Leicester City Council

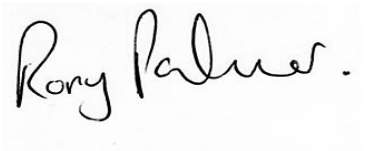
NHS
Leicester City
Clinical Commissioning Group

The Leicester City Better Care Fund

2016/17

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

a) Authorisation and signoff

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

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

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

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

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

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

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

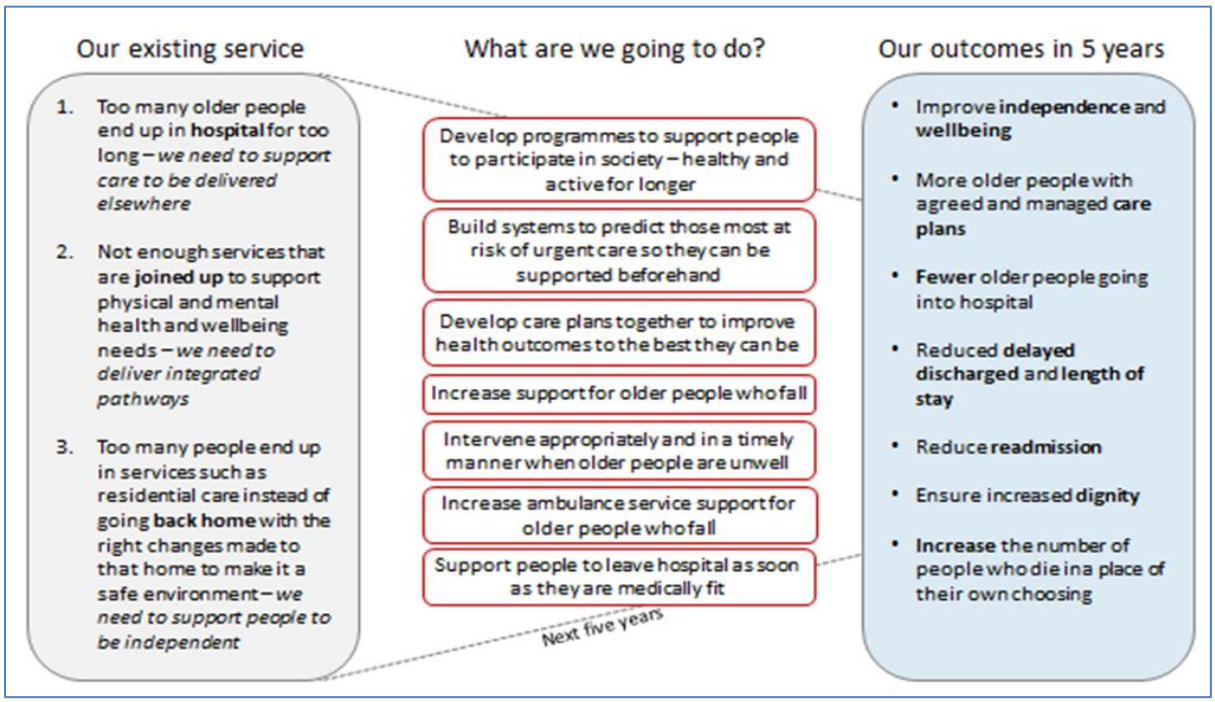
The recent NHS Five Year Forward View enables a far greater focus to be put onto ambitious and transformative change across the totality of the health and social care economy, through new models of care, driving change through relationships with communities and truly achieving parity of esteem for mental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

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

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

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

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



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

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

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

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

We will achieve this by implementing:

- Services for complex patients**:**
  - **Increasing the number of people identified as 'at risk' and ensuring they are better able to manage their conditions, including out of hours, thereby reducing demand on statutory social care and health services. This will include both physical and mental health.**
- The Leicester City Lifestyle hub:
  - **Delivering 'great' experience and improving the quality of life of patients with long term conditions by expanding our use of available technology, patient education programmes and GP-led care planning, reducing avoidable hospital stays.**

