Better Care Fund planning template – Part 1

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

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

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

1) PLAN DETAILS

a) Summary of Plan

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

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

b) Authorisation and signoff

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

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

There is a strong, substantial and successful history of collaborative working across health and social care in Leicester, enabled by robust clinical and political support. This culture of meaningful and effective collaboration has already enabled partners in Leicester to make a real difference, notably through the development of a number of schemes and initiatives aimed at reducing health inequalities in the city.

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

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

We have worked closely as one health and social care community on these programmes of work, aiming for systemic change that provides the right level of care at every step of the patient pathway. Full and open engagement with partner organisations has greatly informed the specific schemes detailed in this paper. The plan has also had significant input from other stakeholders, members of the public, patients and carers.

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

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

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

Significant engagement has taken place throughout 2013 around our aims for systemic transformation, and we first introduced the concept of the Better Care Fund at our joint Call to Action event on 3 December 2013.

The event, which was aimed at stakeholders, General Practitioners, patients, carers and members of the public from across the city, presented an outline of the Better Care Fund, its national goals and objectives and tasked attendees with identifying and sharing areas for improvement in health and social care. These responses have been used as a basis to inform all Better Care Fund work streams.

The key themes that emerged from the engagement are the importance of carrying out a full assessment of all of a patient's needs, including health, social care and mental health; integrating care into community settings and putting the wishes of the patient at the centre of decision making; all of which have directly influenced the initiatives in this draft plan.

To commence moving our plan into implementation, a further workshop event is taking place in February 2014. This event will seek to validate the priorities identified and explore how we should measure and pay for 'good' and 'excellent' health and social care through our emerging model of Outcomes-Based Commissioning rather than traditional contracting methods.

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

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

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

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

	communities. **http://www.leicester.gov.uk/your-council-services/social-care-health/jsna/jsna-reports/**
Joint Health & Wellbeing Strategy (JHWS)	The Joint Health and Wellbeing Strategy sets out the priorities and actions which the Health and Wellbeing Board are planning to carry out in the period 2013 to 2016 for Leicester City. **http://www.leicester.gov.uk/your-council-services/health-and-wellbeing/health-and-wellbeing-board/joint-health-and-wellbeing-strategy/**
Draft CCG Operational Strategy 2014-2016	The Operating Plan sets out the Leicester City Clinical Commissioning Group plan for health care commissioning in 2014/15 and 2015/16. It describes our vision and priorities based upon analysis of public health information and listening to our partners and local people. ***To follow***
A Call to Action: Achieving Parity of Esteem; transformative ideas for commissioners	NHS England has established a Parity of Esteem Programme in order to focus effort and resources on improving clinical services and health outcomes by putting mental health on par with physical health. The Parity of Esteem programme provides ideas on how this can be achieved locally. http://www.england.nhs.uk/wp-content/uploads/2014/02/nhs-parity.pdf

VISION AND SCHEMES

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

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

Our core vision

Our core vision, set out in Leicester's Health and Wellbeing Strategy, remains the same:

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

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

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

Context

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

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

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

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

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

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

Our approach to the development of our core vision

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

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

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

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

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

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

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

This plan forms an integral and significant part of the Leicester City CCG 2 Year Operational Plan and is the key driver to achieving transformative change within the Leicester City Health and Social Care economy over the next 2 years. Our core priorities are coordinated with our partner Health and Wellbeing Board areas across Leciesterhisre County and Rutland County, taking into account the differences in need, demography and geography through differing delivery methods.

The changes presented in this plan will form the first 2 years of an overarching move towards a new way of working in recognition of the significant capacity and demand issues faced within the local health and social care economy. By 2018/19, it is recognised that there will be a significant financial gap if we do not change the manner in which services across health and social care are provided. Across Leicester, Leicestershire and Rutland this is being progressed through the 'Better Care Together' 5 Year Strategic Plan, of which the 3 local Better Care Fund Plans form a part of.

