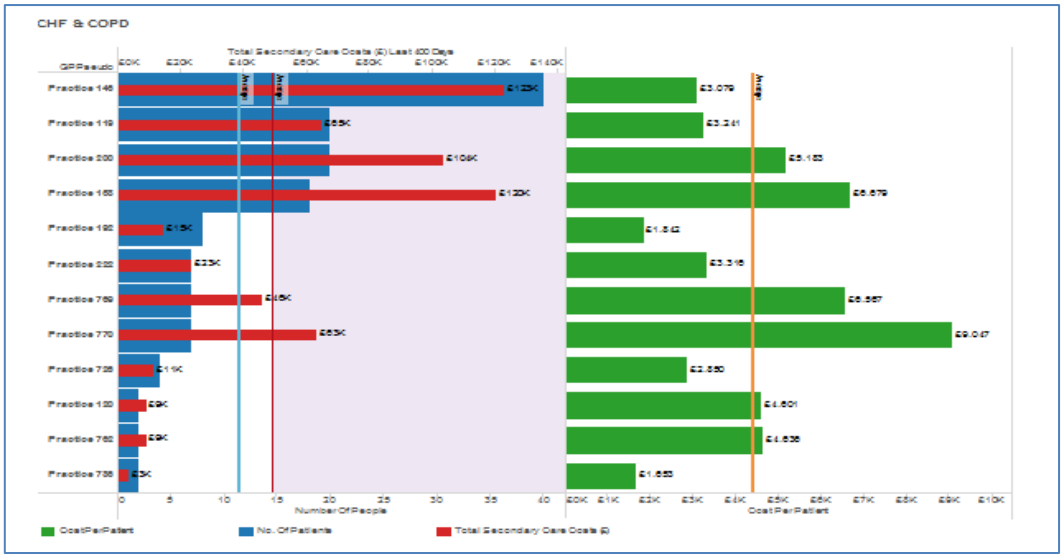
In order to identify the opportunity to improve quality and reduce costs, we have jointly been applying an iterative cycle of:

(a) population profiling,
(b) case-finding (identification of opportunities for clinical and health and well-being improvements of identified sub-groups of patients at practice level)
(c) resource allocation to address inequalities
(d) evaluation based on case-mix adjustment to fairly analyse variation in performance and identify realistic opportunities for improvement

The Adjusted Clinical Groups (ACG) system licensed from Johns Hopkins University School of Public Health is the central platform for supporting all elements of this cycle. The outputs from this risk stratification system will be used in conjunction with other data sets such as public health data and pathway data supplied by the PI Track and Care system to implement an intelligence-driven strategy which targets historical health inequalities in the city as a means of improving clinical outcomes and patient experience.

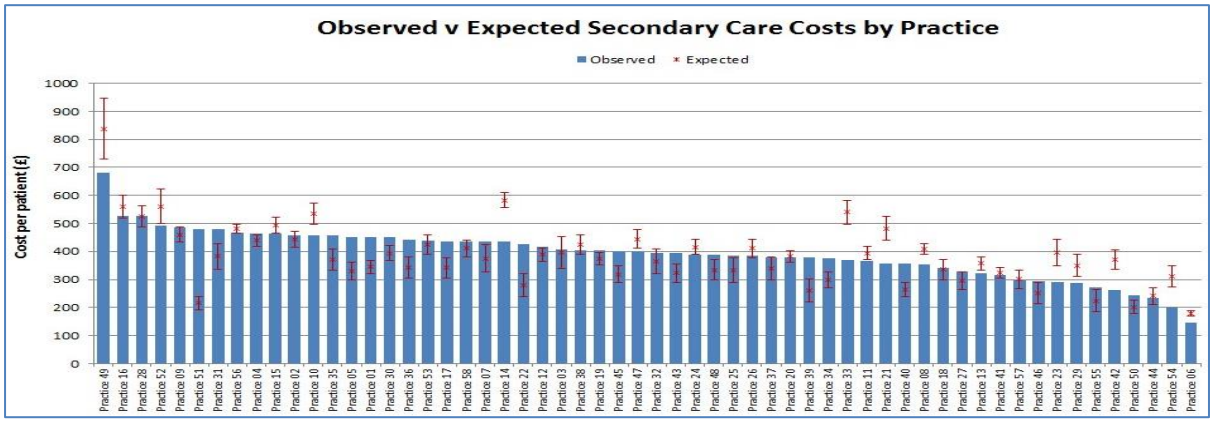
Population profiling - quantifying levels of unmet need, addressing issues of service quality and/or inefficiencies in service delivery

