December 2017

Summary document

Leicestershire's Better Care Fund Plan 2017/19

Delivering our vision for health and care integration

Leicestershire County Council

healthwatch Leicestershire

NHS England

East Midlands Ambulance Service NHS Trust

East Leicestershire and Rutland Clinical Commissioning Group

West Leicestershire Clinical Commissioning Group

Leicestershire Partnership NHS Trust

University Hospitals of Leicester NHS Trust

INTEGRATION AND BETTER CARE FUND

Narrative Plan 2017/18 – 2018/19

Area	Leicestershire
Constituent Health and Wellbeing Boards	Leicestershire
Constituent CCGs	East Leicestershire and Rutland CCG West Leicestershire CCG

Contents

APPENDICES

1. Case for Change
2. DTOC Benchmarking against CIPFA neighbours
3. LLR - 8 High Impact Changes Model Gap Analysis
4. LLR DTOC Action Plan
5. Leicestershire County Council's Adult Social Care Department DTOC Improvement Plan
6. DTOC Digest Report
7. BCF Expenditure Plan
8. Unified Prevention Model
9. BCF Engagement Plan
10. BCF Programme Plan
11. BCF Risk Register
12. BCF Mapping Tables:
    a. Leicestershire BCF mapped to the LLR STP, BCF Metrics and BCF Conditions,
    b. Analysis against the Nuffield Trust's *Shifting the Balance of Care Report*

1.0 INTRODUCTION

The 2015 Comprehensive Spending Review set out the government's intention that by 2020/21 health and social care will be integrated to provide better coordination of care around the individual, reduce inequalities, and support health and care systems to become more sustainable, in the context of rising demands and ongoing financial constraints.

Since 2015 the National Better Care Fund Policy has provided a framework for a joint planning approach, along with a pooled budget mechanism, between Clinical Commissioning Groups (CCG) and Local Authorities (LA) to support this ambition.

Nationally, the central role of integration in transforming health and care has continued to be reinforced. Most recently this has been illustrated in:

- The NHS Planning guidance for 2017/18, published in September 2016.
- The expectations placed on the 44 area Sustainability and Transformation Partnerships (STP), developed in 2016/17.
- The Better Care Fund Policy Framework (March 2017) and the supporting planning guidance (July 2017).
- The introduction of additional funding for Adult Social Care (March 2017), with grant conditions involving joint working with the NHS on improving the management of transfers of care from hospital.

Locally, during 2016, partners across Leicester, Leicestershire and Rutland (LLR) developed a five year plan, the LLR Sustainability and Transformation Plan (STP) (http://www.bettercareleicester.nhs.uk/Easysiteweb/getresource.axd?AssetID=47665), with the vision to create a high quality, integrated, health and care system, which is affordable and meets the needs of local people in the medium term.

Each of the three Better Care Fund plans/pooled budgets in the LLR area underpin the delivery of the LLR five year plan.

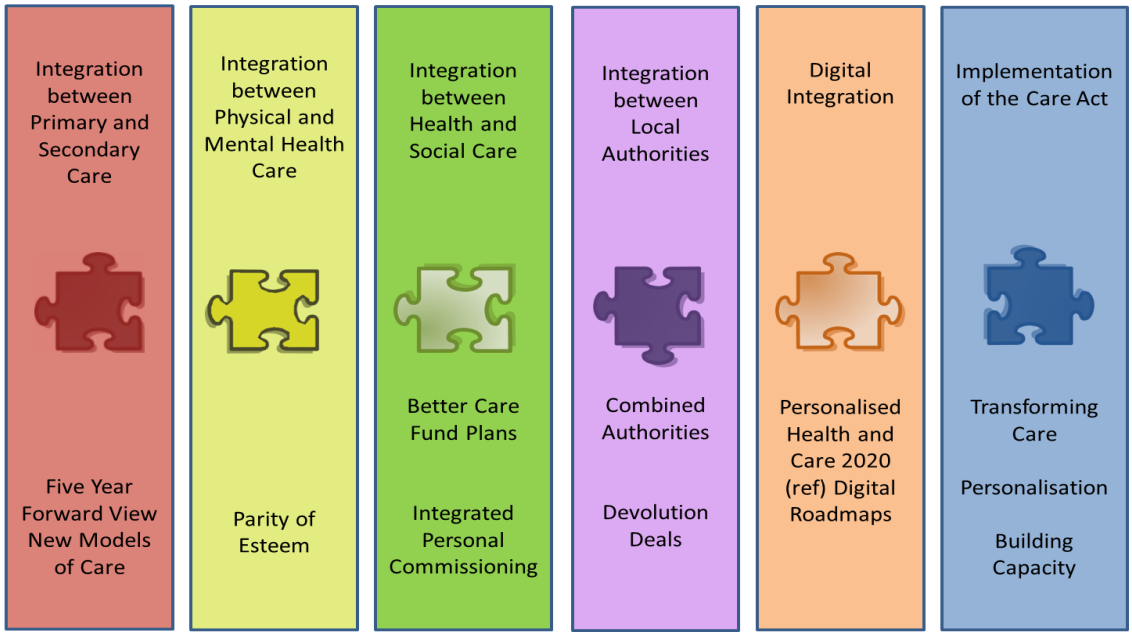
This narrative document is the Better Care Fund (BCF) Plan for Leicestershire 2017/18 – 2018/19 and sets out:

- How the Leicestershire BCF Plan was developed and agreed.
- How the priorities and investments set out within the plan:
    - meet national BCF conditions and outcome metrics;
    - deliver against local commissioning priorities;
    - contribute to the overall delivery of the LLR five year plan.
- How delivery of the plan is resourced, measured and governed.

2.0 INTEGRATION POLICY CONTEXT

Integration Policy has several components. Progress nationally and locally has varied and is still an evolving picture. The diagram below shows the main "pillars" of national policy that are driving integration across health and care systems. The Leicestershire BCF Plan has been developed in this context, underpinned by important principles for person centred integrated care, (as set out by The King's Fund and National Voices in the early stages of BCF policy implementation in 2014/15). The Leicestershire BCF Plan and the LLR STP involve activities across all the pillars.

How National Policy Developments are promoting and driving integration



Evidence of how integration policy has been implemented can be seen in the following developments

- **New Models of Care**
  - Per NHS England Five Year Forward View and Vanguard Sites – new models are being tested and implemented across the country (e.g. integrated community teams, urgent care, and primary care);
  - Transformation of adult social care, focusing on sustainability of the care market, personalisation, more effective support to hospital discharge, and new methods of demand management;
  - New ways of delivering integrated care across organisational boundaries are developing, with new types of organisational forms emerging, such as accountable care organisations/systems.
- **New digital technologies and data sharing capabilities** across health and care systems are being implemented so that records can be integrated and the utilisation of health and care services can be understood across populations and organisations.
- **New integrated approaches to back office, estate sharing and workforce development**, are increasingly coming into place across public sector organisations.
- **New approaches to integrated commissioning**, such as personal budgets, pooled budgets, new methods of contracting and tariffs in support of new models of care.
- **New opportunities and flexibilities arising from devolution** in local government.

3.0 MAKING THE HOME FIRST PRINCIPLE A REALITY

All parts of the health and care system are transforming the way they work so that people can be cared for at home, in their own community, whenever possible, and for as long as possible. In practical terms this means everyone should ask: "Why is this person not at home?" or "How best can we keep them at home? This involves:

- Helping people to help themselves.
- Easy navigation to the appropriate level of care and support on a 24/7 basis.
- Tackling the over-reliance on acute hospital care.
- Implementing community based services that are responsive, integrated, consistent, and reliable.
- Care coordinated effectively across organisational boundaries, care pathways and professions.
- Electronic shared records with integrated data.

If an emergency admission to hospital does occur, after the necessary medical interventions and treatment, the health and care system's primary aim will be to coordinate a timely and effective discharge from hospital and return people to their usual home address.

Over the past two years we have already made some good progress:

- Local Area Coordinators and First Contact Plus were implemented in 2016/17 as part of Leicestershire's new prevention offer, helping people make the most of what is available locally to improve or maintain their health and wellbeing.
- Hospital discharge was redesigned and streamlined into five core pathways, with new integrated discharge teams being implemented in 2017.
- New urgent care services were tested in 2016, and commissioned with effect from April 2017, including new approaches to clinical navigation via 111, home visiting for urgent care, new ways of working for urgent care centres, and a new Emergency Department.
- New integrated locality teams have been implemented in 2017, with primary care, social care and community nursing working hand in hand to coordinate care plans and support people to remain at home.
- A new integrated housing support service (Lightbulb) was designed and tested in Leicestershire in 2016 and is being rolled out across Leicestershire with effect from May 2017.
- A new integrated single point of access, for coordinating all community services 24/7, is in the process of being designed and implemented.
- Phase one of the electronic summary care record has been completed and phase two is now well underway.

<u>Our Journey to become an Accountable Care System</u>

While these important components of an integrated local health and care system have started to take shape in LLR, nationally the expectation is that each area will now move to a more fundamental level of integration, creating fully-fledged integrated health and care systems by 2020/21 where accountability is joint across organisational boundaries. A much clearer vision of what integration will look like across LLR by 2021 is emerging. At the time of this submission, leaders from across the health and care system are currently considering whether moving to a more formal accountable care system over the next two years will form part of the local vision for integration and setting out milestones to achieve this.

Irrespective of the ultimate structure of local organisations within the health and care system, the following key issues need addressing as part of the next phase of integration in LLR:

- Implementing the remaining building blocks for integrated health and care.
- Tackling the remaining cultural, organisational, and technological barriers to integration.
- Supporting the workforce to deliver new models of care effectively.
- Making care more consistent, and reducing variations in care.
- Greater alignment of budgets and outcomes across the public sector, to get the best value for money from the Leicestershire pound.

4.0 VISION AND AIMS OF THE LEICESTERSHIRE BCF PLAN 2017/18 – 2018/19

Our vision remains as follows:

We will create a strong, sustainable, person-centred, and integrated health and care system which improves outcomes for our citizens.

Our aims have been refreshed in light of national policy developments and the development of the LLR five year plan.

The revised aims are as follows:

1. Develop and implement new models of care and new approaches to commissioning, which maximise the opportunities and outcomes for integration.	**2. Deliver measurable, evidence based improvements to the way our citizens and communities experience integrated care and support.**	**3. Increase the capacity, capability and sustainability of integrated services, so that professionals and the public have confidence that more can be delivered in the community in the future.**
4. Support the reconfiguration of services from acute to community settings in line with: • **The LLR STP** • **New integrated models of health and care.**	**5. Manage an effective and efficient pooled budget across the partnership to deliver the integration programme.**	**6. Develop an integrated health and care system by 2020/21, including the local approach to devolution where applicable.**

5.0 WHAT OUR INTEGRATED HEALTH AND CARE SYSTEM WILL LOOK LIKE BY 2020

The transformation of health and care across LLR has a number of components as shown in the diagram below.

The six green hexagons represent the key areas of service transformation which together will make up the new health and care system. This is supported by improved clinical triage, call handling and navigation across the system and a new wrap around prevention offer targeted to helping people to help themselves to reduce the overall demands on the health and care system in the future.

5.1 Critical next steps in realising this vision

1. Ongoing delivery of the transformational work already underway within the green hexagons, including the priorities set out and funded within the three Better Care Fund plans in LLR
2. Final approval of the STP plan for LLR, including confirmation of those elements within the green hexagons that are subject to consultation, and the timescale for this.
3. Determining if an accountable care system (ACS) should be developed within LLR, and if so which components of service/which organisations will be part of this development.

It is anticipated a way forward on bullets two and three above will be in place by December 2017.

6.0 EVIDENCE BASE, CASE FOR CHANGE AND CHALLENGES

The following section outlines the challenges arising from the evidence and analysis to date, summarising our current performance as a health and care system, the local case for change as set out in the STP, and our progress so far on our integration journey

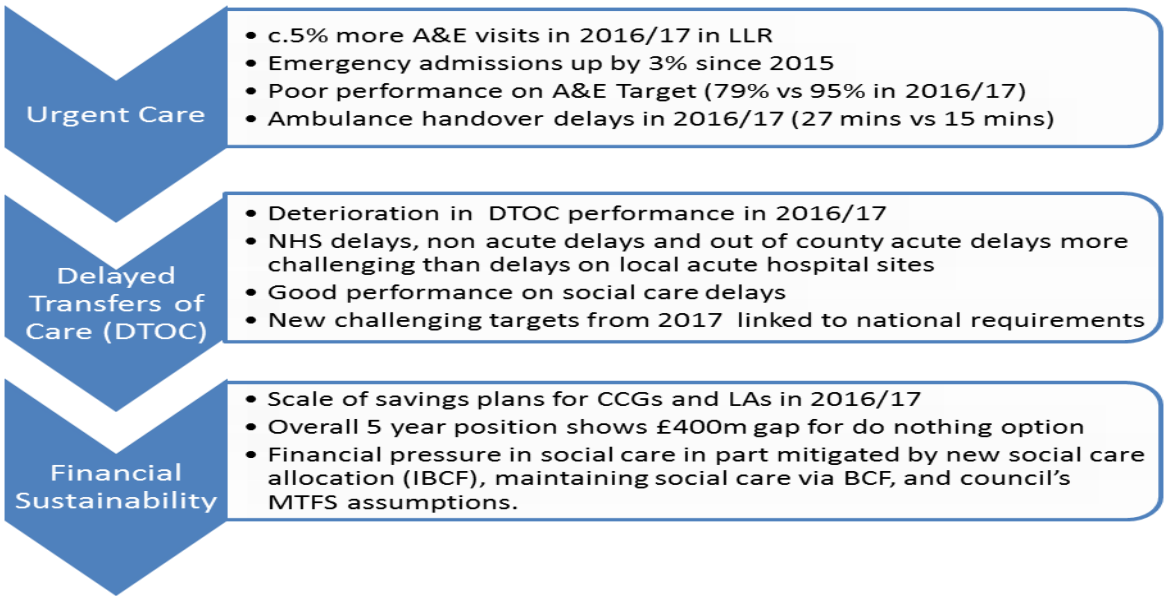
6.1 Case for Change

Considerable work has already been undertaken on the evidence base and local case for change.

Appendix 1 sets out a summary of this analysis with reference to source documents which include:

- Public health analysis, including health profiles and the JSNA.
- Analysis undertaken for the LLR five year plan (Better Care Together/STP).
- Population profiling and risk stratification.
- Analysis undertaken for the Leicestershire Adult Social Care Strategy and Market Position Statement.
- Evidence from evaluation of the BCF Plan 2015/16 – 2016/17.
- A range of customer insight analysis that has informed the Leicestershire BCF.
- Other reference sources including regulatory and benchmarking data.

6.2 Local Service Challenges – Summary Diagram



6.3 Local Service Challenges – Supporting Narrative

The ongoing demands on the acute care system are the local health and care economy's greatest risk to sustainability.

- Total emergency admissions for Leicestershire's residents have again exceeded CCG commissioned levels over the past 12 months.
    - In 2014/15 there were 58,479 emergency admissions for Leicestershire residents.
    - In 2015/16 the outturn for emergency admissions was 60,090 (increase of 1.5%).
    - In 2016/17 the outturn for emergency admissions was 61,966 against a plan for 59,030 (increase of 3.1% on 2015/16 levels).

Analysis by the LLR A&E Delivery Board shows that a proportion of the growth has occurred in the under 10s and working age adults, so the solutions are not purely about avoiding admissions for older people.

In 2016/17 UHL's A&E saw a c.5% growth in attendances, and performance on the four hour target for A&E remained challenging throughout the year, an outturn of 79.6% vs a target of 95%.

Ambulance response times and handover delays at the A&E have also been a key feature of urgent care system pressures, 27.35 mins vs a target of 15 mins.