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

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

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

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

Table 1: Priority areas, national ambitions and local principles

10 National Ambitions	Local principle	Local Priority area
Improving health – working together with the Health and Wellbeing Board to ensure the key elements of commissioning for prevention are delivered	Access to preventative services is essential to prevent ill health, avoid deterioration in overall wellbeing and achieve greater independence	Prevention, early detection and improvement of health-related quality of life

Increasing the proportion of older people living independently at home following discharge from hospital	Care should be provided in an integrated way with services organised around the patient and the needs for their carer(s) People should have early diagnosis and timely access to services, particularly when in crisis	Enabling independence following hospital care	
Parity of esteem – ensuring patients with mental health problems don't suffer inequalities		Prevention, early detection and improvement of health-related quality of life	
Securing additional years of life for the people of England with treatable mental and physical health conditions	Services that proactively support people to maintain their health, wellbeing and independence for as long as possible should be provided, receiving care in their home and local community wherever possible	Prevention, early detection and improvement of health-related quality of life	
Improving the health-related quality of life of the 15 million+ people with one or more long-term conditions, including mental health conditions		Prevention, early detection and improvement of health-related quality of life	
Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital	Acute hospital emergency admissions to be regarded as an exception by all parts of the system	Reducing the time spent in hospital avoidably	
Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care		Reducing the time spent in hospital avoidably	
Reducing health inequalities – ensuring the most vulnerable in our society get better care and better services through integration, in order to get better health outcomes	Tackling the wider or social determinants of health is integral to an approach which puts the patient at the centre of care	Prevention, early detection and improvement of health-related quality of life	

Increasing the number of people with mental and physical health conditions having a positive experience of hospital care	Integration will deliver better outcomes for patients and their carer(s), improves care and patient experience	Reducing the time spent in hospital avoidably
Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community	Services that proactively support people to maintain their health, wellbeing and independence for as long as possible should be provided, receiving care in their home and local community wherever possible	Prevention, early detection and improvement of health-related quality of life

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

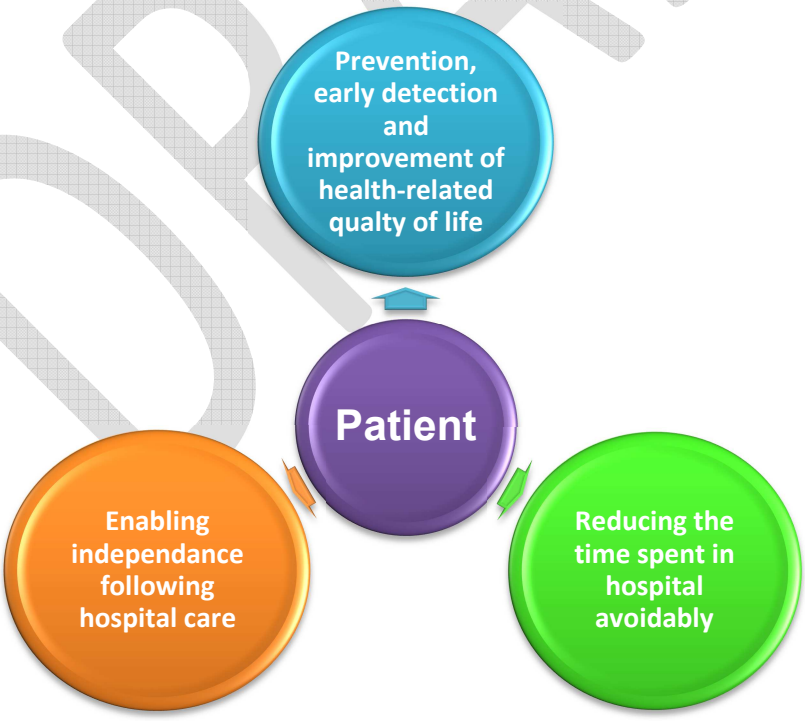

Figure 2: The Leicester City model of integrated care

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

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

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

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

- Prevention, early detection and improvement of health-related quality of life; services such as risk stratification will target patients at risk of deterioration and hospital admission.
- Services designed to reduce the amount of time people spent avoidably in hospital will prevent those patients in crisis being admitted to hospital; instead they will be treated in their own homes using a better, more integrated community approach, delivered in a holistic fashion.
- Services designed to enable independence following hospital care, such as support to keep patients independent as well as to prevent further avoidable time in hospital where possible.