Every GP practice population in the city has been risk stratified using the ACG system. Aggregation of these data to CCG level shows that it is multi-morbidity rather than age which is the main driver of secondary care cost. For example, we know that our multi-morbid patients aged 20-44 with 7 or more LTC's cost as much in acute hospital care as those aged 80+ with similar morbidity.
Our analysis however, also tells us that multi-morbidity is not evenly distributed between our practice populations. Some practices will require more resources as they have a greater burden of ill health to manage. The data below shows that the number of people with a combination of heart failure and COPD is not evenly distributed across one Health Need Neighbourhood and nor do those patients have equal spend in secondary care:



HF and COPD recorded prevalence and actual secondary care spend – HNN 1, Leicester City

Equally, we know that there is wide variation in observed vs expected secondary care spend across the City:



Observed vs expected secondary care cost for Leicester City Practices

This type of evaluation in combination with other data has allowed us to more accurately identify practices where variation in activity may not be warranted and to drill down to disease areas and even to patient level detail to co-produce evidence-based improvement plans.

Application of the data

In order to co-produce a manageable and targeted cohort, we have drilled down from CCG population level through the levels of our Health Need Neighbourhoods to practices and then that of individual patients in order to understand our health inequalities and have a good basis for joint commissioning and resource allocation which gets away from a “one-size-fits-all” approach.
We have subsequently used this systematic analysis to work with our partners to design and implement a range of primary and secondary prevention services in 16/17, targeting those with complex health and social care needs. Through the provision of high quality, integrated health and social care services, our core aim is to reduce the probability of an emergency admission in this cohort.

Our analysis has concluded that the highest 20% at-risk patients account for over 60% of the total cost of emergency admissions for the CCG. Using this model, we have profiled our target population as follows:

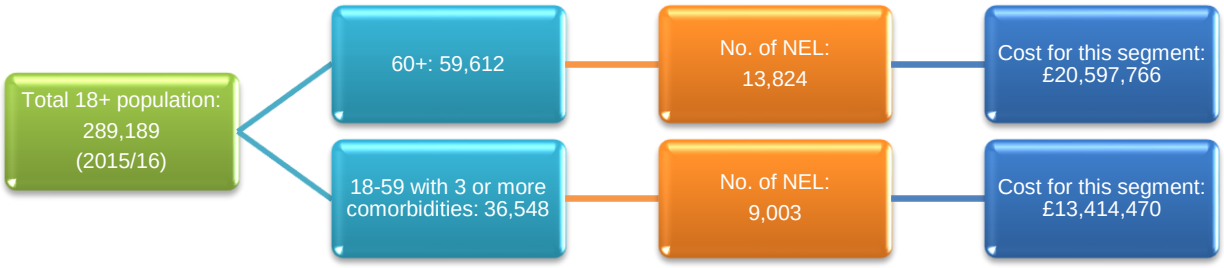


Figure 1: Population segmentation by age, multi-morbidity (December 2015)

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

a) those aged 60 and over;
b) 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);
c) those with dementia.

This gives us a target BCF cohort of approximately 96,160 patients; however, in recognition that this cohort is still fairly large, we have undertaken further analysis to identify where and how to target our resources.

