Leicester City Council

NHS
Leicester City Clinical Commissioning Group

The Leicester City Better Care Fund 2017-19

August 2017

Local Authority:	**Leicester City Council**
Clinical Commissioning Group:	**Leicester City Clinical Commissioning Group**
Boundary Differences:	**None**
Date agreed at Health and Wellbeing Board:	**August 17th 2017**
Date submitted to DCO team:	**September 11th 2017**
Minimum required value of BCF pooled budget 2017-18:	**£33,242,254**
Total agreed value of pooled budget 2017-18:	**£33,242,254**

a) Authorisation and signoff

Signed on behalf of NHS Leicester City CCG	
By	Sue Lock
Position	Managing Director
Date	
Signed on behalf of Leicester City Council	
By	Andy Keeling
Position	Chief Operating Officer
Date	
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	

Contents

Chapter 1: Our core vision and approach for health and social care integration 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 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. Translating national policy into the practical reality on the ground is a complex task, which is being undertaken in the context of ongoing austerity. Partner organisations are facing unprecedented levels of demand with correspondingly large saving requirements.

To truly achieve change at both a system level and a place-based local level, we have fully aligned our Better Care Fund plans for 17/18 to enable delivery of the aims outlined in our LLR Sustainability and Transformation Plan, our CCG Operational Plan and our Adult Social Care Operating Plan – this will take us closer to fully integrated health and social care services by 2020 as mandated in the 2015 Comprehensive Spending Review.

The LLR Sustainability and Transformation Plan

The vision for the Leicester, Leicestershire and Rutland (LLR) health and care system is create a high quality, integrated health and care system, which is affordable and meets the needs of local people in the medium term. The Better Care Fund is a core component in the delivery of this vision,

enabling people to be cared for at home or in their own community, whenever possible, and for as long as possible. This plan was formed during 2016 and has recently been rated as one of the more advanced STP's. The plan is available at http://www.bettercareleicester.nhs.uk/Easysiteweb/getresource.axd?AssetID=47665.

The preparation of the STP has led to improved collaboration on financial and activity modelling across partners in the health and care system. Partners have jointly considered the demand and resource flowing through the health and care system, the interdependencies of activity assumptions, financial assumptions, reconfiguration & transformation plans and savings requirements over the five year period.

The development of the STP signals a move away from an annual planning process that has delivered incremental, organisational-specific improvement to a longer-term view that delivers transformational change across organisational boundaries. The STP therefore represents a combined LLR strategy supported by joint planning assumptions and delivery arrangements for the partners across the health and care economy.

Our entire model of care is being transformed across LLR so that "home first" becomes a reality. This means tackling the over reliance on acute care, and ensuring our community based services are integrated, consistent, reliable and resilient.

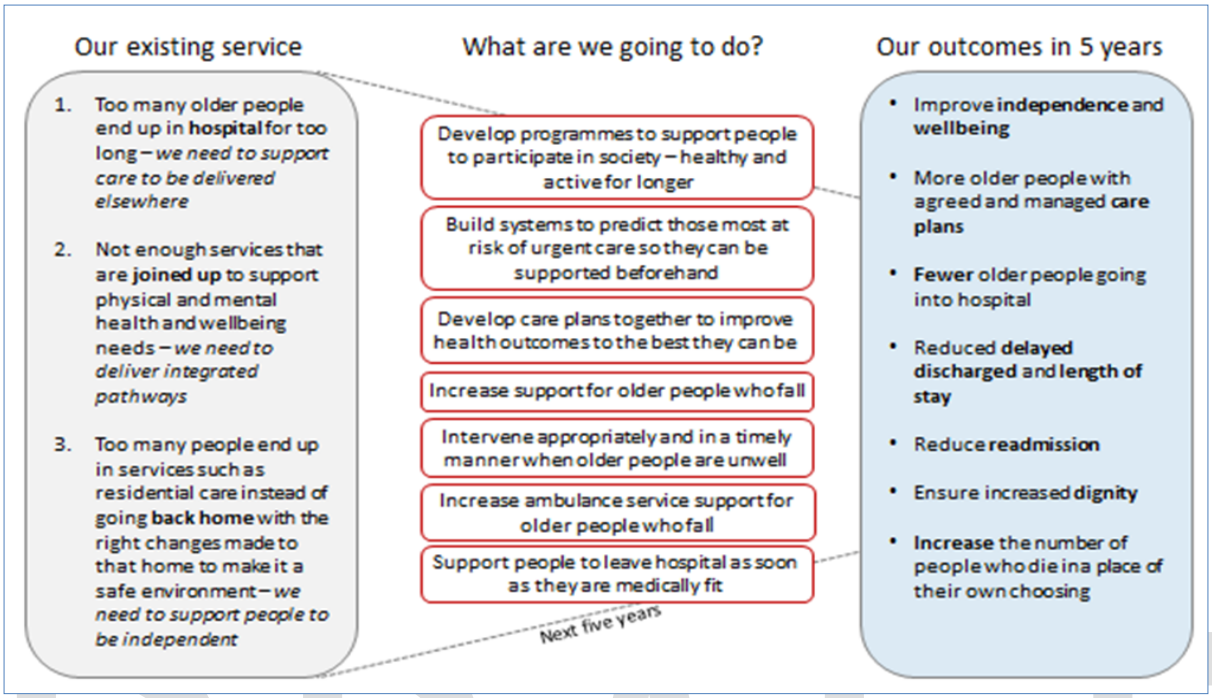
For home first to operate successfully, rapid, easy access to the appropriate level of care and support outside of hospital on a 24/7 basis is required, with person centred care coordinated effectively across organisational boundaries and professions. If an emergency admission to hospital does occur, then the 'home first' principle also applies, so that, if someone is admitted to hospital and after necessary interventions and treatment, the system's primary aim will be to return that person to the home address from which they came as soon as possible.

Over the past two years some core components of the home first model have been developing in LLR, through the Better Care Fund Plan in Leicester City, and other transformational programmes of work such as the LLR Urgent Care Vanguard. These cross-cutting workstreams have included for example providing 2 hour health and social care responses for admission avoidance and consolidating hospital discharge routes into five streamlined pathways across LLR.

Some elements of integration have started to take shape over the past two years but we are now entering a further phase of redesign within the STP, where remaining variations in care pathways and delivery across the LLR area can be fully addressed and where medium term solutions will be implemented across the system. The development of the STP has led partners to achieve consensus on the top priorities across the system, and renew their collective commitment to achieve a much greater level of integration across care pathways and organisations over the next few years.

Our steps towards a fully integrated system of care by 2020 – Background and context to the plan

The services within the Leicester City Better Care Fund were launched in 15/16 and embedded through 16/17, following the roadmap outlined below:



In 16/17, the BCF delivered a series of interwoven interventions including new model of care coordination, integrated crisis response services and enhanced care planning; these were all co-designed to reduce the time spent avoidably in hospital through provision of integrated community services (whether to prevent an admission or to facilitate a holistic discharge back into the community).

Due to the success of these interventions, these services remain the key building blocks upon which our 17/18 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, in line with the intent set out in the 2015 spending review.

