ANNEX 1 – Detailed Scheme Descriptions

Detailed scheme descriptions have been completed for the following schemes:

Ref no.	Scheme
Priority 1: Prevention, early detection and improvement of health-related quality of life	
BCF1	Risk stratification
BCF 2	Lifestyle Hub
BCF 3	General Practice scheme (2.1-10%)
Priority 2: Reducing the time spent in hospital avoidably	
BCF 4	Clinical Response Team
BCF 5	Unscheduled Care Team
BCF 6	System Coordinator
BCF 7	Intensive Community Support service
BCF 8	IT integration
Priority 3: Enabling independence following hospital care	
BCF 9	Planned Care Team
BCF 10	Mental health discharge team
BCF 11	Integrated Mental health step down service

Scheme ref no.
BCF 1
Scheme name
Risk Stratification
What is the strategic objective of this scheme?
Link to Vision: • 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 Response to case for change through delivery of: (a) Reduction in the numbers of patients requiring admission to permanent residential care (b) Increase in the numbers of patients still at home 91 days after discharge from hospital (c) Increase in the number of patients recorded as living with dementia (d) Systematic proactive intervention with moderate to high risk patients identified through risk stratification to enhance self-care and links to wider community support (e) To be a platform to ensure that specialist community services such as Community Matrons Heart Failure and Respiratory Specialist nursing, and Care Navigators caseloads are populated with the right kind of patients – i.e. those with high – very high risk of adverse outcomes where specialist input is likely to have the greatest chance of altering the clinical trajectory.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
The risk stratification of each GP practice's entire population with a monthly refresh of this information is a key platform for the effective functioning of a whole range of BCF services and pathways. The CCG has been working in partnership with Greater East Midlands CSU, Johns Hopkins University and a working party of GPs, Practice Managers, and Practice Nurses since November 2012 to develop a suite of risk stratification reports based on the outputs of the Adjusted Clinical Groups (ACG)

risk stratification tool.

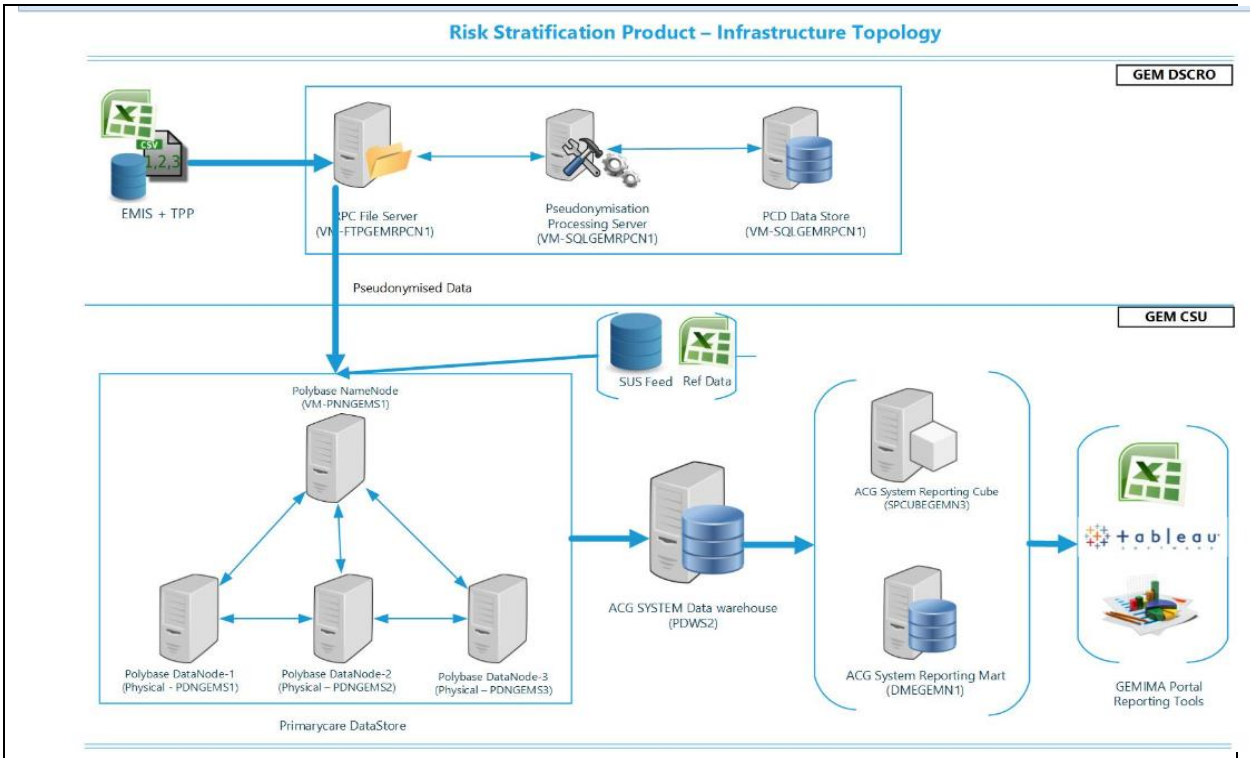
The model of care:
The ACG System considers the total disease experience of each patient, including the implications of co-occurring disease. The ACG System encourages a holistic view of the patient rather than the management of specific diseases or episodes. A disease-based focus may miss important implications of associated co-morbidities. Episodic approaches often focus on acute exacerbations or flare-ups, which potentially represent failures in care management.

The ACG risk stratification scores in the version of the system used in Leicester (Version 9 of the Dx PMx model) are derived from three main data sources:

1. All the patient's diagnoses – major and minor (i.e. not just QOF diagnoses and including mental health diagnoses and any coded symptoms for which there is not, as yet a confirmed diagnosis)) over the last 12 months – and in the case of long term conditions; going back to the patient's date of birth. The read codes will capture the diagnosis regardless of where the patient was first diagnosed – primary care, ED OPD etc.
2. Prescribing data
3. Secondary Care data diagnoses and procedure codes.

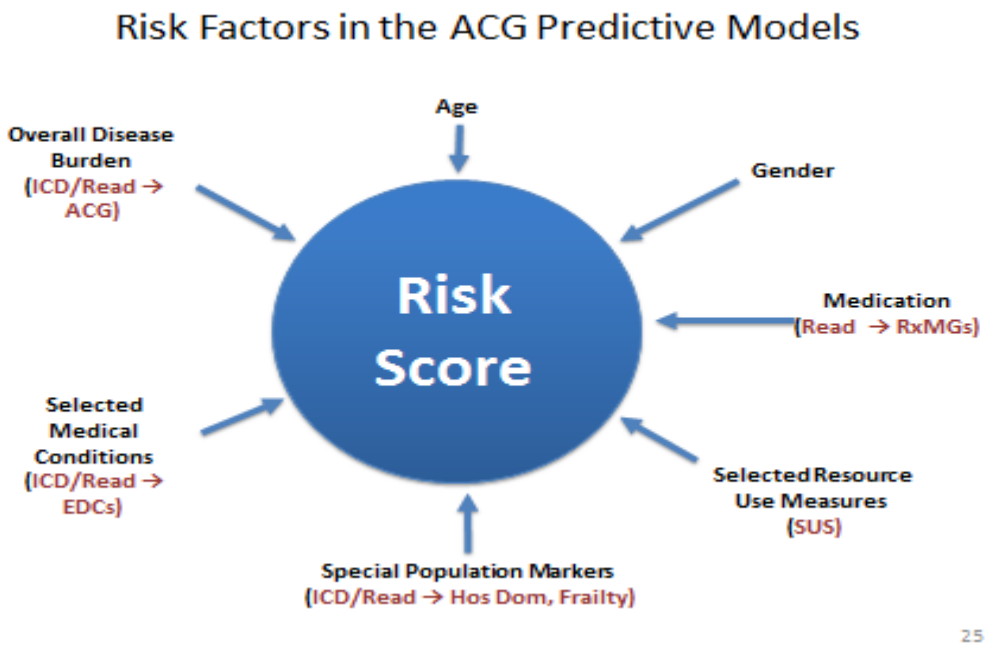
We have undertaken an extensive period of consultation with the LMC, BMA Law, GPC and NHS England back in 2012-13 to ensure that our data processing was in conformity with the guidelines and was acceptable to GPs as the data controllers. This led to a very narrow Information Sharing Agreement (ISA) which gave permission for processing to provide risk stratification reports to GPs only and for no aggregation of data. In 2014 GPs signed an addendum to the original ISA which gave permission for some aggregation of data. There is now increasing demand from GPs and others to have a refreshed ISA which will allow for further processing of these data to create more sophisticated reporting at practice, locality and CCG level for a variety of clinical and business planning purposes

The illustration below shoes how the 'pseudonymised' data is currently processed in the Accredited Safe Haven (ASH).



In addition to the diagnosis and prescribing data above, the risk scores are derived from risk markers unique to the ACG system:

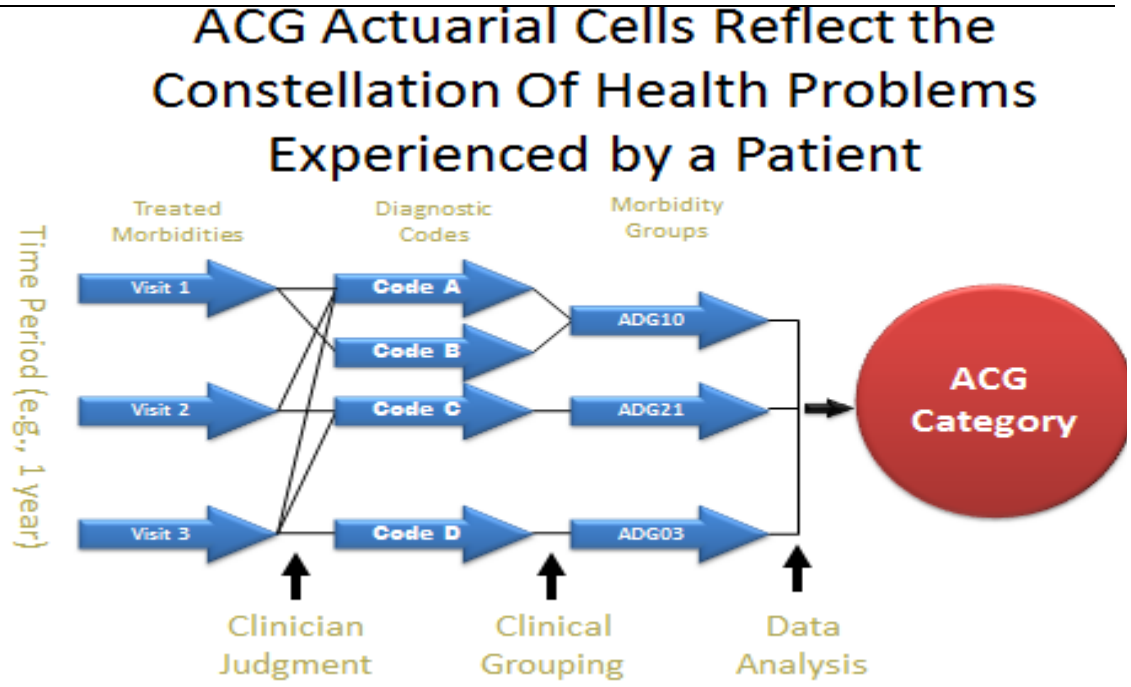
- **Frailty Flag** (a binary flag which is appended to a patient in the presence of one or more of 12 diagnoses strongly associated with significant functional deficit).and
- **Hospital Dominant Condition count** (a Hospital Dominant Condition is one associated with a 50%+ chance of emergency admission over a 12 month period). The illustration below summarises the basic elements used to calculate risk in the logistical regression model.



The Grouper looks at each diagnosis under five domains:

- Duration
  - ✓ Acute, chronic or recurrent
- Severity
  - ✓ Minor/stable versus major/unstable
- Diagnostic certainty
  - ✓ Symptoms versus disease
- Etiology
  - ✓ Infectious, injury or other
- Specialty care involvement

In order to map each diagnosis in to an Aggregated Diagnosis Group (ADG) and finally a number of ADGs can map to only one Adjusted Clinical Group.
An illustration showing how someone who attends their GP on three occasions in a year and is given four different diagnoses is shown below



The suite of reports is refreshed each month and consists of reports aimed at helping primary care identify specific cohorts at the click of a button – Unplanned Admissions DES population and complex diabetes population – and a larger report where the practice can use a series of filters to define for their practice a population of interest. For example a practice might want to identify a segment of their population. An example of this might be if the practice wanted to identify all those women with diabetes who are in risk bands 3 and 4 as a means of selecting patients who would benefit from accessing the DESMOND training for self-management.