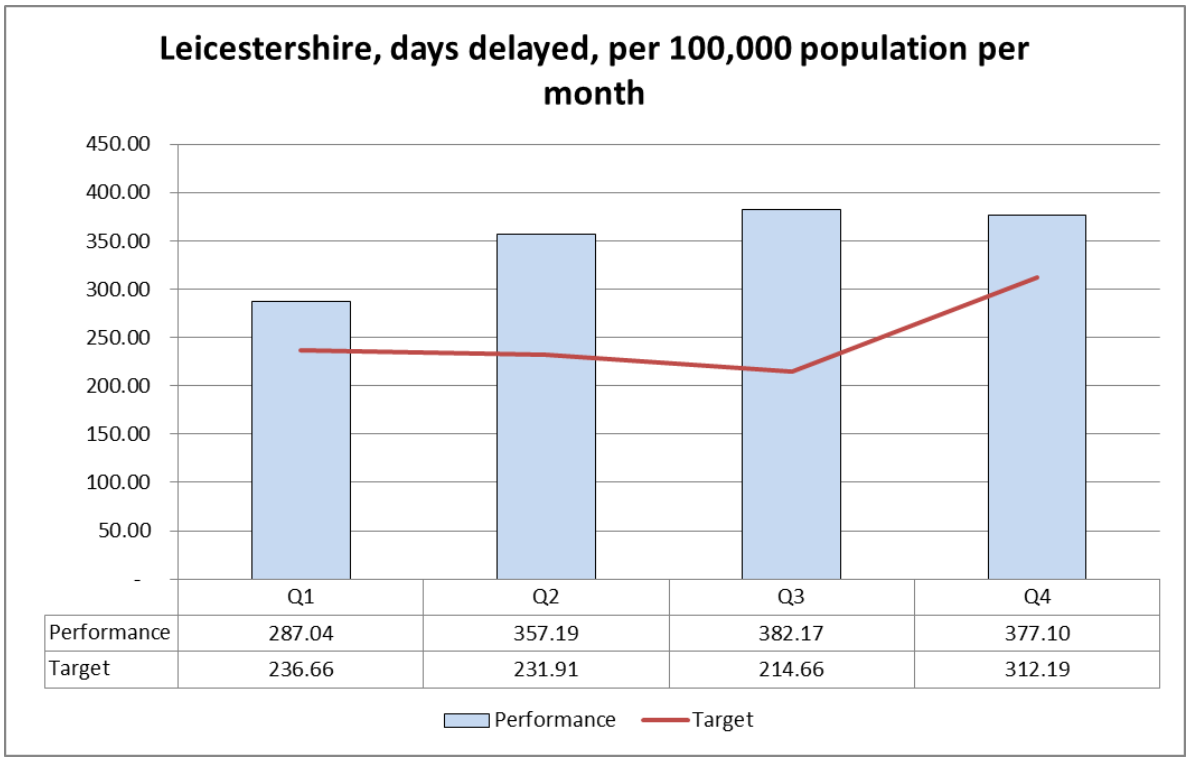
Four emergency admissions avoidance schemes were implemented as part of the original Leicestershire BCF plan in 2015/16. These were independently evaluated in conjunction with Loughborough University, Simul8 Corporation and Healthwatch, via the SIMTEGR8 study. One of these schemes, the Loughborough Older People's Assessment Unit, has been decommissioned as result of the BCF evaluation process.

The others, including the falls non-conveyance pathway with EMAS, and the acute home visiting service (part of new primary care seven day services) have proved very effective and have been commissioned recurrently within LLR's new urgent care model from April 2017. The new model of urgent care and its capacity planning assumptions have been reflected in the LLR STP and CCG operating plans.

In terms of a continued focus on avoiding hospital admissions, the 2017/18 BCF plan includes implementing a further emergency admissions avoidance scheme that was tested in 2016/17, which focuses on short stay cardio-respiratory patients.

The overall trajectory for non-elective admissions for the BCF for 2017/18 – 2018/19 has been aligned with CCG operating plans and further information about this metric can be found in section 13 of this report on page 51.

Our performance on delayed transfers of care (DTOC) in 2016/17 was a marked deterioration from our overall good performance on this metric in 2015/16. The performance in 2016/17 is shown in this graph which confirms the target was not met.



	Q1	Q2	Q3	Q4
Performance	287.04	357.19	382.17	377.10
Target	236.66	231.91	214.66	312.19

- Social care attributable delays have remained low. When benchmarked against CIPFA statistical neighbours and NHS England comparators, Leicestershire has been in the top quartile for each quarter of 2016/17 and Q1 2017/18 (see Appendix 2).
- However the combined total for NHS, LA and joint delays across all settings of care for Leicestershire has remained consistently above the target in 2016/17.
- 54% of the totals days delayed in 2016/17 were in the acute sector and 46% in the non-acute sector.
- The split between acute and non-acute delays has however been volatile, with more days delayed in the non-acute sector than the acute sector for five months of the year.

A combination of factors have affected the position including:

- The overall volume of emergency admissions.
- Problems with patient/family choice especially on non-acute sites.
- Internal flow, within acute sites, and between acute and community hospitals.
- Delays to CHC assessments and funding.
- Mobilisation issues with the new domiciliary care services during the winter of 2016.

With the significant DTOC improvements mandated nationally by November 2017, this remains a significant challenge for the health and care system, and the successful delivery of the Leicestershire BCF plan.

A comprehensive self-assessment has been completed across the whole of LLR against the eight high impact changes for managing transfers of care (see Appendix 3). A joint LLR-wide action plan is already in place to tackle remaining gaps in this model (Appendix 4).

Leicestershire's adult social care department completed an analysis and review of their overall service strategy in 2016 and are already delivering a number of transformation projects, redesigning how social care is delivered, managing demand, developing the market, and ensuring the needs of vulnerable people continue to be met in line with statutory requirements such as the Care Act.

In July 2017 the adult social care department developed a DTOC improvement plan, linked to the LLR self-assessment (see Appendix 5). This reflects all the operational and strategic actions which are already underway, with a much more systematic and intensive focus on patients in non-acute sites.

A new Home First workstream for LLR commenced in 2017. Along with the more operational LLR discharge working group, these two groups lead the implementation of the short and medium term improvements for integrated discharge, interim beds, reablement and rehabilitation, commissioning of care and nursing homes, and support for carers.

Services funded from existing BCF plans across LLR will be redesigned to meet the new model(s) of care proposed by the Home First Workstream with effect from 2018.

Further information about the trajectory for improving DTOC and actions being taken, including those via the Home First workstream, can be found pages at section 11.5 on pages 39-44 of this document.

6.4 Supporting Narrative on Financial Challenges

Financial allocations, the scale of financial pressure and the collective level of savings required across the partnership impact on the ability of all partners to commit to new initiatives, unless funds are reallocated between existing commitments, existing services are decommissioned, or transformation funds can be accessed.

- Leicestershire County Council is required to make savings of £16.4m in 2017/18
- West Leicestershire CCG requires savings of £18.7m
- East Leicestershire and Rutland CCG requires savings of £14.8m
- The financial position of Leicestershire County Council, linked to the council's MTFS, relies on securing the contribution for maintaining social care from the CCG minimum allocation within the BCF plan in line with inflation. In 2017/18 – 2018/19 this represents £22m.

Despite the financial pressures and complexities of BCF funding, partners must commit to the BCF plan, maintain delivery across the BCF plan metrics and national conditions, as well as deliver a medium term view of transformation linked to the LLR five year plan (STP).

To do this, there needs to be even more rigour in aligning financial plans and benefits, with more sophisticated predictive modelling and methods of measuring impact, plus greater alignment between the three LLR BCF plans, and the LLR-wide five year plan/STP.

The BCF plan for 2017/18 also includes the requirement to apply the new non-recurrent Adult Social Care allocation announced in the March 2017 budget. Further information about this can be found in section 12.2 of this document on page 46.

The financial refresh of the Leicestershire BCF for 2017-19 placed additional emphasis on driving out further savings and creating further headroom for transformation within the plan wherever possible.

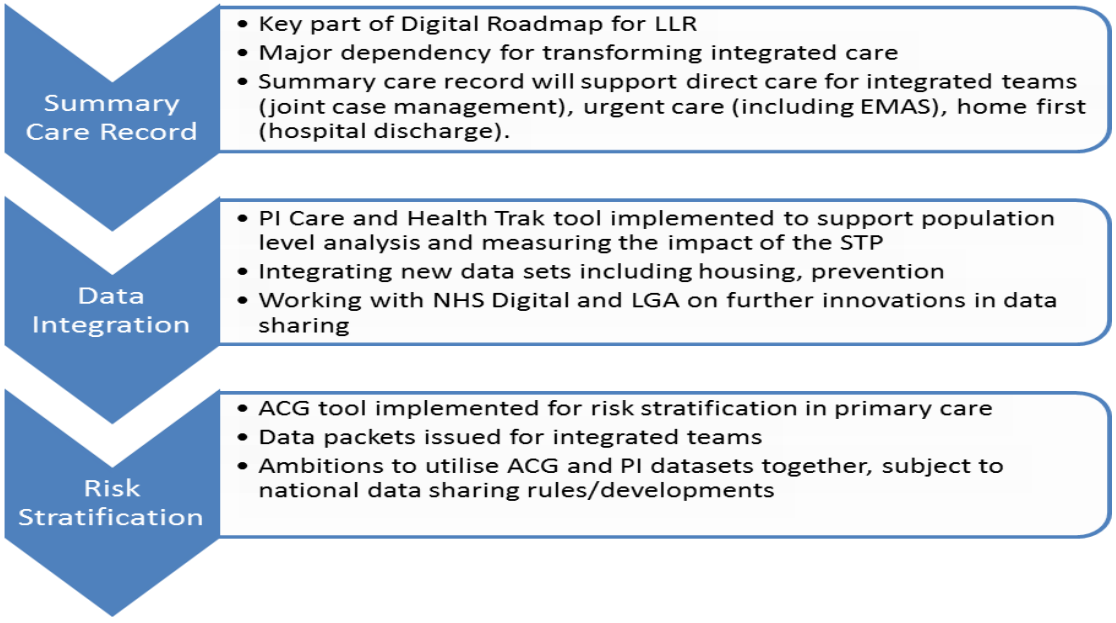
A workplan of priority service reviews was agreed for 2017, with a view to releasing some early savings in year, and taking further commissioning decisions for 2018.

In 2016/17 we developed a framework for integrated commissioning across LA and NHS partners. Further information about this can be found at section 10.9 on page 33.

Disabled Facilities Grants (DFG) allocations proved challenging in the 2016/17 BCF plan due to the late publication of the BCF guidance, and a late and unexpected change to financial allocations associated with DFGs and the (previous) social care grant. Dialogue with Districts has taken place throughout 2016/17, with improved joint planning and forecasting.

The 2016/17 DFG monies previously held back within the BCF plan have been released in full to Districts with effect from 2017/18, placing a £1m recurrent pressure on the 2017/18 BCF financial plan. The additional DFG growth funds announced for 2017/18 have also been passported direct to each District Council in full, and the BCF financial plan has been refreshed to take account of this.

6.5 Data Integration Challenges – Summary Diagram



6.6 Data Integration Challenges – Supporting Narrative

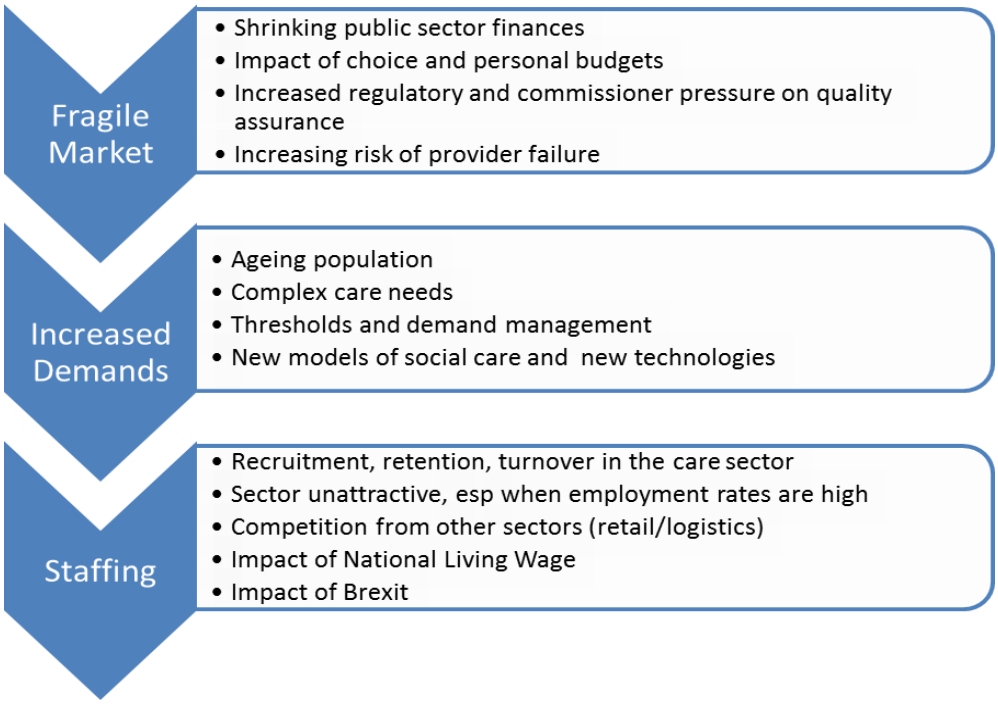
Although really good progress has been made on data integration by using the NHS number on social care records, implementing PI Care and Healthtrak, and deploying the risk stratification (ACG) tool in primary care, further work is needed on the integration of data and IT systems throughout LLR so that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

- A more systematic approach to business intelligence overall.
- The architecture 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 Leicestershire 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 by this, and we are currently working with other LAs and national bodies to resolve this. A DARS application is in progress with NHS Digital in order to seek approval for data integration to be restored across LLR, however the outcome of this will not be known until after the BCF submission in September 2017.

6.7 Sustainability of Social Care – Summary Diagram



6.8 Sustainability of Social Care – Supporting Narrative

The market for social care is increasingly fragile and complex. Growing demands of an ageing population, problems with recruitment and retention, the implementation of the national living wage, increasing pressure from regulatory bodies and commissioners to improve quality and outcomes, and the overall squeeze on public sector finances, mean the margins for care providers are increasingly small.

The number of contracts being handed back to LAs is increasing, with provider failure on quality and/or financial sustainability grounds a significant risk for LA commissioners and self-funders. In Leicestershire we had one contract handed back last year and two care providers ceased trading which is comparable, however the number of new registrations for care services is lower in the county than in other areas.

Spending on social care fell by 9% in real terms in the five years to 2016, and the Local Government Association, representing leaders of 370 English and Welsh authorities, has predicted a funding shortfall of between £1.3bn and £2.6bn by 2020, with fears that some councils could be challenged in the high court for not providing a statutory minimum standard of care.

Despite Leicestershire being the lowest funded authority in the country per capita, the Council has protected social care services which now account for 38% of net expenditure. The main pressures locally are increasing prices causing cost pressures, together with future financial risk due to the implementation of Transforming Care, potential reductions in income and increasing care costs.

In Leicestershire people aged 65 and over represent the majority of the workload of the adult social care department. Future demand has been modelled on the demographic change anticipated within the over 65s, coupled with increasing rates of frailty and long term conditions, based on JSNA projections and the STP analysis. This indicates an increasing complexity in the caseload and an increased cost of care per person in the future with key features as follows:

- During 2016/17 although the number of service users has remained relatively static for residential care there has been an increase in Additional Needs Allowances (ANAs).
- For home care, the average number of hours provided per service user has increased, with this increased pressure partially off-set by a reduction in the number of overall service users. It is not yet clear if the reduction in the number of home care users is due to an increasing number of self-funders in Leicestershire's older population, or is being caused by other factors.
- The level of Learning Disability support required is growing, mainly due to costs of care packages for service users transferring from Children's to Adult Social Care (around 120 per annum), increasing levels of additional needs, and high cost placements. Increased demand will also impact on the number of packages commissioned through the Learning Disabilities Pooled Budget where Continuing Healthcare will be awarded
- During 2016/17 the number of service users funded by the LA who have mental health needs has slightly increased and there has also been an increase in ANAs. It is anticipated that this trend will continue in 2017/18 and growth estimates will continue to be reviewed.

- Upward demand on adult social care has also been factored in for those with physical disabilities and in relation to the ongoing increase number of deprivation of liberty referrals (in line with national trends).

In terms of staffing for the sector, staff turnover in social care, compared with the vast majority of other sectors, is very high. While the average annual turnover rate in England is 15%, many social care roles far exceed this, with 27% of care workers leaving their job each year. In Leicestershire the turnover rate is higher than the national average at over 30%.