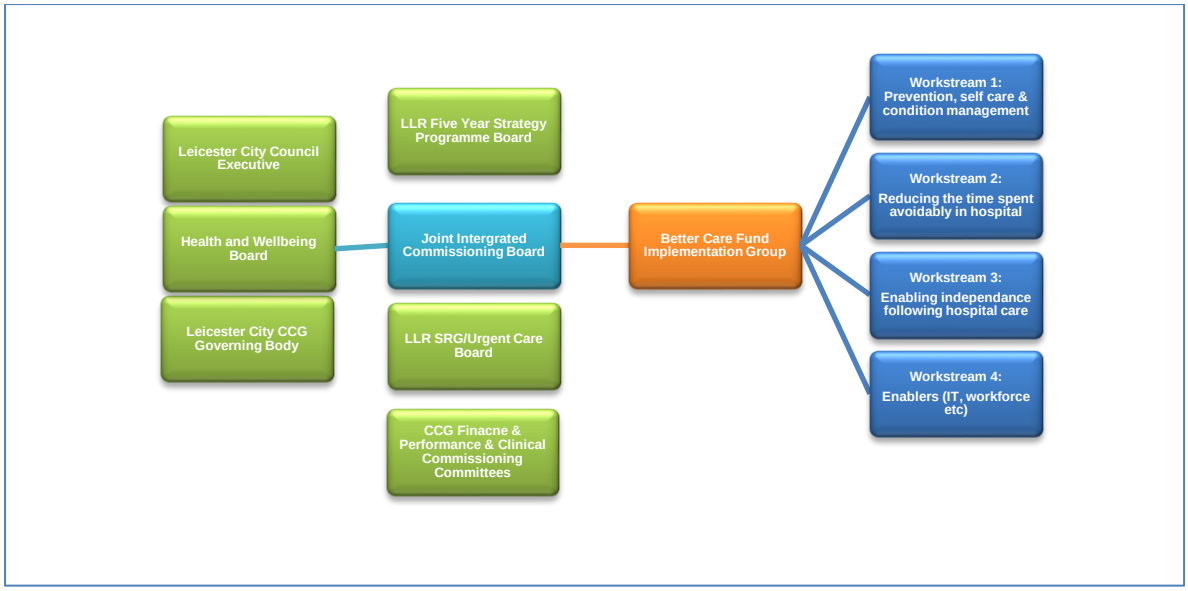
We have limited the second sub-cohort above to those with a specific set of LTC's based on the NHS RightCare Casebook implemented in Slough CCG. This gives a specific cohort of 3,100 patients across the City. For this sub-cohort in 2016-17, we will be implementing a primary care incentive scheme which will support practices to lead on delivery of integrated care across all sectors for those with specific complex combinations of LTCs. The scheme supports primary care to provide extended consultation appointments (to increase productivity and quality and improve patient experience) for these patients and to proactively book appointments with the clinicians or other professionals best placed to deliver key aspects of the patient's integrated management plan.

Chapter 3: A coordinated and integrated plan of action for delivering that change

In April 2013, both the Leicester City Health and Wellbeing Board and the Joint Integrated Commissioning Board were formally established. The JICB holds responsibility for delivery of the HWB strategy as well as overseeing joint commissioning between Leicester Clinical Commissioning Group and Leicester City Council. This joint accountability has been integral to successful strategic oversight & management of delivery of the BCF in the first 2 years of operation.

Governance

The governance of the Better Care Fund Programme builds on a mix of strong existing partnership groups, with the key delivery group being the Better Care Fund Implementation Group.



Leicester City Better Care Fund programme structure

Governance arrangements: strategic oversight

Strategic oversight is provided by the Leicester City Joint Integrated Commissioning Board (JICB) which is the delivery function of the HWB. The JICB consists of executive leaders from the health and social care economy, including the Managing Director of Leicester City CCG, the Chief Operating Officer of the Local Authority, the Director of Adult Social Care, Directors of Finance for the CCG and the local authority as well as clinicians from both the CCG and partner organisations.

Monthly progress reports are provided, including progress against milestones, expected vs actual activity data and any risks associated with the programme. The same report is sent to the Better care Together 5 Year Strategy Group to ensure key stakeholders are sighted on progress.

Governance arrangements: delivery

The delivery of each work stream of the BCF is overseen by the Better Care Fund Implementation Group, which meets monthly. This is chaired by an independent lay member of the CCG and consists of the following stakeholders:

- the four Chairs of the general practice 'Health Needs Neighbourhoods' in the CCG;
- Director of Adult Social Care, Local Authority;
- Deputy Director of Strategy & Planning, CCG;
- Lead Nurse, CCG;
- Heads of Service at the Local Authority;
- Head of Strategic Change, UHL;
- Heads of Service at LPT;
- Heads of Service at SSAFA;
- Heads of Service at EMAS;
- Workstream Project Managers across organisations.

Relevant functions across the organisations attend for specific items as required. Each project completes a highlight report, outlining expected and actual progress, key risks and quality issues and actions for the coming month. Any remedial actions are agreed and monitored here, with unresolved issues being escalated to the JICB Chair within 1 working day. Sub-groups of the BCF Implementation groups, detailed in the diagram above, are predominantly chaired by Governing Body GP's where relevant; where not, they are chaired by senior officers across health and social care.