At the moment reports predict two discrete but related outcomes:

1. The probability of the patient being admitted as an emergency in the next 12 months
2. The probability of the patient being in the top 5% highest costing group pf patients across LLR next year

A series of training sessions for GPs, practice managers and practice nurses has been conducted over the last 18 months –both as one-to-one and as group sessions. This teaches staff about the ACG system, how to create searches to identify segments of the practice population and how to deploy a suite of evidence based interventions for patients at moderate to very high risk.

A guide has been produced for practices as to what kinds of interventions they might consider for at-risk patients and which of the range of community based health and social care services to consider referring patients to for further assessment. (see Appendix 9)

We have engaged GPs, practice managers, practice nurses, public health consultants and commissioners in identifying further developments to the current

reports. The following developments have been requested are expected to be in place by January 2015:

- Installation of version 10 of the ACG system
- Incorporating the RAV UK regression changes to the model (based on revalidation work described below in evidence)
- Addition of filters to allow segmentation of care home population and identification of all those taking 6+ medications
- Development of case-mix adjusted population reports for each practice
- Creation of suite of public health reports focusing on multi-morbidity associated with key local LTCs such as diabetes and mental health
- Building from scratch a local cost model based on pharmacy costs, secondary care costs and reference costs for primary care
- Creation of filter menu to allow tracking of interventions associated with the Unplanned Admission DES and the BCF primary care work – status markers to show care plan completed, membership of target group, need for review of care plan etc.

We will be working closely with our LMC and IG colleagues to develop an updated ISA which will be the framework for some key elements of the above reporting.

All 62 Leicester City GP practices have signed the ISA for risk stratification and receive a monthly refreshed series of reports. As explained in the vision section of this plan, the reports are used to support work to

- Identify the top 2% highest risk adults and children
- Identify the following 2.1 – 10% highest risk patients in their population
- Identify complex diabetes patients
- Identify patients at high risk of adverse outcomes from poly-pharmacy
- Identify the high risk segment of the over 75 population for referral to the Care Navigator Service.

What patient cohorts are being targeted?

In terms of the outputs of the risk stratification system, there are currently five target cohorts for the BCF pathway:

1. Those aged 18-59 years with three or more long term conditions (LTCs) in risk bands 3, 4 and 5
2. Those aged 60+ with one or more LTCs in risk bands 3,4,5
3. Those with dementia
4. Those with a positive frailty flag not already on the end of life or dementia register
5. Those with one or more hospital dominant conditions

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners :

Leicester City CCG.

Leicester City CCG pays the licence fee to the Johns Hopkins University for the use of the ACG system by Leicester city practices and pays GEM CSU for the processing of the data required to produce the risk stratification reports for each practice.

Providers:

- **Johns Hopkins University, Baltimore, Maryland, USA –** providers of the software for the ACG system.

- **Greater East Midlands Clinical Support Unit –** providers of the data processing required to create the risk stratification reports for each practice.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Lewis L, Curry N et al Choosing a predictive risk model: a guide for commissioners in England. Nuffield trust (2011)

Thompson A, Morris C. Risk Stratification: Recalibration of the ACG System Predictive Models Central and Southern CSU 2014 (presented at Nuffield Trust Risk Stratification Conference) this briefing summarises the work carried out by Johns Hopkins University in partnership with Central and Southern CSU to revalidate the statistical performance of the ACG predictive model in a large (523,000 individuals) UK population in November 2013 The new UK model actually performs better as a predictor of emergency admission in the UK than does the US model.

Ham C, Imison C, et al. Avoiding Hospital Admissions; Lessons from Evidence and Experience King's Fund (2010)

"The greatest opportunity to reduce hospital admissions and bed days lies in the proactive management of people with long-term conditions, especially people with multiple conditions. Integrated working between health and social care can result in lower than expected emergency admissions and reduced use of beds, as evidenced by the achievements of Torbay."

Tian Y, Dixon A, Emergency Admissions for Ambulatory care sensitive conditions: Identifying the potential for reductions. King's fund (2012)

- Influenza and pneumonia account for the highest proportion of all emergency admissions (EAs) for ambulatory care sensitive conditions (ACSCs) - 13% – much of this activity is preventable by vaccine administration.
- Those over 75 account for 40% of the total EAs for ACSC
- COPD/CHF/Flu/Pneumonia/Dehydration and gastritis account for 53% of costs associated with EAs for ACSCs.

Oliver D, Foot C et al. Making our Health and care systems fit for an aging population The King's Fund (2014)

Amongst a range of recommendations this paper highlights:

(a) rapid support close to home in times of crisis and (b) integration to provide person-centred co-ordinated care

Roland M, Abel G Reducing Emergency Admissions: Are we on the right Track? BMJ 2012; 345 e6017
Sets out the various segments of risk within the UK population and the proportion of the total amount of emergency admissions accrued by each segment. Highlights the important of not restricting interventions to the highest risk patients and the need to address patients from at least the top quintile of risk within the population.

Salisbury C, Johnson L, Purdy S, Valderas JM, Montgomery AA. (2011) Epidemiology and impact of multi-morbidity in primary care: a retrospective cohort study. Br J Gen Practice 61:e12-e21. Used the ACG system to characterise the distribution of clinical risk and multi morbidity in UK General practice and linked costs to various risk cohorts.

Sylvia ML, Griswold M, Dunbar L, Boyd CM, Park M, Boult C. (2008) Guided care: cost and utilization outcomes in a pilot study. Disease Management 11:29-36.
Demonstrates how use of risk stratification can support case management of those with LTCs to reduce hospitalisation.

Naylor C. et al Long Term Conditions and Mental Health: The cost of Co-morbidities. King's Fund and Centre for Mental Health (2012)

"…by interacting with and exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least 45 per cent for each person with a long-term condition and co-morbid mental health problem." One of the benefits of the ACG system is that it includes all mental health diagnoses in calculating risk of adverse outcomes and on an individual patient level allows practitioners to see the role of the interaction of physical and mental health in deriving a global morbidity score which takes into account the interaction between mental and physical health. This paper underpins our decision to invest in increasing access for older people with LTCs to the CMHT

Leicester City CCG population segmenting and analysis by GEM CSU and LCC Public Health Department

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15: £54,000
2015/16: £54,000

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Using the benefits analysis model developed with PA Consulting, we have attributed an impact on the following metrics:

BCF National Metric 1: Less people going into nursing and residential care
BCF National Metric 4: A reduction in total hospital admissions

BCF Local Metric: More people being identified as living with Dementia

Please see tab 4 of template 2 for further detail

In addition to the national metrics, we have set up a dashboard to monitor outcomes and activity under the following themes:

- **System performance against national BCF metrics**. Risk stratification in primary care as a platform for the activity described above will impact on:
- Emergency admissions and attendances
- Numbers still at home 91 days post discharge
- Numbers entering permanent residential care

Ensuring that patients experience integrated planned community care to prevent deterioration of LTC and promote self-care

- Numbers of patients seen each month by CMHTs, Community Planned Care Health team will go up.
- Number of contact and domiciliary assessments by SPoC will go up.

Increase in evidence based interventions for those identified by the risk stratification system:

- Number of pneumococcal and seasonal flu vaccines
- Number of care plans agreed with patients at risk of hospitalisation
- Number of those with a confirmed diagnosis of dementia
- Number of medicines reviews

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Strategic level – Monthly reporting to the JICB and CCG Performance Exec

At a strategic level, an overarching system dashboard is being formulated, covering the 5 + 1 national metrics as well as other relevant metrics to manage flow at a system level.

Operational Level – Bi-weekly reporting to the BCF Implementation Group

Underneath this, sits a comprehensive Integrated Care Performance Dashboard, specially produced to support the performance management function for the BCF Programme.

Practice level – Weekly reporting

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

In totality, this provides a comprehensive view of both the health and social care

system as a whole and tracks performance of the Integrated Care model.

All draft dashboards are provided as Appendix 7.

What are the key success factors for implementation of this scheme?

- Complete sign up of Leicester City CCG practices to sharing the required data to risk stratify each practice's complete population. This has been achieved
- Sign up to a new Information Sharing Agreement to allow more extensive reporting – especially of aggregated data and practice specific financial modelling. Engagement plan in place.
- Completion of the planned developments of the system – see above.
- Continued engagement with GP practices around the future direction of developments of the reports.

Scheme ref no.
BCF 2
Scheme name
Lifestyle referral hub
What is the strategic objective of this scheme?

Link to Vision:

- Empower our population to be both better informed and better manage their own health and wellbeing using a range of traditional and digital media and technology

Response to case for change through delivery of:

(a) Reduction in the numbers of patients requiring admission to permanent residential care
(b) Increase in the numbers of patients still at home 91 days after discharge from hospital
(c) Reduction in the total numbers of emergency admissions
(d) Increase in the number of patients recorded as living with dementia

Link to wider strategic objectives:

Supporting the community of Leicester to live well and reduce unhealthy behaviours will reduce the number of people who develop non-communicable diseases e.g. CVD, COPD.

Cardiovascular disease accounts for 33% of all deaths in Leicester and 28% of all deaths under 75 years of age. It is the major contributory factor to the gap in life expectancy between Leicester and England, 39% for males and 31% for females. More than half of CVD-related deaths are from coronary heart disease (CHD), and a quarter from stroke. Outcomes for CVD within the city are significantly worse than the rest of the East Midlands, and about 50% higher than the national average. CHD mortality is significantly higher in the most deprived areas of the city, and 13 wards show a significantly higher rate of premature CVD deaths than the England average.

It is estimated that 86% of the risk factors associated with CVD are potentially reversible and include lifestyle issues such as smoking, obesity, poor diet and lack of physical activity, in addition to socio-economic factors such as low income and poor housing.

High blood pressure, raised sugar levels and high blood fats are also predisposing conditions to CVD.

However, timely detection and treatment of these conditions can help reduce prevalence and premature mortality rates from CVD.

The premature CVD mortality rate in Leicester has reduced over the last 10 years but not at the same rate as it has for England. The gap between Leicester and

England has almost doubled over the last 10 years (from 27% in 1998-2000 to 53% in 2008- 2010).

Mortality rates for COPD in 2008-10 are significantly higher in Leicester overall and in Leicester males than England, in both all ages and under-75s.

There has been a gradual downward trend in COPD mortality rates in England over the past 10 years. In Leicester the rate is more variable due in the main to relatively small numbers. However, the rates are generally higher for both males and females with male mortality rates significantly higher than in England in a number of years.

Higher rates of respiratory disease mortality are generally found in the west of Leicester and similar patterns are seen for high COPD mortality (with the exception of Thurncourt and Coleman wards). Higher mortality reflects areas of higher deprivation and high smoking prevalence.

Unhealthy behaviours such as smoking, physical inactivity, poor diet and alcohol consumption are major risk factors for all the main causes of mortality in Leicester (cardiovascular disease, diabetes, cancers and respiratory conditions). Supporting people to make and sustain changes in these behaviours will ultimately reduce morbidity and mortality, improving wellbeing and saving public sector money.

Therefore, the service will help meet the following objectives:

- CCG Outcomes Indicator 1 Preventing people from dying prematurely – reducing under 75 mortality from CVD and respiratory disease

- CCG outcomes Indicator 2 Enhancing quality of life for people with long-term conditions – ensuring people feel supported to manage their condition

- CCG Clinical commissioning strategic objective – CVD – design and implement patient education programme and improve the prevalence rates

- CCG Clinical commissioning strategic objective – COPD – design and implement patient education programme.

- Health & Well-being board Strategic priority 2: Reduce premature mortality
    - Reduce smoking and tobacco use
    - Increase physical activity and healthy weight
    - Improve the identification and management of cardiovascular disease, respiratory disease and cancer

The establishment of the Healthy Lifestyles Hub has been endorsed by the Health and Wellbeing Board as part of Leicester's Joint Health and Wellbeing Strategy.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:
What is the model of care and support?
Which patient cohorts are being targeted?

The Lifestyle Referral Hub will:

- Provide a simple, effective and reliable “one stop” referral service for GPs and other health care professionals
- Look beyond single issues and undertake a holistic assessment of clients’ needs, state of readiness to change, and identify any barriers to change that may need addressing before the client can engage with services e.g. debt, housing problems
- Support clients to access appropriate lifestyle services such as Food & Activity Buddies, DHAL, Active Lifestyle, walking groups, cycle training, Heart smart group and smoking cessation, and build emotional resilience and self confidence
- Motivate clients to make and sustain behavioural changes to reduce their risk factors
- Work with individual GP practices to maximise appropriate referrals
- Monitor the progress of clients and ensure appropriate feedback is provided to GPs

The Lifestyle Referral Hub is an integrated approach to supporting people to attain and maintain good health. This involves building personal resilience, connecting people to local resources and increasing motivation and confidence to make and sustain changes in lifestyle behaviours.