The Care Quality Commission found in 2015 that nationally 20% of nursing homes did not have enough staff on duty to ensure safe care for residents and this can lead to poor staff morale. Locally we have experienced difficulty in recruiting to qualified nursing roles, but also to domiciliary care roles in more rural and affluent areas of the county

The sector is not seen as an attractive option, especially when many other employers can offer similar rates for work that does not involve dealing with personal care, and UK unemployment rates are currently low overall. The impact of Brexit on this sector also needs to be considered.

To meet the changing profile of demand, services will need to be delivered differently and the skill-sets of some roles in social care will need to change. The shape, composition and skills base of the social care workforce is also affected by the government's focus on promoting greater choice. This includes increased take-up of direct payments and personal budgets and greater community based, integrated delivery.

In *The Future of Work: Jobs and Skills in 2038* (UKCES) a number of key points are made about how social care service will change:

- Increased demand for home care and tele-care services, particularly for the elderly, as the high costs of nursing and residential care stimulate more home-based provision.
- Growth in community models and social entrepreneurship (e.g. home-based care networks), based on principles of decentralisation.
- An increasing requirement for social care workers to handle advanced care technology.
- Increased demand for digital skills in the workforce.
- Increased demand for inter-disciplinary skill-sets.

Given the above factors, the adult social care strategy has a number of demand management components, along with a market development and commissioning strategy focused on attracting and retaining quality providers into the local area, with a workforce skilled for the future.

The adult social care service continues to deliver a complex and challenging four year transformation plan which is changing the model of adult social care, including, in part, by a greater integration of care with health services.

The council's medium term financial plan demonstrates the growth applied to supporting adult social care in light of the demands and risks outlined above, however there continues to be a clear dependency on the funding contribution from the BCF and the new IBCF allocation in maintaining and sustaining adult social care to 2020/21, outlined further in sections 11.2 and 12.2 of this document.

7.0 HOW THE LEICESTERSHIRE BCF PLAN RESPONDS TO THE CASE FOR CHANGE AND CHALLENGES

The Leicestershire BCF plan has responded to the case for change and key challenges by partners prioritising services and transformational work that are essential to:

- Build an integrated health and care system in LLR by 2020/21.
- Reduce the overall level of activity and costs associated with acute care, in favour of a shift into proactive and preventative care in community settings.

Specifically this involves:

- Implementing consistently reliable, 24/7 integrated community services, focusing on those with Long Term Conditions (LTCs), frailty and the growing population of over 70s, in particular through crisis response, integrated locality teams, integrated points of access, and the wrap around prevention offer which includes Leicestershire's new housing service (Lightbulb).

- Delivering the critical short and medium term changes for Hospital Discharge and Reablement, being led by the LLR Discharge Working Group and the LLR Home First workstream, (including integrated discharge teams, trusted assessors, etc.)

- Leading innovative work on data integration both at population level and for individual electronic care records.

- Maximising the use of the additional adult social care allocation (IBCF) in support of:
    - Sustaining adult social care.
    - Improving hospital discharge/DTOC performance.
    - Market development for the independent sector.
    - Achieving other health and care transformation priorities with NHS partners, such as integrated locality teams.

- Ensuring housing solutions are an integrated part of the health and care system.

The Leicestershire BCF plan has been fully refreshed and now includes ten priorities which are targeted to the key challenges in delivering our overall vision of health and care integration (see table on next page).

The priorities have been updated to align more effectively with the LLR STP, ensure that our focus remains on delivering the top priorities in relation to health and care integration, and we can continue a rigorous approach to delivery and evaluation.

The supporting expenditure plan at Appendix 7 is also structured using these ten priorities headings. This has been constructed in the context of the complex mandatory requirements of the BCF policy framework, which specifies how the different financial allocations should be used, as well as within the constraints of the significant financial pressures faced by all partners.

7.1 The 10 BCF Plan Priorities

BCF 1 – Unified Prevention Offer	**BCF 2 – Home First**
A core prevention offer that is co-designed across the full range of partners, wraps around people, communities, and locality teams, and is targeted to maintaining wellbeing and independence.	24/7 integrated community care which supports effective hospital discharge, prevents readmission to hospital, and provides maximum reablement. Includes joint approaches to nursing and residential placements, interim beds, and carer support.
BCF 3 – Integrated Housing Support	**BCF 4 – Integrated Domiciliary Care**
Provides a range of (previously fragmented) housing support services in one integrated offer for Leicestershire, supporting hospital discharge and maintaining health, wellbeing and independence at home.	"Help to Live at Home" was commissioned jointly by the LA and CCGs in 2016. It operates across 18 geographical lots, with services organised around the same footprints as the new integrated locality teams and places emphases on reablement outcomes.
BCF 5 – Integrated Locality Teams	**BCF 6 – Integrated Urgent Care**
Integrated community based teams for those with frailty, multiple conditions or at risk of acute care episodes. Proactive care plans, improved coordination of care. Multi-disciplinary teams delivering a joint approach to assessments and care planning, consistent interventions and measuring joint outcomes.	The new model of urgent care for LLR was commissioned in April 2017. It offers clear alternatives to attendance at the A&E department 24/7, with improved clinical triage and navigation, to ensure consistent use of alternatives, and divert people away from acute care where applicable.
BCF 7 – Integrated Points of Access	**BCF 8 – Data Integration**
24/7 integrated call handling and response for health and care in the community. Will provide one point of contact across LLR, helping professionals and service users with home first and coordinating care plans in the community.	Both at population level, so we can track the performance and utilisation of the health and care system, and at the individual care level, so that the delivery of care is supported by an integrated summary care record, accessible by multiple professionals.
BCF 9 – Integrated Commissioning	**BCF 10 – Transforming Care**
Building the approach and joint infrastructure between LA and CCG partners in priority areas such as stabilising and further market development for domiciliary care, or new approaches to joint commissioning for care and nursing homes.	Ensuring the right support is in place for people with learning disabilities, autism or those who have behaviours that challenge, so they can be discharged from hospital care at the right time. To support people who are at risk of being admitted, and to provide appropriate accommodation in the community to maximise their independence.

8.0 OUR PROGRESS TO DATE

The 2016/17 Leicestershire BCF Plan was delivered under four themes. The themes were designed to group together related activity/projects so that:

- These are managed and governed effectively within the local integration programme.
- Their contribution and outputs are connected effectively to LLR-wide governance.

BCF THEME 1: Unified Prevention Offer	**BCF THEME 2: Long Term Conditions**
• Integration of prevention services in Leicestershire's communities into one consistent wrap-around offer for professionals and services users. • Improved, systematic, targeting, access and coordination of the offer.	• Integrated, proactive case management from multidisciplinary teams for those with complex conditions and/or the over 75s.
BCF THEME 3: Integrated Urgent Response	**BCF THEME 4: Hospital Discharge and Reablement**
• Integrated, rapid response community and primary care services 24/7 • Working together to avoid unnecessary hospital admissions, supporting people at home wherever possible.	• Safe, timely and effective discharge from hospital, via consistent pathways, reducing length of stay • "Home First" philosophy, focused on reablement and maintaining independence.

8.1 Progress by Theme 2016/17

Implementation of the integration programme in Leicestershire has continued at pace. The following table is a summary of our achievements during 2016/17:

Unified Prevention Offer	**Integrated, Proactive Care for those with Long Term Conditions**
✓ First Contact Plus – launched a new web-based referral system, which facilitates efficient clinical referral and also a self-referral/ public facing option. ✓ Piloted and developed the business case for Leicestershire's new Lightbulb Housing offer - to provide joined up support across housing, health and care to keep people safe, well, warm and independent in their own homes. ✓ Redesigned falls pathway. Each stage within the pathway has been developed into an agreed level of service that will form part of the LLR Falls Prevention and Treatment Strategy. ✓ Developed the model for social prescribing across Leicestershire.	✓ Integrated locality working between community and social workers in place so they can jointly respond and manage their caseloads using shared operational practices and procedures – organised to support both planned care and urgent care cases in each locality. ✓ Integrated locality teams developed during Q4 2016/17, to support patients with multiple long term conditions, frailty and others who are at risk of high levels of acute care costs if their care is not well managed in the community.

Integrated Urgent Response	Hospital Discharge and Reablement
✓ Achieved 2,010 avoided admissions during 2016/17. ✓ Launched a new electronic falls risk assessment tool (eFRAT) for paramedics, which has resulted in reduced conveyances to hospital. Integrated working with community health services has enabled fallers to stay in their home while receiving any nursing and therapy services required. ✓ Piloted ambulatory care scheme within the Clinical Decisions Unit at Glenfield Hospital for cardiorespiratory patients. ✓ Urgent Care System in LLR has undergone a service redesign and reprocurement process in 2016/17. New services commenced in April 2017, which incorporate a number of the emergency admissions avoidance schemes funded and tested within the Leicestershire BCF.	✓ Launched a new jointly commissioned domiciliary service, called Help to Live at Home, on 7th November. It promotes reablement in the home and integrating domiciliary care providers more effectively with other health and care services, including primary care and prevention services in each locality. ✓ New Integrated Discharge In-Reach team to identify, transfer and then assess suitable patients into bed based reablement. ✓ As part of Lightbulb, the Hospital Housing Discharge support service involves housing specialists working directly with patients and hospital staff to identify and resolve housing issues that are a potential barrier to discharge and to help prevent readmissions. Service demonstrating impressive results.

8.2 Progress with Integration Enablers in 2016/17

- The Leicestershire Integration Programme led work to scope opportunities to integrate the various points of customer access across the health and care economy in LLR.
- PI Care and Healthtrak was adopted as a business as usual tool with customised dashboards providing new insights into patient journeys and how the health and care system is being utilised in LLR.
- Individual trajectories developed for each emergency admissions scheme.
- SIMTEGR8 - Independent evaluation of a further four components of the BCF via a research partnership with Loughborough University, Healthwatch Leicestershire and SIMUL8.
- 98% of adult social care users have a validated NHS number as a key enabler to data sharing.
- Launched new Health and Care Integration Website for Leicestershire http://www.healthandcareleicestershire.co.uk/, and a social isolation campaign Autumn 2016 http://www.healthandcareleicestershire.co.uk/health-and-care-integration/reducing-loneliness/.
- Integration Stakeholder Bulletins published monthly featuring our progress and case studies http://www.healthandcareleicestershire.co.uk/health-and-care-integration/health-and-care-integration-newsletters/ along with the @leicshwb twitter feed.

8.3 BCF Metrics - Our Overall Performance 2016/17

The table below sets out the overall performance against the BCF national metrics, and our locally selected metric (admissions due to falls) during 2016/17.

The most significant area of challenge was the delayed transfers of care target (DTOC) where performance in 2016/17 was a marked deterioration from 2015/16.

Further detail on our performance in relation to delayed transfers of care in 2016/17 can be found on pages 39-40 below.

Our plans to improve DTOC performance across the health and care system and the target for improvement that has been set for 2017/18 can be found in section 11.5 on page 39.

Metric	Target	Position at March 2017	RAG	Commentary
Metric 1: Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population per year.	606.4	633.5	R	The BCF target for 2016/17 was a maximum of 827 admissions. The forecast during Q4 was the potential for up to 873 admissions (640.7 per 100,000 population) however the final position for the year was 864, a rate of 633.5 per 100,000.
Metric 2: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/ rehabilitation services	84.2%	86.5%	G	The target relates to people discharged from between October and December 2016 and their accommodation location between January and March 2017. Performance was 86.5%, in line with the previous year, and has met the BCF target.
Metric 3: Delayed transfers of care (DTOC) from hospital per 100,000 population	312.19	377.10	R	BCF DTOC targets are measured quarterly - the 312.19 target covers the period Jan-Mar 2017 (Q4). Performance is measured by the average days delayed during Jan-Mar 2017 as a rate per 100,000 (for those aged 18+). The Q4 performance was 377.1 per 100,000, therefore significantly in excess of the target.
Metric 4: Total non-elective admissions into hospital (general and acute), per 100,000 population, per month	724.37	759.84	A	For the period Apr-16 to Mar-17 there were 61,920 non-elective admissions, against a target of 59,030. The target is set by the clinical commissioning groups based on the amount of emergency activity planned for and commissioned on an annual basis.
Metric 5: Patient/service user experience. Patients satisfied with support to manage long term health conditions	62.2%	63.6%	G	Results are published annually linked to the GP patient survey. The performance results are based on the national survey undertaken in March 2016, published in July 2016, and show this target was achieved, and with a slight improvement above the target.
Metric 6: Emergency admissions for injuries due to falls in people aged 65 and over per 100,000 population, per year	1,677.1	1602.9	G	There were 137 falls, where the injuries resulted in admissions, for Leicestershire residents aged 65 and over in March 2017. This gives a final year outturn of 1,602.9 against the target of 1,677.1, showing the target was achieved, and with a notable increase in performance.

9.0 HOW WE DEVELOPED THE BCF PLAN FOR 2017/18 – 2018/19

A systematic approach has been undertaken.

Leicestershire's (multiagency, director level) Integration Executive has overseen this work on behalf of the Leicestershire Health and Wellbeing Board.

Detailed work to evaluate the performance of the BCF plan has been led by the Integration Operational Group. This is a multiagency group of commissioners and providers reporting into the Integration Executive.

In order to refresh the Leicestershire BCF plan for 2017/18 in summary we have undertaken the following activities:

- Considered the strategic context of the integration policy pillars on our local vision and plans.
- Examined our progress and performance to date and the milestones we still need to achieve to become an integrated health and care system by 2020/21.
- Clarified the contribution the Leicestershire BCF plan and pooled budget will continue to make to deliver specific components of the system level transformation set out within LLR's five year plan.
- Completed a full financial refresh, in line with the significant financial pressures and risks affecting all partner organisations.
- Completed a review across all BCF plan components, led by the Integration Operational Group. This included taking account of evaluations and service reviews completed in 2016/17, assessing current risks and issues affecting plan delivery, and identifying priority service lines where further work needs to be undertaken, and/or savings achieved in 2017/18.
- Undertaken a significant programme of engagement across all partners.
- The Leicestershire Health and Wellbeing Board was briefed and engaged throughout the refresh process, with additional briefings for county councillors following the local and national elections in Q1 2017.
- Assessed the implications of the BCF policy framework, technical guidance and the grant conditions applying to the additional adult social care allocation.

The following section sets out in more detail the approach we have taken:

The BCF plan was divided into categories for the refresh:

1. Elements of the plan considered embedded and business as usual, some of which date back to the original health transfer monies allocations in 2011/12 which preceded the BCF. The refresh process ensured partners could discuss and agree which schemes should remain in this category and if additional review work should be undertaken either now or in the future.

2. Elements of the plan which were new in 2016/17 and subject to evaluation/ commissioning decisions either by December 2016 or post December 2016.

3. Elements of the plan which were emerging for 2017/18.

4. Elements of the plan which were already planned to be decommissioned by 31st March 2017.

5. Elements of the plan where funding was assumed to be recurrent but services would be redesigned during 2017/18 - in particular for Home First and Integrated Urgent Care.

The Integration Operational Group worked through a series of workshops and meetings between October and December 2016 to review the plan in detail, creating an action plan by commissioner, compiling evidence from a range of sources including the findings of formal evaluations being undertaken, emerging business cases/proposals, and routine performance and service information/decisions gathered via existing governance processes.

The group directed actions and clarifications over this three month period, ensuring these elements could be reflected in CCG operating plans, and NHS and LA contractual requirements for 2017/18.

Initial recommendations from these outputs were made to the Integration Executive at their meetings in November and December 2016 to inform the first cut of the BCF refresh by 20th December 2016. This deadline was set locally in the absence of national guidance for the 2017/18 BCF, but was deemed necessary by partners, to align with the submission of CCG operating plan on 23rd December 2016.

In parallel with the above:

- A full financial refresh was undertaken, profiling the plan for 2017/18.

- A review of how Adult Social Care would be maintained was undertaken in conjunction with CCGs.

- A review of additional pressures affecting CCGs and adult social care in the context of local allocations and savings targets was undertaken.

- A review of the threshold for the reserve/risk pool within the plan was undertaken in conjunction with CCG Finance Directors.