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

We will achieve this by implementing:

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

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

We will achieve this by implementing:

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

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

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

As at 2012/13:

Fragmented pathways across health and social care, not mapped to general practice

Unsustainable demand on all services, creating a significant financial gap by 2018/19

Significant variation in outcomes from care as a result of health inequalities

Sub-optimal provider performance as a result of demand on services and processes between sectors

Insufficiant workforce, both in terms of capacity and capability to deliver new models of care

Sub-optimal use of assets & resources across LLR

Delivered in 2015/16:

Preventative services co-located into one **Lifestyle Hub**, with a single referal process

Joint health and social care teams, with streamlined referal pathways, matched to GP localities, providing a two hour response in crisis

Increased p**lanned care** community capacity, including in g**eneral practice capacity** to provide care in the community, focussing on acute demand reduction

Co-located access teams, making the best use of assets across the health and social care system, with **joined up IT systems**

By 2020:

Preventative models of care embedded into every pathway of care, with a city-wide **Lifestyle Hub**

A new **model of primary care** launched across the city, ensuring timely access, care planning and management, with **one simple integrated pathway into community support**

Neighbourhood health and social care teams with single referral pathways & assessment processes, working in specific GP localities, **with one IT system**

A new model of integrated care, fully utilising **joint teams across neighbourhood areas** to deliver seamless care

16/17 Investments

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

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

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

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

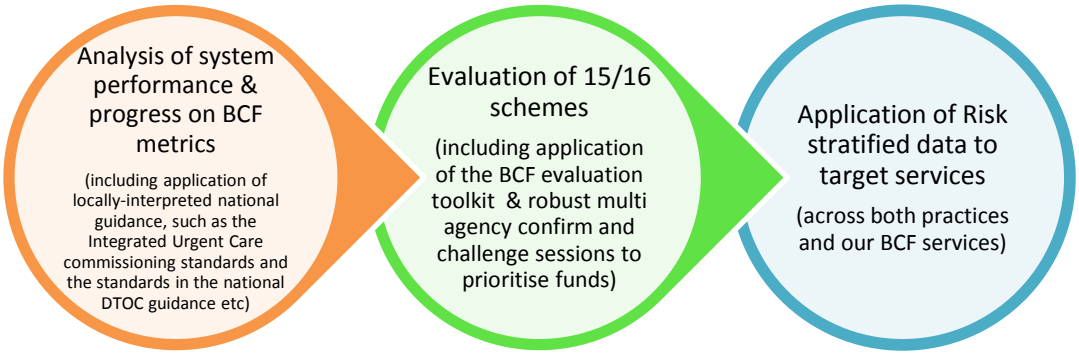
Chapter 2: Our evidence base

Our local evidence based planning process

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

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

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



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

Analysis of system performance

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

Progress against BCF metrics in 15/16

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

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

Non-elective admissions (General and Acute)

Performance in 15/16

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

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

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

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

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

Opportunity analysis for 2016/17

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

Focus Cohort 1: EMAS G3 and G4 calls

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

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

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

Focus Cohort 2: Care home patients

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

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

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

Care home emergency admissions trend, Leicester City registered patients

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

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

Focus cohort 3: Multi-morbid, high risk populations

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

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

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

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

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

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

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

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

Admissions to residential and care homes

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

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

Opportunity analysis 16/17

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

Effectiveness of reablement

Performance in 15/16

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

Opportunity analysis 16/17

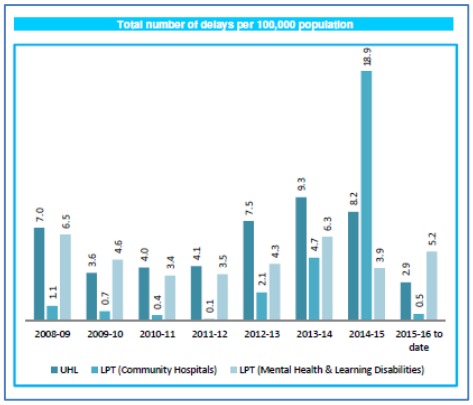
The target for 2016/17 reflects our ambition to ensure that those receiving reablement services are afforded the greatest chance of maximising independent living. As such, we have reflected the challenge of meeting this objective by maintaining a high target for the proportion of over 65's still at home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