As well as providing a solution to streamline referrals, the hub will deliver added benefit through the holistic assessment of clients, and an awareness of the wide range of services and activities available within the city.

The assessment will enable a better understanding of clients’ lifestyle risk factors, which factors they feel ready to address (many people have more than one risk factor), their state of readiness to change and what the barriers to achieving and sustaining behaviour change might be. For example concerns about debt or housing problems can prevent clients from being able to address their lifestyle risk. If this is the case, the referral hub can signpost clients to advice services to get support to address these issues at the same time as being referred to lifestyle support services. In this way clients will be better prepared and able to engage successfully with health improvement services, thus making more effective use of those services. Many people who are referred to lifestyle support services currently don’t engage fully. This situation can be improved by understanding the social context of clients’ health behaviours.

All practices in the city have signed up to the NHS Health Check programme whereby all patients aged 40-74 will be invited into their GP practice to have a health check. This is an ideal opportunity for those patients that are inactive, overweight or in need of other support to be referred into appropriate lifestyle services.

GPs report the main reason that they do not currently refer patients is due to confusion about the number of services/ initiatives available in the city and how to access them. It is considered, therefore, that a single point of access into these services would increase referrals and subsequently improve the health of patients.

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

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

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

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Leicester GPs, Nurses or other health care professionals refer into the lifestyle hub commissioned by Public Health within Leicester City Council and provided by Parkwood Healthcare.

The provider contacts the patient and may refer them to anyone of a number of voluntary and community groups or professional organisations commissioned across Leicester's health and social care community.

The provider may also, if the criteria are met, make an appointment for the patient to see a Tier 2 Health trainer service. The health trainers are employed by the provider

A contract variation with Parkwood Healthcare (current provider of the pilot scheme and health trainer service) will be needed to expand the lifestyle referral hub for the duration of the current contract (i.e. until end March 2015).

30 practices to have access to the hub from April 2014 and all practices to have access from April 2015.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

The need for a Lifestyle Referral Hub has been demonstrated by the lack of referrals into lifestyle services (e.g. FAB weight management/ Active Lifestyle Scheme/ Health Trainers etc) by GP practices in Leicester.

Nottingham City experienced a similar problem regarding lack of referrals into lifestyle services from GPs. They commissioned a lifestyle referral hub and saw a significant increase in referrals within a short space of time (over 4,000 referrals in the first year). By 2012/13 5,480 patients were referred (including self-referral) into the hub in Nottingham.

A pilot of the lifestyle referral hub in Leicester has been running with 7 city practices since February 2013 and a further 6 practices have recently been recruited. The existing health trainer service is providing the referral hub pilot and non recurrent funding was provided to employ an additional health trainer to take on this role. Referrals into the hub started slowly but have gradually increased in these 7 practices. Data from the pilot scheme to the end of October 2013 suggest there would be 5,000 referrals annually if all practices had access

Providing motivational support, advice and referral to appropriate services can help individuals to reduce their risk factors for non-communicable disease. This is evidenced from the evaluation of a similar service in Nottingham which shows statistically significant improvements in a range of factors including BMI, physical activity and diet. The Nottingham evaluation also found clients' general health and wellbeing improved. The Nottingham service operates a slightly different model to that being proposed in Leicester but the extract from their evaluation is included as an indication of what can be achieved.

Risk Factor	n	Start of Coaching Period (mean & 95% CI)	End of Coaching period (mean & 95% CI)	Mean Difference	P value*
BMI (kg/m^2)	2273	35.9 (35.7-36.2)	33.5 (33.2-33.8)	2.4	p<0.01
Moderate Physical Activity (days/week)	976	2.9 (2.7-3.0)	3.2 (3.0-3.4)	0.3	p<0.01
Fruit and vegetable (portions/day)	2896	3.8 (3.7-3.9)	4.76 (4.7-4.9)	0.9	P<0.01
Alcohol (units/week)	650	8.2 (7.1-9.3)	7.4 (6.3-8.5)	0.8	P<0.01
Smokers	512	512	479	33	p<0.01

*paired t-test for continuous data/ chi-squared test for smoking.

Wellbeing measure	n	Start of Coaching Period	End of Coaching period	Mean Difference	P value*
WHO five wellbeing (score)	1195	53.4	62.5	9.1	p<0.01
General Health score	1190	57.2	67.6	10.4	p<0.01

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15: £60,000
2015/16: £100,000

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Using the benefits analysis model developed with PA Consulting, we have attributed an impact on the following metrics:

BCF National Metric 1: Less people going into nursing and residential care
BCF National Metric 2: More people receiving help to recover at home
BCF National Metric 4: A reduction in total hospital admissions
BCF National Metric 5: Improved patient/service user experience

Please see tab 4 of template 2 for further detail

In addition to the national metrics, we have set up a dashboard to monitor outcomes and activity under the following themes, linking into the overarching Leicester City integrated care dashboard, attached as Appendix 7.

Reduction in health inequalities	Lifestyle risk factors are socially patterned and more prevalent in deprived communities. Addressing lifestyle risk factors will benefit deprived communities proportionately more.
	The target is for 80% of health trainers to be recruited from the most economically deprived areas in Leicester.
Reduction in barriers to access	The target is for 50% of new client registrations to be from BME communities
	The target is for 50% of new client registrations to be men (men are currently under represented in clients accessing health improvement service)
Achievement of Personal Health Plans	Target 60% partial achievement, 45% full achievement
% weight loss for clients with weight loss as a goal within their personal health plan	Target average of at least 3%
Increased fruit and vegetable consumption for clients with diet improvement as a goal within their personal health plan	Target average of at least 1.5 portions/day
Increased sessions of moderate/vigorous intensity activity for clients with physical activity as a goal within their personal health plan	Target average of at least 2 sessions/week
Proportion of clients achieving 4 week quit where smoking cessation is a goal within their personal health plan	Target 50%
Proportion of clients not exceeding guidelines for safe	Target 70%

drinking levels where alcohol consumption is a goal within their personal health plan	

Output	**Target Number**	**Supporting Evidence**
Percentage of all clients referred to the Healthy Lifestyles Hub contacted within 5 working days	85%	Contract minimum data set
Number of initial assessments undertaken	No target set	Contract minimum data set
Breakdown of primary risk factors (i.e. diet/exercise/ smoking/alcohol etc.)	Not applicable	Contract minimum data set
Number of clients signposted/referred to health improvement services	80%	Contract minimum data set
Number of clients who attend first appointment with health improvement service	70%	Contract minimum data set
Breakdown of health improvement services signposted/referred to	Not applicable	Contract minimum data set
Number of 6 weeks follow up calls successfully completed	80%	Contract minimum data set
Number of successful calls to clients who have 'dropped out' of health improvement services	70%	Contract minimum data set

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The service will be commissioned by Public Health within Leicester City Council.

A steering group will be set up to oversee the project, chaired by public health and including representation from the provider (currently Parkwood Healthcare), the CCG, IT (HIS) and representation from other lifestyle services such as FAB and the Active Lifestyle Scheme.

A group already meets to oversee the pilot; this will be expanded to report into the Better Care Fund Implementation Group

What are the key success factors for implementation of this scheme?

KSF's identified with processes in place to manage them:

1. Successful use of the LRH by GP's and other health professionals
2. Successful uptake of the services by the referred population

3. Successful tendering process in place and securing of a suitable provider to deliver the service

Scheme ref no.
BCF 3
Scheme name
General Practice scheme (2.1-10%)
What is the strategic objective of this scheme?
Link to Vision: • 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 Response to case for change through delivery of: (a) Reduction in the numbers of patients requiring admission to permanent residential care (b) Increase in the numbers of patients still at home 91 days after discharge from hospital (c) Reduction in total emergency admissions (d) Increase in the number of patients recorded as living with dementia **(e)** Increase in patient and service user satisfaction
Overview of the scheme Please provide a brief description of what you are proposing to do including: What is the model of care and support? Which patient cohorts are being targeted?
To support the BCF identified cohort , LCC will aim to address their top 0 – 2% high risk patients via the Unplanned Admission DES, allowing them to maximise the BCF funding on the 2.1 -10% high risk population, which will include the BCF cohort: • 60 + years • 18- 59 with 3 or more co- morbidities • Including dementia By concentrating the work on this cohort of patients, the CCG will be maximising the impact on the workload in avoiding unnecessary emergency admissions. This proposal will ensure the identification of patients who are in need of better care and provide experienced clinical time to: • Undertake routine assessments of patients with long term conditions in their home. This helps people with such conditions to better manage their own health and avoid unnecessary visits to hospital • increase population-based interventions e.g. access to vaccinations, reducing social isolation, increasing access to third-sector and Local Authority services • improve, for selected high-risk individuals, chronic disease management, medicines-related safety and concordance • improve self-care and self-management skills; reiterating Choose Better campaign messages where appropriate

- promote use of personal health budgets
- provide both proactive and reactive care
- assess carers health needs; enhancing the resilience of the carer population
- prescribe and administer medications within the remit of local PGD, where appropriate, and undertake medication reviews across the cohort
- take a holistic approach to patient care, bringing together their medical, social and psychological needs – both for patients and Carers
- refer patients to alternative health and/or social services through appropriate signposting and guidelines, linking with the wider BCF services and supporting patients in their own homes
- Ensure high quality, detailed care plans are in place and up to date/reviewed.

There are a number of benefits for following this mixed economy of increasing capacity within the primary care setting, including:

- ability for collaborative working for those practices that are seeking to share resources e.g. for sickness cover etc
- more responsive and flexible solution, providing greater continuity of care
- minimal, if any, additional management support will be required (e.g. recruitment costs; referral management processes)
- most appropriate skill mix to best meet needs of individual practices with different requirements e.g. Flexibility for individual practices to choose where to focus their staffing needs
- best use of scarce human resources
- some staffing mainly sourced through existing staffing levels, no recruitment issues
- little set up time; ability to start the work on 1st August 2014
- introduction of shared learning through peer review at locality meetings and PLT

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

General Practice commissioned by Leicester City CCG.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

As set out in the earlier sections of this plan, we know that citizens in Leicester City already suffer reduced life expectancy and more ill health than the national average. Moreover, analysis of specific diseases which are amenable to early intervention and preventative strategies shows equally adverse outcomes; therefore it is even more important for Leicester City to invest in the right interventions for these groups of patients, especially in light of the health inequalities seen across the City. The Marmot Review called for a strengthening in the role and impact of ill-health

prevention, through prevention and early detection of the key long term conditions related to health inequalities.

Many long term conditions are preventable and have common behavioural risk factors, amenable to public health intervention. Even when someone may have been identified as having one of these conditions there may still be opportunities, through appropriate health and social intervention, to prevent or delay the onset of complications and extend disability-free life. However, managing these conditions appropriately can be complex and challenging. The Better Care Fund programme provides major opportunity to improve services and their organisation locally, for the effective management of people with LTC.

Prevention and effective management of conditions in the community is also likely to be more cost effective than waiting for patients to turn up sick at the doors of our GP surgeries or hospitals. Of more than 250 studies on prevention published in 2008, almost half showed a cost of under £6,400 per quality-adjusted life year and almost 80% cost less than the £30,000 threshold used by NICE. And although some interventions take many years to pay-off, others do not - for example, effective management of atrial fibrillation or hypertension can show results within a couple of years. Smoking cessation programmes can have an impact over the short term when targeted on Chronic Obstructive Pulmonary Disease patients at risk of acute admission, (NHS call to action, Nov 2013).

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2015/16: £1,000,000

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Using the benefits analysis model developed with PA Consulting, we have attributed an impact on the following metrics:

BCF National Metric 1: Less people going into nursing and residential care
BCF National Metric 2: More people receiving help to recover at home
BCF National Metric 3: A reduction in hospital bed days due to discharge being delayed
BCF National Metric 4: A reduction in total hospital admissions
BCF National Metric 5: Improved patient/service user experience

BCF Local Metric: More people being identified as living with Dementia

Please see tab 4 of template 2 for further detail

In addition to the national metrics, we have set up a dashboard to monitor outcomes and activity under the following themes:

There are a number of KPI's which the individual practices, and the locality as a whole, will be monitored on. These include:

- QIPP reductions in activity at UHL, both in expenditure and activity; across Out Patients; A&E and Emergency Admissions – this will be monitored through existing reporting mechanisms (% practice/locality target)
- A&E reductions in activity at UHL, both in expenditure and activity (% practice/locality target)
- Reductions in emergency admissions from Care Homes (Actual - practice/locality target)
- Increased number of care plans in place for the 2.1-10% high risk cohort (Actual practice/locality target)
- Recording of patient contacts for the patient cohort (Actual - practice/locality target)
- Additional hours/appointments (Actual - practice/locality target)
- Ensure appropriate usage of wider BCF services through increased reported usage (% practice/locality target)
- Increase in number of seasonal flu/pneumococcal vaccinations undertaken (% practice/locality target)
- Increase in recording of Residential Institute (RI) codes on patient records (Actual - practice/locality target)
- Increase in the number of people on the dementia registers (Actual - practice/locality target)
- Evidence of collaborative working through peer review meetings
- Confirmation of the practice direct phone line to care homes where they have registered patients
- Increase in the number of MURs undertaken (Medicine Usage Reviews) (Actual - practice/locality target)
- Evidence of increased referrals to the following self-care services:
    - DESMOND/DAFNE for diabetic patients
    - Pulmonary Rehabilitation
    - Heart Failure Nurse Specialist
    - SPRINT for COPD patients
    - STOP for smokers
    - Lifestyle hub
    - Care Navigator for 75+ patients

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to

understand what is and is not working in terms of integrated care in your area?