- Following the announcement of additional monies for adult social care in March 2017, and the publication of the LA grant conditions, additional working sessions took place in March and April 2017 to prioritise this allocation, involving all partners and the LLR A&E Delivery Board.

- A review of delayed transfer of care performance and the development of an improvement trajectory across LLR (for LA, NHS, and jointly attributable delays).

- A refresh of integration programme delivery resources, in terms of the management support available to deliver the plan, both within the core BCF delivery team and via matrix working across our partnership. This included participation in the LLR STP Programme Management Office resource planning review led by Midlands and Lancashire Commissioning Support Unit.

10.0 WHAT WE WILL DELIVER AGAINST EACH OF THE BCF PLAN PRIORITIES

10.1 BCF 1 Unified Prevention Offer

The Leicestershire BCF has, since its inception, placed priority on developing a Unified Prevention Offer for Leicestershire's communities, making the best use of community assets and building community capacity. It is recognised that many of these interventions should be non-medical and can be provided from a range of partners and sources, including the voluntary sector and other community based support.

With leadership from Public Health and District Councils, together with other council services, NHS partners, Fire, Police, and the Voluntary Sector, the Unified Prevention Board (UPB) have agreed that:

1. Partners will together prevent, reduce or delay the need for statutory services by investing in low level support and supporting people to make positive choices to maintain their health, wellbeing and independence for as long as possible.
2. The scope of the UPB's work will be tiers 0-1 of prevention,
3. The focus of the UPB's work will therefore be developing a new consistent and local wrap around prevention offer, which will support in particular the Joint Health and Wellbeing Strategy, Integrated Locality Teams and Leicestershire's Communities Strategy.
4. There will be four key outcomes against which the effectiveness of the UPB's work will be measured.
5. The LLR STP prevention workstream will focus on the other tiers of prevention (2-3).

Please refer to Appendix 8 for more detail on the above approach.

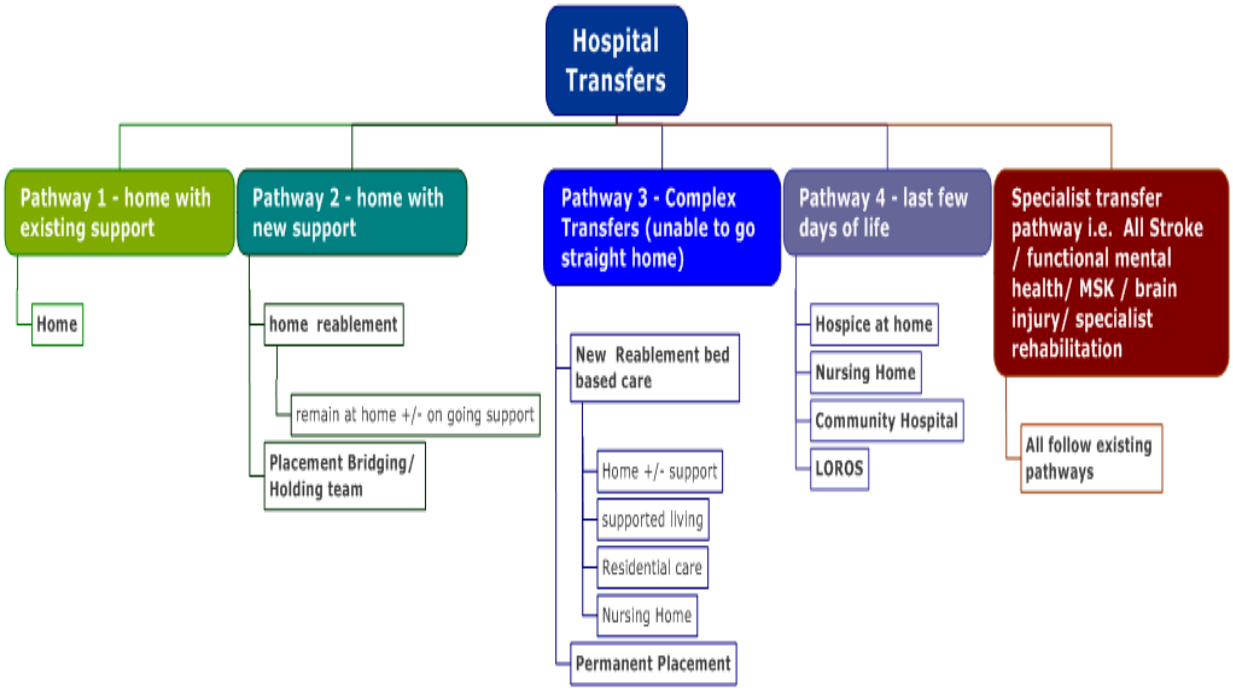
The Leicestershire BCF plan has prioritised ongoing investment for First Contact as our single point of access to refer into and navigate across the local menu of preventative interventions, which span multiple partners. During 2017 First Contact has developed into First Contact Plus so that along with professional referrals there is a new web based self-referral portal/facility which means local people can access the service direct.

The menu of prevention interventions already includes public health lifestyle services such as smoking cessation and weight management, local area coordinators who provide vulnerable people with low level support in their community, and a range of wellbeing services such as support for carers, home safety and falls prevention

First Contact Plus also now provides the point of access into Leicestershire's new integrated housing service, called Lightbulb. Lightbulb provides a "one stop shop" for assessing and coordinating all housing support, including hospital discharge housing support, affordable warmth, aids and adaptations, home maintenance, home safety, benefits advice and advice on future housing options.

10.2 BCF 2 - Home First

LLR hospital discharge pathways were redesigned in 2016 per the diagram below:



Further reviews of the local position have been undertaken in 2017, overseen by the LLR A&E Delivery Board as follows:

- An ECIP review in Q4 of 2016/17 – this considered the current services operating between hospital and community settings and the partnership working arrangements and referrals processes between health and social care partners to facilitate hospital discharge, and made recommendations about where further improvements can be made.

- Completion of the LLR self-assessment against the high impact changes framework in Q2 2017, which has led to a refreshed action plan and informed the local trajectory of improvement for DTOC in 2017/18.

- Learning from the East Midlands High Impact Changes workshop on 5th July 2017 and associated national best practice tools/publications.

The LLR self-assessment and action plan against the eight high impact changes for managing transfers of care are at Appendices 3 and 4, along with a supporting action plan from Leicestershire's adult social care department at Appendix 5.

10.2.1 Short Term Actions To Improve Delayed Transfers of Care

The main immediate actions to improve hospital discharge arising from the self-assessment and other system issues, (already being implemented), are as follows:

1. Focus on performance improvement, supported by:

    a) All the existing daily operational management activities across NHS and LA partners to address individual cases and maintain system flow.
    b) A new integrated dashboard for monitoring delayed transfers of care which provides weekly performance management data by setting of care (implemented July 2017).
    c) A fully refreshed LLR DTOC action plan incorporating all actions across all settings of care, latest update August 2017 (Appendix 3).
    d) A new Discharge Working Group which coordinates performance and delivery of DTOC improvements, with dual reporting to the A&E Delivery Board and Home First STP workstream.

2. Implementation of a new integrated discharge team and trusted assessor model across eight wards at the acute trust (implemented July 2017).

3. Integrated discharge team and trusted assessor model being extended to other acute wards, community hospitals and MH wards during 2017/18.

4. Trusted assessment electronic solution – business case being proposed to LLR STP IM&T workstream (September 2017). Implementation plan and milestones to be confirmed following approval of business case and resource allocation.

5. Option appraisal for further interim/discharge to assess beds - being led by the Home First workstream during 2017/18.

6. New end to end Continuing Health Care processes for CCGs, being supplied by Midlands and Lancashire Commissioning Support Unit (implemented July 2017).

7. Further stabilisation of the domiciliary care market (Leicestershire), via the Help to Live at Home Programme. Final three lots of the Leicestershire procurement completed August 2017, ongoing improvement plan with one provider who had poor CQC inspection in February 2017, ongoing performance management of all contracts.

8. Future domiciliary care and residential care market development actions/investments using Leicestershire's IBCF allocation 2017 onwards.

9. Improvements to internal acute hospital processes in support of hospital discharge using the "red to green" system - implemented Q1 2017/18 (e.g. once the patient is medically fit for discharge, rapid and coordinated activities across the hospital to ensure discharge happens at pace – including senior clinical decisions early in the day, prompt access to medications for discharge, effective transport etc.)

10. Improvements to patient/family choice policies and information across hospital sites.

11. Hospital Discharge and Care Homes – implementing the red bag scheme and improved telemedicine solutions by the end of November 2017.

12. The LLR Winter Plan for 2017/18 includes commitment to two multi agency Discharge Events, during December and January to reduce DTOC and improve flow over the Christmas and New Year period.

13. A clear set of communications/briefings, led by the Discharge Working Group to ensure consistent and coordinated messages about:

    a) Current performance and the target we will achieve by the end of 2017/18.

    b) All the actions being undertaken across all settings of care, with emphasis on the importance of achieving improvement across both acute and non-acute settings.

    c) Progress and achievements in year against the short term actions.

(Communications about the medium term actions will be led by the Home First Workstream).

10.2.2 Short Term Actions - Mental Health

In addition to the above, there are specific actions targeted to improving mental health delayed discharges.

In early 2017 a strategic senior level group was established to identify and agree actions required to ensure sustained reduction in DTOC levels for mental health patients.

This group is chaired by the Leicestershire Partnership Trust (LPT) Medical Director with representatives from CCG's, Local Authority Social Care, housing services and NHS England.

The group has focused on improving the weekly clinical discharge meeting and the quality and timeliness of DTOC data reporting, analysing the root causes and barriers to discharges which. This has led to the mental health action plan shown in the table below, already being implemented:

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 five 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 six 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	October 17-March 2018

Adult Social Care and LPT are also working closely on a small number of learning disability cases where there has been a prolonged period to determine final accommodation solutions. These are complex cases but individual action plans are in place to resolve these, with one of these three cases already resolved as at August 2017.

The above immediate actions to improve hospital discharge are now in place, however there are a number of medium and longer term improvements also required and these are being led by the LLR Home First workstream.

10.2.3 Medium & Longer Term Actions to Improve Delayed Transfers of Care

The Home First Workstream will consider both step down and step up 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 remit of the Home First workstream includes:

- Overseeing the implementation of the Home First strategy across LLR
- Continuing the service redesign needed to fully embed the new discharge pathways (e.g. integrated discharge teams/trusted assessor).
- Further reviews of referral processes (such as for CHC and discharge to assess).
- Review all current reablement and rehabilitation services/capacity and make recommendations in terms of further service redesign and commissioning intentions.
- Consider options for medium term, joint commissioning solutions and market development priorities for interim beds, nursing and care home placements, and domiciliary care across LLR.

Further information about our target for improving hospital discharge can be found in section 11.5 on pages 39-44.

10.3 BCF 3 – Integrated Housing Support

During 2016/17 we developed a business case for our new integrated housing service across Leicestershire, called Lightbulb.

The service brings together a range of previously fragmented housing support services provided by district councils, the county council and other providers into one integrated and consistent offer across the local population.

The service will operate on a hub and spoke model with locality based spokes in each District Council and will form part of the wrap around prevention offer detailed in BCF1 on page 21.

We have designed and tested all the elements of the integrated housing service over the past 18 months using a transformation grant from the Department of Communities and Local Government (DCLG).

The business case evaluated the outcome of the testing, demonstrated the effectiveness of the proposed model and proved how the model can be funded from existing resources across partners. The model includes introducing a new housing coordinator role who will provide one point of contact for supporting customers to access major and minor adaptations, affordable warmth, hospital discharge support, home safety, home maintenance etc.

A new housing MOT is also central to the model which offers a holistic assessment of need with early intervention targeted to health and wellbeing (e.g. falls prevention within the home environment).

Within the Lightbulb service model are specific staffing resources for supporting hospital discharge. These staff are currently based at Leicester Royal Infirmary and the Bradgate Mental Health Unit, working closely with the integrated discharge team to support patients with a range of housing solutions such as homelessness, rent/tenancy or benefit 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.

Key benefits from the Lightbulb housing service include streamlining adaptation processes with fewer handoffs and delays, the opportunity to provide on average three housing interventions to vulnerable people (based on the findings from our housing MOT pilot), integrating housing support into locality based health and care teams, significant reductions in delayed transfers of care due to housing related issues, as demonstrated by the work of the discharge housing support staff over the past year.

The business case was approved by all partners during Q4 2016/17 and Q1 2017/18 and the new service is in the process of being rolled out by October 2017.

The Lightbulb business case can be found at this weblink
http://politics.leics.gov.uk/ieListDocuments.aspx?CId=135&MId=4607&Ver=4 (item 499)

10.4 BCF 4 – Integrated Domiciliary Care – Help to Live at Home (HTLAH)

During 2016/17 a new domiciliary care service, called Help to Live at Home was commissioned jointly by the County CCGs and Leicestershire County Council.

The procurement secured nine new providers for the Leicestershire area covering 18 geographical lots aligned to the CCG boundaries. The service has been commissioned to deliver improved reablement and provide the opportunity for local home care providers to be integrated with other parts of the health and care system in their locality.

The new service went live on 7th November 2016. However, just prior to the launch, one of the providers exited the process, which led to the council enacting a contingency plan across West Leicestershire, where three geographical lots were affected by this situation.

These lots were covered by other local providers on an interim basis, and a re-procurement concluded in August which resulted in successful awards and mobilisation of these lots in November 2017.

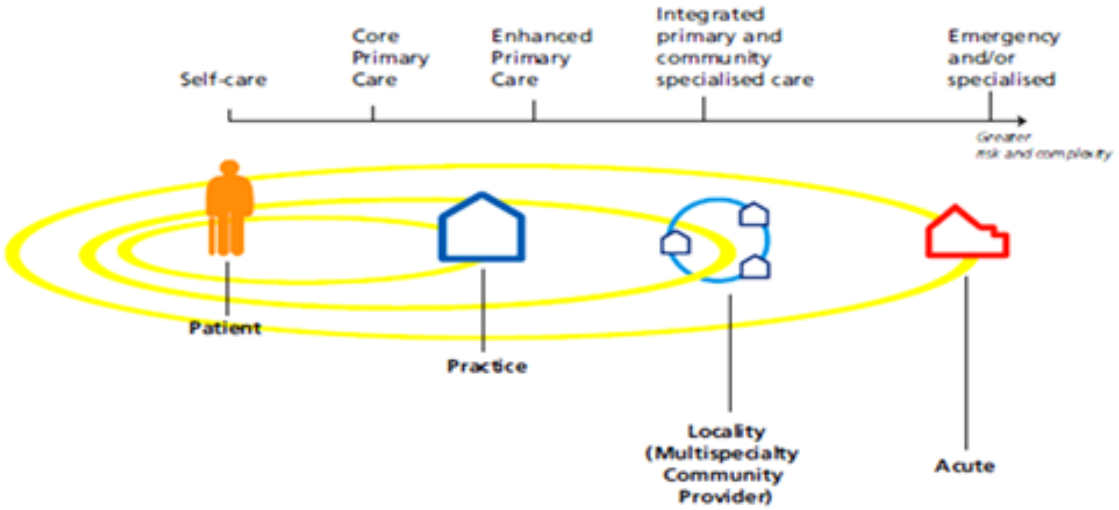
A back office joint commissioning function is in place to support the delivery of HTLAH and resources supporting the back office form part of the Leicestershire BCF financial plan.

Further work is being undertaken in 2017/18 to stabilise provision across all the new providers, maximise capacity and monitor ongoing quality assurance requirements with the new providers. This includes remedial work with one provider who received a poor CQC report in February 2017.

The learning from the implementation of this service will be used to inform further market development work in 2017/18 across domiciliary and nursing/residential care as part of sustaining adult social care using the IBCF allocation.

10.5 BCF 5 – Integrated Locality Teams

Per the diagram below, our model of integrated health and care includes integrated teams which have been arranged around GP practice locality footprints, with a view to moving more care into community settings.



Critical to this model, in terms of the contribution from across the Leicestershire BCF plan are:

- Implementing new multidisciplinary teams and integrated services that are configured on a locality basis around clusters of GP practices.
- Community based alternatives for urgent care.
- Ensuring those being discharged from hospital are received safely back into local community services/teams.
- Shifting demand into non-medical support where appropriate by providing a broad and consistent range of preventative services.