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 (enhanced self-care):
  - **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 (integrated into a 24/7 home visiting service):
  - **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 Integrated Locality Teams:
  - **Four integrated physical and mental health teams, ranging from health and social care to housing and financial services, which respond in a coordinated way to ensure care is delivered in the community and around the individual, geographically aligning services from our Adult Social Care, GP practices and Community services for the first time .**
- 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 Hospital based Health Transfers Team**
  - Ensuring optimal discharge pathways for our patients requiring Adult social care – this team is based on-site at the acute trust preventing delays to discharge
- 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 any service listed above 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 STP:

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 2016/17

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

4 Integrated Locality Teams, geographically aligning General Practice, social care and community services

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

This plan moves us towards the goals set out in the 2020 column in a systematic fashion.

Chapter 2: Progress to date

Analysis of system performance

The LLR health & social care system has been under sustained pressure for much of 2016/17, reflected in declining performance on a number of key indicators in the City, particularly access to General Practice and A&E waiting times. A summary of the key challenges noted in 16/17 is reflected below:

LLR system performance challenges in 16/17	A&E 4 hour standard - 79.6% vs target of 95%
	Ambulance handover times - 27.35minutes vs target of 15 minutes
	Demand for acute care overall - A&E saw c5% growth in attendance
Leics City performance challenges in 16/17	Access to General Practice - Ease of making an appointment with GP fell from 68% to 63%
	Mental health Delayed Transfers Of Care - between 12-15% of all occupied bed days
	Permanent admissions to residential care - 282 people were admitted vs target of 260
Overall financial challenge	CCG acute budget significantly over plan (+£2,407,046)
	Adult social care budget pressures of c£14m in 16/17
	Acute provider deficit - £27.2m in 16/17

Despite these challenges, the City saw some positive movement during 16/17 against some key indicators. For example, for Non-elective admissions, the City noted a 2.62% reduction in non-elective admissions compared to 15/16 – this has not been seen in recent times and goes against the national trend of increasing activity.

Other challenges

Although really good progress has been made on data integration by using the NHS number on social care records, implementing PI Care and Healthtrak, and deploying the risk stratification (ACG) tool in primary care, further work is needed on the integration of data and IT systems throughout LLR so that we have:

- A more systematic approach to business intelligence overall
- The architecture is in place to implement the electronic summary care record (SCR2).

SCR2 is a large programme of change within the LLR Digital Roadmap. It impacts on direct care for patients, in particular on services where multiple professionals need access to shared records, such as in urgent care, home first, integrated locality teams, and all the associated case management in primary care and community settings. The Leicester City BCF plan has an overall dependency on the development of an LLR wide solution for the electronic summary care record with an expectation of solutions being implemented from 2017/18.

The directive from NHS Digital in early 2017 about restrictions imposed on LA's accessing SUS (hospital) data, and the ability to link this data with other data sources, have presented further challenges to our locally ambitious plans for data integration. In particular system wide analysis using PI Care and Healthtrak has been inhibited.

Progress against BCF metrics in 16/17

Addressing overall system performance is a key priority in the LLR STP and will require further transformative work via both the BCF and the wider system. The Leicester City BCF performed well within the context described above, with year on year activity increasing within the services commissioned and the outcomes noted also improving.

Overall performance summary shows that 2 of the 5 BCF targets were achieved:

Metric	Plan 16/17	Actual 16/17	Status
DTOC	8.0/100,000	11.9/100,000	Not Achieved
Non elective admissions	32888	33092	Not Achieved
Residential Care	260	282	Not Achieved
Reablement	90%	91.3%	Achieved
Dementia prevalence	70%	82%	Achieved

Although the Non elective admission target was not achieved, it is important to note that the target was missed by only 203 admissions and represented a reduction of 2.62% (893 admissions) on the 15/16 position.

As part of our planning process, we have analysed performance against each of these metrics in depth in order to target our 17/18 plans. A summary of performance in 16/17 and a brief opportunity analysis is detailed for the BCF metric areas below. Further detail of our plan is outlined in Chapter 4.

Non-elective admissions (General and Acute)

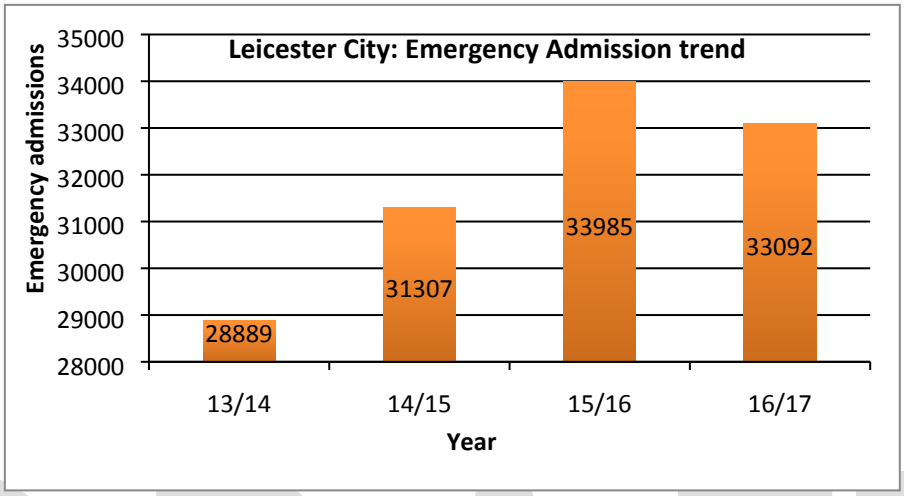
Performance in 16/17

Despite activity in every BCF scheme reaching capacity in 16/17, Leicester City missed our non-elective admissions target by 0.62% (203 admissions) – although this is a significant improvement against previous years where the target has been missed by a much larger percentage.

Clinical audit of BCF schemes shows significant impact on the non-elective admission rate and this is noted in our activity profile at UHL:

Commissioner (16/17)	Variance to:	
	Contracted activity plan	**Activity in 15/16**
NHS LEICESTER CITY CCG	+0.62% (+203 admissions)	-2.62% (-893 admissions)

Given the national and local trends of rising emergency admissions, this is a significant achievement for the City. Equally when comparing our own trends over the last few years, the performance improvement is even starker:



No coding changes in emergency admissions have been noted in 16/17 and our partner CCG's in LLR have experienced significant rises against both contracted activity and year on year growth; therefore this is likely to be a 'real' reduction in activity. Clinical audit has shown a reduction in admissions of c1560 in 16/17 from the schemes provided via the BCF.

Opportunity analysis for 2017/18

Our 17/18 non-elective reduction plans continue to be 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.

Admissions to residential and care homes

Performance in 16/17

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. These measures have led to 282 permanent admissions to residential homes during 16/17 against a target of 260.

Opportunity analysis 2017-19

Admissions to care have reduced each year during the lifespan of the BCF, except for the increase noted in 16/17. Processes have been strengthened for 17-19, with the process supported by the effective crisis response services funded by the BCF and the responsive discharge pathways which ensure people are returned home quickly. In 2017/18 we will be implementing extended reablement

at home services with a 24/7 support plan, to further avoid admissions to short or long term care. We anticipate that this will enable a sustained reduction in care admissions for 2017 -19.

Effectiveness of reablement

Performance in 16/17

Our reablement teams have been embedding best practice through 16/17, with the changes in pathway and process resulting in 91.3% of patients who received reablement still at home 91 days after hospital discharge.

Opportunity analysis 2017-19

Reablement is offered to people who will benefit from this service; increased use of patient frailty tools in hospital settings is assisting with identification of people who will benefit or will not benefit from reablement, to ensure it is targeted at the right cohort. This supports the delivery of targets around 91 day independence. Reablement services are being extended to people who were previously being directed into bed based services, by offering a 24/7 home first model utilising commissioned domiciliary care alongside reablement service provision. We anticipate that the numbers of people receiving reablement will not change significantly but the outcomes should continue to be at or above target.