Strategic level – Monthly reporting to the JICB and CCG Performance Exec

At a strategic level, an overarching system dashboard is being formulated, covering the 5 + 1 national metrics as well as other relevant metrics to manage flow at a system level.

Operational Level – Bi-weekly reporting to the BCF Implementation Group

Underneath this, sits a comprehensive Integrated Care Performance Dashboard, specially produced to support the performance management function for the BCF Programme.

Practice level – Weekly reporting

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

In totality, this provides a comprehensive view of both the health and social care system as a whole and tracks performance of the Integrated Care model.

All draft dashboards are provided as Appendix 7.

What are the key success factors for implementation of this scheme?

- UHL contract at the 14/15 year end delivered to planned levels.
- UHL contract at the 14/15 year end is £500k (or more) below plan.

Scheme ref no.
BCF 4
Scheme name
Clinical Response Team
What is the strategic objective of this scheme?

Link to Vision:

- Reduce the amount of time spent in hospital avoidably by our citizens, by focussing on health and social care pathways and services such as housing

Response to case for change through delivery of:

(a) Reduction in the numbers of patients requiring admission to permanent residential care
(b) Increase in the numbers of patients still at home 91 days after discharge from hospital
(c) Reduction in the total numbers of emergency admissions
(d) Reduction in the number of delayed transfers of care
(e) Increase in the number of patients recorded as living with dementia

Link to wider strategic objectives:

This service is part of this wider transformative change within the health and social care economy in Leicester City. At a local level, by joining up our services from the bottom up, we will make a fundamental change in both culture and delivery mechanisms within our local health and social care economy, linking particularly into our priority areas for improvement;

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

In accordance with Work stream 4: Access to the highest quality urgent and emergency care, EMAS will be able to respond more efficiently to the most appropriate calls, whilst the lower acuity calls are managed within an appropriate non-acute setting. This will allow timely referrals to be made to those services necessary within the whole range of community services. Also to allow immediate treatment as required followed by a holistic assessment to ensure that suitable, effective and manageable care planning is made to facilitate the patient to remain at home and feel more confident to manage any ongoing health needs. Details of

interventions will be communicated to all relevant parties to ensure that follow ups are made.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

A skill mix of clinicians (GPs and ECPs) will support EMAS by responding to a pre-agreed referral criteria, either as a first response for lower category calls or as a secondary response from Paramedics on scene to provide appropriate safe and timely clinical treatment to maximise opportunities to avoid unnecessary ambulance dispatches, visits to A&E or short stay unplanned medical admissions when they could be looked after at home by a GP. The clinicians will assess, treat and stabilise the patient and, of appropriate, prevent the requirement for conveyance to the ED at the Acute site, preventing the ED attendance and preventing a potential admission into an acute bed. Referrals to community services will be utilised wherever possible to ensure an appropriate immediate intervention and a programme of ongoing care developed to try and prevent the need for unnecessary contact with emergency services in the future. In addition, it will help to educate the public around the range of community services available within the City.

A phased approach has been taken to the introduction of this Service, with the final phase to be implemented by November 2014. In addition to EMAS referrals, Leicester City care homes and GP practices will be permitted to refer appropriate patients directly into the Service. The Clinical Response Team is also being added to the Electronic Directly of Services, making it visible to NHS 111 for appropriate referrals also.

This variety of referral routes will permit anyone aged 60+, or aged 18-59 with pre-existing co-morbidities to be appropriately cared for within the community following initial contact with EMAS, care homes, GPs or 111.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioner:	NHS Leicester City CCG
Service Provider:	SSAFA Care CIC
Working in partnership with:	EMAS (East Midlands Ambulance Service)
Community service providers:	Leicestershire Partnership Trust (health care) Leicester City Council (social care) Derbyshire Health United (NHS 111) Central Nott's Clinical Services (Out of Hours) Various care home providers within Leicester City

The evidence base

Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Modelling has shown a potential pool of up to 20275 calls in 2013/14; this covers R2 – G4 999 calls and a selected number of chief complaints which are deemed as ambulatory. In 2014/15, this number is expected to increase with the full roll out of NHS 111 across the City.

Of this pool, 50% of these patients aged 60+ conveyed to UHL and once at UHL, the conversion rates for these patients is 65%. The chief complaints chosen for focus are those which are best treated in primary and community settings and therefore, this scheme is designed to reduce the conveyance of such patients (where clinically appropriate) to the acute site and instead support the patient at home.

In 2013/14, the CCG took part in a similar GP in a Car scheme which resulted in reductions in both ED attendance and ambulance conveyance. Learning from this scheme has been applied here.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15: £1,365,000
2015/16: £1,365,000

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Using the benefits analysis model developed with PA Consulting, we have attributed an impact on the following metrics:

BCF National Metric 1: Less people going into nursing and residential care
BCF National Metric 2: More people receiving help to recover at home
BCF National Metric 3: A reduction in hospital bed days due to discharge being delayed
BCF National Metric 4: A reduction in total hospital admissions
BCF National Metric 5: Improved patient/service user experience
BCF Local Metric: More people being identified as living with Dementia

Please see tab 4 of template 2 for further detail

In addition to the national metrics, we have set up a dashboard to monitor outcomes as outlined below:

- A reduction in time spent avoidably in hospital
- An increase in EMAS call response times
- Improved clinical outcomes
- Improved patient satisfaction
- Simplified local access
- Eliminated duplication
- Improved clinical and cost effectiveness
- Better allocation of resource to genuine emergencies improving performance in these categories

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Strategic level – Monthly reporting to the JICB and CCG Performance Exec

At a strategic level, an overarching system dashboard is being formulated, covering the 5 + 1 national metrics as well as other relevant metrics to manage flow at a system level.

Operational Level – Bi-weekly reporting to the BCF Implementation Group

Underneath this, sits a comprehensive Integrated Care Performance Dashboard, specially produced to support the performance management function for the BCF Programme.

Practice level – Weekly reporting

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

In totality, this provides a comprehensive view of both the health and social care system as a whole and tracks performance of the Integrated Care model.

All draft dashboards are provided as Appendix 7.

What are the key success factors for implementation of this scheme?

The non-conveyance rate remains above the target of 70%, and the CRT clinicians are reporting back on excellent standards of care which have seen patients referred onto the Unscheduled and Planned Care teams for management within a community setting. In addition, there have been >25 referrals back to the registered GP practices for follow up, enabling the practices to make their own contact and provide appropriate support for both the patient and any carers.

No complaints or serious incidents have been reported and a patient experience survey is due to be carried out in September 2014.

Scheme ref no.
BCF 5
Scheme name
Unscheduled Care Team
What is the strategic objective of this scheme?
Link to Vision: • Provide a modern model of integrated care with a senior clinician taking responsibility for coordination of care • Reduce the amount of time spent in hospital avoidably by our citizens, by focussing on health and social care pathways and services such as housing Response to case for change through delivery of: (a) Reduction in the numbers of patients requiring admission to permanent residential care (b) Increase in the numbers of patients still at home 91 days after discharge from hospital (c) Reduction in the total numbers of emergency admissions (d) Reduction in the number of DTOC's (e) Increase in the number of patients recorded as living with dementia Link to wider strategic objectives: The strategic intention of this scheme is to create a responsive integrated multidisciplinary health and social care team to be available seven days a week twenty four hours a day to respond to patients aged 18 and over who have called an ambulance/ activated their Leicester Care alarm/ or had an urgent GP consultation but whose conditions or needs can be treated and cared for at home provided the right community support is provided.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
A substantial left-shift in activity to have many more patients with long term conditions managed at home requires the right level of community support to be available on a seven day basis. Patients are quite often admitted to hospital by ambulance service/social care staff and GPs because there is a perceived lack of reliable community services to provide further assessment and provision of monitoring and care – and so hospital is often seen as the only safe option. This Integrated Unscheduled community service will provide a solution to this problem by establishing a robust and reliable integrated community health and social care service available 24/7. The service will support primary care, Clinical Response Team (CRT) and Out of Hours (OOH) GPs and ambulance crews who want to initiate rapid response and high intensity care in a community setting as a safe

alternative to hospitalisation. Regardless of which location the patient is first seen in on an urgent basis (home/care home/GP surgery/community) the clinician or social care worker will be able to mobilise a rapid and comprehensive assessment and management response for the next 72 hours following the initial referral.

The BCF investment in this element – Unscheduled health and Social care - specifically targets the following elements of our model described below:

- Uplift and development of the capacity of the Unscheduled Integrated community health services team and development of integrated pathway for joint response with rapid response social care team (ICRS)
- Increase in the capacity in overnight nurse service – to work side by side with ICRS
- Increase in the capacity of Adult Social Care Rapid Response team (ICRS) – for both day and overnight rotas to work jointly with unscheduled health care team.
- Co-location of both health and social care Unscheduled care teams to develop integrated working, joint visiting and sharing of intelligence and skill sets.
- Increase in investment in Assistive Technology and Practical Help at Homes teams. Minor home adaptations and equipment and Assistive Technology devices can be key facilitators of independence and safety at home for older people

The model of care: A patient –centred and holistic approach to bringing care closer to home over the whole 24/7 cycle through:

(1) A Single Point of Access (SPA) for integrated Unscheduled Community Health and Social Care
(2) Physical co-location of Unscheduled health and social care staff to facilitate integrated response and to reduce duplication for the patient
(3) A maximum response time of 2 hours 7 days a week across the 24 hour cycle
(4) Holistic assessment of patients' health (including mental health)and social care needs in their home setting followed by:
(5) Rapid deployment of domiciliary care, nursing, therapy and equipment services with the aim of stabilising the patient and identifying ongoing care needs
(6) An increase in evening and overnight staffing in health and social care teams (including at weekends) to ensure that there is prompt response and continuity of care for frail older people in crisis
(7) A continuous cycle of reassessment and evaluation over the next 72 hours with close cooperation from the patient's primary care team leading to:
(8) Planned discharge from the Integrated Unscheduled into (a) Integrated Planned Community Care Services such as:
    - Reablement
    - Adult social care
    - Community Therapy
    - Community nursing services – including specialist heart failure and respiratory services where appropriate
    - Community mental health services

Or (b) into planned primary care follow up with or without personal budget commissioned social care support.

(9) Into some or all of the above with additional input from our voluntary and 3rd sector services (e.g. Age Concern "let's get moving together", Memory Cafes, Lifestyle Hub, IAPT, CLASP, Mental health charities).

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

What patient cohorts are being targeted?

There are three target cohorts for the BCF pathway:

2. Patients aged 18-59 years with three or more long term conditions (LTCs)
3. Patients aged 60+ with one or more LTCs
4. Patients with dementia

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners :

Leicester City CCG
Leicester City Council Adult Social Care Services

Providers:

Leicestershire Partnership Trust Community Health Services (LPT CHS) - Providers of **Unscheduled Integrated Community Health Services** including specialist nursing, district nursing, mental health practitioners, physiotherapy, health care assistants, and continence specialists for example.

Leicester City Council – Providers of

- **the Integrated Crisis Response Service** (Adult Social Care's 24 hour Rapid Response Service bringing to bear social care assessment/ Occupational Therapy assessment, provision of domiciliary care/help with nutrition and hydration, referral on to reablement and a wide variety of social inclusion opportunities.
- **Assistive Technology Service** (rapid assessment of patient needs and the installation of tailored suite of assistive Technology solutions such pendant alarms, electronic medication reminders, continence alarms, falls detectors, wandering alarms, gas detection alarms – all focused on reduction of risk and maintenance of independence in the home.
- **Practical Help At Home** – Home Handyman service which in the Unscheduled care setting aims to install grab rails, hand rails, lighting, minor floor repairs etc.in response to identified high risk situations. Works hand in hand with unscheduled health and social care services to ensure prompt response to prevent potential admission to hospital.