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

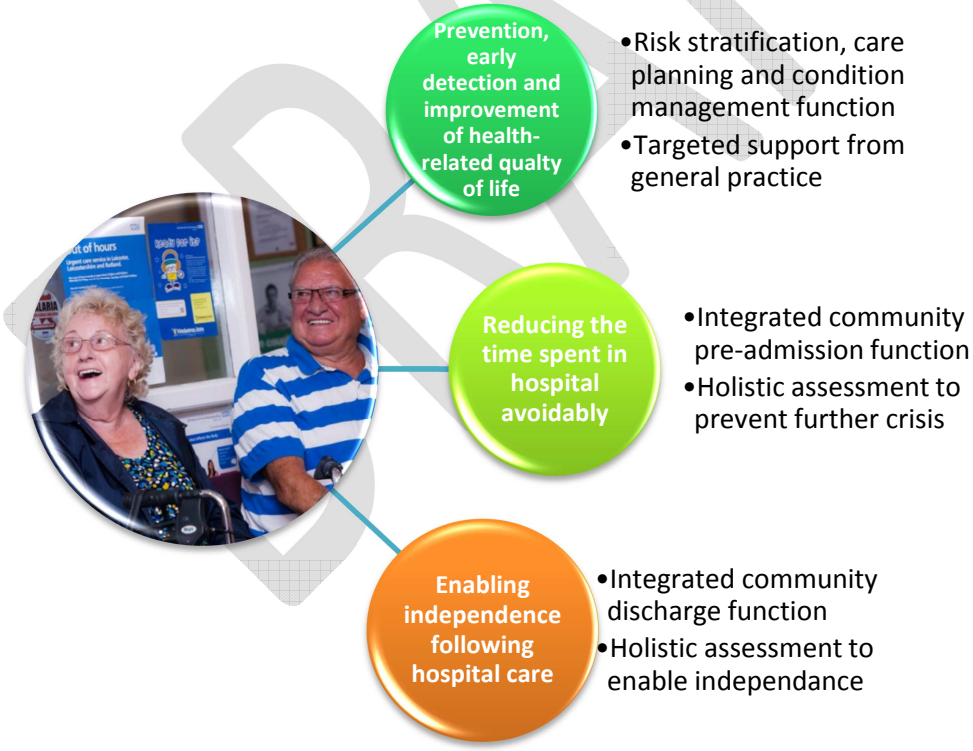

Figure 3: The Leicester City pre- and post-hospital pathway 2014-2016

This integrated model of delivery will enable us to achieve what we set out originally to do: work together with communities to improve health and reduce inequalities, enabling children, adults and families to enjoy a healthy, safe and fulfilling life.

Key enablers of our vision

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

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

Table 2: Better Care Fund workstreams

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

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

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

What will be different in five years?

This programme is purposely aligned with longer-term strategic change across the

Leicester, Leicestershire & Rutland health and social care economy. This is coordinated through the Leicester, Leicestershire and Rutland *Better Care Together* programme and our plans form a part of the Leicester, Leicestershire & Rutland 5 year Strategic Plan. The Strategic Plan will set out the medium term direction for the models of health, care and support services that will need to apply in five years' time across Leicester, Leicestershire and Rutland (the LLR 'unit of planning' footprint) and the steps needed to realise that vision.

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

There will be a significant shift in activity which has traditionally been delivered through the acute sector to a modern model of integrated care, provided at scale in the community. We expect this new model of integrated care to change patient flows to the extent that in five years, we will have seen up to a 15% reduction in the form and function of the acute sector and a significant growth in the services offered in the community.

This transformative change in form and function, while keeping with each organisation's individual responsibilities, will change the landscape of all future commissioning of integrated care models for our city. We will not let traditional boundaries stop us from progressing towards our vision of whole-scale transformational change.

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

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

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

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

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

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

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

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

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

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

b) Aims and objectives

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

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

The aims and objectives of our integrated system

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

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

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

hospital care.
- To provide safe, transparent and open data sharing across our system, enabling proactive coordination of care for our citizens.

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

Priority 1: Prevention, early detection and improvement of health-related quality of life
We will achieve this by:
- Increasing the number of people identified as 'at risk' and ensuring they are better able to manage their conditions, including out of hours, thereby reducing demand on statutory social care and health services. This will include both physical and mental health.
- Delivering 'great' experience and improving the quality of life of patients with long term conditions using available technology and patient education programmes, reducing avoidable hospital stays.
- Enabling the use of the NHS number as a primary identifier for all patients, linked to high-quality care plans for our frail elderly patients or those with complex health needs.

Priority 2: Reducing the time spent in hospital avoidably
We will achieve this by:
- Ensuring every person in the cohort experiences coordinated unplanned and planned care from an integrated team, ranging from health to 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. This includes increasing capacity in General Practice.
- Reducing the number of avoidable hospital admissions through the provision of rapid community responses, instead of a 999 response. This will focus primarily on those over 60 years of age.