Delayed transfers of care

Performance in 16/17

During 16/17, BCF teams worked closely across commissioner and provider to reduce DTOC rates, including participation in the implementation of the 'Red2Green' process at UHL to minimise delays. Despite significant improvement in delays in acute beds, our focus now needs to shift to delays in mental health, learning disabilities and in our community beds. In 16/17, delays amounted to 11.4 per 100,000 patients against a target of 8.0 delays per 100,000 population.

Of these, our social care delays have been minimal through the year with the majority of delays being noted for NHS-attributable delays. When broken down, our delays are no longer at the acute site but have become much more evident in mental health, learning disabilities and in our community beds – these delays are to principally attributable to delays in the CHC process and patient and family choice.

Opportunity analysis for 2017-19

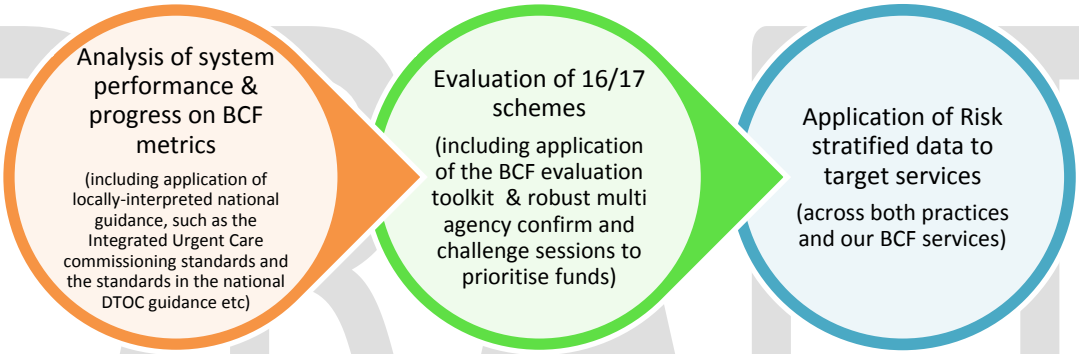
Given the level of delay noted, delivery of the standard expected (3.5% delays of all occupied beds) will be ambitious. The required transformative change will be led by a sub-group of the LLR STP under the aegis of the Home First Programme Board. The work plan has been agreed with the LLR A&E Delivery Board and includes recommendations from both an ECIP (Emergency Care Improvement Programme) review and an LLR gap analysis against the 'High Impact Changes' framework.

Chapter 3: 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 STP. LLR was 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. 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.

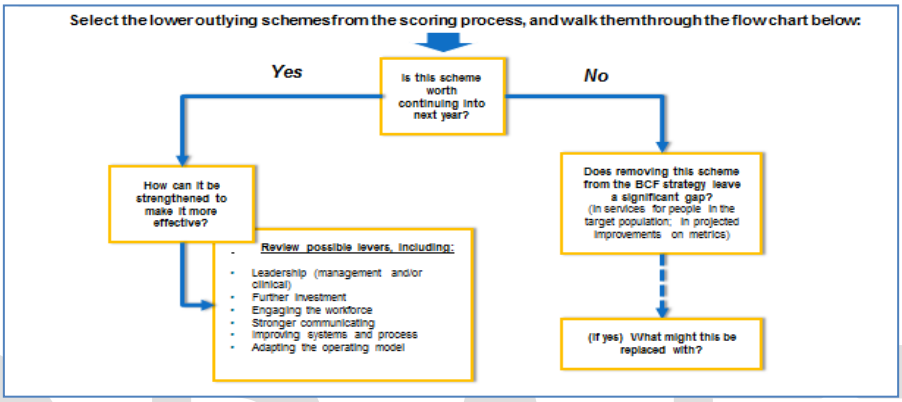
As part of our evaluation process, we have also self-assessed the interventions in the Leicester City BCF against those in the recent Health Foundation report, "*Shifting the balance of care – Great Expectations",* published in March 2017. 27 initiatives were reviewed academic and grey literature) across elective, non-elective and community care and of these 10 were relevant to the BCF. Our self-assessment showed that:

- 4 of our schemes are in the 'most positive evidence' category
- 3 schemes are in the 'emerging positive evidence' category
- 3 schemes are in the 'mixed evidence' category

None of the schemes funded via the Leicester City BCF are in the category of 'evidence of potential to increase costs'.

Evaluation of 16/17 schemes

We know we have made progress in 16/17 through the implementation of BCF schemes in the City; each intervention resourced 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 Joint Integrated Commissioning Board.

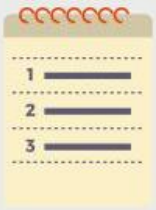
As a result, each scheme has been either up scaled or re-focussed in readiness for 2017/18. Key changes include expansion of our Integrated Crisis Response Teams & Health Transfer Team and enhanced, targeted use of our ACG system (described below) to target our services to those patients who need them the most.

Usage & efficacy of schemes in 2016/17

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

Joint board rounds between health and social care take place in our Integrated Care Centre

46 ICS beds have enabled flow across LPT and UHL sites

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

Patient outcomes have also improved over the lifetime of the Leicester City BCF. Our most recent 'Outcomes Framework' results, released in March 2017, show that we have improved outcomes in a number of areas. These include:

Whilst these are not all directly attributable to the interventions delivered via the Better Care Fund, the systematic health and social care offer to our patients (particularly those vulnerable to hospital admissions) will have contributed to these improvements.

Chapter 4: Developing the 2017-19 BCF plan for Leicester City

Since the inception of the BCF, Leicester City health and social care commissioners have embraced systems thinking, applying this to both strategic and operational plans. This is reflected in our pre- and post-hospital systems of care which have proven successful in keeping our patients safe at home or getting them back to their own home safely following an episode of ill health.

This chapter of our plan describes firstly how we have used risk stratification and other business intelligence to identify our focus cohorts, the systems of care we have put into place for these

patients and then a brief description of the actions being taken to improve or embed processes during 2017-19 for these cohorts.

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:

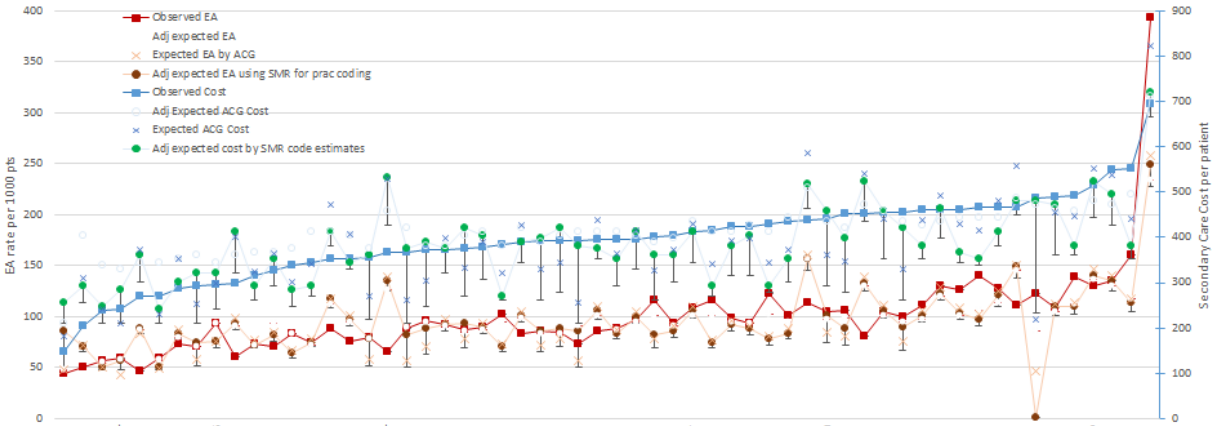
(a) population profiling,
(b) case-finding (identification of opportunities for clinical and health and well-being improvements of identified sub-groups of patients at practice level)
(c) resource allocation to address inequalities
(d) evaluation based on case-mix adjustment to fairly analyse variation 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 are being 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. Equally, we know that there is wide variation in the actual amount of acute activity per patient (the observed rate) when compared to the amount expected based on the burden of ill health (the expected) across the City:



Observed vs expected secondary care cost for Leicester City Practices

This type of evaluation in combination with other data (such as identifying the characteristics of the practices above who have an lower observed vs expected rate of acute usage by mapping this against their Patient Experience Scores) has allowed us to more accurately identify practices where variation in activity may not be warranted.

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.
We have subsequently used this analysis to work with our partners to design and implement a range of primary and secondary prevention services, targeting those with complex health and social care needs. It also forms the basis of a primary care improvement programme focusing on continuity of care, improved access for frail patients and clinical coding/record keeping.

Through the provision of high quality, integrated health and social care services, our core aim is to reduce the probability of an emergency admission and subsequent requirement for adult social care services in this cohort. In 2017-19, our plans include embedding this process into our Integrated Locality Teams.

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

1. Over 18's with 5 or more chronic conditions
2. All adults with a 'frailty' marker, regardless of age but related to impaired function
3. Adults whose secondary care costs are predicted to cost three or more times the average cost over the next twelve months

This gives us a target BCF cohort of approximately 92,104 patients; this relatively more complex cohort of patients have an average probability of emergency admission to hospital of 46% in the next 12 months. These patients over a 12 month period have had 39,745 ED attends (£5.3m), 33,699 elective admissions (£34m) and 29,630 non-elective admissions (£49m).

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 c3% of the total population, based on a combination of clinical judgement and risk stratified 'score'.

For this sub-cohort in 2017/18, 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, recognising that continuity of care from the same clinician has a significant impact on the patient's outcome.

Our Integrated system of care

We recognised at the inception of the BCF that delivering safe and effective health and social care cannot be done from within organisational or commissioning silos. It requires cooperation between and within numerous organisations and services, and collaboration between clinicians and supporting staff who place patient care at the centre of all they do. This understanding has led to the construction of an integrated system of care for the population of Leicester City which spans multiple programmes of work (including primary care & urgent care) which is led primarily via the Leicester City Integrated Systems of Care Programme Group (ISOC). This group oversees the delivery of the entirety of the City BCF. The diagram below shows the key areas of focus, the services included and the Programme under which is sits:

Prevention, early detection & improvement of quality of life
(City ISOC)

- The Leicester City Lifestyle Hub
- The Leicester City prevention checklist
- Planning for Integrated Care in General Practice
- Integrated Locality Teams

Reducing time spent avoidably in hospital
(LLR A&E Delivery Board/LLR Home First/City ISOC)

- 24/7 2 hour health and social care crisis response, inc. falls service
- Access to Urgent care servicesPrimary care hubs
- Clinical Navigation Hub
- Integrated Crisis Response Service
- Health Transfers Team
- Integrated Discharge Team

Services to maintain independance
(LLR Home First)

- Reablement services
- Housing Services

The key interventions/services within this system funded through the BCF are detailed below.

Key Interventions to be delivered

Focus 1: Prevention, early detection & improvement of health related quality of life

In order to have a significant impact on the prevention of disease and reduction in health service and ultimately social care demand, action on prevention must be increased. The Joint Strategic Needs

Assessment 2017 for Leicester identifies that overall the city has big challenges, with low life expectancy and healthy life expectancy and high levels of disease related to lifestyle factors e.g. cardiovascular disease and respiratory disease. Rates of both adult and childhood obesity continue to increase both nationally and locally and although reducing, rates of smoking continue to be high locally, leading to high levels of estimated prevalence in long term conditions. Equally, utilisation of the ACG System within the population of Leicester City CCG has demonstrated that there is a clear relationship between multi-morbidity, usage of the wider system and subsequent cost. People associated with the highest costs were those with 7 or more chronic conditions, with costs consistently high in pharmacy and secondary care usage and predicted costs in social care.

The Leicester City Lifestyle Hub

The World Health Organisation has estimated that 80% of cases of cardiovascular disease and 40% of cases of cancer could be avoided if common lifestyle factors were eliminated. The conditions most strongly related to health inequalities, such as cancer, cardiovascular disease and respiratory diseases are associated with lifestyle behaviours and factors such as smoking, obesity, physical activity, alcohol intake and substance misuse.

In order to ensure those patients requiring these services can access them with ease, an integrated lifestyle service for Leicester City has been developed for smokers, those who are obese, inactive or have poor diet. This includes a single point of access for GPs and other professionals, a person-centred approach considering the individuals wider social issues such as debt, housing etc., a generically trained lifestyle team to provide both 1-1 intensive support and group-based sessions, specialist support from e.g. smoking cessation advisors, dieticians and exercise professionals where necessary and additional support from a team of volunteers.

Planning for Integrated Care in General Practice - Integrated Locality Teams

We started this programme of work in 2016/17 and will build upon these foundations through 2017-19 through the implementation of newly formed Integrated Locality Teams. Our GP's, community services and social care teams will work together within the primary care setting for a cohort of multi-morbid patients. As described earlier in this plan, the Leicester City cohort for this service is 92,104 patients across the city, with c3% of these patients selected for more intensive work. These patients will be provided with a combination of interventions, including targeted longer GP appointments, case management and further education on condition management.

Since November 2016 the following activities have been undertaken within the Integrated Locality Teams workstream:

- Setting up a multi-agency Programme Board as one of the key workstreams of the STP - with joint SROs across health and care, and joint clinical leads across primary and secondary care and developing a PID.
- Identification of 11 locality leadership teams across LLR comprised of designated senior professionals from primary care, CCGs, social care and community nursing teams and undertaking a readiness self-assessment with them.
- Assessing and adapting the learning from MSCP Vanguard sites, including in particular Hampshire and Sunderland, to inform the local model.

- Via risk stratification, defining the cohorts in scope for integrated locality teams to focus on and providing data analysis packets by locality and a self-serve guide to promote the ongoing use of this analysis.
- Defining the model of case management, care coordination, and how multidisciplinary working should develop.
- Defining the key evidence based interventions that should be applied to the patient cohorts to improve case management, care coordination and reduce acute/urgent care spend and developing a framework for evaluating the impact of integrated locality teams.
- Developing a governance and accountability framework for integrated locality teams, and in support of the early discussion on accountable care systems.
- Delivering a leadership development programme for integrated locality teams
- Using a range of the above outputs to create a "manual" for integrated locality teams for LLR to help structure their operational work, and capture learning and impact in the early stages of implementation.
- Setting up test beds across LLR with initial evaluation from September 2017.
- The programme has also adopted existing transformation work related to end of life, falls and cardio-respiratory services into its remit given the alignment with the work of integrated locality teams and their patient cohorts.