- Emergency duty Team – Adult Social Care out of hours duty team available from 5PM – 8AM to provide emergency assessment and safeguarding interventions.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Ham C, Imison C, et al. Avoiding Hospital Admissions; Lessons from Evidence and Experience King's Fund (2010)

"The greatest opportunity to reduce hospital admissions and bed days lies in the proactive management of people with long-term conditions, especially people with multiple conditions. Integrated working between health and social care can result in lower than expected emergency admissions and reduced use of beds, as evidenced by the achievements of Torbay."

Purdy S. Avoiding Emergency Admissions: what does the evidence say? King's Fund (2010)

Points to the potential of integration of Health and Social care responses in reducing admissions

Tian Y, Dixon A, Emergency Admissions for Ambulatory care sensitive conditions: Identifying the potential for reductions. King's fund (2012)

- Influenza and pneumonia account for the highest proportion of all emergency admissions (EAs) for ambulatory care sensitive conditions (ACSCs) - 13% – much of this activity is preventable by vaccine administration.
- Those over 75 account for 40% of the total EAs for ACSC
- COPD/CHF/Flu/Pneumonia/Dehydration and gastritis account for 53% of costs associated with EAs for ACSCs.

Oliver D, Foot C et al. Making our Health and care systems fit for an aging population The King's Fund (2014)

Amongst a range of recommendations this paper highlights:

(a) rapid support close to home in times of crisis and (b) integration to provide person-centred co-ordinated care

Roland M, Abel G Reducing Emergency Admissions: Are we on the right Track? BMJ 2012; 345 e6017

Sets out the various segments of risk within the UK population and the proportion of the total amount of emergency admissions accrued by each segment. Highlights the important of not restricting interventions to the highest risk patients and the need to address patients from at least the top quintile of risk within the population.

Igual et al. Challenges, issues and trends in fall detection Systems BioMedical Engineering OnLine 2013, 12:66

Highlights the importance of avoiding "long lie" for patients who have fallen and are unable to get themselves up. Assistive technology linked to rapid response teams can be vital in avoiding this adverse outcome.

Leicester City CCG population segmenting and analysis by GEM CSU and LCC Public Health Department

Investment requirements

Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15: £926,000
2015/16 £1,475,000

Impact of scheme

Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Using the benefits analysis model developed with PA Consulting, we have attributed an impact on the following metrics:

BCF National Metric 1: Less people going into nursing and residential care
BCF National Metric 2: More people receiving help to recover at home
BCF National Metric 3: A reduction in hospital bed days due to discharge being delayed
BCF National Metric 4: A reduction in total hospital admissions
BCF National Metric 5: Improved patient/service user experience
BCF Local Metric: More people being identified as living with Dementia

Please see tab 4 of template 2 for further detail

In addition to the national metrics, we have set up a dashboard to monitor outcomes and activity under the following themes:

- Monthly discussion of anonymised individual case studies at BCF Implementation Group meeting
- Monthly BCF Operational Group meetings for providers to discuss any challenges/successes in implementing the pathway.
- Feedback of outcomes of cases to individual referring clinicians
- Quality report – reporting on any incidents/complaints issues – by exception based on quality schedule of main LPT CHS contract

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Strategic level – Monthly reporting to the JICB and CCG Performance Exec

At a strategic level, an overarching system dashboard is being formulated, covering the 5 + 1 national metrics as well as other relevant metrics to manage flow at a system level.

Operational Level – Bi-weekly reporting to the BCF Implementation Group

Underneath this, sits a comprehensive Integrated Care Performance Dashboard, specially produced to support the performance management function for the BCF Programme.

Practice level – Weekly reporting

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

In totality, this provides a comprehensive view of both the health and social care system as a whole and tracks performance of the Integrated Care model.

All draft dashboards are provided as Appendix 7.

What are the key success factors for implementation of this scheme?

- Co-production and co-ownership of the model and aims of the BCF pathway.
- Guarantee of rapid response for patients to those colleagues who will be referring in patients – primary care GPs, CRT GPs, OOH GPs, EMAS crews, Integrated Community Health Services, Locality Adult Social Care Staff (Doing what we said we would do for front line staff in terms of increasing access to reliable support for patients to be safely managed at home).
- Engagement of front line clinical and social care staff to refer patients into the pathway
- Commitment by commissioners and providers to work together to implement the practical elements of the pathway – a two hour maximum response time day or night, a willingness to share information and work in a joined up fashion with patients with complex needs, good discharge planning to ensure effective transitions from the Unscheduled care team to the next phase of care within the community.
- Recruitment of staff to plan to ensure that the increased volume of patients being kept at home can be successfully managed within the community setting.
- Co-location of health and social care day and night staff
- Ability to regularly collect activity and relevant outcome and quality data from individual services

Scheme ref no.
BCF 6
Scheme name
System Coordinator
What is the strategic objective of this scheme?

Link to vision:

- Provide a modern model of integrated care with a senior clinician taking responsibility for coordination of care
- Reduce the amount of time spent in hospital avoidably by our citizens, by focussing on health and social care pathways and services such as housing

Response to case for change through delivery of:

- Reduction in emergency admissions and especially readmissions to acute care
- Reduction in the numbers of patients requiring admission to permanent residential care
- Increase in the numbers of patients still at home 91 days after discharge from hospital
- To be a platform to ensure that specialist community services such as Community Matrons Heart Failure and Respiratory Specialist nursing, and Care Navigators caseloads are populated with the right kind of patients – i.e. those with high – very high risk of adverse outcomes where specialist input is likely to have the greatest chance of altering the clinical trajectory.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

As the city PCT and then CCG and Local Authority have been developing additional community based services and pathways over the last few years to try to facilitate a "left-shift" in care away from acute hospitals, a variety of both in-patient intermediate care type facilities and intensive domiciliary services have been commissioned. The challenge remains to ensure that the total available capacity in the community – in-patient and domiciliary, health and social care, NHS and independent sector – is used to optimum (not necessarily maximum) capacity throughout the year **and** throughout the 7 day cycle.

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

(a) support flow through the system
(b) take pressure off the acute sector by facilitating discharge and reducing inappropriate admission
(c) Ensure that patients are managed in the least intensive setting consistent with their meeting their treatment and therapy goals safely

Skilled nurse leadership is fundamental to the achievement of integrated care and to

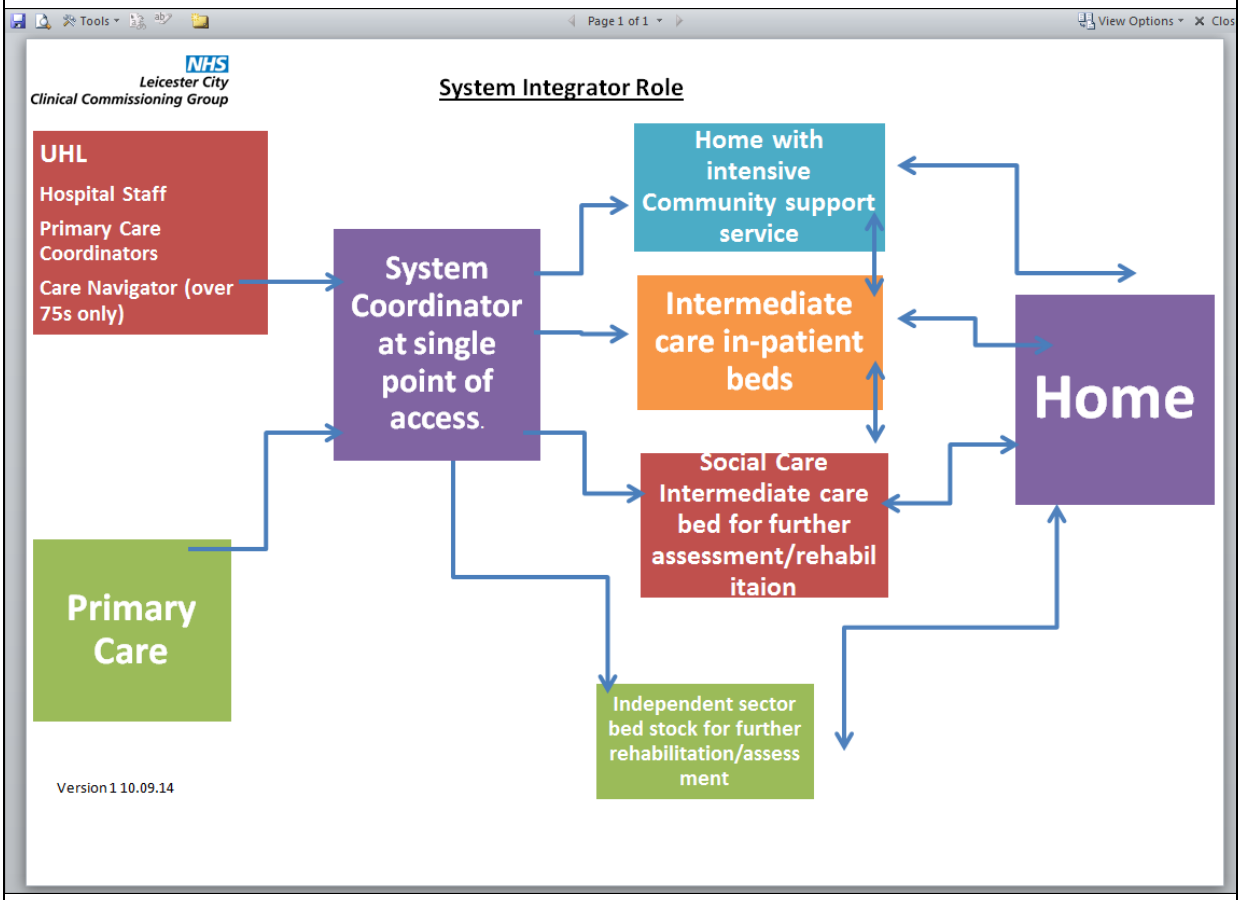
the optimal functioning of the total health and social care community based resource , The System Integrator (an experienced nurse situated in our Single Point of Access) will deliver optimum efficiency across all systems through:

1. Bed and other resource management at whole system level outside of UHL – and close liaison with UHL bed manager on twice daily or more frequent basis.
2. Providing input into decision-making processes (for example challenging decisions to keep patients in hospital where there is a lack of knowledge about what can be offered in the community setting)
3. Clinical leadership
4. Proactive communication with all partners. Providing patient care to ensure that resources are freed up in a timely manner and that where a chain of patient moves through several services is required to happen in order to ensure that each patient is treated in the right place at the right time; that such moves occur in a timely fashion.
5. To lead a twice daily conference call with UHL, LPT CHS and Adult Social Care to coordinate the discharge planning and movement between services from UHL into the community and between various community services.
6. To provide a series of ward based education opportunities over the course of the winter 2014-15 periods to UHL staff on base wards to educate them as to the capacity of community services to support patients with quite complex needs at home.

Nursing expertise must be recognised and utilised to provide the “glue” and the drive to ensure that in the absence of true vertical integration of organisations, that patients reap the benefit of vertically integrated pathways between acute and community services. The ability of nursing staff to view whole care pathways and to take holistic perspectives that go beyond day-to-day clinical issues affords them a vital role in delivering optimum levels of bed occupancy, length of stay and outcomes from each of the linked services.

The slide below illustrates how the System Integrator based at the Single Point of Access will coordinate entry into and movement out of services

The model of care:



What patient cohorts are being targeted?

5. The System Integrator will be targeting all patients over the age of 18 who are being discharged from UHL who are not able initially to return to live **independently** at home.

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners :

Leicester City CCG.

Leicester City CCG will commission this post on behalf of all the BCF partners in the city

Provider:

Leicestershire Partnership Trust Community Health Services will provide a suitably experienced and credentialed staff member to fulfil this challenging role.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme

- to drive assumptions about impact and outcomes

Health and Social Care Act 2012 The act gives a duty to NHS England, clinical commissioning groups, Monitor and health and wellbeing boards to make it easier for health and social care services to work together. This will improve the quality of services and people's experiences of them.

Ham C, Imison C, et al. "Avoiding Hospital Admissions; Lessons from Evidence and Experience" King's Fund (2010)
"The greatest opportunity to reduce hospital admissions and bed days lies in the proactive management of people with long-term conditions, especially people with multiple conditions. Integrated working between health and social care can result in lower than expected emergency admissions and reduced use of beds, as evidenced by the achievements of Torbay."