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 ensure a joint approach to assessments and care planning, improve case management and care coordination, reduce acute/urgent care spend and develop 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.

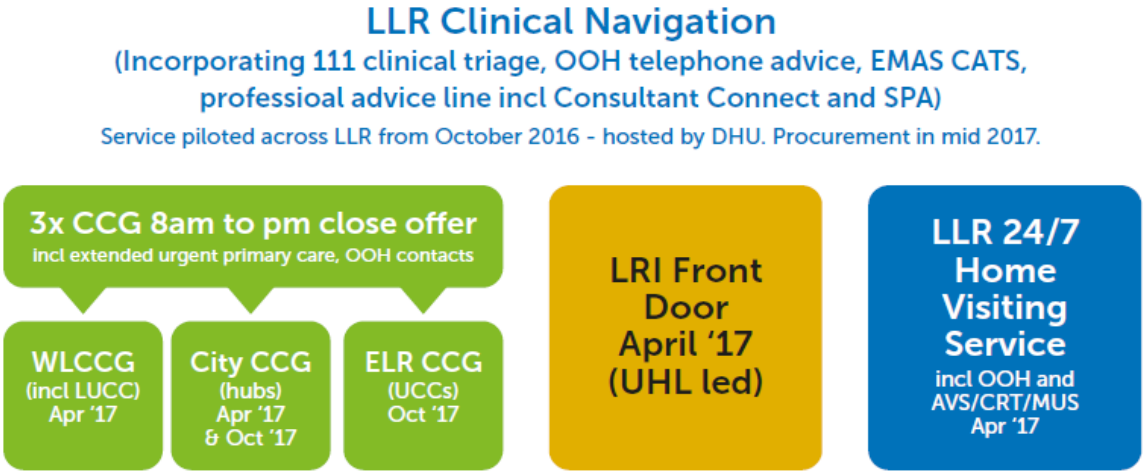
Following evaluation in the Autumn/Winter of 2017/18, and decisions about the future model, the funding currently in place via the Leicestershire BCF (for existing case management approaches) will be reconfigured into the new proposed model for integrated teams with effect from April 2018.

10.6 BCF 6 – Integrated Urgent Care

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 culminated in a procurement for a new model of service commencing from April 2017, 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 following diagram identifies the components of the new integrated urgent care system.



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 Leicestershire BCF supports delivery of this new model of service by providing investment associated with the following components of the new urgent care model.

The table below details the BCF urgent care schemes for 2017/18 which support the new model of urgent care from April 2017 (reflected in Appendix 7).

BCF6 - Integrated Urgent Care	Total Budget £'000
End of Life Night Nursing Service	251
Released funding for Crisis Response Service - Night Nursing Service	148
Crisis Response Service (CRS) - Social Care	566
Loughborough Super Hub	890
Integrated Community Health	563
Care Home Support (Pressure Sores)	54
ANPs Physical Health Assessment (MHSOP Patients)	77
Care Home and Community Inreach Support (Mental Health)	82
Home Visiting Service	1,901
Total Integrated Urgent Care	**4,532**

The CCG operating plans for 2017/18 indicate that the total number of emergency admissions commissioned for 2017/18 as 63,123 admissions, (comprising 34,779 for WLCCG and 28,344 for East Leicestershire and Rutland CCG.

The total number of emergency admissions commissioned reflects the impact assumed from the new urgent care system in totality, including the contribution from each BCF funded component.

While the performance of these schemes will be reported monthly via the Integration Executive (and quarterly via NHSE governance routes), local performance management and assurance for the delivery of the urgent care system as a whole is via the LLR A&E Delivery Board.

10.7 BCF 7 – Integrated Points of Access

The Integrated Points of Access programme is an important enabler to the delivery of our urgent care system, Integrated Locality Teams and Home First. The service will provide integrated call handling across community based health and care services on a 24/7 basis.

Following production of an outline business case approved in the early part of 2016, LLR partners are currently in phase one of this development which culminates in a gateway review in Q3 of 2017/18 and a full business case in Q4.

The Integrated Points of Access programme is working with seven existing call centres across health and care which currently coordinate different community based services. These vary in size, scope and purpose, operate with differing models and performance requirements and are providing services from different locations within a range of NHS and LA organisations.

The business case demonstrates the benefits of enhancing the model of care by moving to a more consistent call handling approach across these services, and integrating them into a consolidated management structure, using the same technology and operating from a consolidated estate.

Phase one of the work involves each existing call centre adopting the new model of service, and delivering initial operational benefits from this change. A gateway review then follows including estates and technology appraisals, before partners consider the full business case to determine if they should proceed to phase two, with decisions on this expected by January 2018.

10.8 BCF 8 – Integrated Data

Leicestershire is seen as a national exemplar in data sharing due to the early adoption of the NHS number onto social care records (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 this tool during 2016/17 to support a range of transformation priorities including the emerging workstreams of the STP, the Lightbulb Business Case and the evaluation of the Leicestershire BCF.

The implementation of PI Care and Healthtrak has provided valuable insights into the utilisation of health and care services across LLR and the impact of changes in care pathways. It has also been the catalyst for the creation of a business intelligence network across LLR, and provided the data source/sets for the STP workforce analysis and the evaluation of BCF services through simulation modelling with Loughborough University.

During 2017 preparatory work will be undertaken to recommission the data sharing functionality currently provided by the PI Care and Healthtrak tool and determine the optimum solution for this from April 2018 onwards. Leicestershire County Council is currently the lead commissioner for this work across LLR.

The development of the summary care record solution for LLR is a further critical enabler to the STP and Leicestershire Integration Programme. Phase 2 of this development is currently in progress and the milestones for this are included in the Programme Plan at Appendix 10.

A key objective for the period July – December 2017 is increasing the number of individual patients who consent to the SCR, with an active campaign in progress with all health and care communication teams involved.

The adoption of the SCR within integrated locality teams will be a particular focus of the Leicestershire BCF in 2018.

The use and application of risk stratification data via the ACG tool is a key component of the approach to Integrated Locality Teams. Each integrated locality team has been supplied with a risk stratified data packet for the three cohorts of patients in scope for the model in 2017/18 (those with frailty, those with multiple long term conditions, those with project high acute care cots). This data can be interrogated to individual practice level and into sub cohorts which are being used to test the new model of care. This approach will be supplemented with the new frailty marker being implemented in GP practice records in Q2 2017.

10.9 BCF 9 – Integrated Commissioning

Following the implementation of the new integrated commissioning approach to domiciliary care (Help to Live at Home) in 2016/17, further integrated commissioning is anticipated during the two year period of this BCF plan.

In particular this will relate to commissioning priorities arising from Home First, Integrated Locality Teams, Integrated Points of Access and Transforming Care. This will include for example:

- Joint market development for accommodation solutions and placements including extra care, transforming care (learning disabilities), step down facilities from hospital (including mental health step down), further integrated approaches to commissioning and quality assuring nursing and residential homes and domiciliary care providers
- Integrated commissioning intentions arising from the new carers strategy (being developed in Q3 and Q4 of 2017/18).
- Specification and procurement of the new model of Integrated Locality Teams, pending confirmation of the model and commissioning intentions during Q3-Q4 2017/18.
- Specification and procurement of a new Integrated Points of Access, pending the outcome of the gateway review taking place in Q3 2017 and further work on the model and co-location solutions.
- A new combined dementia service for LLR was commissioned in 2017 and details of the implementation can be found in the Programme Plan at Appendix 10.

The development of an accountable care system within LLR will fundamentally impact on the approach to integrated commissioning during 2017/18 and 2018/19, with the aim that more health and care commissioning intentions and commissioning activities are conducted jointly at system level, in the future, spanning multiple CCGs and LAs across LLR.

10.9.1 Personal Health Budgets (PHBs) & Integrated Personal Budgets

The NHS England Mandate sets a clear expectation that 50,000-100,000 people will have a personal health budget or integrated personal budget by 2020 – this translates to around one to two people per thousand of the population.

Local plans for Transforming Care need to show how people with a learning disability and/or Autism, who have a mental health condition or display behaviour that challenges, are provided with the same rights to choice and control over their health care as everyone else., so they are supported to live to their full potential within their local community and avoid admission to out of area specialist placements or mental health inpatient settings.

The expectation for LLR CCGs to achieve one to two per 1,000 people in the population being in receipt of a PHB over the next three to five years translates to between 1,011 and 2,022 PHBs for Leicester City, West Leicestershire and East Leicestershire and Rutland Clinical Commissioning Groups.

Currently PHB's are directed at individuals who are eligible for Continuing Healthcare and Continuing Care as well as those where health is making a contribution to their care.

The request and provision of PHBs for adults and children is via a single referral pathway to the Personal Health Budgets Team, currently based at ELRCCG.

Personal health budgets are part of a much wider programme of personalisation in health and social care. It is LLR CCGs' intention to extend the offer and availability of personal health budgets to more people over time, and that the end to end process for offering personal budgets will change from a CHC focus to wider elements of commissioned spend.

During 2017/18 the CCGs have an agreed timeline for the implementation of PHBs to more people, to include those with mental health needs, wheelchair users, and children and young people with an education, health and care plan. During 2018/19 further extension of the offer to those with Long Term Conditions is also being planned.

There is an established LLR-wide implementation group focused on the development of the offer and achieving the target level of personal budgets across LLR.

To ensure ongoing co-production of the PHB offer, the Implementation Group membership includes several patient and carer representatives as well as Healthwatch representatives from the three Local Authority areas.

10.9.2 Section 75 Agreements

The Integration Finance and Performance Group (see details on page 59) has overseen the development and management of the BCF Section 75 agreement since the inception of the BCF plan in 2015/16.

During 2016/17 an additional Section 75 agreement was developed in support of the new domiciliary care service (Help to Live at Home). In addition, there are pre-existing Section 75s covering the Learning Disabilities budget and one for the whole LLR area for community equipment services. The Lead Commissioner for the latter is the City Council.

As part of the accountable care system developments, further consideration will be given to the governance arrangements and Section 75 agreements required across the health and care system.

In the meantime the Integration Finance and Performance Group will continue to discharge its duties in relating to existing agreements, and ensure these are updated in line with the new BCF plan as set out in this document.

The Section 75 for the BCF will be updated by November 2017, in line with the national timetable, with a view to governance approvals by January 2018.

10.10 BCF 10 – Transforming Care

The LLR Transforming Care Programme (TCP) ensures the right support for people to be discharged from inpatient hospital care at the right time and also helps people who are at risk of being admitted to hospital. The programme is focused on offering good support for carers, the use of personal health budgets, and works hand in hand with local NHS providers, care providers, housing providers and the local workforce to develop services to meet current and future need.

The LLR TCP plan seeks to minimise the use of out of area placements/packages or specialised commissioning (NHS England funded) placements out of area.

The closure of two beds in the Agnes Unit took place in October 2016 and a further two beds closed on the 31 March 2017. The current contract with Leicestershire Partnership Trust (LPT) is for 12 beds in the Agnes Unit. However, by March 2019 we will be aiming for less than 12 people being placed there.

The Learning Disability Outreach Reach Service has been expanded to provide intensive support in the community and the impact of this is that between January 2017 and July 2017, a significant number of potential admissions have been avoided through timely and appropriate interventions in the community. Further scoping work is underway to enhance community support for people potentially at risk of admission, including community forensic support and step up crisis accommodation.

All people being discharged from an assessment and treatment unit or long stay inpatient bed will require a package of care and support to enable them to live in the community. They will also need access to mainstream services and those provided to the whole learning disability and autism population.

There is currently a chronic shortage of appropriate accommodation available for this cohort of people waiting to be discharged from inpatient settings in LLR. We have prioritised investment from the new adult social care allocation (IBCF) to improving the availability of suitable accommodation. This will be used to develop local, bespoke accommodation, both step down/step up provision, by funding the purchase of specific properties, adaptations to current properties, along with the development of different accommodation in order to address delayed transfer of care situations and to prevent admissions.

There is now a requirement to complete discharge planning at the point of admission to an inpatient setting. The TCP Discharge Planning Case worker is working closely with inpatient, outreach and social work teams to support inpatient reductions and to identify those people who require bespoke accommodation. The Discharge Planning Case Worker has a clear understanding of the housing needs related to current inpatients and the actions being undertaken are discussed at the multi-disciplinary Discharge Planning meetings.

11.0 BCF NATIONAL CONDITIONS

11.1 A Jointly Agreed Plan

There has been extensive engagement across all partners in the preparation of the Leicestershire BCF as shown in the engagement planner in Appendix 9.

The detailed work to refresh the BCF has been led by the Leicestershire Integration Executive per the scheme of delegation in place via the Health and Wellbeing Board Terms of Reference.

The Leicestershire Health and Wellbeing Board have been fully engaged with progress and:

- Received a report and presentation on the initial progress with the BCF refresh in January 2017.
- Received a draft BCF submission in March 2017.
- Further to the conclusion of the election period the Board received a further briefing on the financial plans and preparations for the BCF submission in June 2017.
- Received a briefing on the new BCF planning guidance, and DTOC target requirements at their meeting in July 2017.

As the next meeting of the Health and Wellbeing Board now falls after the 11th September 2017 BCF national submission deadline, delegated approvals are in place so that the BCF submission can be finalised, and the NHS England submission timescales can be achieved between formal Board meetings.

The Health and Wellbeing Board will receive the submitted BCF Plan for assurance at their meeting on 21st September 2017.

11.2 NHS contribution to social care in maintained in line with inflation

Within the 2016/17 BCF plan we agreed a number of investments where specific types of packages of care and other social care services were to be protected and maintained. In the 2016/17 BCF plan this totalled £22m of the £42m pooled budget.

The prioritisation and type of resource to be protected has been reviewed for 2017/18 and determined by analysing:

- The population demand profiles/projections for adult social care.
- The impact of the savings target in adult social care for Leicestershire County Council.
- The priorities in the Adult Social Care Strategy.
- The protection that can be seen through the allocation of growth funding applied in the Council's, Medium Term Financial Strategy (MTFS).
- The delivery requirements of the local care system, including changes to models of care being driven by the BCF and the five year plan.
- Specific requirements linked to BCF Metrics and National Conditions, for example for the Care Act and Delayed Transfers of Care.

- The service and financial pressures that are still to be addressed in the medium term.

11.3 Impact of LLR-wide system changes on Adult Social Care

In the LLR health and care economy, a funding gap of £400m has been identified by 2020/21 if no action was taken on how current services are being delivered. This includes the current funding pressures faced by social care services, and the NHS, together with anticipated increased demand and costs over the next five years due to the ageing population inflation and medical advances.

The five year plan has identified a number of clinical and enabling workstreams which will help eliminate the combined financial gap by 2020/21 and contribute to closing key health and wellbeing and care quality gaps.

Interventions are focussed on prevention, avoiding hospital admissions, a 'home first' model of care and greater integration across social care, community health care and primary care, it will all impact on levels of demand for social care support, public health interventions and community services.

It is recognised by all partners that sustaining adult social care services within the BCF, and the incremental changes already being made to integrated care delivery through the BCF, are a crucial part of maintaining system delivery while the longer term system changes are implemented, and the implications of the five year plan on adult social care can be calculated in more depth.

Leicestershire County Council is required to make a total of £66m budget savings between 2017-21, of which £10m is earmarked to be saved from Adult Social Care. The Council recognises the need to protect adult social care and accordingly has allocated the department only 12% of required savings despite, spending 38% of the Council budget in this area.

The Council's MTFS 2017-21 shows an increased financial allocation for growth totalling £13m in Adult Social Care for the next four years, representing a 4% growth in adult social care budgets, whilst overall council spending will fall.

The funding proposed from the BCF will in part meet increasing demand and cost and continue to protect social care services alongside the council's own measures.

The levels of funding identified within the BCF plan for adult social care does not resolve all aspects of the increased demographic pressure on a recurrent basis, nor does it address the impact of wider LLR system changes that are still to come, however priority has been given to areas where insufficient social care support will be detrimental to the delivery of the BCF plan's aims and metrics, in particular:

- To reduce emergency admissions.
- To ensure a more streamlined and responsive health and care system supporting hospital discharge seven days a week.

- To provide sufficient social care support for frail older people and those with LTCs to remain in their community for as long as possible.
- So that the existing social care resource can be redesigned to integrate more effectively with community services and primary care services in integrated locality teams.