The Leicester City BCF supports delivery in this area by providing investment associated with various components of the model:

Service	Investment	Status
The Lifestyle hub	£100,000	LIVE
Risk stratification	£69,146	LIVE
Planning for Integrated Care	£1,242,119	LIVE
Carers Funding	£650,000	LIVE

Focus 2: Reducing the time spent avoidably in hospital (In home crisis services, discharge services and services to maintain independence)

These services service cover both pre- and post-hospital services across the City and largely pertain to workstreams under the LLR Home First Programme Board & the LLR A&E Delivery Board. As these are embedded services, the focus for 2017-19 will be to transform pathways into LLR pathways where possible, making it easier for patients at risk of hospitalisation or following hospitalisation to access services from an acute or community bed, regardless of whether they are a City patient or a patient with one of our partner Leicestershire and Rutland CCG's.

Currently City patients at risk of hospital admission have access to a 24/7 2 hour health and social care response service, including mobile paramedics, mobile social care staff and mobile nursing support. Similar services also cover patients requiring discharge from hospital. This service is now embedded within the Leicester City system and the discharge elements of this will morph into the new LLR Integrated Discharge Team.

This offer includes the Lightbulb service, which provides specific staffing resources for supporting hospital discharges relating to housing issues. Staff are based at Leicester Royal Infirmary and the Bradgate Unit, working closely with the integrated discharge team to support patients with a range of housing solutions such as homelessness, rent/tenancy issues, furniture packs, cleaning and

clearing patients homes that have become cluttered or unsuitable (e.g. due to hoarding), moving furniture to accommodate a change in the person's mobility/reduce risks of falls, expediting adaptations, and tackling heating problems.

Reducing the time spent in hospital – discharge services/services to maintain independence (LLR Home First Programme)

The Home First Workstream will consider both pre- and post-hospital services within its remit and will work closely with the LLR A&E Delivery Board and the LLR Discharge Working Group in delivering its objectives. The key immediate action will be to improve hospital discharge with many of these actions already being implemented in light of an ambitious DTOC target:

1. A new integrated dashboard for monitoring delayed transfers of care which provides weekly performance management data by setting of care. This is supported by all the existing daily operational management activities across NHS and LA partners to address individual cases and maintain system flow.
2. Implementation of a new integrated discharge team at the acute trust, with similar developments planned for non-acute sites later in 2017/18.
3. Implementing the Trusted Assessor model.
4. Options for further interim/discharge to assess beds - being led by the Home First workstream during 2017/18.
5. New CHC processes, implemented with effect from July 2017 via Midlands and Lancashire Commissioning Support Unit.
6. Improvements to processes in support of hospital discharge within hospital sites using the red to green system (once the patient is medically fit for discharge, rapid and coordinated activities across the hospital to ensure discharge happens at pace, e.g. senior clinical decisions early in the day, prompt access to medications for discharge, effective transport etc.)
7. Improvements to patient/family choice policies and supporting materials.

The target for improvements to hospital discharge in 2017/18 have been agreed at the LLR A&E Delivery Board, with the LLR system working towards the 3.5% target, as per the BCF planning framework .

Mental health discharges

In early 2017 a strategic senior level group was established to identify and agree actions required to ensure sustained reduction in AMH DTOC levels. This group is chaired by the LPT Medical Director with representatives from CCG's, Local Authority Social Care, Housing and NHS England. Originally, a target was set of achieving 5% DTOC level of bed occupancy by January 2018 from current levels of circ. 12-15%. In light of the national requirements for a 3.5% DTOC level, this trajectory is under revision.

Key actions being taken:

Strengthened weekly clinical discharge meeting - The purpose of this meeting is to track every patient's progress through the care pathway and challenge and resolve the barriers that may affect the planned discharge date. This is chaired by the Clinical Director from Leicestershire Partnership

Trust and involves the ward based medical and nursing staff as well as representatives from housing and social care.

Strengthening data reporting - Internal LPT data quality process has been strengthened to ensure the patient coding details are reviewed and checked prior to submissions.

Key actions currently in train are summarised below:

Area	Action	Completion by
Patients with no recourse to public funds (NRPF)	Develop a guidance sheet for inpatient unit staff understand future options available to support early discharge.	September 2017
DToC **Exercising Choice**	To develop a local shared agreement in relation to Mental Health, based on UHL Exercising Choice policy.	September 2017
Information sharing agreement	Ensure ISA for sharing PII regarding DTOC from localised meetings across stakeholders.	September 2017
Discharge support	Review function of Housing Enablement and Assertive In reach teams to maximise staffing resource to deal with patient's housing issues.	October 2017
Development of Housing step down/ move on facility	Pilot a 5 unit supported accommodation 'move-on' scheme with local housing provider for patients fit for discharge but awaiting long term accommodation to be finalised.	October 2017
Access to longer term housing for people with mental health support needs.	To explore alternative housing solutions through the Hospital Housing Steering Group (hosted by Blaby District Council).	Ongoing
Development of local a Psychiatric Intensive care Unit (PICU Beds)	Explore local opportunity to provide 6 PICU beds to reduce the need to consider out of area placements.	December 2017
Review of rehabilitation pathway	To ensure pathways in line with national best practice and scope need for development of community and supporting housing rehabilitation schemes to support flow	October17-March 2018

This workstream will be aligned to governance structures of both the BCF and the A&E Delivery Board to ensure that focus remains on delivery of agreed actions.

Reducing the time spent in hospital – Access to urgent care services (LLR A&E Delivery Board)

During 2016/17 LLR partners have been working towards a new model of integrated urgent care in line with the NHS England Five Year Forward View, through our participation across LLR in the national Urgent Care Vanguard programme. This work has culminated in a procurement for a new model of service for April 2017 onwards which has the following key design principles:

- Responsive, accessible person-centred services as close to home as possible.
- Services will wrap care around the individual, promoting self-care and independence, enhancing recovery and reablement, through integrated health and social care services that are innovative and promote care in the right setting at the right time.
- Urgent care services in LLR will be consistently available 24 hours per day, seven days a week in community and hospital settings.
- Clinical triage and navigation is a central part of the new integrated urgent care offer, reducing demand on ambulances and acute emergency services.

The main changes to urgent care which will be delivered by the new service model are:

- The creation of a clinical navigation service, providing telephone advice, assessment and onward referral for people calling NHS 111 and 999.
- The clinicians working in the service will have access to patients' primary care records and care plans, where relevant, and will be able to directly book patients into primary and community urgent care services.
- The service will include warm transfer callers to specialist advice for mental health, medication and dental issues.
- Future plans for the navigation hub include bringing it together with a professional advice line and integration with a single point of access for social care.
- Extended access to primary care across LLR – so that patients can access primary care services 8am to a minimum of 8pm every day of the week.
- Urgent Care Centres will offer a range of diagnostic tests and medical expertise for people with more complex or urgent needs, and we will strengthen community based ambulatory care pathways which can avoid admission without the need to referral to acute hospital.
- An integrated streaming and urgent care service at the front door of Leicester Royal Infirmary Emergency Department, staffed by senior GPs working within the rebuilt Emergency Department.
- A 24/7 urgent care home visiting service across LLR, including out of hours home visiting and an acute visiting service for people with complex needs or living in care homes.