Humphries R Curry N "Integrating Health and Social Care. Where next?" King's Fund 2011

"The Integration of Health and Social Care" Health Policy and Economic Research Unit (2012)

Oliver D, Foot C et al. Making our Health and care systems fit for an aging population The King's Fund (2014)
Amongst a range of recommendations this paper highlights:
(b) rapid support close to home in times of crisis and (b) integration to provide person-centred co-ordinated care

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Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15: £63k
2015/16: £63k

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Using the benefits analysis model developed with PA Consulting, we have attributed an impact on the following metrics:

BCF National Metric 1: Less people going into nursing and residential care

BCF National Metric 2: More people receiving help to recover at home
BCF National Metric 3: A reduction in hospital bed days due to discharge being delayed
BCF National Metric 4: A reduction in total hospital admissions
BCF National Metric 5: Improved patient/service user experience
BCF Local Metric: More people being identified as living with Dementia

Please see tab 4 of template 2 for further detail

As part of our overall dashboard we will be measuring the following metrics which will indicate the effectiveness of this investment:

1. Occupied bed days in Intensive Community Support service (ICS)
2. Number of episodes of care per month in ICS
3. Average LOS in ICS
4. Occupied bed days in Intermediate Care beds at Evington Centre
5. Monthly average LOS at Evington Centre
6. Occupied bed days at Local Authority Intermediate care in-patient facility at Brookside Court
7. Average monthly LOS at Brookside Court

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Strategic level – Monthly reporting to the JICB and CCG Performance Exec

At a strategic level, an overarching system dashboard is being formulated, covering the 5 + 1 national metrics as well as other relevant metrics to manage flow at a system level.

Operational Level – Bi-weekly reporting to the BCF Implementation Group

Underneath this, sits a comprehensive Integrated Care Performance Dashboard, specially produced to support the performance management function for the BCF Programme.

Practice level – Weekly reporting

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

In totality, this provides a comprehensive view of both the health and social care system as a whole and tracks performance of the Integrated Care model.

All draft dashboards are provided as Appendix 7.
What are the key success factors for implementation of this scheme?
• Ability to recruit candidate of sufficient experience and character to exert influence over system wide resources in context of multiple stakeholders and multiple pathways • Ability to engage UHL staff in changing traditional patterns of care in order to fully utilise the available community capacity • Capacity in ancillary services such as community equipment, Practical help at Home, Transport services etc. to support the decisions of the System Coordinator to move patients towards safely returning to home.

Scheme ref no.
BCF 7
Scheme name
Intensive Community Support service
What is the strategic objective of this scheme?
Link to vision: • Reduce the amount of time spent in hospital avoidably by our citizens, by focussing on health and social care pathways and services such as housing • Ensure that people are kept independent for as long as possible following hospital care The strategic objective of this scheme is to : (a) Reduce delays to transfers to care from both secondary care and from the Intermediate care in-patient beds (b) Increase the numbers of patients independent at home 91 days after discharge (c) Reduce emergency admissions and readmissions to acute care (d) Reduce the number of people admitted to permanent residential care (e) Improve patient experience of care
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
A substantial left-shift in activity to have many more patients with long term conditions managed at home requires the right level of community support to be available on a seven day basis. The current pressures noted through the urgent and emergency care system are compounded by the lack of discharge capacity, specifically into discharge destinations relating to community services. These patients, often older vulnerable patients, occupy acute beds when they could be cared for in the community if more capacity was available. Moving these patients into appropriate community services will improve the quality of care for this cohort of patient whilst releasing valuable acute capacity. Intensive Community Support is a model of care underpinned by the principles of comprehensive geriatric assessment (CGA), which has a strong evidence base for improving outcomes for older people. These include reduced mortality or functional decline, improved cognition, improved quality of life, reduced length of stay, reduced readmission rates and reduced rates of long term care use. CGA has also demonstrated that home and bed-based intermediate care schemes through adequately resourced community based services improve outcomes including reduced mortality, increased patient satisfaction and reduced costs. The BCF investment in this element – Intensive Community Support service - specifically targets the following elements of our model described below:

Commissioning of 30 “virtual Ward” beds which allow patients with complex health and social care needs and relatively high levels of dependency to be stabilised and re-abled at home.

The model of care:
A patient –centred and holistic approach to providing intensive integrated health and social care to patients with long term conditions and /or frailty syndrome through intensive community nursing , therapy and social care input to patients in their own homes

- The service will operate from 8 AM – 10 PM 7 days per week.
- Treatment and care will be delivered to the patient in their own home but on a more intensive and extended scale than is the case with routine community nursing care
- Patients will be able to receive up to 4 visits per day from health and social care staff
- For those patients with overnight monitoring or care needs care after 10PM will be provided by the increased Night nursing capacity commissioned via the BCF investment – working side by side with the night time ICRS team from Adult Social Care
- Patient are kept on with the ICS for up to 6 weeks
- Although the team will be led by an Advanced Nurse Practitioner, there will be access to the community consultant geriatrician in the Rapid Intervention Team for additional clinical input if required.
- The ethos of ICS care is rehabilitative where possible and therefore dedicated occupational and physiotherapy staff contribute to assessment and treatment of patients – working in partnership with domiciliary care staff to restore independence in activities of daily living
- The service may refer patients on to Reablement for further support towards achieving therapy goals
- Parity of esteem for mental health needs though Community Mental Health Practitioner team (CMHT). Extra emphasis on the importance of managing the mental health aspects of living with long term conditions and social isolation – through the commissioning of extra capacity in the CMHT. This team will work in close association with the ICS service to determine whether latent cognitive impairment or mental health issues are a part of the patient’s complexity of need.
- Robust reablement service which includes community health assessment as standard. Up to 6 weeks of free access to reablement services will be offered to all those ICS patients who might benefit.

What patient cohorts are being targeted?

There are three target cohorts for the BCF pathway:

6. Patients aged 18-59 years with three or more long term conditions (LTCs)
7. Patients aged 60+ with one or more LTCs
8. Patients with dementia

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners :
Leicester City CCG
Leicester City Council Adult Social Care Services

Providers:
Leicestershire Partnership Trust Community Health Services (LPT CHS) – Providers of the Community Geriatricians, Advanced Nurse Practitioner (ANPs), CMHTs and other specialist nurses Therapy and Health Care Assistant Staff that make up the **health component of the ICS**. The service will work very closely with other members of the planned and unscheduled teams.

Leicester City Council Adult **Social Care** – Providers of

- **Single Point of Contact (SpoC) –** this service provides ASC contact and domiciliary assessment for access under FACS criteria to Adult Social Care. Capacity in this team will be increased by 6.53 WTE under the BCF Investment in 2015-16. This additional support will enable prompt assessment and commissioning of care for patients requiring intensive social care support during their period with ICS.
- **Practical Help at Home (PHAH)** see description in Unscheduled Care annex. PHAH may have an input to ICS to provide some minor home adaptations to allow patients to remain at home safely.
- **Assistive Technology (AT) team** See the Unscheduled Care annex for details of this service. Installation of selected AT devices may be part of the support needed to complete the input from the ICS team for frailer patients in order to reduce future risk of readmission.
- **Reablement –** see above and annex on Planned Care for description of this service

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Evidence to support this approach can be found in the following papers:

- Ernst & Young. (2012) National Evaluation of the Department of Health's Integrated care Pilots: Rand Europe
- Laurant MJ, Harmsen M, Faber M, Wollersheim H, Sibbauld B, Grol R (2010). Revision of Professional Roles and Quality Improvement: A review of the evidence. London: The Health Foundation.
- Ellis G, Whitehead M, Robinson D, O'Neill D, Langhorne P (2011) Comprehensive geriatric assessment for older adults admitted to hospital:

meta-analysis of randomised controlled trials' British medical Journal, vol. 343, d6553.

Purdy S. Avoiding Emergency Admissions: what does the evidence say? King's Fund (2010)
Points to the potential of integration of Health and Social care responses in reducing admissions

Oliver D, Foot C et al. Making our Health and care systems fit for an aging population The King's Fund (2014)
Amongst a range of recommendations this paper highlights:
(c) rapid support close to home in times of crisis and (b) integration to provide person-centred co-ordinated care

Salisbury C, Johnson L, Purdy S, Valderas JM, Montgomery AA. (2011) Epidemiology and impact of multi-morbidity in primary care: a retrospective cohort study. Br J Gen Practice 61:e12-e21.

Naylor C. et al Long Term Conditions and Mental Health: The cost of Co-morbidities. King's Fund and Centre for Mental Health (2012)
"…by interacting with and exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least 45 per cent for each person with a long-term condition and co-morbid mental health problem." This paper underpins our decision to invest in increasing access for older people with LTCs to the CMHT

Leicester City CCG population segmenting and analysis by GEM CSU and LCC Public Health Department

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15: £710,000
2015/16: 874,000

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Using the benefits analysis model developed with PA Consulting, we have attributed an impact on the following metrics:

BCF National Metric 1: Less people going into nursing and residential care
BCF National Metric 2: More people receiving help to recover at home
BCF National Metric 3: A reduction in hospital bed days due to discharge being delayed
BCF National Metric 4: A reduction in total hospital admissions

BCF National Metric 5: Improved patient/service user experience

Please see tab 4 of template 2 for further detail

As part of our overall dashboard we will be measuring the following metrics which will indicate the effectiveness of this investment:

- Occupancy rate of ICS beds
- Occupied bed days
- Monthly completed episodes of care
- Monthly BCF Operational Group meetings for providers to discuss any challenges/successes in implementing the pathway.
- Feedback of outcomes of selected cases to individual referring clinicians
- Quality report at BCF Subgroup on Planned and Unscheduled care– reporting on any incidents/complaints issues – by exception based on quality schedule of main LPT CHS contract

Feedback loop

What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Strategic level – Monthly reporting to the JICB and CCG Performance Exec

At a strategic level, an overarching system dashboard is being formulated, covering the 5 + 1 national metrics as well as other relevant metrics to manage flow at a system level.

Operational Level – Bi-weekly reporting to the BCF Implementation Group

Underneath this, sits a comprehensive Integrated Care Performance Dashboard, specially produced to support the performance management function for the BCF Programme.

Practice level – Weekly reporting

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

In totality, this provides a comprehensive view of both the health and social care system as a whole and tracks performance of the Integrated Care model.

All draft dashboards are provided as Appendix 7.

What are the key success factors for implementation of this scheme?

- Co-production and co-ownership of the model and aims of the BCF pathway.

We have had input from GPs, LPT CHS management, Adult Social Care Management EMAS and UHL in the creation of this scheme.

- Engagement of front line clinical and social care staff to refer patients into the pathway. There has been extensive engagement with primary care and Adult Social Care in particular on the drive to adequately resource ICS to support patients with quite intensive needs at home – including those with overnight needs
- Recruitment of staff to plan to ensure that the increased volume of patients being kept at home can be successfully managed within the community setting.
- Integrated working between community geriatricians and the rest of the ICS staff
- Ability to regularly collect activity and relevant outcome and quality data from individual services – we have engaged with all providers to agree the relevant and available data items which can be collated to evaluate progress on this scheme.

Scheme ref no.
BCF 8
Scheme name
IT Integration Project
What is the strategic objective of this scheme?
The incorporation of the NHS number into the Social Care record has been identified as one of the main strategic priorities in relation to the BCF and is a national condition and one of the core metrics identified by the Better Care Fund Guidance To develop the delivery of more seamless and integrated health and social care for those with complex needs a single unique identifier will be required where records are to be shared to improve communication across the local health and social care economy. This scheme is fundamentally concerned with developing a technical and information governance infrastructure across health and social care in Leicester. The system integration project is aimed at meeting the national condition of data sharing through enabling the NHS number to be used as the primary identifier. It will also have the potential to support each of the key projects to integrate its business process and information sharing to an optimised level. This will bring capability for the generation of integrated management information to support strategic and operational decision making.
Overview of the scheme Please provide a brief description of what you are proposing to do including: - What is the model of care and support? - Which patient cohorts are being targeted?
Phase 1 Phase 1 will firstly involve the development of an overarching information governance framework between the NHS Leicester City and Leicester City Council Adult Social Care. This will allow the sharing of information and the development of a set of associated Individual Information Sharing Agreements (ISA) to support particular functions/services as they integrate more closely in a phased way, in line with the wider programme. Compliance with the IG toolkit is an activity in this phase and a key enabler to allow phase 2 to commence. The establishment of NHS numbers through the Demographic Batch Service (DBS) for all customers known to Adult Social Care is a key milestone for this phase and is a key enabler in supporting; strategic and operational decision making, service

redesign and understanding performance across functions of the integrated care pathway.

Indicative timescales for this phase of work are anticipated to be from April 2014 – November 2014.

Phase 2

This phase aims to build an integral link between NHS and Council information systems respectively. This will facilitate a long term solution to enable day to day transfer of the NHS number and other Personal Demographic data from the NHS SPINE to the Adult Social Care case management system namely Liquid Logic IAS. This link will involve dedicated technical work with the deployment of specialist software modules which are designed to support this type of integration.

Indicative timescales for this phase of work are anticipated to be from October 2014 – January 2015.