Delayed transfers of care

Performance in 15/16

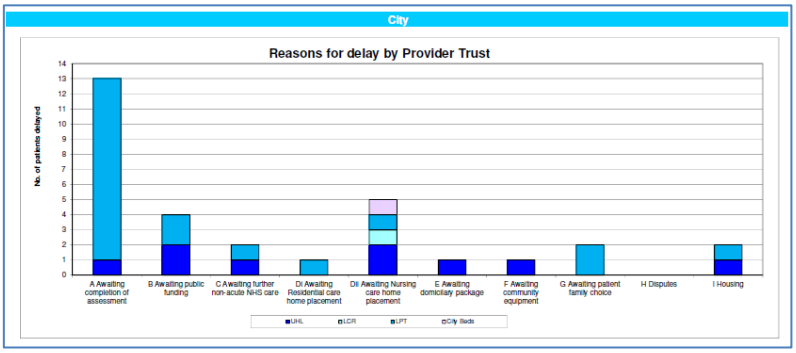
During 15/16, BCF teams worked closely across commissioner and provider to reduce DTOC rates. This involved analysis of the reasons for delay by site and subsequent plans enacted to deal with each reason for delay in a systematic fashion. As a result of this, our DTOC rate has reduced significantly as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

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



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

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

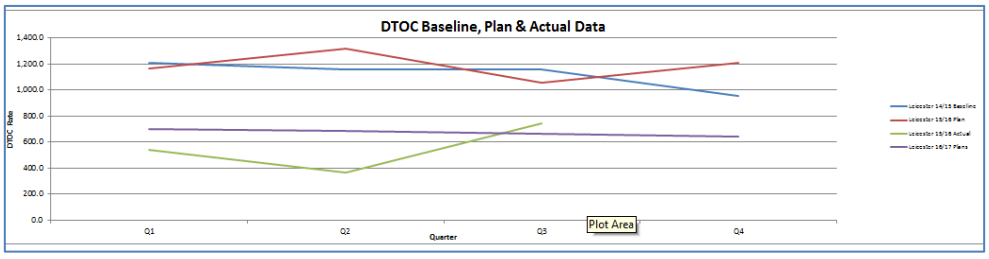


Reasons for delay by Provider Trust, Leicester City CCG, March 2016

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

Opportunity analysis for 2016/17

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



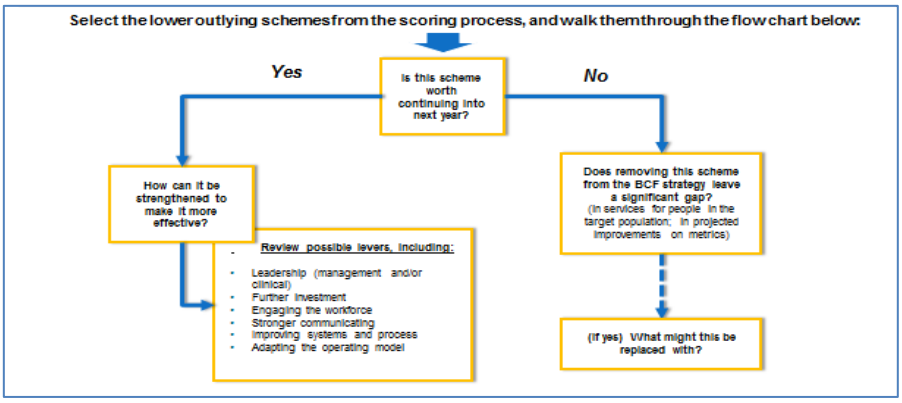
Leicester City DTOC BCF plan, Jan 2016

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

Evaluation of 15/16 schemes

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

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



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