The expenditure plan at Appendix 7 shows the service lines where the CCG minimum contribution has been applied to sustaining adult social care. These lines are colour coded in green, and the total of this investment is £22m.

11.4 Investment in NHS Commissioned Out of Hospital Services

The detailed BCF expenditure plan at Appendix 7 demonstrates the breadth of the Leicestershire BCF plan in investing in NHS commissioned services out of hospital.

The proportion of the plan invested in these services is illustrated in the following table:

	2017/18 £000	**2018/19 £000**
NHS Commissioned Out of Hospital Ring fence*	£10,424	£10,622
BCF Plan Total Out of Hospital Spend (from CCG minimum contribution	£14,064	£13,577
Variance	**£3,640**	**£2,955**

* *This is the proportion of the CCG minimum allocation from the core BCF which must be allocated to out of hospital services per the definition in the BCF policy framework.*

The Leicestershire BCF plan demonstrates more than £14m of the fund will be allocated to this category of spend and therefore meets the national condition.

In addition to the above allocation, the CCGs have allocated £2.5m for the Intensive Community Support Service which is also NHS commissioned out of hospital services.

11.5 Our Target for improving Delayed Transfers of Care (DTOC)

The most challenging aspect of finalising the Leicestershire BCF plan has involved setting the trajectory for improving delayed transfers of care.

This was made more difficult by the late publication of BCF technical guidance (July 2017) which included unexpected new requirements set by NHS England about the rate of improvement expected nationally against the DTOC metric.

The national target set by NHS England was no more than 3.5% of occupied bed days should be coded as delayed nationally, by November 2017.

During August 2017, partners in LLR assessed the new requirements, re-examined the action plan including the high impact changes self-assessment findings, and set out our proposed trajectory of improvement.

The improvement trajectory was agreed via individual partners, the Leicestershire Integration Executive and the LLR A&E Delivery Board. Partners agreed that it was not possible to achieve the required level of improvement by November 2017, and instead set out how this would realistically be achieved, with a profile to achieve this no later than March 2018.

During September and October 2017 NHS England, DH and DCLG insisted all parts of the country comply the improvement trajectory by November 2017, otherwise BCF plans would not be approved, with significant financial penalties potentially being applied to local councils. Due to this, partners in LLR had to reluctantly accept and re-profile the target, despite the fact that our ability to achieve this target remained extremely low.

A summary of key points in relation to setting this target and the implication for Leicestershire is given below:

- The national target of 3.5% has been apportioned across each Health and Wellbeing Board area and translated into a rate per 100,000 population for each local area.
- In order to make our contribution to the national percentage, Leicestershire is required to achieve a rate of no more than 6.84 beds delayed per 100,000 population, by November 2017.
- At this stage the exact arrangements in relation to financial penalties have not been confirmed, but it has been made clear by NHS England that council areas who do not meet the target by November 2017 will face escalation and could have funds withheld from their BCF pooled budgets in 2018/19.
- This could affect either the new IBCF grant that councils received 2017/18 (£9million for Leicestershire), or a larger sum from the core BCF pooled budget (up to £22million for Leicestershire), the element of the fund that CCG contribute in support of adult social care services.
- The BCF programme and corporate level risk registers have been updated accordingly, with a red rated risk.

- If placed in escalation this will involve:
    - Escalation meetings for key officers from health and care with NHS England, which could also involve the Chair of the Health and Wellbeing Board.
    - The withholding of funds from councils, and/or further conditions being placed on how funds should be prioritised via the BCF plan and pooled budget.
    - A Care Quality Commission (CQC) system area review being imposed on the local authority.

The table below sets out the profile of the revised DTOC target for Leicestershire:

	**Delayed transfers of care from hospital per 100,000 population (average per month)**	
This is a nationally defined metric measuring delivery of the outcome of effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults. The aim is therefore to reduce the rate of delayed bed days per 100,000 population.		
2016/17 Performance	**Trajectory for 2017/18**	**Target setting methodology and rationale**
287.04, 357.19 and 382.17, 377.10 days delayed per 100,000 population aged 18+ per month for quarters 1-4 respectively	• Apr-17 – 255.04 • May-17 – 277.74 • Jun-17 – 318.39 • Jul-17 – 295.31 • Aug-17 – 278.57 • Sep-17 – 253.38 • Oct-17 – 245.07 • Nov-17 – 205.32 • Dec-17 – 212.22 • Jan-18 – 210.70 • Feb-18 – 190.31 • Mar-18 – 210.70	The Leicestershire BCF DTOC metric has been re-profiled to reflect the rate of improvement as mandated by NHS England (e.g. to achieve Leicestershire's contribution to the 3.5% target, by November 2017)

Overview of Current Performance

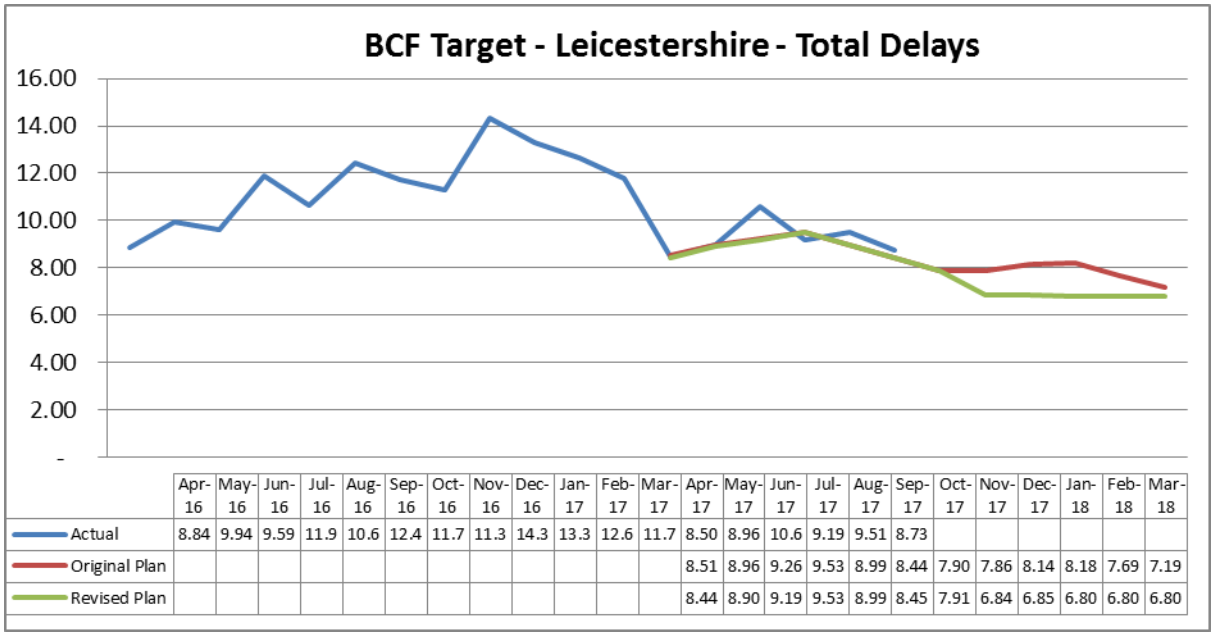
In August 2017 there were 1,611 days delayed, representing a rate of 294.95 per 100,000 population against a target of 278.57.

This translates to 9.51 average days delayed per day per 100,000 population, against the revised target of 8.99 for August 2017, which drops to 6.84 by November 2017.

The table below shows the Leicestershire 6.84 target broken down into the three DTOC categories, along with our current performance (latest available data – September 2017).

	NHS Delays	LA Delays	Joint	Total
Performance at September 2017	6.21	0.79	1.73	8.73
Target for November 2017	**3.78**	**1.33**	**1.73**	**6.84**

Below is a graphical representation of performance, mapped against Leicestershire's original trajectory (shown in red) and the NHSE imposed trajectory (shown in green).



	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Actual	8.84	9.94	9.59	11.9	10.6	12.4	11.7	11.3	14.3	13.3	12.6	11.7	8.50	8.96	10.6	9.19	9.51	8.73						
Original Plan													8.51	8.96	9.26	9.53	8.99	8.44	7.90	7.86	8.14	8.18	7.69	7.19
Revised Plan													8.44	8.90	9.19	9.53	8.99	8.45	7.91	6.84	6.85	6.80	6.80	6.80

The LLR-wide DTOC action plan is being enacted by all partners and this continues to be a top priority for all partners, including Leicestershire's adult social care team. There is a good joint understanding of the position across the partnership and the impact of delayed bed days is now primarily on non-acute sites and out of county acute sites.

The LLR Discharge Working Group has been reconvened, with a refreshed purpose and senior level direction in order to oversee delivery, and ensure one set of LLR data is available and analysed, giving a consistent view of system wide performance weekly and monthly.

All existing actions remain in place to support University Hospital of Leicester discharges. A positive position is being maintained at the acute site where adult social care coded delays for Leicestershire remain very low.

Further details of current performance and analysis based on local data can be found in the latest DTOC digest report, available in Appendix 6.

It remains statistically highly unlikely the revised target can be reached by November for Leicestershire, even though recent improvements on non-acute delays are having an impact.

Successful delivery of the DTOC improvements, depend on the following:

- Delivering in full the immediate actions already agreed across all partners in LLR, jointly tackling the known barriers and root causes of delays that are either within hospitals or external to hospitals.

- The short term action plan outlined on pages 23-25 has been based on existing health and care system issues and LLR's self-assessment (Appendix 3) against the high impact changes for managing transfers of care and has been commissioned and funded accordingly from April 2017.

- Achieving a stepped improvement in NHS related delays (the largest element of improvement gap).

- Maintaining our generally good performance on adult social care related delays, throughout the remainder of this financial year.

- Delivering further social care improvements where possible, with particular emphasis on non-acute patients and out of county patients.

- Preparing for the medium term actions within the Home First workstream of the LLR STP (see section 10.2.3 on page 26) so that these will have a further positive impact beyond March 2018.

Within the BCF expenditure plan at Appendix 7, £16.4m is invested in delivering improved DTOC performance per the agreed action plan priorities.

- £11.4million of this is recurrent investment from our refreshed BCF plan, for example, our existing seven day social care services which supports hospital discharge, the Intensive Community Support Service and the Improving Mental Health Discharge scheme.

- £5million is new investment with effect from April 2017, funded from the IBCF, for example Hospital Housing Discharge Enabler scheme and the development of an integrated discharge pathway/team at the Bradgate Unit.

11.6 Assuring DTOC Improvement and Managing Risk

DTOC performance will be routinely measured nationally, quarterly by NHSE and DCLG using national returns. Regular benchmarking information is also available on a national and regional basis.

Within the supporting guidance to the BCF planning framework it states that the Government will review progress against the DTOC target across the country in November 2017, and will consider changes to the new non recurrent IBCF allocations for poorly performing areas. Ultimately this could mean financial penalties being imposed for areas of poor performance, however further details about this are awaited.

The CQC will be involved in reviewing 12 poorly performing local areas (already identified) in the first tranche of this process. No areas within LLR were identified in this first group. Further reviews of local areas are planned between February and April 2017, which may also include assessing some high performing areas.

Local assurance on DTOC improvement is governed by the A&E Delivery Board on an LLR-wide basis (bi-weekly), with operational support from the LLR Discharge Working Group.

LLR wide governance is supplemented by local BCF governance arrangements in each LA area, where the overall delivery BCF plans is scrutinised monthly.

In the case of Leicestershire this is via the Leicestershire Integration Executive with reporting into the Health and Wellbeing Board, no less than quarterly (see governance section on page 58).

The risks in relation to the delivery of the 3.5% DTOC target have been assessed in light of the LLR action plan, the level of ambition to achieve the target, and available funding envelope.

The overall risk rating (with mitigation applied) is reflected in the BCF plan risk register at Appendix 11, risk 10.

12.0 OVERVIEW OF THE SOURCE OF FUNDS AND DIFFERENT BCF ALLOCATIONS

12.1 Financial Context

The BCF refresh for 2017/18 and 2018/19 has involved a comprehensive review of the proposed expenditure plan for that period, and the sources of funds and their purposes within the guidance.

The BCF Operational Group and the Integration Finance and Performance Group have led the detailed work to evaluate the performance of the BCF plan in 2016/17 including assessing financial performance and risks. The outputs of this work have been reported via the Integration Executive, approved by the Integration Finance and Performance Group and assured via the Health and Wellbeing Board.

Partners have considered the overall pressures within the BCF expenditure plan, the level of investment needed to meet the BCF metrics and national conditions, ensured local agreement on any risk pools, and the impact of national BCF allocations including inflationary factors and DFG allocation requirements. These discussions have taken place in the context of substantial financial pressures affecting all partners in the health and care system, balancing priorities within the complex planning environment, and in a health and care economy which continues to face significant sustainability risks linked to the over use of acute care.

The table below confirms the source of funds to be applied to the BCF over the two year planning period.

Better Care Fund Funding 2017/18 and 2018/19		
Funding Source	2017/18 £000	2018/19 £000
Minimum Contributions		
East Leicestershire & Rutland CCG*	15,838	16,139
West Leicestershire CCG*	20,843	21,239
	36,682	37,378
DCLG Funding		
Disabled Facilities Grants	3,350	3,632
IBCF (Comprehensive Spending Review -Autumn 2015)	Nil	5,582
IBCF (Adult Social Care Grant Spring Budget 2017)	9,526	6,837
	12,876	16,051
Additional Contributions		
Additional CCG allocations (ICS Scheme)	2,563	2,563
Total BCF Funding	**52,120**	**55,993**
* Inclusive of Care Act Funding	1,388	

12.2 Improved Better Care Fund (IBCF)

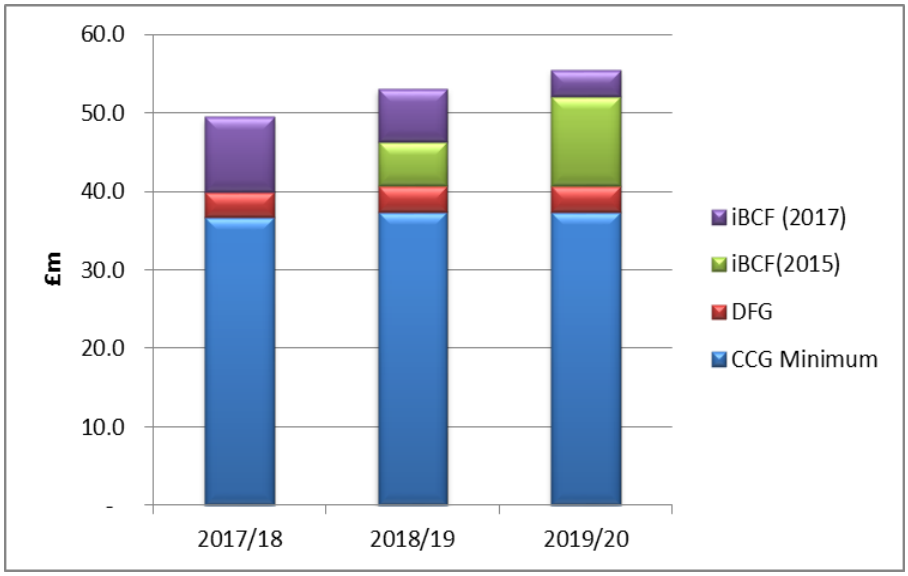
There are two parts to the IBCF allocations, which form the LA component of the Better Care Fund.

The first of these is the IBCF allocation linked to announcements made in the 2015 Comprehensive Spending Review. Local Authorities were expected to benefit from this allocation from 2017/18 onwards, however the amount received per area depends on the ability of the council to raise funding from the social care precept. Leicestershire County Council included a 2% social care precept in 2017/18 with budget plans including proposals to introduce a further 2% for 2018/19. As a result, Leicestershire does not receive any additional 2015 CSR IBCF funding in 2017/18, and reduced levels in later years. It is anticipated that £5.6m of IBCF additional funding will be available via Local Authority allocations in 2018/19.

The second IBCF allocation was announced in the March 2017 Budget in the form of a non-recurrent grant to each LA with specific grant conditions. Leicestershire has since received an allocation on this basis which has been factored into the BCF plan with effect from April 2017. This additional Adult Social Care allocation amounts to £9.5m in 17/18, £6.8m in 18/19 and £3.4m in 19/20.