The Leicester City BCF supports delivery of the new Home First model by providing investment associated with various components of the new model:

Service	Investment	Status
Reablement funds - LA	£825,000	LIVE
Strengthening ICRS - LA	£985,000	LIVE
Assistive technology	£259,139	LIVE
Intensive Community Support Beds - LPT	£889,126	LIVE
Unscheduled Care Team - LPT	£477,615	LIVE
MH Planned Care Team - LPT	£236,178	LIVE
Reablement - LPT	£1,137,375	LIVE
Housing team	£41,164	LIVE
Health Transfers Team	£326,621	LIVE
MH discharge team	£43,222	LIVE

The Leicester City BCF supports delivery of the new model of urgent care by providing investment associated with various components of the new model:

Service	Investment	Status
Clinical Response Team	£1,365,000	LIVE
Enhanced night nursing - LPT	£92,619	LIVE
Other non-BCF investments		

Chapter 5: National conditions

National Condition 1: Plans to be jointly agreed

The BCF Plan, covering a minimum of the pooled Fund specified in the Spending Review and the use of the iBCF, has been jointly agreed by the JICB, Leicester City Council and the CCG in July 2017 and the Health and Wellbeing Board in August 2017.

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 Integrated Systems of Care Programme Group and the Joint Integrated Commissioning Board. Presentations have been made to the UHL executive team and formal approval of 17/18 plans is expected at the Health and Wellbeing Board in August 2017.

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. 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 (£2,035,322) has been agreed with the Housing Department when setting the budget for 2017/18. 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.

Health inequalities

Developments within the BCF Plan are subject to an equality, quality and privacy impact assessment and the evidence base supporting the BCF Plan has been tested with respect to Leicester City Joint Strategic Needs Assessment. An equality, quality and privacy impact assessment has also been undertaken.

National Condition 2: Social Care maintenance

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 line with inflation for 17/18 and 18/19, with additional funding allocated to social care in 2017/18 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. Each of the social care interventions have evidenced that they support the aims of the BCF plan, the STP and will also benefit health.

The comparison to 2016/17 is set out in the BCF planning template and the approach is consistent with the guidance outlined in the BCF Planning Framework (July 2017), with the transfer to social care in 18/19 exceeding the transfer in 17/18.

National Condition 3: NHS commissioned out of hospital services

The plans set out in the planning template demonstrate the breadth of the investments in NHS out of hospital services through the Leicester City BCF.

The proportion of the plan invested in these services is set out below and meets the national condition as outlined in the BCF Planning Framework:

	2017/18 £000	2018/19 £000
NHS Commissioned Out of Hospital ring fence	£6,323,613	£6,443,761
BCF Plan – Total NHS commissioned out of hospital spend	£7,485,448	
Variance		

As part of our core delivery offer our Better Care Fund plans include seven-day working across the system (where applicable & feasible) as a standard expectation to support the flow across the health and social care system. For example, most schemes mobilised since the start of 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 17/18.

Non-elective admissions

An additional target has not been set for 17/18 and 18/19 for non-elective admissions. However, a proportion of funds are being held in a contingency pool as per the guidance; this is to ensure that if preventative measures are unsuccessful, the financial position of the CCG is not compromised. Funds will be released as per the guidance issued. This is set out in Chapter 6 of this plan.

National Condition 4: Managing Transfers of care

The LLR health and social care system is working together to assess our position against the 'High Impact Change Model for Managing Transfers of Care' – this mapping is available as Appendix X with the position agreed by the LLR A&E Delivery Board. The local BCF services funded from the Leicester City BCF will support any process and/or service changes required to implement improvements in the 8 areas identified in the model. These are set out in greater detail later in this plan and have been drawn from a variety of national literature, including the relevant 'Quick guides' and the Social Care Institute for Excellence.

The local system has proposed a trajectory via the A&E Delivery Board to achieve the target of 3.5% of occupied bed days by March 2018. This has been agreed with NHS Improvement and presents a realistic assessment of delivery – this is principally because the City system has been focusing on reducing DTOC's in our acute provider for the last year, with processes greatly improved. Our focus will now shift to our community and mental health trust where delays are less due to process issues but long-standing issues of step-down housing availability and patient choice and these delays are not amenable to short term solutions. Key actions being taken (including those from the High Impact Change Model) are described in Chapter 4.

Delivery of former national conditions

Delivery of 7 days services (national condition 3 from BCF policy 16/17)

Our commitment to delivery of 7 day services has not wavered despite this national condition being removed for 2017-19. The BCF since inception has mandated services on a 7 day basis, with each service commissioned as part of a crisis response done so on a 7 day basis.

BCF Intervention	Impact on 7 day service provision
Services for complex patients	Enhanced access to primary care, inc access to Hubs on a 7 day basis
Clinical Response Team/Home Visiting Service	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

Better data sharing between health and social care (national condition 4 from BCF policy 16/17)

Leicester, Leicestershire and Rutland are seen as national exemplars in data sharing due to the early adoption of the NHS number onto social care records (currently at 98%), the adoption of the ACG tool in primary care for risk stratification and the adoption of the PI Care and Healthtrak tool since 2015/16, and the application of these tools during 2016/17 to support a range of transformation priorities including the emerging workstreams of the STP.

The development of the summary care record solution for LLR is a further critical enabler to the STP and Integration Programme across LLR. Phase 2 of this development is currently in progress and the milestones for this are summarised below:

Phase	Activity	Timescales
Phase 1	The Integrated Care Planning (ICP) template was successfully rolled out across primary care during March and April 2017. This feeds the patient's Summary Care Record with care planning information, when explicit patient consent is recorded. The template also enables the recording of that consent. Once consent is recorded, the SCR is updated in real-time every time the GP record is amended.	March- April 2017
	The ICP template will be updated on a quarterly basis with version 2 of the template rolled-out in August 2017.	Quarterly
	Initial focus will be on patients who are case managed in primary care, via new integrated locality teams including those with the frailty.	By October 2017
	The aim is that all LLR patients will have an enhanced SCR, other than the small number who dissent.	By April 2018
Phase 2	The focus in on secondary and community care providers using the information either accessed through SCR directly, or via SCR links in other clinical IT systems (such as SystmOne).	Live
	Monitor the uptake of patients consenting to enhanced SCRs, and the number of SCR views by provider. The most significant aspect of this communications drive is consent.	Ongoing
	Other Phase 2 workstreams are looking at streamlining the Special Patient Note (SPN) process, and maximising the benefits of SystmOne sharing in LLR.	Ongoing
Phase 3	The focus of this phase is sharing health records with Adult Social Care staff, through the SCR. NHS Digital are in the process of discussing national issues related to this. In July, plan is to meet with some of NHS Digital SCR Clinical and Product Leads to progress the matter, and try to influence their national steer on social care sharing.	Timescale TBC

The adoption of the SCR2 within integrated locality teams will be a particular focus of the Leicester City BCF in 2017/18.

Joint approach to care planning and assessments (national condition 5 from BCF policy 16/17)

The BCF plans described demonstrate our commitment to joint assessments and joint care planning, and this commitment is embedded within the development of Integrated Locality Teams across the City. This is described earlier in this plan.