The group also oversees the BCF Risk log; this is a fully populated and comprehensive risk log, developed in partnership with all stakeholders. Risks are escalated at project level to the Deputy Director of Strategy (CCG) who holds the risk log. The log is updated to reflect the risk and signed off by the risk owner. Any risks above the Risk Threshold in the CCG/LA risk management policies are escalated appropriately. The risk log is interrogated monthly at the BCF Implementation Group to ensure that risks are managed and escalated where appropriate if mitigations are not secured.

The risk log as at February 2016 is available as Appendix 4.

Performance management of the programme

As the BCF is one of the key enablers to multiple streams of work across the CCG, Local Authority and provider organisations, a comprehensive suite of monitoring has been formulated. These outcome measures have been agreed at the BCF Implementation Group, with input from all partner commissioner and provider organisations across the Health and social care economy and align to HWB strategy, the JSNA and the CCG Operational Plan and five year STP plans.

Strategic level – Monthly reporting to the JICB and CCG Clinical Commissioning Committee

At a strategic level, an overarching system dashboard has being formulated, covering the 5 + 1 national metrics as well as other relevant metrics to manage flow at a system level. These have been drawn from the ASC, NHS and public health outcomes frameworks as well as local flow measures and enables all health and social care organisations to understand the quality of services and the patient flow through the system in terms of inflow, throughout and outflow metrics.

Monitoring at this level has enabled the JICB and the CCG Clinical Commissioning Committee to understand issues affecting performance and intervene early to mitigate more strategic issues. For example, monitoring at this level has enabled early identification of issues affecting delayed transfers of care within mental health units and has accelerated multi-organisational change to improve patient experience and performance.

Operational Level – Monthly reporting to the BCF Implementation Group

Underneath this, sits a comprehensive Integrated Care QIPP Dashboard, specially produced to support the performance management function for the BCF Programme. This shows a suite of local metrics by project, providing a coordinated view which aids understanding of any barriers to achievement of the overarching national metrics, as well as providing further commissioning intelligence across the Leicester City health and social care system.

Again, monitoring at this operational level has already led to change in pathways. For example, monitoring of the Clinical Response Team activity outlined capacity in the service to take on a wider range of calls from EMAS early on in the project. As a result, call categories were increased, leading to a greater number of calls being diverted to the CRT within a few weeks.

Practice level – Weekly reporting

Finally, GP practice level monitoring has been added to monitor progress against practice level targets for interventions aligned to the BCF, such as care planning, access to preventative services and overall acute care usage by practice.

In totality, this provides a comprehensive view of both the health and social care system as a whole and tracks performance of the Integrated Care model. Examples of these are provided in Appendices 5 & 6.

Key milestones for 16/17

The key milestones associated with delivery of our vision are highlighted below:

Summary of BCF Implementation Plan 2016/17	A	M	J	J	A	S	O	N	D	J	F	M
Launch expanded CRT & ICRS services												
Launch Housing Enablement Team												
Launch expanded care home service												
Integrate community bed pathway												
Launch expanded MH team												
Lifestyle hub 'summer push'												
Vanguard/BCF/SRG alignment												
BCF 17/18 design programme launched												

Chapter 4: National conditions

Condition a: An agreed approach to financial risk sharing and contingency

Following the publication of the revised BCF guidance in March 2016, the impact of non-delivery of the calculated reduction in emergency admissions has been risk assessed for the Leicester City BCF plan. Given the volatile nature of emergency admissions trends for Leicester City CCG (which has

seen swings of -23.6% to +8.2% over the last 4 years), both the CCG and LA are in agreement that a risk pool should be created.

Our risk pool of £1.9m equates to 1293 emergency admissions based on the average cost of an emergency admission of £1490. However, as the modelling in later chapters shows, the 16/17 BCF is aimed at reducing our ultra-short stay admissions (0-6 hours) – therefore a local price of £914 has been modelled for this cohort, with an associated reduction of 2078 NEL. This is the proportion of the Leicester City pooled budget which will be subject to pay for performance; this has been agreed between the CCG, Local Authority (and will be with partner providers, including the Acute Trust as capacity and financial planning progresses).