During April and May 2016 Leicestershire County Council worked closely with NHS partners to discuss and agree the prioritisation of the IBCF allocation in line with the grant conditions with a significant proportion of this allocation swiftly agreed in support of joint health and care integration priorities, in particular within the new Home First workstream of the STP where work to improve hospital discharge and reablement pathways is already underway.

The graph below shows how the BCF financial plan is comprised of the multiple funding allocations and how these are expected to change over the three year period, with the non-recurrent allocation (the new IBCF Spring 2017) shown in purple, at the top of each bar.



12.3 Disabled Facilities Grant Allocations

Funding allocations for major adaptations in the home will continue to be routed via the BCF to each district council in line with national policy.

Growth funding has been issued by government in line with the expectations set out in the 2015 comprehensive spending review.

The allocations for each District Council for 2017/18 (confirmed) and 2018/19 (projected) are noted in the table below:

	2017/18	**2018/19**
Leicestershire	**£3,349,869**	**£3,632,291**
Blaby	£499,481	£542,165
Charnwood	£846,293	£920,160
Harborough	£385,744	£418,476
Hinckley and Bosworth	£439,674	£472,848
Melton	£259,427	£281,543
North West Leicestershire	£572,989	£621,202
Oadby and Wigston	£346,261	£375,897

The BCF policy framework confirms upper tier authorities are required to passport the DFG allocation in full to each District Council, unless local agreement has been reached to direct resources to other strategic housing priorities

During 2016/17 significant work has been undertaken with District Council Chief Executives and Finance Leads to forecast DFG demand across Leicestershire, to inform the local position, and quarterly reporting is in place to compare actual demand against the allocations made.

Although current forecasting information assumes the majority of the DFG allocation will be required to meet local demand, should any allocation remain uncommitted/or be forecast to be uncommitted, each District will agree how this is to be used in the context of the BCF policy, e.g. in support of strategic priorities which integrate of health, wellbeing and housing, for the benefit of their local residents.

Where individual Districts do wish to consider the use of DFG allocations for other strategic housing, health and wellbeing solutions, this will be welcomed and supported by Leicestershire County Council and other partners, especially given the transformation already being undertaken via the Lightbulb Housing Service.

12.4 Confirmation of Key Financial Matters

In summary, the process to refresh the BCF financial plan has confirmed the following:

- Leicestershire's plans for the non-recurrent IBCF grant were agreed locally in April 2017. This has been prioritised per the grant conditions, and by agreement with NHS partners, targeted to the following areas
    - Overall sustainability of adult social care
    - Joint working with the NHS (home first and the integration of health and care)
    - increasing capacity for domiciliary care and residential care

- Capital investments for transforming care/whole life disability

- Plans have been considered over the medium term, with partner contributions to the pool exceeding the minimum required BCF funding levels of £43m in 2017/18 and 2018/19 (£39.1m in 2016/17)
- Additional contributions above the required minimum BCF level of funding total include:
    - An additional CCG contribution of £2.6m due to the addition into the BCF plan from 2017/18 of the second phase of the Intensive Community Support service in Leicestershire. This over and above the BCF minimum contribution and the s75 agreement will be revised to reflect this
- The investment in maintaining adult social care within the fund will be £22m which reflects the inflationary uplift associated with the CCG minimum contribution.
- That £3.3m in 2017/18 (the full DFG allocation) will be passported directly to Districts for DFG delivery, in line with grant conditions.
- A further financial refresh will take place during Q3-Q4 2017/18 to take account of budget planning for 2018/19, including ongoing commissioning developments linked to the LLR five year plan, national policy requirements and any further savings/re-prioritisation needed to ensure a sustainable pooled budget in the medium term.

12.5 Confirmation of Risk Pools

- The creation of a £1m 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.
- Should the £1m risk pool not be able to be achieved from the service review/VFM activities outlined in the programme plan, the risk will be shared between CCG core budgets and the BCF plan on a 50%/50% basis. This will be reflected in the s75 agreement.
- There is no risk pool 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.
- Section 18 below outlines the governance arrangements for the BCF s75 pooled budget and risk pools, which is via the quarterly Integration Finance and Performance Group.

12.6 Leicestershire BCF Section 75

The (rolling) section 75 for the Leicestershire BCF was initially approved in 2015 and refreshed in line with the 2016/17 BCF plan schedules in June 2016.

This work was undertaken in partnership across the two CCGs and LA, and with the support of respective finance officers, corporate governance officers and legal advisers.

The BCF s75 was also updated in 2016/17 to reflect the inclusion of back office functions and reablement services associated with the new Help to Live at Home Service, which itself has a related s75 document.

Work to refresh the BCF s75 for 2017/18 will be undertaken in Q2 & Q3 of 2017/18 and the s75 will be approved via the existing governance routes of the CCG Boards, and by delegated authority from Leicestershire County Council's Cabinet by January 2018.

13.0 BETTER CARE FUND METRICS

The following tables set out each BCF metric, our performance in 2016/17, our proposed trajectory for the two year period of this BCF plan and a summary of the rationale for the level of performance we are aiming for.

	Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population
This is a nationally defined metric measuring delivery of the outcome to reduce inappropriate admissions of older people to residential care.	

2016/17 Performance	Trajectory for 2017/18 and 2018/19	Target setting methodology and rationale
633.5, based on SEQELs and submitted to NHS Digital. Full dataset for all local authorities will be released in October 2017.	630.60 and 630.60	These targets have been set in agreement with the Adults and Communities Directorate at Leicestershire County Council based on the forecast end of year position for 2016/17 based on the Apr-Dec data. More challenging targets were not set because the new Help to Live at Home domiciliary care scheme has yet to achieve stability, and the evidence from the JSNA shows that the number of people aged 85+ is set to grow at a greater rate than the rest of the population from 2016 onwards. IBCF money will not be spent on funding extra permanent residential placements.

	Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
This is a nationally defined metric measuring delivery of the outcome to increase the effectiveness of reablement and rehabilitation services whilst ensuring that the number of service users offered the service does not decrease. The aim is therefore to increase the percentage of service users still at home 91 days after discharge.	

2016/17 Performance	Trajectory for 2017/18 and 2018/19	Target setting methodology and rationale
87.0%	87.0%, 87.0%	These targets have been set in agreement with the Adults and Communities Directorate at Leicestershire County Council. The target has been set to maintain the current good levels of performance.

	Delayed transfers of care from hospital per 100,000 population (average per month)

This is a nationally defined metric measuring delivery of the outcome of effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults.
The aim is therefore to reduce the rate of delayed bed days per 100,000 population.

2016/17 Performance	Trajectory for 2017/18	Target setting methodology and rationale
287.04, 357.19 and 382.17, 377.10 days delayed per 100,000 population aged 18+ per month for quarters 1-4 respectively	• Apr-17 – 255.22 • May-17 – 277.74 • Jun-17 – 277.74 • Jul-17 – 295.31 • Aug-17 – 278.57 • Sep-17 – 253.38 • Oct-17 – 245.07 • Nov-17 – 205.32 • Dec-17 – 212.22 • Jan-18 – 210.70 • Feb-18 – 190.31 • Mar-18 – 210.70	The Leicestershire BCF DTOC metric has been re-profiled to reflect the rate of improvement as mandated by NHS England (e.g. to achieved Leicestershire's contribution to the 3.5% target, by November 2017).

	Non-Elective Admissions (General & Acute)

This is a nationally defined metric measuring the reduction in non-elective admissions which can be influenced by effective collaboration across the health and care system.
Total non-elective admissions (general and acute) underpin the payment for performance element of the Better Care Fund.

2016/17 Performance	Trajectory for 2017/18 and 2018/19	Target setting methodology and rationale
760.40 admissions per 100,000 population per month	737.92 and 737.71 admissions per 100,000 population per month – based on CCG operating plans	In 2016/17 the target of avoiding 1,517 admissions was set, based on alignment with CCG operating plans. This number of avoided admissions was achieved by the end of September and by the end of March 2017, 2,010 admissions had been avoided by BCF funded schemes. CCG Operating Plan 2017/18 – 2018/19 indicates the county CCG's will commission 60,582 emergency admissions in 2017/18 and 61,009 in 2018/19 for Leicestershire residents.

14.0 PROGRAMME PLAN

Our Programme Plan has been refreshed in light of the work undertaken to review the BCF plan for 2017/18- 2018/19. A high level summary is given below (the more detailed Gantt chart is available at Appendix 10).

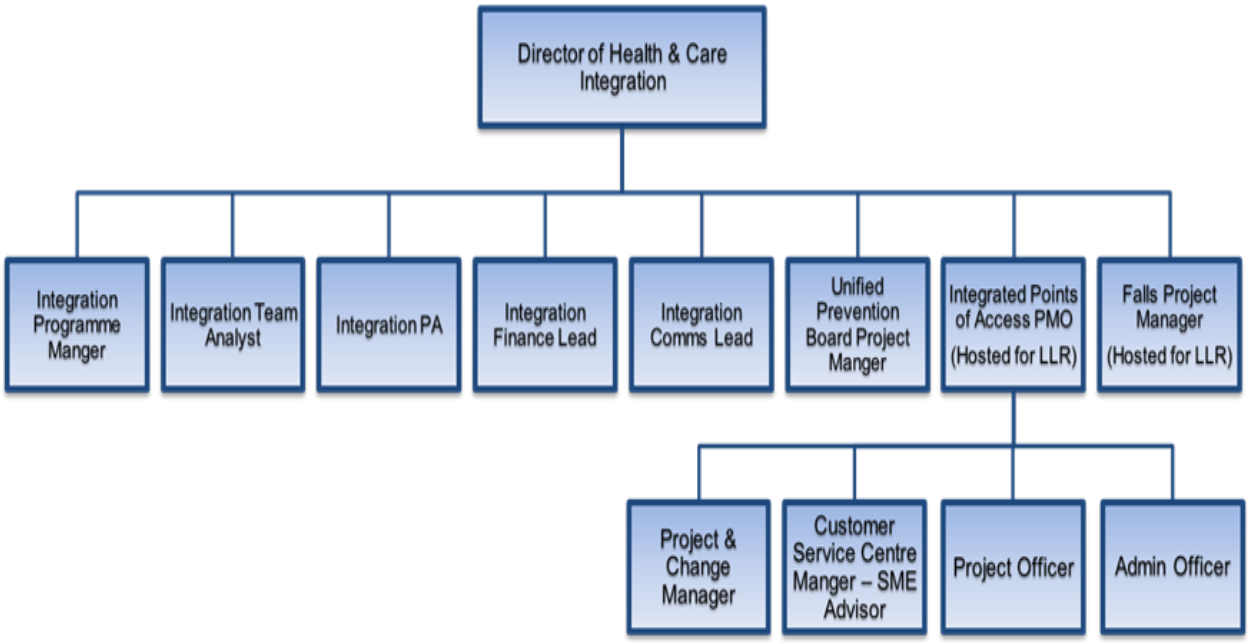
The BCF refresh identified a number of specific commissioning actions and activities including service reviews and ongoing VFM assessment will take place in 2017/18. These are highlighted in red for ease of reference.

	Q1	Q2	Q3	Q4
Programme Management				
Sign-off section 75 agreement			■	
Monitor and report BCF performance and finance process	■	■	■	■
Agree communications and engagement plan for 2017/18	■			
Annual review of BCF Equalities Human Rights Impact Assessment (EHRIA)				■
Develop and agree evaluation plan for integration programme	■			
BCF Schemes				
Unified Prevention Offer				
Develop/agree unified prevention model for Leicestershire		■	■	
Map all areas of STP for prevention	■			
Undertake review of First Contact Plus service		■	■	
Scope development of outcomes framework for prevention & social prescribing interventions		■	■	
Integrated Locality Teams (STP workstream)				
Confirmation of case management model across LLR	■	■		
Review Integrated Care/Proactive Care models and redesign LLR approach	■	■		
Mobilisation of new falls pathway across LLR			■	
Develop and implement phase 3 eFRAT (Falls Risk Assessment Tool)	■	■		
Further development of falls prevention programme		■	■	
Pilot new pathway for end of life (including 24/7 service)	■			
Scope and mobilise cardiorespiratory service	■	■		
LLR Dementia Workstream				
Launch new jointly procured post diagnostic support & community in-reach service for people affected by dementia			■	
Housing				
Develop a proposed business model for medium term approach for Assistive Technology across Leicestershire		■	■	
Implement phase 1 (early roll-out in 1 District) of Lightbulb Programme	■			
Full roll-out of Lightbulb Programme across Leicestershire			■	
Refresh Disabled Facilities Grants quarterly forecasting for 2018/19			■	
Home First (STP Workstream)				
Baseline review of all current reablement spend, activity & outcomes				
Further milestones to be confirmed post baseline review				
Develop a new joint health & care LLR Carers strategy for 2017-20	■			
Explore recommendations to revise training approach for Health and Social Care Protocol	■	■		
Confirm commissioning intentions for Health & Social Care Protocol for April		■		

	Q1	Q2	Q3	Q4
2018 onwards				
Develop medium & longer term approach for integrated discharge services				
Undertake the CQC self-assessment for DTOC				
Urgent Care Model (STP workstream)				
Implement new urgent care services				
Review the social care Crisis Response Service				
Integrated Commissioning				
Scope joint commissioning of placements / fee reviews				
Review of integration and quality review teams				
Help to Live at Home – mobilisation of new contracts				
Integrated Points of Access				
Standardisation phase for existing customer centres				
Conduct gateway review				
Agree progress to phase 2 (implementation stage)				
Integrated Data				
Agree commissioning plan for the PI Care and Health tool (or equivalent) from April 2018 onwards (developed in overall context of STP BI Strategy)				

15.0 INTEGRATION PROGRAMME RESOURCES

The diagram below shows the core integration team staff structure chart and the associated level of resource in place to deliver the Leicestershire Integration Programme and BCF. These have been included in the BCF programme management costs in the BCF expenditure plan at Appendix 7.



15.1 Matrix Management for Programme Delivery across the Partnership

The majority of the BCF is delivered through matrix working with partners, with individual project/delivery leads from a wide range of partner organisations, including on an LLR wide basis.

The detailed programme plan at Appendix 10 shows the distribution of the work across, the partnership including the managerial lead and governance route for each element of the workplan.

The Integration Operational Group, which meets monthly, coordinates delivery and inputs across all agencies in order to achieve the integration programme milestones.

Further information about the role of this group and the governance of the programme overall can be found in section 18 of this document.

There are a number of key roles and relationships in the matrix management system which ensures we deliver the totality of our programme. For example:

- Leicestershire County Council Transformation Unit and Corporate PMO
- LLR STP PMO
- County CCG's Integration Leads (x 2)
- Adult Social Care Department's Transformation Leads
- Lightbulb Housing Service PMO
- STP Workstream PMOs for:
    - Urgent Care
    - Home First
    - Integrated Teams
    - Integrated Points of Access
- Respective District Council Leads for Health and Housing

16.0 PROGRAMME EVALUATION & MEASURING IMPACT

The impact of the plan is measured in the following ways:

a) Quarterly, nationally using a national template into NHS England. This measures the delivery of each local plan in relation to the *BCF national conditions* and *BCF national metrics* as detailed by definitions provided the BCF policy framework and technical guidance for 2017/18.

b) Quarterly, nationally via a DCLG template linked to the IBCF Adult Social Care grant (with effect from 2017/18).

c) Quarterly, locally via our Integration Finance and Performance Group – (oversight of the BCF section 75/pooled budget).

d) Quarterly, locally to Leicestershire's Health and Wellbeing Board.

e) Monthly, locally via the Leicestershire Integration Executive, via the integration performance dashboard and programme highlight report.

f) Monthly, locally via individual project/theme level governance boards, with monthly operational oversight by the BCF operational group. This tier providing much more in-depth discussion on specific milestones, trajectories and KPIs at project level.

g) Via specific evaluation activity– for example clinical audits, independent evaluations, academic studies, e.g. the evaluation of Local Area Coordination and the SIMTEGR8 programme (see below).

h) During the BCF refresh for 2017/18 we conducted a number of in depth reviews of existing BCF funded services to examine their overall efficacy and VFM. The findings were scrutinised by the Integration Operational Group and Integration Executive and informed specific commissioning and decommissioning decisions for the 2017/18 – 2018/19 BCF plan.

i) The interventions assessed by the Nuffield Trust in their Shifting the Balance of Care report in March 2017 have also been analysed against the LLR STP and Leicestershire BCF, with a summary of this analysis provided in the mapping tables at Appendix 12.