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

Usage of schemes in 2015/16

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

Leicester City Better Care Fund

Service usage

Care plans
15,000 care plans completed since inception

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

Creation of one co-located health and social care team

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

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

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

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

46 ICS beds have enabled flow across LPT and UHL sites

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

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

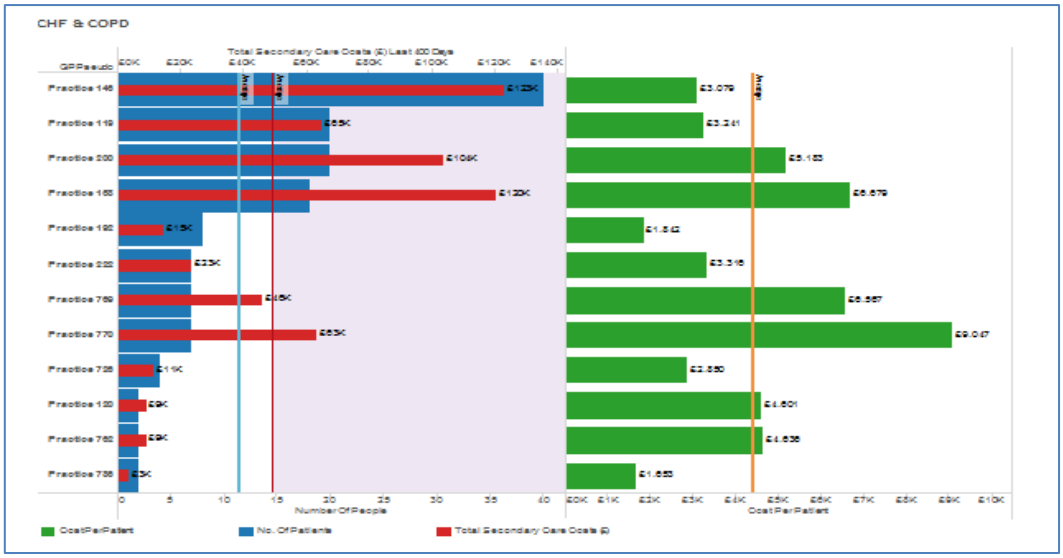
In order to identify the opportunity to improve quality and reduce costs, we have jointly been applying an iterative cycle of:

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

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

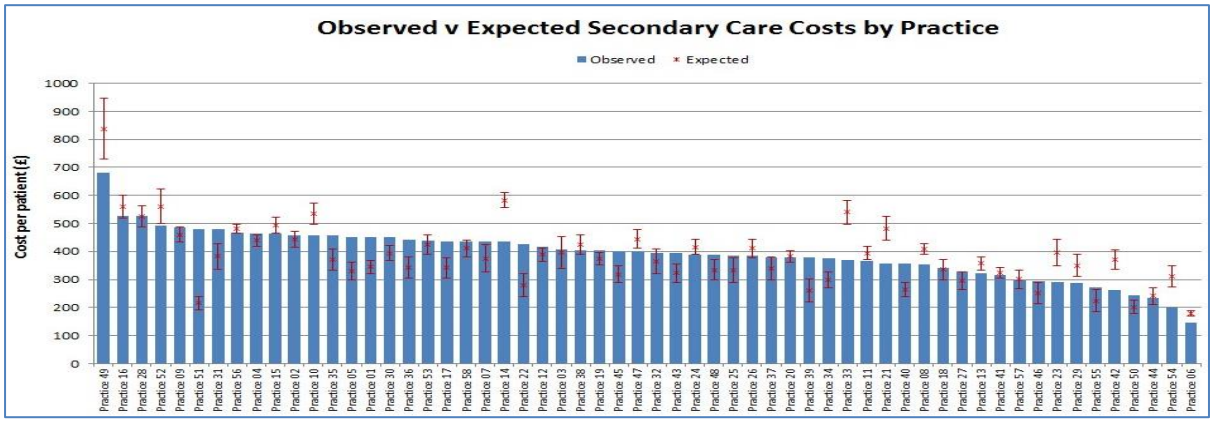
Population profiling - quantifying levels of unmet need, addressing issues of service quality and/or inefficiencies in service delivery