It is recognised that other factors outside of the BCF interventions and related HRG codes will have an impact on the total emergency admissions performance, given the definition of this metric. For example in 2015/16, Leicester City CCG saw its short-stay emergency admissions increase by c37% without any corresponding increase in either ED attendance or decrease in community activity. Investigation shows that this as a result of pathway changes in the urgent care system. This increase is currently under review with UHL. The intention within the Leicester City BCF plan is to be clear about the relative contribution of the interventions mobilised and be able to record and demonstrate their impact.

Equally, we have applied a PESTEL analysis to assess the non-financial interdependencies and risks of non-delivery; our analysis shows that key risks for the City continue to be the variability of performance of the urgent care system, negative patient outcomes and experiences, deprivation and socio-economic impacts of changes to the welfare system and appropriate provider contracting and payment mechanisms.

Condition b: Plans to be jointly agreed

The BCF Plan, covering a minimum of the pooled Fund specified in the Spending Review, has been signed off by the HWB, Leicester City Council and the CCG in February 2016.

In agreeing the plan, Leicester City CCG and the local authority have engaged with health and social care providers likely to be affected by the use of the Fund in order to achieve the best outcomes for local people. This has been done through a transparent and open evaluation process, which all stakeholders have been party to and then approved by both the BCF Implementation Group and the Joint Integrated Commissioning Board. Presentations have been made to the UHL executive team and formal approval of 16/17 plans is expected in March 2016.

There is joint agreement across commissioners and providers as to how the BCF will contribute to a longer term strategic plan – this has been demonstrated in earlier chapters of this plan. This includes an assessment of future capacity and workforce requirements across the system, which feeds into the Workforce workstream of the 5 Year Better Care Together Programme. The implications for local providers have been set out clearly for HWBs so that their agreement for the deployment of the Fund includes recognition of the service change consequences. This is especially

true for the acute trust who will see a reduction in both activity and Length of Stay if current projections are realised.

The DFG allocation has been agreed with the Housing Department when setting the budget for 2016/17. There is an agreed plan to deliver adaptations, with a policy in place and well established joint working arrangements across housing, social care and health.

Condition c: Maintain provision of social care services

Adult Social Care Services continue to be protected; through the allocation of resources to ensure both eligible needs and preventative needs can be supported. The level of protection has been maintained in real terms, with additional funding in 2016/17 to recognise the increasing pressures through rising demand. This level been jointly agreed with all partners through a transparent process of funding allocation, overseen for the Health and Wellbeing Board by the Joint Integrated Commissioning Board. This takes account of the whole system and has been actioned to ensure there is no adverse impact on the wide Health and Social Care system.

The comparison to 2015/16 is set out in the BCF planning template and the approach is consistent with the 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013-14.

Condition d: Agreement for the delivery of 7-day services across health and social care to prevent unnecessary non-elective (physical and mental health) admissions to acute settings and to facilitate transfer to alternative care settings when clinically appropriate

As part of our core delivery offer our Better Care Fund plans include seven-day working (where applicable & feasible) as a standard expectation to support the flow across the health and social care system. For example, most schemes mobilised in 2015/16 through the Better Care Fund have been on a seven-day service expectation. This includes the Clinical Response Team, the Unscheduled Care team and the Planned Care Team and these will continue in 16/17.

We recognised in 14/15 that traditionally these types of services were poorly utilised, both for admissions avoidance and discharge. In recognition of this, relevant elements of the BCF services in 15/16 were commissioned to include a 'pull' mechanism with both our acute and community trusts whereby BCF teams are on-site, working in partnership with providers over 7 days to safely avoid admission or expedite discharges. This has led a reduction in our DTOC rate and the usual Monday morning pressures at the acute site in particular and will continue on in 16/17.

How will the BCF interventions enable 7 days services to be delivered?