Having a means of linking health and social care records is a key step towards having shared records for patients in receipt of health and social care. A shared record is one of the mechanisms for ensuring that care is more joined up for patients and avoids patients having to retell their histories multiple times especially if they have episodes of care at different locations at different times.

Another critical strategic impact of this work will be to allow the local health and social care community to evaluate the impact of the new pathways integrating health and social care responses in the community. It is essential that we are able to gather the evidence of the impact on individual patients in terms of usage of the acute care system so that changes can be made to the pilot if necessary.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Below are brief details of those involved in the delivery of this scheme:

Business Improvement Manager, Adult Social Care – This role provides overall project management and delivery of the scheme through coordinated and planned activity across partner organisations.

Head of Service, Adult Social Care – This role provides a senior management input to ensure that new technical capability is implemented with due consideration of operational business processes.

Strategy and Planning Manager, LCCCG – This provides commissioner input and supports the coordinated and planned activity across partner organisations through identification of data to be shared

Information Assurance, LCC – This role provides assurance that the necessary

information governance standards are being met at an organisational level such as compliance with the NHS toolkit level 2

Information Governance, LCC – This role represents social care and provides the information governance framework at local organisations level in order to support data sharing between various partners
Information Governance, (GEM CSU) – This role represent the health economy and provides the information governance framework at local organisations level in order to support data sharing between various partners

Senior IM&T Manager, (GEM CSU) – This role provides a view on technical requirement and best practice process to be undertaken in order to deliver the scheme

Application Support Manager, LCC – This role provides a view on technical requirements and best practice processes to be undertaken in order to deliver the scheme

RA service programme Manager (GEMSCU) – This role provides support and services in relation to the Registration Authority Service

Liquid Logic Project Manager – This role provides the technical resources and expertise in relation to the interface software between Liquid Logic and the NHS SPINE

Partner organisations

Leicester City Council – Joint commissioner of scheme and recipient of health data

Leicester City CCG – Joint commissioner of scheme

GEMCSU – Is the local approved ASH and is expected to provide the RA authority service to social care in order to ensure secure access to health systems

Liquid Logic (McKesson) – Is the supplier of Adult Social Care's Case Management system and provides capability to incorporate health data into social care records

Health and Social Care Information Centre (HSCIC) – Provides necessary authorisation and tools with which to undertake data matching at a local level

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Fundamentally, this scheme is about supporting integrated care across the health and social care economy. The real time capabilities and sharing of data across organisational boundaries through the implementation of identified technology and an associated culture change has proven to be a key enabler of integrated care.

Other areas such as Barnsley Council, whom we have been in contact with, have realised the benefits that can be achieved through joint information governance and information sharing to deliver more integrated health and social care.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15: 96k
2015/16: 4k

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Phase 1 Outline Benefits

• Information governance framework in place covering Leicester City NHS and Leicester City Council Adult Social Care;

• Leicester City Council obtains compliance status in line with NHS IG toolkit which is a necessary precursor to any system integration activity;

• Will allow for the commencement of data modelling around potential co terminus arrangements.

Phase 2 Outline Benefits

• Will support systematic tracking of customer journey across Health and Social Care boundaries providing the platform for integrated management information which will support strategic decision making;

• Time saving for Adult Social Care staff through eliminating need to manually enter some key health related customer information. It will be possible to look up customer/patient information within the Patient Demographic Service (PDS) and imported;

• Adult Social Care staff will have the ability to validate, in real-time, a customer's individual NHS Number on their Liquid Logic record against their health care record;

• Adult Social Care staff will no longer have to ask customers for some of their personal details;

• Should increase speed of communications/referrals between integrated functions across the Health and Social Care economy;

• Ensures Adult Social Care staff and Health Professionals are talking about the same person across health and social care;

• Supports the Adult Social Care staff to have up to date customer details when they change and ensure that changes are reflected accurately;

• Prevention of duplication or inaccuracy across patient / customer records;

• Enhanced data integrity in Adult Social Care systems resulting in trusted information to inform decision making both strategically and operationally.

• Information sharing should facilitate seamless delivery of care across both Health and Social Care economies.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The outcomes and benefits are anticipated to be across the whole integrated pathway in Leicester. Whilst financial benefits are not directly anticipated to result from this scheme, intangible benefits such as the overall smoother journey for the customer and the elimination where possible of the customer having to tell their twice when working are expected. In addition, integrated management information to support the tracking of people across the health and social care is expected to be available.

The routine availability of integrated management information and an associated performance dashboard will support strategic and operational decision making to enable validation of what is and not working.

A further measure of the success of this scheme will be the tangible use of health data in social care as a matter of course in day to day activities including the mandatory requirement to input onto social care systems.

What are the key success factors for implementation of this scheme?

There are a number of key success factors associated to the successful implementation of this scheme which are detailed below:

1) Joint partnership appetite at a strategic leadership and operational level to share and use data;

2) The development of a coherent and jointly agreed set of Information governance arrangements;

3) Joint staff communication and briefings on when and how to use shared data routinely as part of day to operational working;

4) Good inter organisational team working including the establishment of a joint multi-disciplinary system integration group consisting of representation of an array partner organisations;

5) A change in working culture between health and social operational teams;

Scheme ref no.
BCF 9
Scheme name
Planned Care Team
What is the strategic objective of this scheme?

Link to Vision:

- Provide a modern model of integrated care with a senior clinician taking responsibility for coordination of care
- Reduce the amount of time spent in hospital avoidably by our citizens, by focussing on health and social care pathways and services such as housing
- Ensure that people are kept independent for as long as possible following hospital care

Response to case for change through delivery of:

(a) Reduction in the numbers of patients requiring admission to permanent residential care
(b) Increase in the numbers of patients still at home 91 days after discharge from hospital
(c) Reduction in the total numbers of emergency admissions
(d) Reduction in DTOCs
(e) Increase in patient satisfaction
(f) Increase in the number of patients recorded as living with dementia

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

A substantial left-shift in activity to have many more patients with long term conditions managed at home requires the right level of community support to be available on a seven day basis. The BCF investment in this element – Community Planned Care Health and Social Care teams - specifically targets the following elements of our model described below:

- Uplift and development of the capacity of the Community Mental Health Practitioner team to proactively address the needs of older people's mental health in the community
- Establishment of a new Care Navigator Service – a team of Health and Social care coordinators to coordinate health and social care services for the frailest over 75s
- Increase in the capacity of Adult Social Care (ASC) Single Point of Contact (SPoC) to facilitate alignment of their working times of the Health Single Point of Access (SPA)
- Year long process of Organisational development by Leicester City Adult Social care Services to redesign their current Locality boundaries to align them to be co-terminous with the neighbourhood structure of Leicestershire Partnership Trust Community Health Services

The model of care:
A patient –centred and holistic approach to providing systematic integrated health and social care to patients with long term conditions and /or frailty syndrome through:

- **Systematic use of risk stratification software** to support primary care in identifying patients with moderate to high risk of emergency admission of the next twelve months (see separate annex)
- **Deployment at scale of proactive community interventions** to reduce risk of admission in those with LTCs (care planning and patient education) and to reduce incidence of preventable admission for ambulatory care sensitive conditions
- **A seamless pathway into on-going community support for those being discharged from unscheduled health and social care services.** We know that many patients who have entered integrate services as an emergency will require further monitoring and longer term intervention such as reablement. Planned care services will liaise with unscheduled services to plan the transition from unscheduled to planned care.
- **Parity of esteem for mental health needs though Community Mental Health Practitioner team** (CMHT) - Extra emphasis on the importance of managing the mental health aspects of living with long term conditions and social isolation – through the commissioning of extra capacity in the CMHT. This team will work in close association with primary care and with community health and social care colleagues in the rest of the planned care and unscheduled care teams
- **Care coordination for the most complex older people through our Care Navigator team** – targeted to coordinate the health and social care services deployed to the frailest cohort of the over 75s (identified via risk stratification tool and GP intuition). This team will have access to read and entry access to both the health and social care electronic record systems to facilitate joined up communication for the most vulnerable and complex patients. We have identified at least 18 different health and social care agencies and services that the Care Navigators can refer into on behalf of their patients.
- **Increased access to Adult Social Care services though the Single Point of Contact (SPoC)** Increased Adult Social Care Locality staff complement to

facilitate more community assessments and sign posting to Advice, Information and Guidance. The proactive identification of greater numbers of patients at potential risk of admission will require more capacity in ASC locality Teams to deliver timely responses to requests for non-urgent help.

- **Robust reablement service which includes community health assessment as standard and is accessible either on discharge from hospital or from community services. Up to 6 weeks of free access to reablement services will be offered to all those who might benefit. Reablement will aim to optimise the functional independence of older people at home by providing therapy and equipment as needed to promote achievement of agreed therapy goals. In addition** Part of the planned health care provision will include a community nurse assessment on entry into reablement as standard. We know from pilot work done in the CCG last winter that the addition of health monitoring improves outcomes of reablement and reduces readmission to hospital within 30 days.
- **Co-terminus health and social care neighbourhood boundaries** to facilitate more integrated working via multi-disciplinary team meetings hosted by primary care and greater continuity of care for those with complex health and social care needs

What patient cohorts are being targeted?

There are three target cohorts for the BCF pathway:

9. Patients aged 18-59 years with three or more long term conditions (LTCs)
10. Patients aged 60+ with one or more LTCs
11. Patients with dementia

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners :

Leicester City CCG
Leicester City Council Adult Social Care Services

Providers:

Leicestershire Partnership Trust Community Health Services (LPT CHS) - Providers of **Community Mental Health Practitioner Services**. These practitioners will support both primary care and community health and social care teams in the assessment and monitoring of older people with symptoms of mental ill-health. We know that the prevalence of mental health problems such as depression and anxiety are common amongst older people with LTC and can have a bearing on their use of emergency services. Specialist CMHTs can support improving access for such patients to the right assessments and treatments. The service will work very closely with other members of the planned and unscheduled teams.

Providers of physiotherapy and education services for reablement (in partnership with Leicester City Council Adult Social Care).

Leicester City Council – Providers of

- **Single Point of Contact (SPoC) –** this service provides both (a) call handling for sign posting to advice, information and guidance to a wide variety of statutory and non-statutory services and an assessment and (b) ASC contact and domiciliary assessment for access under FACS criteria to Adult Social Care. Capacity in this team will be increased by 6.53 WTE under the BCF Investment in 2015-16
- **Care Navigator (CN) Service**– 5 WTE Care Navigators have been recruited to support primary care in coordinating the care of patients over 75 with complex health and social care needs. These Navigators will work with the patients named GP to ensure optimal integrated of health, social care and voluntary sector service for these patients. The CNs focused on reduction of risk and maintenance of independence in the home.
- **Reablement – current CCG funding of reablement**.

The evidence base

Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Ham C, Imison C, et al. Avoiding Hospital Admissions; Lessons from Evidence and Experience King's Fund (2010)

"The greatest opportunity to reduce hospital admissions and bed days lies in the proactive management of people with long-term conditions, especially people with multiple conditions. Integrated working between health and social care can result in lower than expected emergency admissions and reduced use of beds, as evidenced by the achievements of Torbay."

Purdy S. Avoiding Emergency Admissions: what does the evidence say? King's Fund (2010)

Points to the potential of integration of Health and Social care responses in reducing admissions

Tian Y, Dixon A, Emergency Admissions for Ambulatory care sensitive conditions: Identifying the potential for reductions. King's fund (2012)

- Influenza and pneumonia account for the highest proportion of all emergency admissions (EAs) for ambulatory care sensitive conditions (ACSCs) - 13% – much of this activity is preventable by vaccine administration.
- Those over 75 account for 40% of the total EAs for ACSC
- COPD/CHF/Flu/Pneumonia/Dehydration and gastritis account for 53% of costs associated with EAs for ACSCs.

Oliver D, Foot C et al. Making our Health and care systems fit for an aging population The King's Fund (2014)

Amongst a range of recommendations this paper highlights:

(d) rapid support close to home in times of crisis and (b) integration to provide person-centred co-ordinated care

Roland M, Abel G Reducing Emergency Admissions: Are we on the right Track? BMJ 2012; 345 e6017

Sets out the various segments of risk within the UK population and the proportion of the total amount of emergency admissions accrued by each segment. Highlights the important of not restricting interventions to the highest risk patients and the need to address patients from at least the top quintile of risk within the population.

Igual et al. Challenges, issues and trends in fall detection Systems BioMedical Engineering OnLine 2013, 12:66
Highlights the importance of avoiding "long lie" for patients who have fallen and are unable to get themselves up. Assistive technology linked to rapid response teams can be vital in avoiding this adverse outcome.