Chapter 6: Overview of funding contributions

17/18 Investments

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

	2017/18	2018/19
BCF Pooled Total balance	£33,242,254	£37,235,635
Local Authority Contribution balance exc iBCF	£2,035,322	£2,216,673
CCG Minimum Contribution balance	£22,252,794	£22,675,597
Additional CCG Contribution balance	£0	£0
iBCF	£8,954,138	£12,343,365

Aligned to the services above, the expenditure plan for the 17/18 BCF is as follows:

Scheme Name	Total 16/17 Expenditure (£)	2017/18 Expenditure (£)	2018/19 Expenditure (£)	New or Existing Scheme	Agreed at BCF joint confirm and challenge?	Impact on service
Risk Stratification/IT	£64,000	£69,146		Existing	Yes	None
Lifestyle Hub	£100,000	£100,000		Existing	Yes	None
Clinical Response Team	£1,380,015	£1,365,000		Existing	Yes	None
Assistive Technology	£213,321	£259,139		Existing	Yes	None
LPT Unscheduled care team	£469,216	£477,615		Existing	Yes	None
ICRS	£835,000	£985,000		Existing	Yes	Expansion
Night Nursing team	£90,990	£92,619		Existing	Yes	None
Services for complex patients	£1,220,277	£1,242,119		Existing	Yes	None
Mental Health Planned Care Team	£232,025	£236,178		Existing	Yes	None
Housing team	£40,440	£41,164		Existing	Yes	---
Health Transfers Team	---	£326,621		New	Yes	Expansion
MH Discharge team	£42,462	£43,222		Existing	Yes	None
ICS (+)	£883,614	£889,126		Existing	Yes	None
Reablement - LPT	£1,137,375	£1,137,375		Existing	Yes	None
Existing ASC Transfer	£5,901,968	£5,901968		Existing	Yes	None
Carers Funding	£650,000	£650,000		Existing	Yes	None
Reablement funds - LA	£825,000	£825,000		Existing	Yes	None
2017-18 ASC Increased Transfer	£5,650,000	£5,650,000		Existing	Yes	None
Performance Fund	£1,926,540	£1,961,024		Existing	Yes	None
Uncommitted	£194,757	---		New	Yes	---
DFG	£2,035,322			Existing	Yes	---

As the above table shows, financial allocations have been made to cover requirements for implementation of the new Care Act duties, carer-specific support, reablement and the Disabled Facilities Grant. The use of the iBCF is described below.

Risk pool

The creation of a £1.9m risk pool from within the BCF during 2017/18 is in recognition of the need to achieve further savings and headroom so that the plan can become more sustainable in the medium term. This is due to the significant financial pressures affecting partners in 2017/18, and the fact that, unlike the previous two financial years, the BCF plan does not have the benefit of any other contingencies or reserves to draw on from 2017/18 onwards.

This pool is not linked to emergency admissions performance as the BCF plan for 2017/18 – 2018/19 does not include any activity or investments above or beyond CCG operating plans assumptions. However, given the risk of unplanned activity in the area of non-elective care, the pool has been agreed as a contingency measure and has been ring fenced from the CCG allocation, without compromising the minimum transfer to the LA. This arrangement is consistent with guidance with release of the funds to be approved at the Joint Integrated Commissioning Board at the end of each quarter where relevant.

iBCF

The spring budget this year contained an announcement of a new adult social care grant of £2bn over the next three years of which £1bn is available in 2017/18.

For Leicester City Council the sum allocated from this non-recurrent grant is:

	2017/18	2018/19
iBCF	£8,954,138	£12,343,365

The Government has made it clear that part of this funding is intended to enable local authorities to quickly provide stability and extra capacity in the local care systems. It is also expected to ensure that the High Impact Changes for reducing delayed transfers of care will be implemented within local health and care systems.

The City Council continues to prioritise the meeting of social care need in the utilisation of these funds. The Council has a strong commitment to supporting the most vulnerable in our community and in ensuring that sufficient funds are made available to effectively meet these needs. This commitment was the key driver behind the decision for 2016/17 in utilising Council reserves to meet the growing pressures on the ASC budget.

Likewise the City Council retains its commitment to working as an effective partner in our local health and social care economy. It can demonstrate with its ongoing commitment to funding throughout challenging financial times that it is effective in working with NHS partners. The council have in the recent years:

a) Seen significant reduction in the DTOC numbers to an all-time and potentially sustainable low;

b) Moved away from a reliance on formal discharge notices to a far more proactive case finding model in hospital setting which ensure that on average between 65% to 70% of all discharges from hospital where there is adult social care involvement take place prior to a formal notice of discharge having to be issued;
c) Sustained a 'Level 1' status on regular daily escalation meeting / teleconferences reporting for the last three years – through being in a strong positon to meet social care need where necessary from hospital discharge;
d) Continued staffing engagement in developing the new models of care that underpin key developments in the original BCT and now STP agenda, and are fully committed to the development of integrated teams, discharge planning improvement and prevention;
e) Retained a small but essential staffing function around transformation and developing new systems – which supports our continued improvement and development of models of care and delivery.

The City Council's current budget profile supports continued investment over the period up to 2019/10 in areas that although not statutory, enable us to support meeting social care need and in supporting the whole health and social care system.

Investment in professional staffing levels - £1.2m

Through a use of resources analysis undertaken in early 2016 it was identified that the Department was staffed at a higher level than both regional comparators and the national average in relation to professional social work, OT and assessment and case management staff – in the region of some 30%.

The council's agreed savings plan removes some 20% of the staffing from these areas over 2017/18 to 2019/20, but the council is electing to retain a slightly higher staffing ratio than regional comparators / England average as this continues to support them in dealing with key pressure points, such as hospital discharge effectively. This additional staffing investment equates to in the region of £1.2m (around 35 social work posts) and the council will continue to deploy these staffing resources in key areas mainly:

a) the Hospital Transfers Service (enabling discharge and into reablement services or 'home first')
b) the 'front door' Contract and Response Team
c) emerging integrated community teams, where activity would be aimed at deflecting admission to hospital and prevention of long term need

Reinvestment of intermediate care resources - £150K

With the decisions to close the Kingfisher Unit (37 bedded short term beds) and transfer social care intermediate care beds to a commissioned model (12 beds), the council reduced the overall savings delivered (from a planned £600K) by £150k, and re-invested this sum back into the Reablement Service (RS). This reinvestment was to ensure that the council could extend the service hours of the RS into late evening and overnights, to support effective discharge from hospital and the 'home first' principle;

Establishment the Enablement Service - £3.2m

In seeking to reduce the demand for statutory services the council has invested heavily in 2016/17 onwards in preventative and enabling services. The new Enablement Service, established in mid-2016, is aimed at supporting people with physical disabilities, learning disabilities and mental health needs to gradually move away from statutory support. The Service supports people into a range of self-care, peer support, low level equipment and adaptations and universal services. This aims to reduce the reliance on long term person to person care and support.

This service is wholly discretionary and does not need to be provided as a statutory eligible service. The council has opted to invest in this service, even in these financially challenging times, as it is assured that it can support a longer term reduction in demand for adult social care.

The council will formally evaluate the success for the Service in 2018/19, and will implement a planned reduction of £700K in 2019/20, but at the moment the current plan is to retain a recurring investment of £2.5m.

Investment in Prevention and Crisis Intervention - £1m

The council continues to maintain a number of services that are aimed at preventing need and supporting people out of non-social care crisis so as to ensure that they do not default into ASC as their housing, family and self-caring skills deteriorate.

These services are mainly delivered through existing contracts and grants with independent sector and voluntary sector organisations. On current data it is estimated that this range of services is supporting around 500 – 1,000 people a year to maintain their own lives and self-caring skills and there is strong evidence to demonstrate that these services are diverting people away from a trajectory which leads to dependence on statutory social care.