BCF Intervention	Impact on 7 day service provision
Services for complex patients	Enhanced access to primary care

Clinical Response Team	7 day service to prevent hospital admissions
Unscheduled Care Team	7 day service to prevent hospital admissions
Intensive Community Support service	7 day service to prevent hospital admissions and increase weekend discharge
Planned Care Team	7 day service to prevent hospital admissions and increase weekend discharge
Mental Health Discharge Team	7 day service to prevent hospital admissions and increase weekend discharge

As part of our commitment to deliver seven-day services, the 2016/17 Acute Service Development and Improvement Plan includes a specific action plan to deliver against the clinical standards outlined in the 7DS document. This is monitored and delivered through the Leicester, Leicestershire and Rutland Urgent Care Board but due to the interdependencies, is also aligned with the BCF plans for 16/17. We will evaluate the impact of these and where relevant will move these into the quality requirement section of the NHS Standard Contract for future years.

After discussions with the Academy of Medical Royal Colleges, the following four standards have been identified as being most likely to have the most impact on reducing risk of weekend mortality for 16/17. These are:

- Standard 2: Time to Consultant Review
- Standard 5: Access to Diagnostics
- Standard 6: Access to Consultant-directed Interventions
- Standard 8: On-going Review

We in the process of agreeing plans to enact these standards as part of the 16/17 contracting process with our acute provider; once agreed, we will report the results of bi-annual surveys of progress which will take place in September and March, using the national Seven Day Service Self-Assessment Tool.

Condition e: Better data sharing between health and social care, based on the NHS number

There is local commitment to share data lawfully in order to improve outcomes. The data agenda is owned at a senior level in order to demonstrate the right cultures, behaviours and leadership required to foster a culture of secure and lawful data sharing.

The LA is consistently using the NHS number with 94% of cases having a verified NHS number in place. Through a process of Information Governance Compliance the LA system (Liquid Logic) is now able to connect to the NHS spine, to obtain verified NHS numbers. Processes are now in place to ensure that all new cases use the NHS number as the primary identifier. Additionally work has been completed locally to develop PI Care Trak, which draws data from Health and Social Care IT systems in order to provide pseudonimised patient information on cost and activity across the whole system.

IG controls are in place with an information sharing agreement and are compliance with revised Caldecott principles. The responsible data holder has provided information to local people about

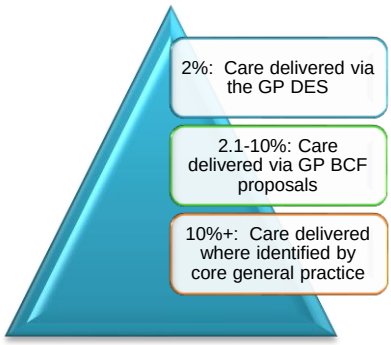
how data is used, routinely capturing consent to share data where data is shared, in line with IGA guidance.

With the above in place, and further work in progress to link in primary care (GP) data, the system has access to a consistent NHS number for the purposes of primary identification. With PI Care Trak we are able to interrogate costs, activity and extrapolate this in many ways in order to understand the impact of interventions/services and patient pathways. This will allow informed whole system commissioning based on evidence of cost, outcomes and patient journeys. Shared data is also being used in integrated teams with LA staff using the NHS system 1 to receive and feedback on patient referrals by primary care.

Condition f: 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

Proportion of case managed patients

As outlined in the case for change above, using the Adjusted Clinical Groups (ACG) risk predictive software, we plan to have a tiered approach to case management in 16/17:



Services for the top 2%:
The new DES that came into effect in 2014/15 and is focused upon providing targeted support for the top 2% of at risk patients.

Services for the 2.1-10%:
Risk stratifying our next 2.1-10% of high risk patients suggests a sub-cohort of 3,100 patients (predominantly from our local BCF population definition of those aged 60+ or 18-59 with three of more comorbidities or with dementia), who would require a named care coordinator and case management.

Joint management of care
In 15/16, disparate health and social care teams were bought together under the aegis of the Joint health and social care Planned and Unscheduled Care Teams – this, for the first time, bought together health and social care teams together structurally. The teams were then co-located into one building, encouraging partnership working at a scale not seen before in the City. Finally, the

teams across both health and social care have been realigned to the 4 'Health Need Neighbourhoods' in the City, creating a truly integrated health and social care team, aligned to General Practice.

These teams run daily MDT meetings for specific joint cases and this has improved patient experience and communications between agencies tremendously. In 16/17, we plan to work on a joint assessment protocol which will allow joint assessments to take place – this is an LLR piece of work being taken forward via our Vanguard Programme.