Salisbury C, Johnson L, Purdy S, Valderas JM, Montgomery AA. (2011) Epidemiology and impact of multi-morbidity in primary care: a retrospective cohort study. Br J Gen Practice 61:e12-e21.

Sylvia ML, Griswold M, Dunbar L, Boyd CM, Park M, Boult C. (2008) Guided care: cost and utilization outcomes in a pilot study. Disease Management 11:29-36.
Demonstrates how use of risk stratification can support case management of those with LTCs to reduce hospitalisation.

Naylor C. et al Long Term Conditions and Mental Health: The cost of Co-morbidities. King's Fund and Centre for Mental Health (2012)

"…by interacting with and exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least 45 per cent for each person with a long-term condition and co-morbid mental health problem." This paper underpins our decision to invest in increasing access for older people with LTCs to the CMHT

Leicester City CCG population segmenting and analysis by GEM CSU and LCC Public Health Department

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15: £382,000
2015/16: £382,000

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Using the benefits analysis model developed with PA Consulting, we have attributed an impact on the following metrics:

BCF National Metric 1: Less people going into nursing and residential care
BCF National Metric 2: More people receiving help to recover at home
BCF National Metric 3: A reduction in hospital bed days due to discharge

being delayed
BCF National Metric 4: A reduction in total hospital admissions
BCF National Metric 5: Improved patient/service user experience
BCF Local Metric: More people being identified as living with Dementia

Please see tab 4 of template 2 for further detail

In addition to the national metrics, we have set up a dashboard to monitor outcomes as outlined below:

- numbers of patients seen each month by CMHTs, Community Planned Care Health team,
- Number of contact and domiciliary assessments by SPoC
- Monthly performance management of targets for primary care BCF scheme at QED and Locality meetings
- Monthly discussion of anonymised individual case studies at BCF Implementation Group meeting
- Monthly BCF Operational Group meetings for providers to discuss any challenges/successes in implementing the pathway.
- Feedback of outcomes of cases to individual referring clinicians
- Quality report at BCF Subgroup on Planned and Unscheduled care– reporting on any incidents/complaints issues – by exception based on quality schedule of main LPT CHS contract

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Strategic level – Monthly reporting to the JICB and CCG Performance Exec

At a strategic level, an overarching system dashboard is being formulated, covering the 5 + 1 national metrics as well as other relevant metrics to manage flow at a system level.

Operational Level – Bi-weekly reporting to the BCF Implementation Group

Underneath this, sits a comprehensive Integrated Care Performance Dashboard, specially produced to support the performance management function for the BCF Programme.

Practice level – Weekly reporting

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

In totality, this provides a comprehensive view of both the health and social care

system as a whole and tracks performance of the Integrated Care model.

All draft dashboards are provided as Appendix 7.

What are the key success factors for implementation of this scheme?

- Co-production and co-ownership of the model and aims of the BCF pathway. We have had input from GPs, LPT CHS management, Adult Social Care Management EMAS and UHL in the creation of this scheme.
- Guarantee of a smooth entry into planned care for patients to those colleagues who will be referring in patients – primary care GPs, CRT GPs, Integrated Community Health Services, Locality Adult Social Care Staff (Doing what we said we would do for front line staff in terms of increasing access to reliable support for patients to be safely managed at home).
- Engagement of front line clinical and social care staff to refer patients into the pathway. There has been extensive engagement with primary care and Adult Social Care in particular on the drive to adequately resource community care to support more proactive intervention with patients identified via risk stratification.
- Recruitment of staff to plan to ensure that the increased volume of patients being kept at home can be successfully managed within the community setting.
- Alignment of health and social care neighbourhood boundaries to support continuity of care and greater integrated working on the front line.
- Ability to regularly collect activity and relevant outcome and quality data from individual services – we have engaged with all providers to agree the relevant and available data items which can be collated to evaluate progress on this scheme.

Scheme ref no.
BCF 10
Scheme name
MH discharge team
What is the strategic objective of this scheme?

Link to vision:

- Provide a modern model of integrated care with a senior clinician taking responsibility for coordination of care
- Reduce the amount of time spent in hospital avoidably by our citizens, by focussing on health and social care pathways and services such as housing
- Ensure that people are kept independent for as long as possible following hospital care

Link to wider strategic objectives:

Strategic objectives are to enhance life chances and independence reducing inequalities in health status (Parity of Esteem) and associated costs.

Improving Mental Health service outcomes is a priority for both the CCG and local authority and a LLR Better Care Together priority. In particular the plans are to increase resilience in the population, earlier and more effective intervention, integrated local care delivery and proactive timely response to crisis and to managed demand for secondary care services.

Unnecessary stays in mental health units have a detrimental impact on patients. A study in 2010 showed that 27% of respondents rarely feel safe whilst in hospital and 51% of inpatients reported suffered some form of mistreatment, (Tansella, 2010). Local analysis of data has shown the majority of DTOC's on the mental health units are due to waits for assessments. In depth analysis has identified that demand is not matched to capacity, leading to excess waits for assessment.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

In order to meet the demand identified and to negate any detrimental impact on patients, this intervention will increase the capacity of the social work assessment team on 2 key units:

The Bennion ward (Mental health services for Older person)
The Bradgate Unit (Adult mental health)

It is envisaged that these posts will work in partnership with the Unscheduled and

planned care teams described earlier in this plan to ensure that holistic care is provided for these patients.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners Leicester City CCG
Post hosted by Leicester City Council adult social care.
Working with Leicestershire Partnership Trust (Mental Health) inpatient services provider.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

A recent independent review of the LLR mental health pathway has evidenced that it is under significant pressure, with increasing delayed transfers of care, increasing length of stay, and people placed in out of county acute placements due to lack of local provision.

Benchmarking indicates bed capacity is within range of peer services but that community options are less developed leading to a higher LOS. Analysis shows:

1. In 2013/14 out of county (OOC) placements increased significantly. LLR spend on OOC placements in 2013/14 was £4m, with Leicester City CCG contribution of £1.9m towards this.
2. The average weekly cost of OOC placement was £3,600 per week, significantly higher than local provision.
3. City MH/LD DTOC has been increasing during 2013/14. It has been consistently higher per weighted population than county HWB areas, on average 4.5 higher per 100,000 population.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15: £42000
2015/6: £42000

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Using the benefits analysis model developed with PA Consulting, we have attributed an impact on the following metrics:

BCF National Metric 3: A reduction in hospital bed days due to discharge being delayed
BCF National Metric 4: A reduction in total hospital admissions
BCF National Metric 5: Improved patient/service user experience

Please see tab 4 of template 2 for further detail

In addition to the national metrics, we have set up a dashboard to monitor outcomes as outlined below:

- Ongoing reduction in Mental Health Delayed transfer of care measured by- Delayed transfers of care (delayed days) from adult MH and MHSOP inpatient wards per 100,000 population (average per month).

- Supporting reduction in OOC placements

	Quarter 1 14/15	Quarter 2 14/15	Quarter 3 14/15	Quarter 14/15
Estimated average OoA placements	15	2	0	0
Estimated average OoA placements	19	6	1	0
Estimated average OoA placements	21	14	8	5

- Reduction in average LLR length of stay in a MH unit from 46.7 days in 2013/14 to the national mean of 30 days by April 2016.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Strategic level – Monthly reporting to the JICB and CCG Performance Exec

At a strategic level, an overarching system dashboard is being formulated, covering the 5 + 1 national metrics as well as other relevant metrics to manage flow at a system level.

Operational Level – Bi-weekly reporting to the BCF Implementation Group

Underneath this, sits a comprehensive Integrated Care Performance Dashboard, specially produced to support the performance management function for the BCF Programme.

Practice level – Weekly reporting

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

In totality, this provides a comprehensive view of both the health and social care system as a whole and tracks performance of the Integrated Care model.

All draft dashboards are provided as Appendix 7.

What are the key success factors for implementation of this scheme?

- Co-production and co-ownership of the model and aims of the BCF pathway. We have had input from GPs, LPT MH management & Adult Social Care Management as well as patients
- Engagement of front line clinical and social care staff to refer patients into the pathway.
- Recruitment of staff to plan to ensure that the increased volume of patients being kept at home can be successfully managed within the community setting.
- Alignment of health and social care neighbourhood boundaries to support continuity of care and greater integrated working on the front line.
- Ability to regularly collect activity and relevant outcome and quality data from individual services – we have engaged with all providers to agree the relevant and available data items which can be collated to evaluate progress on this scheme.

Scheme ref no.

BCF 11

Scheme name

Integrated Mental health step down service

What is the strategic objective of this scheme?

Improving Mental Health service outcomes is a priority for both the CCG and local authority and a LLR Better Care Together priority. In particular the plans are to increase resilience in the population, earlier and more effective intervention, integrated local care delivery and proactive timely response to crisis and to managed demand for secondary care services.

Unnecessary stays in mental health units have a detrimental impact on patients. A study in 2010 showed that 27% of respondents rarely feel safe whilst in hospital and 51% of inpatients reported suffered some form of mistreatment, (Tansella, 2010). Local analysis of data has shown the majority of DTOC's on the mental health units are due to waits for assessments. In depth analysis has identified that demand is not matched to capacity, leading to excess waits for assessment.

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

Local Mental Health Trust (NHS Leicestershire Partnership Trust) to commission a provision of semi-independent apartments for mental health service users stepping down from acute inpatient care

The service aims to:

- Provide a short term step down facility that promotes independence, inclusion and community engagement for service users, following an episode of acute
- mental illness
- Facilitate a successful and sustainable discharge from hospital, back in to the community for service users
- Facilitate reduced lengths of stay within LPT acute inpatient beds
- Provide a cost effective service that meets the needs of service users who no longer require the intensity of support provided within an acute ward

The delivery chain

Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

Commissioners

Leicester City CCG/ West Leicestershire CCG/ East Leicestershire & Rutland CCG

Provider:
Local Mental Health Trust provider (NHS Leicestershire Partnership Trust) funded to purchase service from independent sector Leicester City Council adult social care.

The evidence base
Please reference the evidence base which you have drawn on
- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

A recent independent review of the LLR mental health pathway has evidenced that it is under significant pressure, with increasing delayed transfers of care, increasing length of stay, and people placed in out of county acute placements due to lack of local provision.

Benchmarking indicates bed capacity is within range of peer services but that community options are less developed leading to a higher LOS. Analysis shows:

1. In 2013/14 out of county (OOC) placements increased significantly. LLR spend on OOC placements in 2013/14 was £4m, with Leicester City CCG contribution of £1.9m towards this.
2. The average weekly cost of OOC placement was £3,600 per week, significantly higher than local provision.
3. City MH/LD DTOC has been increasing during 2013/14. It has been consistently higher per weighted population than county HWB areas, on average 4.5 higher per 100,000 population.

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

2014/15: £150k
2015/16: £300k

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Using the benefits analysis model developed with PA Consulting, we have attributed an impact on the following metrics:

BCF National Metric 3: A reduction in hospital bed days due to discharge being delayed
BCF National Metric 4: A reduction in total hospital admissions
BCF National Metric 5: Improved patient/service user experience

Please see tab 4 of template 2 for further detail

In addition to the national metrics, we have set up a dashboard to monitor outcomes as outlined below:

- Ongoing reduction in Mental Health Delayed transfer of care measured by- Delayed transfers of care (delayed days) from adult MH and MHSOP inpatient wards per 100,000 population (average per month).
- Ongoing and sustainable reduction in OOC placements per quarter over 2014/15
- Reduction in average LLR length of stay in a MH unit from 46.7 days in 2013/14 to the national mean of 30 days by April 2016.

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

Strategic level – Monthly reporting to the JICB and CCG Performance Exec

At a strategic level, an overarching system dashboard is being formulated, covering the 5 + 1 national metrics as well as other relevant metrics to manage flow at a system level.

Operational Level – Bi-weekly reporting to the BCF Implementation Group

Underneath this, sits a comprehensive Integrated Care Performance Dashboard, specially produced to support the performance management function for the BCF Programme.

Practice level – Weekly reporting

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

In totality, this provides a comprehensive view of both the health and social care system as a whole and tracks performance of the Integrated Care model.

All draft dashboards are provided as Appendix 7.

What are the key success factors for implementation of this scheme?

- Co-production and co-ownership of the model and aims of the BCF pathway. We have had input from GPs, LPT MH management & Adult Social Care Management as well as patients
- Engagement of front line clinical and social care staff to refer patients into the pathway.

- Recruitment of staff to plan to ensure that the increased volume of patients being kept at home can be successfully managed within the community setting.
- Alignment of health and social care neighbourhood boundaries to support continuity of care and greater integrated working on the front line.
- Ability to regularly collect activity and relevant outcome and quality data from individual services – we have engaged with all providers to agree the relevant and available data items which can be collated to evaluate progress on this scheme.