16.1 SIMTEGR8

During 2016/17, we conducted a second phase of our integration evaluation and research study (SIMTEGR8) in conjunction with Loughborough University, SIMUL8 Corporation and Leicestershire Healthwatch. Building on the methodology developed in 2016/17 where we evaluated four emergency admissions avoidance services, a further four BCF services in 2016/17 (Help to Live at Home, Cardio/Respiratory, Lightbulb Housing Service and Intensive Community Support)

Findings are being disseminated regionally and nationally during 2017/18. Further information can be found here http://www.healthandcareleicestershire.co.uk/health-and-care-integration/monitoring-and-evaluation/

17.0 RISK REGISTER AND RISK MANAGEMENT

The risk register for the Leicestershire Integration Programme which reflects the risks associated with the delivery of the BCF plan can be found at Appendix 11.

The risk register for the BCF plan has been fully updated in light of the new two year planning requirement, the impact of the updated national conditions, metrics, and planning guidance, and in the context of the BCF allocations and the financial framework/financial pressures affecting the Leicestershire BCF plan.

The programme level risk register is reviewed operationally and strategically at regular intervals as part of the routine work of the Integration Executive, Integration Operational Group and Integration Finance and Performance Group. The high level risks are reflected in the corporate risk registers of Leicestershire County Council and the two County CCGs, updated on a quarterly basis.

The Programme Director's highlight report at the Integration Executive summarises key issues and risks on a monthly basis. The key risks relating to the delivery of the BCF plan are summarised below. These are can characterised as a combination of:

- Overall LLR system level risks (service, financial and transformational), per the LLR STP, and
- Specific risks affecting the Leicestershire BCF plan/pooled budget (arising from both the LLR system level risks and the national policy position for the BCF).

The following is a summary of key strategic risks associated with the BCF refresh as at August 2017:

a) Impact of the 2017/18 financial position across the health and care economy – risk that partners are forced to address immediate/short term system pressures versus investing in medium term solutions/ transformation, e.g. per the STP priorities.

b) Lack of financial headroom within the Leicestershire BCF Plan, including lack of reserves and contingencies from 2017/18 onwards.

c) Increased significant risks in CCG financial plans from 2017/18 onwards.

d) Ongoing urgent care pressures, including the ongoing upward trend of emergency attendances/admissions.

e) Improving Delayed Transfers of Care (DTOC) performance following the deterioration in performance experienced in 2016/17. (see Appendix 11, Risk 10)

f) Reliance on the delivery of further in-year savings from service review and redesign across a number of BCF service lines in order to deliver a more sustainable medium term financial plan. A number of these BCF service lines are subject to work being led by LLR STP workstreams during 2017/18, with key milestones and quantifiable impact in some areas still to be confirmed.

g) Implementation of large and complex areas of transformation across LLR such as solutions for Integrated Points of Access, new models for Integrated Locality Teams, adoption of the electronic summary care record.

18.0 PROGRAMME GOVERNANCE

Since February 2014 the Leicestershire Integration Programme has been governed by the Leicestershire Health and Wellbeing Board, with day today oversight of the integration programme, including associated pooled budgets, provided by the Leicestershire Integration Executive which meets on a monthly basis.

18.1 Leicestershire Integration Executive

- Chaired by a clinical lead from the CCG (rotating approx. every 18 months) the Leicestershire Integration Executive is a very productive, delivery focused group which has consistently benefited from excellent engagement at Director level across health and care organisations. The Integration Executive includes representation from the County Council, District Councils and Healthwatch, plus all local NHS organisations, both commissioners and providers.
- This group is the overarching governance group responsible for the delivery of the whole integration programme in Leicestershire on behalf of the Health and Wellbeing Board. The group sets the vision for integration, oversees the delivery and evaluation of the BCF in totality, sets strategic priorities across workstreams and ensures alignment with LLR-wide programmes of work. Members of this group are also SROs for key deliverables within the LLR five year plan/Leicestershire Integration Programme.

There are currently three other key groups in place which support delivery of the Integration Programme:

18.2 Integration Operational Group

- Chaired by the Director of Health and Care Integration, this group comprises senior managers responsible for delivery of the various components of integration across the programme, with representatives from all partners on the Integration Executive.
- The group meets monthly and is responsible for overall detailed coordination of the Integration/BCF programme plan, including business case development, investment and disinvestment proposals, project management, programme/project level budget management, scheme level trajectories, metrics, KPIs and evaluation, digesting national policy and best practice, staffing resources into key elements of the programme, troubleshooting across the programme partnership, communications and engagement plans/materials, governance planners and reporting into respective partner organisations, refreshing the annual BCF plan/submission and ensuring the quarterly reporting to NHSE is prepared, approved and submitted.

18.3 Integration Finance and Performance Group

- Chaired by a CCG Director of Finance, this group comprises director/senior manager level commissioning and finance leads from the LA and two County CCGs.

- The group is primarily responsible for oversight of the pooled budgets supporting the integration programme, including setting strategy for contingencies and risk pools, and the overall financial management and performance of the section 75 for the BCF.

- During 2016/17 the terms of reference have been updated to include oversight of other section 75 agreements and pooled budgets which support the Integration Programme including Help to Live at Home, Learning Disabilities and Integrated Community Equipment Service. The group is tasked with overall prioritisation of investments and making final recommendations on the BCF financial plan/pooled annually, as well as refreshing the BCF s75, and ensuring the appropriate governance approvals for the s75 via LCC Cabinet, CCG Boards and the Health and Wellbeing Board.

18.4 Unified Prevention Board

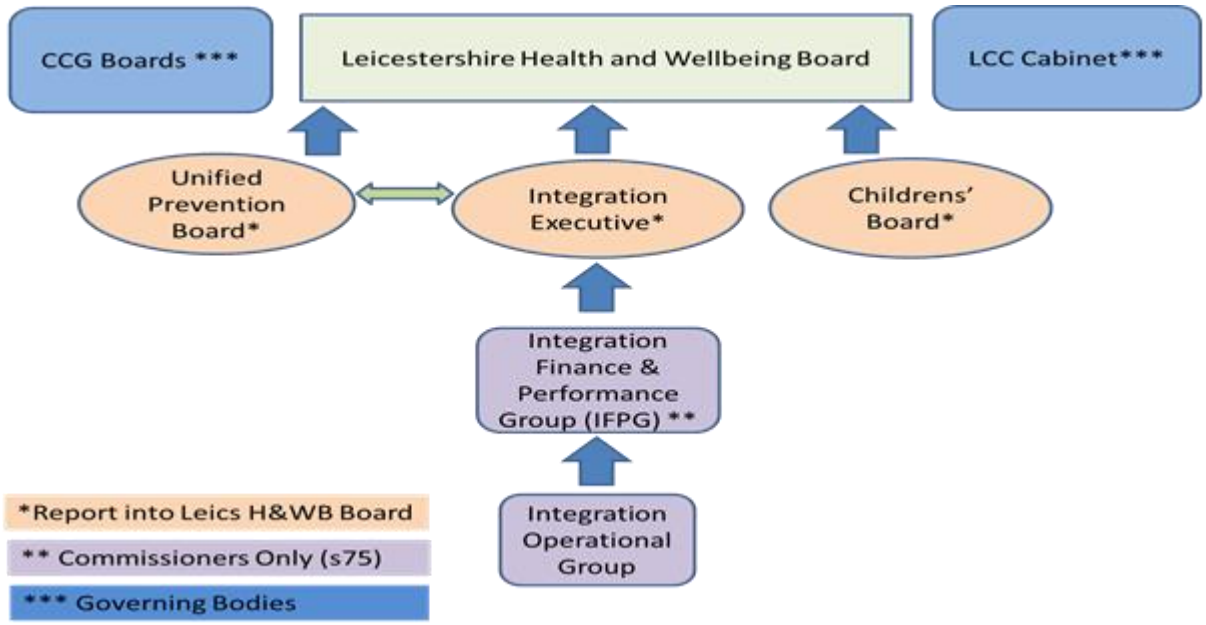
- Chaired by the Director of Public Health and a District Council Chief Executive, this group meets monthly and comprises senior managers from all health and care partners as well as the voluntary sector, fire, ambulance service and police.

- The group has been tasked with a baseline review of existing services, designing the model for a unified prevention offer for Leicestershire's communities/localities for the future, and recommending the forward commissioning strategy. During 2016/17 the group has been assessing the most appropriate model/mechanisms for social prescribing in support of the unified prevention offer. This group reports directly to Leicestershire's Health and Wellbeing Board given the importance of this work in relation to both Leicestershire's Joint Health and Wellbeing Strategy and LLR STP prevention workstream. (See section 10.1 on page 21 and Appendix 8).

The Leicestershire Integration Programme has maintained good visibility, communication and engagement across partner organisations with regular all member briefings, reports to executive teams of NHS Trusts, CCG Board meetings, scrutiny committees, Cabinet and the District Councils, (for example via District Council Health and Wellbeing forums, the Housing and Health Members Advisory group, the Lightbulb Programme Board and District Council Chief Executives meetings).

Governance approvals for the Integration Programme can be complex but the governance planner and programme plan ensure activities are well coordinated and that individual organisations are engaged in the development, assurance and approval of plans with clear records of decisions and delegated authority where applicable.

The diagram below shows the current governance arrangements for the Integration programme and how the Integration Executive reports into the Leicestershire Health and Wellbeing Board.



The Integration Programme has participated in two internal audits to test the delivery and governance mechanisms associated with the programme including the BCF specifically, both of which have returned high levels of assurance. CCG and LA internal and external auditors are also closely involved in testing the financial arrangements and financial governance operating between the three commissioners who lead the s75 BCF.

While the above arrangements have served us well to date, with the introduction of the LLR STP, it is timely to review our local arrangements, especially as the new STP workstreams will bring together integration deliverables across the three LA footprints and we would wish to avoid duplication of effort and governance arrangements where possible.

18.5 STP Governance

The following LLR –wide workstreams will now involve oversight of some of the deliverables within the three BCF plans in LLR

- Integrated Locality Teams
- Home First
- Urgent Care
- Integrated Points of Access
- Prevention
- IM&T (e.g. for implementation of the electronic shared record, SCR2)

The progress of integration across health and care will therefore increasingly be delivered and measured on an LLR wide basis, with the BCF plans and pooled budgets as a key enabler to delivering improved models of care in LLR.

However the development, approval, submission, and quarterly monitoring of local BCF plans, including their national conditions, metrics and budgets is still required (via NHSE and DCLG) on the basis of each LA footprint for the next two financial years.

With the introduction of the IBCF (social care grant) in 2017/18, and the additional local and national assurance requirements this involved, a further aspect of governance is the role of the Adult Social Care Department's Transformation Board.

This pre-existing group will take day to day oversight of IBCF delivery from May 2017 onwards, with their outputs feeding into the Integration Executive and Integration Finance and Performance Group in the same way as other aspects of the BCF plan. The Director of Adult Social Care and the Council's Section 151 Officer will provide oversight of the quarterly reporting to DCLG in line with the LA grants conditions.

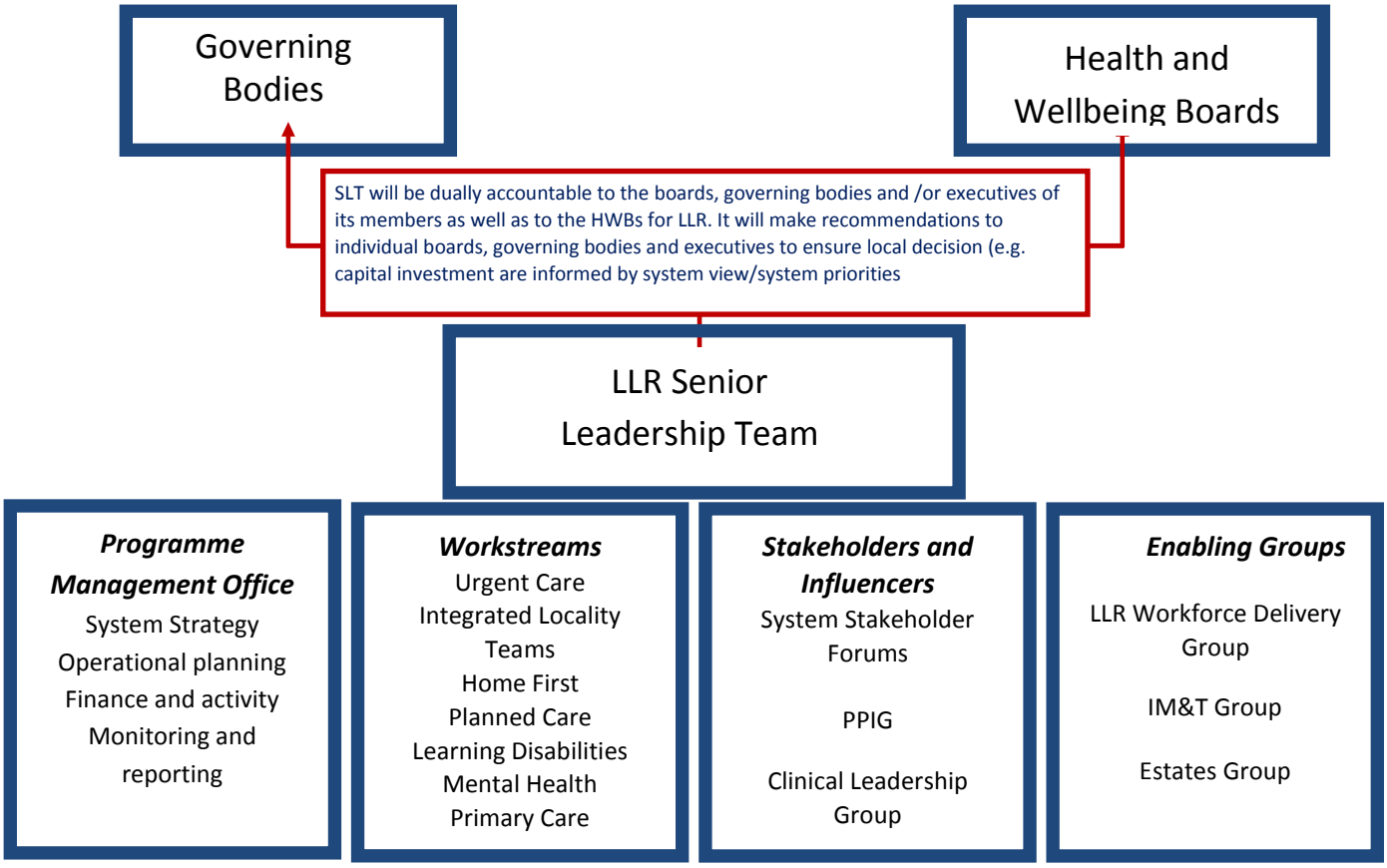
Given the above context, we will review our governance structures again in Q3 2017/18 so our programme arrangements keep pace with the evolving matrix working which is required to deliver specific BCF components, as well as keeping in place a lean local structure to govern assurance and reporting for the Leicestershire Health and Wellbeing Board area.

In addition to the issues noted above, it has already been agreed that each Health and Wellbeing Board in LLR should take a lead oversight role in one or more of the STP workstreams.

For Leicestershire this will be Integrated Locality Teams and Community Hospitals reconfiguration.

Local governance arrangements and terms of reference for the Health and Wellbeing Board have been being updated to reflect this and a paper setting out the Board's role and actions in this regard was presented at the January 2017 Health and Wellbeing Board meeting – see this weblink:
http://politics.leics.gov.uk/documents/s125463/Outputs%20from%20Development%20Session.pdf

A diagram showing the governance arrangements for the LLR STP is given below.



19.0 EQUALITY AND HUMAN RIGHTS IMPACT ASSESSMENT

Developments within the BCF Plan are subject to an equality impact assessment and the evidence base supporting the BCF Plan has been tested with respect to Leicestershire Joint Strategic Needs Assessment. An equalities and human rights impact assessment has been undertaken which is provided at - http://ow.ly/1sgC309cJUu .