Condition g: Agreement on the consequential impact of the changes on the providers that are predicted to be substantially affected by the plans

Our key providers have been a part of the design and implementation of the Leicester City BCF since inception of the Fund. Formal updates are provided to provider boards annually, either through a face to face presentation or a written report. The impact of our local plans is due to be taken through a clinical confirm and challenge in March 2016 with UHL and LPT to ensure organisational and political buy-in.

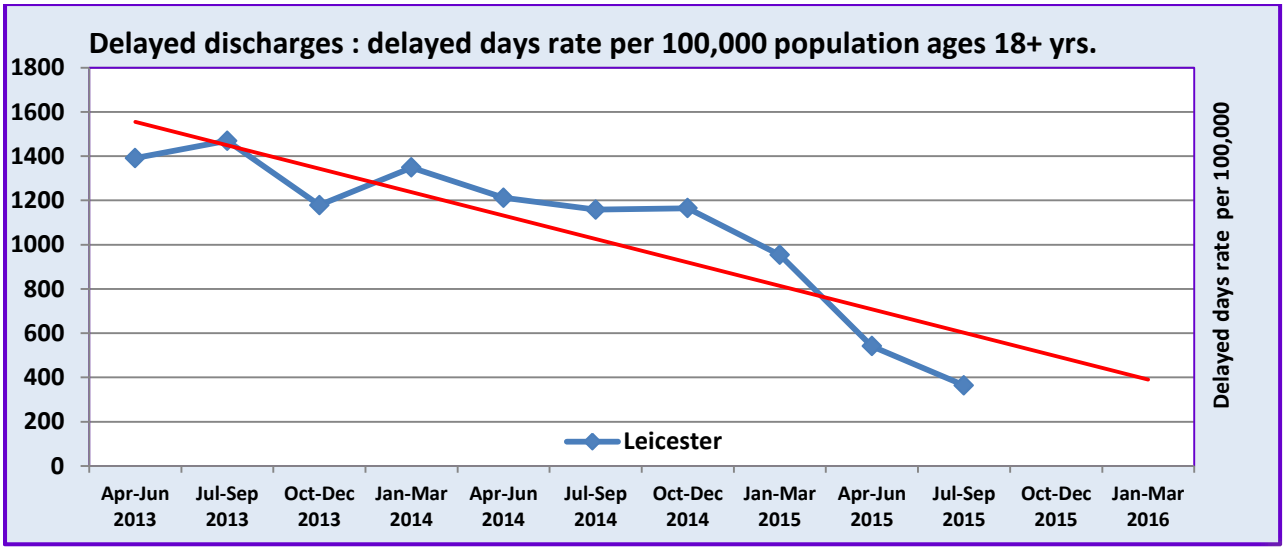
Condition h: Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care

As discussed in earlier chapters, we have agreed as a system to implement a local risk sharing arrangement, given the risk of unplanned activity in the area of non-elective activity. Our base analysis is data driven and includes consideration of the long term trend in admissions and the success of schemes implemented to date. Our risk sharing arrangement is consistent with guidance.

Condition i: Agreement on local action plan to reduce delayed transfers of care (DTOC)

As part of our SRG and urgent care programme, we have developed a local action plan for managing DTOC. This is based on analysis of the reasons for delay by acute site. This is managed by our Discharge Steering Group, which reports into the Urgent Care Board and includes executive level representation from each commissioner and provider. The plan is within the context of the overall System Resilience Group plan for improving patient flow and as a result performance. We have acknowledged that action is required by all partners both in hospital and in the community to achieve and maintain the rate. This includes reducing avoidable admissions, effective in-hospital management and timely and safe discharge.

Through 15/16, we have been enacting this plan using our BCF commissioned services. This has included on-site LA support 7 days per week and additional commissioning of virtual beds in the community to unblock flow. As a result, our DTOC rate has fallen steadily:



Leicester City BCF DTOC monitoring, Jan 2016

For 16/17, we have established own stretching local DTOC target and this has been agreed between the CCG, Local Authority and relevant acute and community trusts and our relevant voluntary sector partners. Given our significant improvement in 15/16, this target is to reduce the rate of DTOC's further but then to maintain a low rate. This target is reflected in our CCG operational plan. Given our current performance, we will not be applying or using local risk sharing agreements with respect to DTOC. The BCF Implementation Group will monitor the target and report this monthly to the LA and CCG via the JICB.