Priority 3: Enabling independence following hospital care
We will achieve this by:
- Ensuring timely hospital discharge via the provision of in-reach (pull) teams to swiftly repatriate people to community based services and maintain independence.
- Increasing the number of patients able to live independently following a hospital stay.

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

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

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

	(including those in Section 256 agreements)					
Workstream 2: Wider primary care, provided at scale	Proactive care plans will be drawn up for our target population, specifically focussing on the 60+ and 18-59 with 3 or more comorbidities					
	Invest in preventative services, such as our new Leicester City Lifestyle Hub					
Workstream 3: A modern model of Integrated Care				Commission a Non-Elective team (NET), comprising of traditionally separate teams of health and social care, as one team, providing one service, 24/7.		
					Increase the capacity of the NET team above to be able increase the offer to support patients being discharged home, 7 days a week	
					Create a network of 10 new joint integrated teams covering all of Leicester City, including General Practice	
					Increase the number of these virtual beds through the life of the Better Care Fund, but commission them specifically for our patients in acute mental health services so that they may step down into community facilities	
				Review and then strengthen our reablement offer across both health and social care providers		
Workstream 4: Access to the highest quality urgent and emergency care				Commission one virtual team of 6 local GPs who will respond to 999 calls deemed clinically appropriate 7 days a week between 8am and 10pm		
				Securing community geriatric support for the whole pre-hospital pathway (covering GP team, Non-Elective Team and Planned Intervention Team as described above)		

Measures of success for these aims and objectives

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

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

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

- Estimated diagnosis rate for people with dementia.

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

Other measures of success

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

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

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

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

Measures of health gain

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

c) Description of planned changes

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

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

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

Work stream 1: Citizen participation and empowerment

We will use the Better Care Fund to:

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

Work stream 2: Wider primary care, provided at scale

We will use the Better Care Fund to:

- Invest an additional £4 per head of population (subject to approval) in GP services to ensure that our older population is cared for proactively by a named GP and has access to relevant services in General Practice
- Specific condition-management plans will be drawn up for our target

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

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

Work stream 3: A modern model of integrated care

We will use the Better Care Fund to:

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

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

We will use the Better Care Fund to:

- Commission one virtual team of up to six local GPs who will respond to 999 calls deemed clinically appropriate, seven days a week between 8am and 10pm. These GPs will assess and stabilise the patient and, where clinically appropriate, not-convey the patient the hospital but treat them in their own home. Basic diagnostic equipment will be part of the service, with access to on-call consultants at the

acute site should further consultation be required. If more complex diagnostics are required, the patient will directly access the Emergency Frailty Unit at the Leicester Royal Infirmary and be discharged home, rather than via a base ward.

- Commission community geriatric support for the whole pre-hospital pathway (covering the GP team, Non-Elective Team and Planned Intervention Team) to ensure that our patients are not admitted unnecessarily and equally, are admitted when clinically appropriate.

Other planned activity:

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

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

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

We will also continue to strengthen the involvement of our vibrant voluntary sector in the City. A workshop specifically with the voluntary sector has been held to ensure that we harness the expertise within the organisations to enable us to achieve our objectives. The recommendations which resulted from the workshop have been incorporated into our planning, with further input planned through 2014/15.

Application of Equality and Diversity principles

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

The current schemes have been fully assessed and local Equality leads are part of the Implementation groups for each scheme.

Indicative timeline

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

Actions completed to date:

Q3 2013-14

- Engagement process with our patients, service users and population to agree end-point outcomes began in October 2013.
- Governance structure to ensure all organisations are signed up to the ambition, scale and pace of the Fund was formulated in November 2013.
- Target population for interventions was identified and agreed in November 2013.
- Agreement reached with frontline staff across organisations about what and how to radically change to meet the aims and objectives for our Integrated Care programme in November 2013.
- A high-impact shortlist was developed from qualitative and quantitative intelligence, and developed into outline cases for evaluation in November/December 2013.

