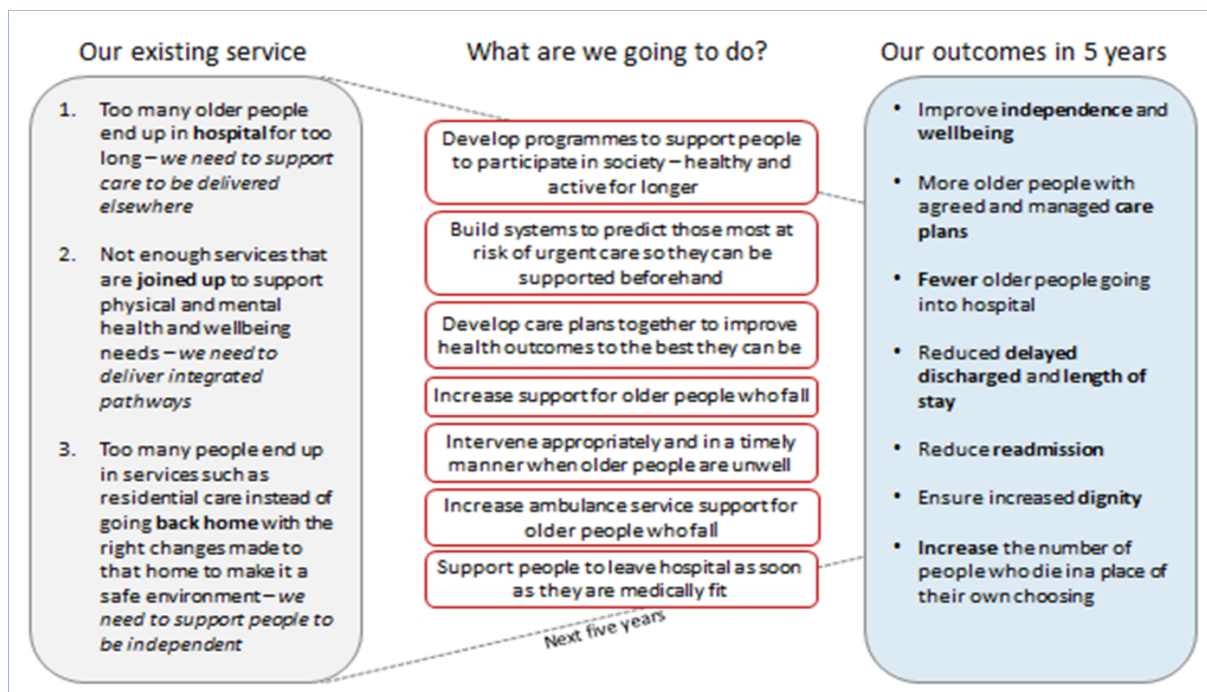
Leicester City Better Care Fund 2016/17
Update for ASC Scrutiny Commission
8th March 2016

Strategic context

Within Leicester City we have agreed jointly to use the opportunities presented by the Better Care Fund to drive a clinically-led, patient-centred transformative change programme. This will harness the collective views, innovations and ideas of many experienced health and social care professionals as well as the views of our patients and carers.

The programme is purposefully aligned with longer-term strategic planned change in our acute sector, including the plans of Leicester, Leicestershire and Rutland *Better Care Together* programme. The figure below depicts our plans at a strategic level:



Our Better Care Fund 2016/17

Our vision for a healthier population goes much further than just ensuring people get the right care from integrated, individual services. We set out to create a holistic service delivery mechanism so that every Leicester citizen benefits from a positive experience and better quality of care during the first two years of our BCF and we have delivered tangible improvements across all 5 of the nationally mandated metrics. We have, however, struggled to achieve a sustainable reduction in emergency admissions during the first 2 years of the BCF and so have placed more emphasis on delivery of this standard in 2016/17 – we know that our patients who do not require hospital admission could be better cared for in their own homes and we will strive to ensure that this happens through 2016.

In looking ahead to 2016-17, it is important that Better Care Fund plans are aligned to other programmes of work within the Better Care Together programme, including the new models of care as set out in the NHS Five Year Forward View and delivery of 7-day services as well as our Vanguard programme for urgent care.

We have adapted our plans for 16/17 in line with the guidance outlined in the Better Care Fund Policy Framework (Dec 2015) and will continue to deliver schemes designed to either prevent acute activity (and avoidable emergency admissions), release acute activity (and continue to decrease our rate of delayed transfers of care) or enable independence (and reduce dependence on social care). Our plans will fulfil the two new national conditions, requiring local areas to fund NHS commissioned out-of-hospital services and to develop a clear, focused action plan for managing delayed transfers of care (DTOC), including locally agreed targets.