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



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

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



Observed vs expected secondary care cost for Leicester City Practices

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

Application of the data

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

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

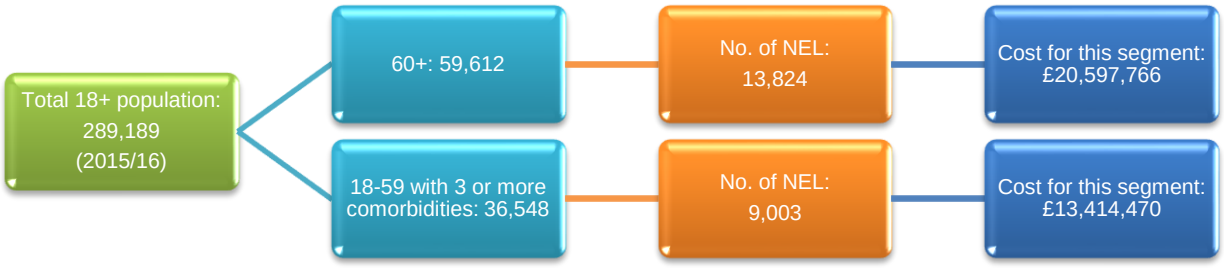


Figure 1: Population segmentation by age, multi-morbidity (December 2015)

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

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

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

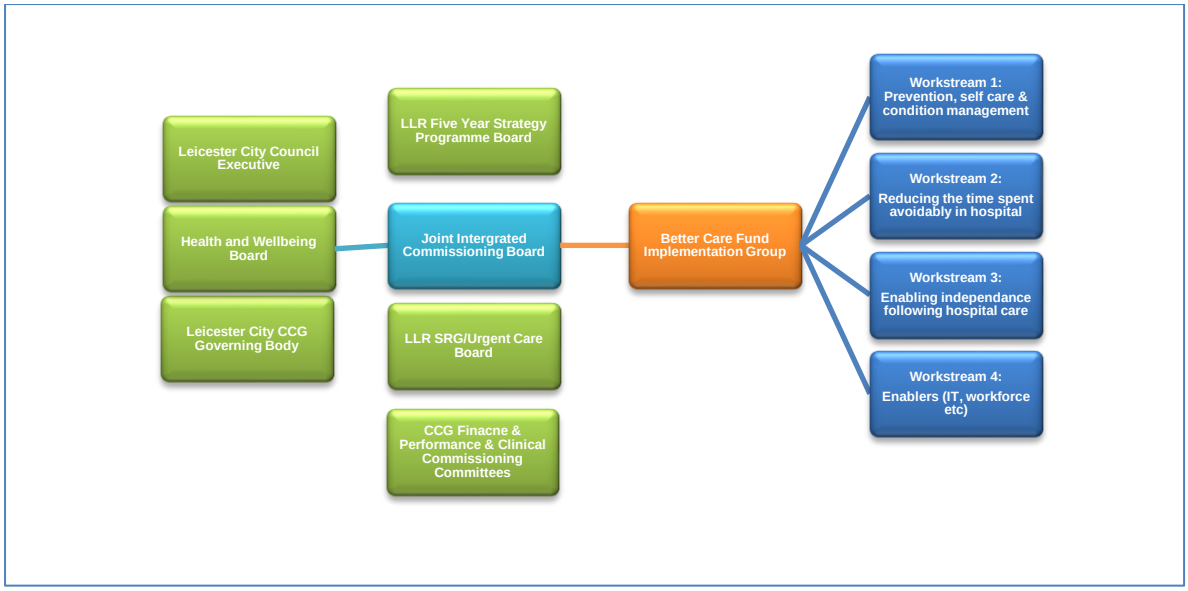
We have limited the second sub-cohort above to those with a specific set of LTC's based on the NHS RightCare Casebook implemented in Slough CCG. This gives a specific cohort of 3,100 patients across the City. For this sub-cohort in 2016-17, we will be implementing a primary care incentive scheme which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