Q4 2013-2014

- Detailed activity, finance and workforce implications developed for every scheme under the Better Care Fund programme, including viability of mobilisation timescales, recruitment implications and any procurement implications.
- Further engagement with both patients and service users as well as key stakeholders including Leicester City General Practitioners.
- Approval achieved from all relevant bodies for priority schemes
- Mobilisation of priority schemes begun
- Governance structure agreed and mobilised, with agreed reporting lines and dashboards under further development

Actions planned:

Q1-Q2 2014-15

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

Q3-Q4 2014-15

- Begin mobilisation of remaining schemes.

From April 2015

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

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

These timescales may change subject to any unforeseen circumstances. However, the

risk of this will be limited by regular briefings to the *Better Care Together* Programme Board.

d) Implications for the acute sector

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

The long-term strategic direction of travel for the Leicester, Leicestershire and Rutland health and social care economy has been agreed collectively at the *Better Care Together* Programme Board. The membership of this includes Chief Executives and Lead Clinicians of all agencies across Leicester, Leicestershire and Rutland to ensure that individual organisations' plans, geographically aligned change programmes and all other plans strategically fit together.

The Leicester City Better Care Fund programme will regularly report into the *Better Care Together* programme to ensure that any modelling, in terms of activity reductions or increases, is explicitly understood by all organisations at an executive level as well via individual work streams at ground level.

There is an already established understanding that to achieve the shift of activity from an acute setting into the community will need significant investment in pre-hospital services, in both primary and community care. The Leicester, Leicestershire and Rutland *Better Care Together* five-year strategic plan, due to be completed by the end of 2013-14, will set out our vision for this.

This may include:

- Increasing the community footprint for Leicester, Leicestershire and Rutland
- Improved provision and access to primary care services, including an upskilling of GPs in Leicester City to provide more complex care in the community.
- Downsizing the acute footprint for Leicester, Leicestershire and Rutland

Leicester's Hospitals are currently consulting with their clinical base to assess options for a strategic outline case, looking at options available for the UHL footprint. Leicester, Leicestershire and Rutland CCGs have been an active part of this process and continue to support UHL in this objective.

The schemes detailed in this paper will support any downsizing by significantly reducing activity flowing into Leicester's Hospitals and increasing faster activity flows out. The schemes also enable the requirement set out in the NHS Planning Guidance 2014/15-2018/19 to reduce emergency hospital activity by 15%.

Clinical engagement from Leicester's Hospitals, Leicestershire Partnership Trust and East Midlands Ambulance Service for these schemes has been ongoing through the life of the Better Care Fund and will continue throughout to ensure that the ambitions set out in this paper are owned by the health and social care economy as a whole. We are currently modelling the impact of our schemes in detail, including the impact on estate, workforce and finance across the system.

Since the beginning of 2013/14 UHL have been operating at a financial deficit, which is expected to reach £39.8m by the end of the financial year. UHL has struggled with an unsustainable underlying financial deficit for a number of years, which has been compounded by an escalation in its spending during 2013/14 and some assumptions made by the Trust about income from CCGs and elsewhere which had not been agreed.

Much of UHL's deficit has however been driven by an inability to recruit medical and nursing staff ensuring that this level of support is now at c. £4m per month. Accordingly a reduction in emergency activity at least initially should be mutually beneficial with reductions in income at UHL more than offset by reductions in agency and locum costs and therefore contribute positively to the underlying UHL deficit.

There will inevitably be a point at which further removal of acute work will require UHL to start to reduce resources including physical and human. The scope and pace of this will require further detailed analysis and it is our expectation that there will potentially be a need for transitional support from the 1% transformation fund for UHL during this period.

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

Shared vision, shared leadership

The delivery of the Better Care Fund builds on a mix of strong existing partnership groups and a new Better Care Fund Implementation Group.