Our priority areas continue to be:

Figure 2: The Leicester City model of integrated care

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

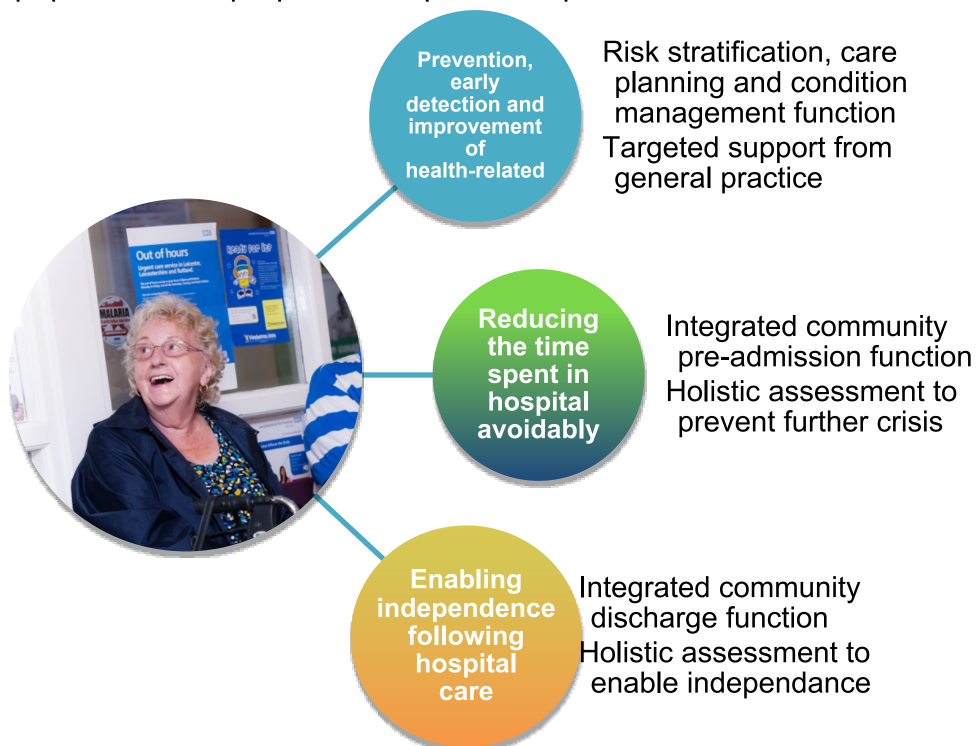


Figure 3: The Leicester City pre- and post-hospital pathway

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

Plans for BCF in 2016/17

Our plans continue to develop the programme of work delivered in 2015/16 as therefore many schemes are rolled over into this year's funding programme or enhanced.

Work stream 1: Prevention

We will continue to use the Better Care Fund to:

- Invest in preventative services, such as our Leicester City Lifestyle Hub, empowering people in our target population to access services such as weight management, STOP smoking services, reduction of social isolation and exercise programmes. This will be directly linked to our hugely popular and successful NHS Health Check programme.
- Commit to integrating health and social care systems and data around the NHS number to ensure that all health and social care staff who need access to the data can access it to provide better holistic care to our population.
- Increase our offer of assistive technologies, particularly for falls and specific conditions such as COPD and hypertension, so that patients feel safe and remain independent and manage their own health proactively.
- Extend our routine patient and service-user satisfaction surveys to include a wider range of services in health and social care to ensure that any service change we implement is increasing patient and service-user satisfaction.

We will also:

- Begin the process of integrating our community health 'single point of access' and our local authority 'single point of contact'.
- Improve our ability to manage and track outcomes for our population, ensuring that every pound spent on the services described above increase outcomes for our target population as well as returns the most value for our patients.

Work stream 2: Integrated Crisis Management

We will continue to use the Better Care Fund to:

- Invest in GP services to ensure that our population of the most complex patients are cared for proactively by a named GP and supported within their Health Needs Neighbourhoods as appropriate.
- Commission virtual team of six local ECPs who will respond to GP referred and 999 calls deemed clinically appropriate, seven days a week between 8am and 8pm. These ECP's will assess and stabilise the patient and, where clinically appropriate, not-convey the patient the hospital but treat them in their own home. Basic diagnostic equipment will be part of the service, with access to on-call consultants at the acute site should further consultation be required. If more

complex diagnostics are required, the patient will directly access ambulatory pathways at the Leicester Royal Infirmary and be discharged home, rather than via a base ward.

- Commission a proactive element to the team detailed above, providing services directly to our care home population – this team will proactively target those patients most at need in our care home population. This will include, for example, baseline observations & care plan review and also includes training on usage of community services to care home staff as an alternative to 999.
- Commission a joint co-located Unscheduled Care Team, bringing together traditionally separate health and social care teams to provide one service, 24 hours a day, seven days a week. These teams will provide care for patients (and carers, where appropriate) in their own homes for up to 72 hours following a crisis call out with the aim of preventing admissions to hospital and promote independence at home. This will cover both physical and mental health and work on an HNN level. The services will include both an admission prevention and a discharge element.
- Create a network of 10 new Joint Planned Care Teams covering all of Leicester City, and mapped onto HNN's. These teams will offer holistic planned interventions, keeping people independent at home as well as preventing both physical and mental health crises. These teams will refer into all core offers of health and social care services as well actively link with the voluntary sector services in the city.

We will also:

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

Work stream 3: Enabling independence

We will continue to use the Better Care Fund to:

- Invest in the current Intensive Community Support service which discharges patients home into one of 36 virtual beds.

  We will also:
- Review and then strengthen our reablement offer across both health and social care providers to patients to promote independence and reduce admissions to care homes.

Other planned activity:

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

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

We will also scope the joint commissioning of aligned services with our Local Authority, including provision of domiciliary care, therapy and specific mental health and learning disability provision.

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