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

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

Governance

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



Leicester City Better Care Fund programme structure

Governance arrangements: strategic oversight

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

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

Governance arrangements: delivery

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

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

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

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

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

Performance management of the programme

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

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

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

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

Operational Level – Monthly reporting to the BCF Implementation Group

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

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

Practice level – Weekly reporting

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

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

Key milestones for 16/17

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

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

Chapter 4: National conditions

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

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

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

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

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

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

Condition b: Plans to be jointly agreed

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

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

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

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

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

Condition c: Maintain provision of social care services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

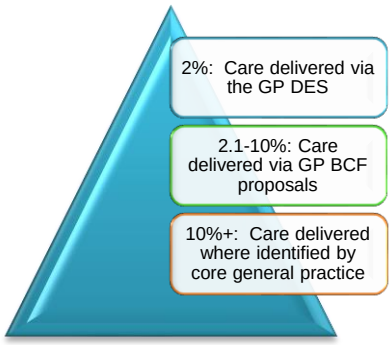
how data is used, routinely capturing consent to share data where data is shared, in line with IGA guidance.

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

Condition f: Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Proportion of case managed patients

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



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

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

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

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

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

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

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

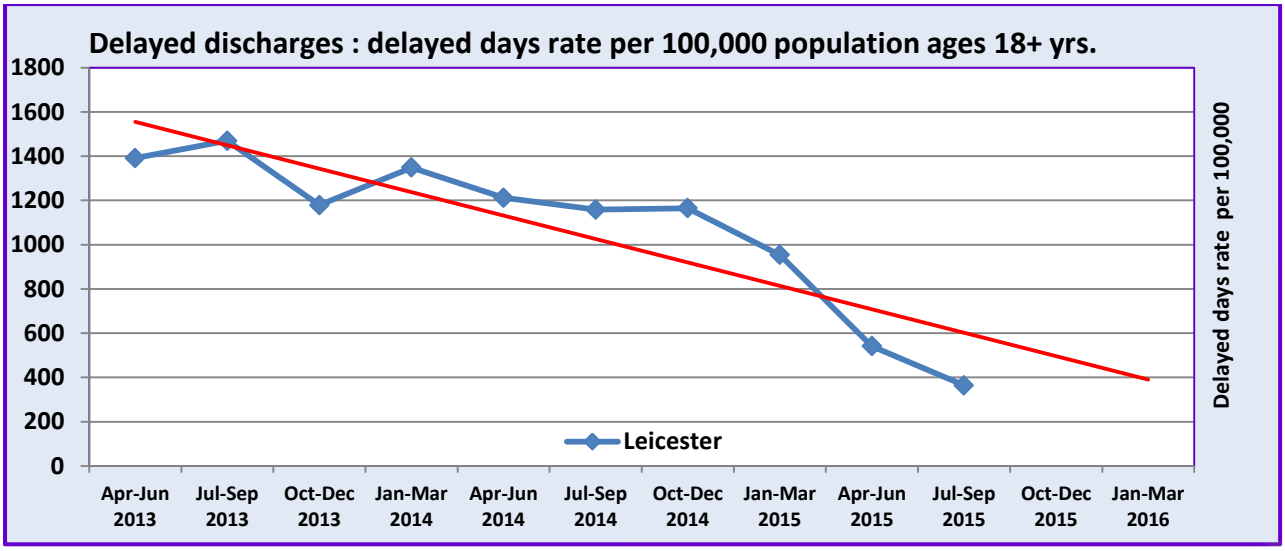
Condition h: Agreement to invest in NHS commissioned out of hospital services, which may include a wide range of services including social care

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

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

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

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



Leicester City BCF DTOC monitoring, Jan 2016

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