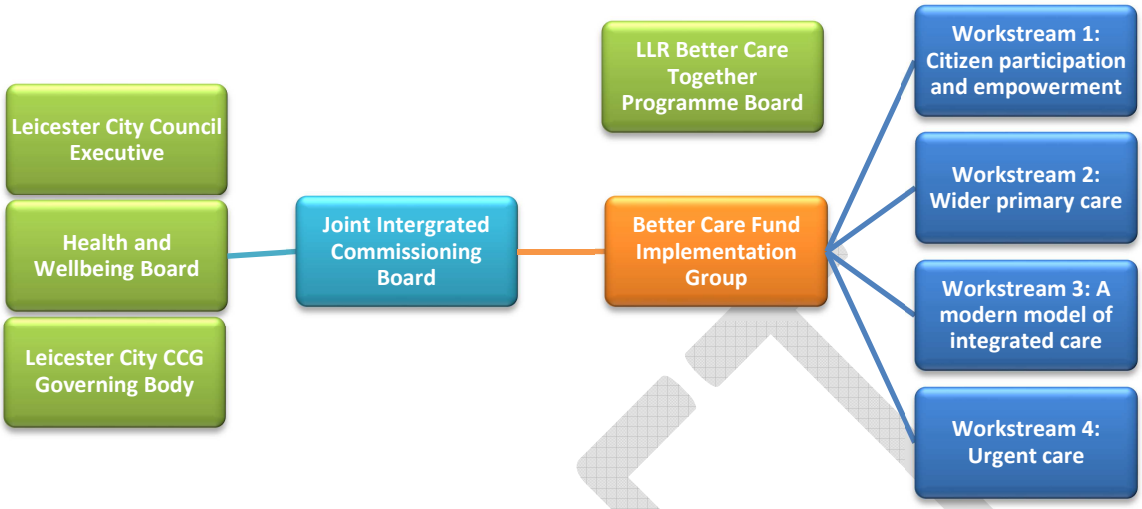

Figure 4: Better Care Fund Programme Structure

The Joint Integrated Commissioning Board consists of executive leaders from the health and social care economy, including the Managing Director of Leicester City CCG, the Director of Adult Social Care, Directors of Finance for the CCG and the local authority as well as clinicians from both the CCG and partner organisations. This Board will oversee the implementation of the Better Care Fund as one of its priority delivery groups.

The delivery of each work stream will be overseen by the Better Care Fund Implementation Group. This will run bi-weekly and be chaired by an Independent Lay member of the CCG. The Implementation Group will be attended by heads of service at both the local authority and partner organisations, and involved teams from relevant functions across the organisations. This will report into the Joint Integrated Commissioning Board for oversight and rapid issue resolution as well as the CCG Performance Executive for active interrogation of the key measures of success outlined above.

Given the collaborative nature of this programme, regular progress reports will also be provided to the LLR *Better Care Together* Programme Board to ensure alignment with the overall strategic direction of travel of the LLR health and social care economy.

Throughout the implementation of the programme, regular checkpoints have been arranged so that key CCG and partner organisation clinicians and elected members can confirm and challenge the overall programme of work.

NATIONAL CONDITIONS

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

Protecting social care services in the Leicester means:

Ensuring that those people with eligible needs within our city **continue to receive the support they require**, in a time of growing demand and budgetary pressures.

Delivering **new approaches to joined up care**, which help people to remain healthy and independent.

By ensuring **proactive interventions to our target population**, to support prevention, self-care and to enable people to tackle the wider determinants of poor health and poor quality of life.

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

Funding currently allocated to the Council has been used to enable the local authority to sustain the current level of eligibility criteria and to provide timely assessment, care management and commissioned services to eligible clients. This has also supported the provision of advice, signposting and a range of preventative services to the wider population.

Sustained funding from the Better Care Fund is required to maintain this position, and additional resources will need to be invested in social care to deliver the rapid access services that are required to respond to our agenda to reduce unplanned admissions and admissions to care homes.

A process has been completed which has identified a recommended level of support for social care that both requires Leicester City Council to ensure that it is delivering services in the most cost efficient manner and allows for a fund in 2015/16 with an investment pool equal to the expansion of services needed to meet the required reduction in use of the acute sector.

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

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

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

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

This builds on the existing enhanced service provision within community health and social care services to facilitate hospital discharge and/or admission avoidance. For example, there are already specific community health and social care services available over the weekend but we recognise that traditionally these have been poorly utilised, both for admissions avoidance and discharge. The test weekends described have proven that a more integrated model of seven-day working across front-line health and social care is vital for a more responsive and patient-centred service.

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

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

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

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

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

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

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

What we plan to do next
To ensure that Liquid Logic can use the NHS number as a primary identifier, Leicester City Council have started engagement with HSCIC to ensure appropriate procedures are in place to have access to the NHS number. The Council will apply, as a commissioner, to the HSCIC for the NHS numbers in order to populate the new care system shortly after its live launch. Role based access control will be in place and all staff will be trained to use the NHS number. The NHS number as primary identifier is expected to become standard procedure by June 2014.

All future information sharing agreements between the Council and health partners will include the NHS number as a specific piece of data that is required.