The total of these predominantly non-statutory services continuing financial commitments is £5.5m. The new Adult Social Care Grant facilitates the continued investment in these service areas, as well as enabling the reduction in the use of one-off reserves. In turn as stated earlier this potentially provides for a 'safety net' in 2019/20, where some reserves that would have been used in 2017/18 and into 2018/19 may be available for use in later years, subject to other financial pressures across the Council's overall service and budget profile.

However, should further funding requirements arise through 17-19, these will be considered through the JICB as per normal joint commissioning processes. This has been agreed through our BCF governance structures and at the LLR A&E Delivery Board.

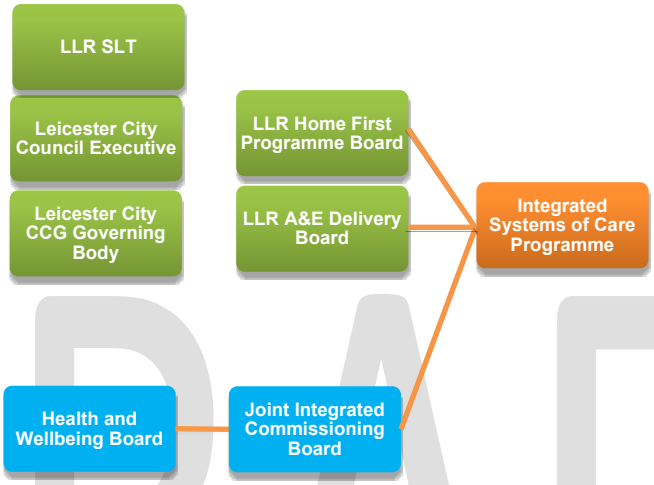
Chapter 7: Programme Governance

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. With the advent of the LLR STP, much of the work has been enveloped into STP-owned workstreams. The BCF has effectively become an enabler to the successful delivery of STP workstreams, reporting into various different programme boards

across LLR. However, oversight and delivery of the Leicester City BCF remains within the BCF structure below.

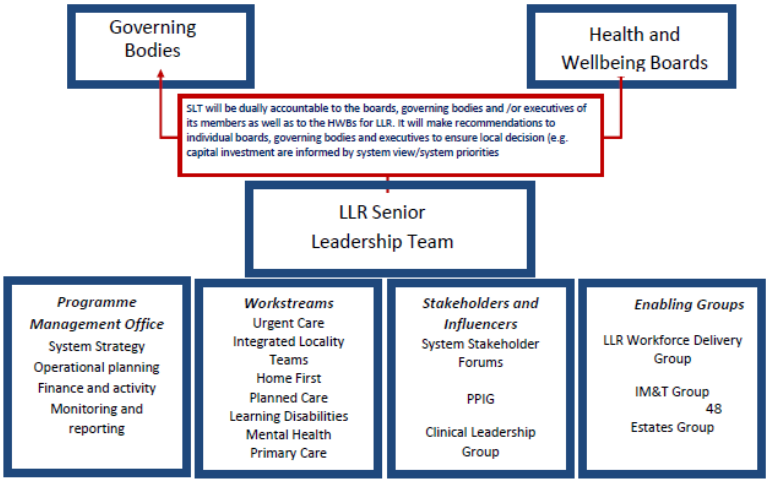
Governance

The governance of the Better Care Fund Programme builds on a mix of strong existing partnership groups, with the key delivery group being the Leicester City Integrated Systems of Care Group (ISOC).



Leicester City Better Care Fund programme structure

Given the emerging STP programme structure, the majority of the BCF is delivered through matrix working with partners, and project/delivery leads come from a wide range of partner organisations, including on an LLR wide basis. The structure above sits within the STP structure shown:



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 the CCG and public health.

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 STP governance process to ensure key stakeholders are sighted on progress. Quarterly updates are also provided to the UHL executive team.

Governance arrangements: delivery

The delivery of each work stream of the BCF is overseen by the Integrated Systems of Care Programme Group (ISOC), 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 & Implementation, 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, benefits realised vs benefits expected, 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.

However, as the workstreams re-align to the emerging STP workstreams, this structure will change. Currently, all work from relevant LLR STP workstreams is funnelled through ISOC to ensure that interdependencies with the established City system of care are noted, with no unintended consequences.

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 – Quarterly reporting to the JICB and CCG Integrated Governance Committee

At a strategic level, an overarching system dashboard has being formulated, covering the 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 Integrated Governance 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 ISOC

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 and expected benefits 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.

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 X and X.

Assessment of Risk and Risk management

The ISOC also oversees the joint BCF Risk log; this is a fully populated and comprehensive risk log, developed in partnership with all stakeholders. Risks considered in the log cover:

- Risks to delivery & subsequent organisational impact
- Financial risks to CCG's, Local authority and providers
- Risks to patient care and/or experience

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 Integrated Systems of Care Programme Group to ensure that risks are managed and escalated where appropriate if mitigations are not secured.

The risk log as at March 2017 is available as Appendix X.

Chapter 8: National metrics

The following table sets out the performance trend noted over the last 4 years and our proposed trajectory for the two year period of this BCF plan based on this analysis:

	2013/14 actual	2014/15 actual	2015/16 actual	2016/17 actual	2017/18 target	2018/19 target
Non-elective admissions	28889	31307	33985	33092	37345	36981
Delayed Transfers of Care	---	5.02%	2.69%	4.03%	3.50%	3.50%
65+ admissions	291	287	258	282	**266**	**254**
At home 91 days after hospital admission	86.9%	84.3%	91.5%	91.3%	**91.6%**	**92.0%**

These targets have been set following analysis of both performance of the system through the last 4 years and also take into account delivery of scheme-level benefits through 16/17. For example, we know through clinical audit that our pre-hospital pathway accounted for c1560 non-elective admissions being saved in 16/17. However, expected growth and coding changes at the acute trust have also been taken into account hence the rise in planned admissions in 17/18.

The opportunity analysis outlined in chapter X provides further detail of how these targets will be reached.

These targets have been agreed through the BCF governance structures as well as through the A&E Delivery Board and the LLR Home First Programme Board.

Chapter 9: Delayed Transfers of Care

Leicester, Leicestershire and Rutland CCG's via the A&E DB has proposed a trajectory and action plan in discussion with NHS Improvement to bring the number of beds occupied by delayed patients down to 3.5% by March 2018. According to paragraph 66 of the BCF planning requirements, 3.5% equates to 9.4 average patients per day per 100,000 population. Applying this to Leicester's population of 268,644 gives the number of days delayed in March as 782.8. Work is underway to set a trajectory in terms of maximum days delayed per month for each local authority, split by attributable organisation, which will bring us to 782.8 total days delayed for Leicester by March 2018.

This work has the support of the Urgent and Emergency Care team, all 3 CCGs, all 3 local authorities, our 2 main providers locally, University Hospitals of Leicester and Leicestershire Partnership Trust, and the Sustainability and Transformation Plan Senior Leadership Team. The trajectories are

supported by a comprehensive plan of action which includes the development of Integrated Discharge Teams, improvements to the Continuing Health Care process, improvements in pathways to community hospitals, new trusted assessment models, and plans to bring down levels of delays due to patient choice as detailed in earlier chapters of this plan. As an integrated plan with the support of all partners locally, we believe that this local plan, agreed with NHS Improvement, is achievable.

Further details of how this will be delivered are set out in Chapter X.

Approval and sign off

As per front sheet of this document, the Leicester City BCF has been approved by the JICB, the CCG Governing Body and the Health and Wellbeing Board.