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

Leicester City Council is firmly committed to adopting systems that are based upon Open APIs and Open Standards (i.e. secure email standards, interoperability standards (ITK)). Any new systems that are procured for health and social care will have this as a core requirement. This will allow greater interoperability between systems and allow for greater electronic sharing of information.

The first step in the process has been to procure a new social care system (Liquid Logic). Liquid Logic has the ability to communicate and interoperate with health's IT systems. Once installed, the Council will work with health partners to ensure that information flows between health and social care are carried out electronically, securely and safely by using national standards.

The Council is currently a member of the NHS LLR IM&T Strategy Board. A key objective of this Board is to look at opportunities of sharing and using information better between various organisational systems to improve patient care. Open APIs, Open Standards and ITKs are reviewed as part of any new solution that the Board take forward.

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

Leicester City Council, Leicestershire Partnership NHS Trust and Leicester's Hospitals are signed up to the Leicestershire information sharing protocol which sets out the minimum standards expected from secure transfer of personal data (e.g. secure email, encryption, pass worded documents, registered post, secure FTP transfer). Newly formed health organisations such as the CCG and Greater East Midlands Commissioning Support Unit (GEM) are currently being invited to sign up.

Where data sharing takes place between these organisations written information sharing agreements are put in place. The county-wide Leicestershire Strategic Information Management Group are currently producing security standards for all partners in the county to adhere to when sharing information based on these standards.

We can confirm that we are committed to ensuring that the appropriate IG Controls will be in place. The existing county-wide information sharing protocol already introduced robust information governance standards across the county and followed Caldicott principles where health data was involved.

An information sharing protocol has been drafted between partners to cover all aspects of information sharing as part of the Better Care Fund. Individual information sharing agreements will be implemented for data sharing relating to the Better Care Fund.

All partners are committed to reviewing their relevant IG policies and fair processing notices to reflect the Caldicott 2 recommendations, and future information sharing agreements will reflect this. Leicester City Council's public health team has attained level 2 of the NHS IG Toolkit.

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

The Council has a named Caldicott Guardian within the organisation. The Guardian plays a key role in ensuring that the Council with social services responsibilities and partner organisations satisfy the highest practical standards for handling patient identifiable information. The Guardian actively supports work to enable information sharing where it is appropriate to share, and advises on options for lawful and ethical processing of information.

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

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

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

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

What we have done so far:

Leicester City CCG has supported practices in using the Adjusted Clinical Groups (ACG) risk predictive software (licenced from Johns Hopkins University in the USA) to risk stratify their registered population and identify those at highest risk of admission to hospital in the next year. We have invested in this to enable our practices to proactively identify patients at high risk of admission and apply a Multi-Disciplinary Team approach to their care.

What we will use the BCF to do next:

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

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

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

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

What we have done so far:

Using the Adjusted Clinical Groups (ACG) risk predictive software, this is approximately 7,200 people or 2% of the 360,000 residents of the city. We are working with our practices to implement proactive, holistic and responsive services for those patients identified using our RS model.

What we will use the BCF to do next:

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

Using our local population definition of those aged 60+ or 18-59 with 3 of more comorbidities, a further modelling exercise will take place with practices in July 2014. This will result in a targeted cohort of patients identified as high risk of admission with specific services available to support these patients. In partnership with our General Practices, our 'Planned Intervention Team' will be key to managing both the health related aspects of care required by these patient but also the social care required to manage the patient care in the community and to keep the patient independent. A care navigator will support the clinical lead in identifying the most appropriate service elements for their patient.

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

What we have done so far:

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

We have, in partnership with NHS England, implemented a Direct Enhanced Service, which incentivises our General Practices to apply the risk stratification system to their population and provide multi-disciplinary assessment and care for those patients identified as being at highest risk.

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

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

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

patients

What we will use the BCF to do next:

As part of our CCG Operating Plan 2014-2016, we have a commitment to ensuring that all patients over 75 registered in Leicester City have a named GP and those at high risk within this cohort will have a joint health and social care plan to enable proactive care management, integrated around the patient.

We will also aim to introduce the same methodology to our target cohort of patients (over 60 years and 18-59 with 3 or more comorbidities); this will involve prioritising our high risk patients from this cohort and provision of a personalised care plan where required. This is a longer term strategic commitment, delivered on a phased basis and driven by the risk predictive scores of the population.

2) RISKS

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

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

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

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