Oadby and Wigston Borough Council

TO COUNCILLOR:

G A Boulter	Ms K M Chalk	Dr T K Khong
J W Boyce	J Kaufman (Chair)	

Dear Councillor et al

I hereby invite you to attend a meeting of the **HEALTH AND WELLBEING BOARD** to be held at the **COUNCIL OFFICES, STATION ROAD, WIGSTON** on **TUESDAY, 11 OCTOBER 2016** at **1.30 PM** for the transaction of the business set out in the Agenda below.

Yours faithfully

Council Offices
Wigston
03 October 2016

Mark Hall
Chief Executive

A G E N D A **P A G E N O ' S**

1. **Welcome by Chairman, Councillor Jeffrey Kaufman**
2. **Apologies for Absence**
3. **Minutes of the Previous Meeting held on 12 July 2016** **1 - 4**
4. **Communications Update**
5. **Oadby & Wigston Priority 2 - Diabetes / Healthy Weight**
6. **Any Other Business**
7. **Future Meetings**

MINUTES OF A MEETING OF THE HEALTH AND WELLBEING BOARD HELD AT THE COUNCIL OFFICES, STATION ROAD, WIGSTON ON TUESDAY, 12 JULY 2016 COMMENCING AT 1.30 PM

IN ATTENDANCE:

Chair - Councillor J Kaufman

COUNCILLORS (4):

G A Boulter	Ms K M Chalk	Dr T K Khong
J W Boyce	Dr T K Khong	

OFFICERS IN ATTENDANCE (4):

S Glazebrook	Ms A Lennox MBE	Ms J Morris
	Ms Henna Gohil (Note-Taker)	

OTHERS IN ATTENDANCE (12):

Dr V Varakantam	Ms S Rose	A Bohannon
N Thandi	Ms Liz Steel	L Wills
Cllr Mrs HE Loydall	Ms Suzanne Lucas	Ms J Leadbetter
Ms L Redfern	M Sandys	Cllr E White

Min Ref.	Narrative	Officer Resp.
9.	**WELCOME BY CHAIR** Chair, Councillor Jeffrey Kaufman, welcomed all attendees to the meeting. He confirmed that Oadby and Wigston Health & Wellbeing Board (HWBB) has recently gone through a re-structure. Whilst the HWBB does not have any funding to support or deliver projects, the aim of this group is to bring key decision makers together from a range of local health providers to review local health data, share information on service provision and lobby for change. Each planned meeting will concentrate on a particular area of health. This meeting has a focus on Dementia and Mental Health. Attendees were asked to bring information about their projects or programmes that are taking place across Oadby and Wigston (or planned to take place), which aim to address these priorities. In addition to confirming what outcomes will be achieved through the delivery of such programmes. A 'Partner Organisation Priorities' form was handed out to each external attendee, in order to capture organisational aims and objectives over the coming year; in order to help map the priority of Mental Health and Dementia across the borough.	
10.	**APOLOGIES FOR ABSENCE** An apology of absence was received from James Naylor, Contract Manager at Parklands Leisure Centre.	
11.	**COUNTY HEALTH AND WELLBEING UPDATE**	

	Ernie White and Mike Sandys (County Health & Wellbeing Board) provided their County update. Topics included Transforming Health and Care across Leicester, Leicestershire and Rutland; the National requirements of the Better Care Fund; and an overview of the Leicestershire Integration Plan 2016/17. The County Board thanked everyone at a local level for their current contribution. There is a need to improve integration with District and County, to provide more power at a district level as they are better placed to understand the needs of the community. Difficulties at a County level as Health Grants being cut by 6% (1.6 million saving needed) without consulting with colleagues. Therefore Health & Wellbeing board reviewing its priorities to manage Health and Wellbeing with a need to manage reductions in public health grants. The County Board realises there is a need to reduce emergency admissions and reduce the reliance on Hospital care by concentrating on identifying the most vulnerable residents and a greater need to support ethic minority communities. Also a need to do more regarding signposting for people struggling to get help and advice. The County Board can press for better services and co-ordination and for providing up-to-date advice and an online list of services and charities that can help. Copies of County's presentation papers can be found in Appendix 1, 2 and 3. In addition Mike Sandys forwarded a copy of the draft 'Joint Health and Wellbeing Strategy 2017 - 2022' (Appendix 4). Comments to be forwarded direct to Mike.Sandys@leics.gov.uk	
12.	**<u>OADBY AND WIGSTON PRIORITY 1 - DEMENTIA/MENTAL HEALTH (KEY ACTIONS)</u>** Phoenix Therapies and Training provides over 25 years experience to improving mental wellbeing. They provide a stress relief toolkit to maintain positive outcomes and reduce mental health issues in communities. The aim is to teach people skills on how to be happy and successful and feel positive in situations, offering a working relationship with clients. They focus on helping people who are scared to build bridges between needing medical services and access to them. They also train professionals to improve the help they give to patients. The main aim is to take pressure off GPs and the Cedar Centre, providing early intervention and support. Copy of the presentation can be found at **Appendix 5.** **Introductions – Around the Table Discussion** **Nic Thandi – Alzheimer's Society** • The Alzheimer's Society runs dementia support groups across Leicester City, Leicestershire and Rutland. • Offers support information programmes and community programmes and provides support and activity groups. • Provides early onset groups, members of the public need to book onto these groups. • Set up Dementia Action Alliance which focuses on supporting people	

with dementia and their carers.
- Main aim is to prioritise links with GPs, work to engage with other communities, being realistic about utilising communities.

Suzanne Lucas – J&S Day Service

- J&S Service offers day services for people with dementia, opening on 15th August in South Wigston.
- Offers support and advice for carers.
- Focuses on the critical end of dementia.
- Taking referrals through Adult Social Care or self funded. Can meet 15-20 people per day.

Helen Loydall – Senior Citizen Advice Group

- Senior Citizen Advice Group provides forums with various speakers regarding dementia, approximately 60 – 70 attend each forum.
- Sends information via mailing list to residents, 900 residents on register.
- Organises the annual Young at Heart day.

Sharon Rose – C.C.G.

- Clinical Commissioning Group is creating work plans with GPs to work on dementia.
- Trying to identify patients with dementia, increasing numbers on register diagnosed with dementia.
- Commissioning services from Leicestershire Partner Trust.
- Offering Better Care Together – can allocate patients to a social worker.
- Looking at ways to offer a practical support with difficult patients.
- Question arises on struggle to contact CCG and a need for information early on without waiting for diagnosis.

Lynn Redfearn – Rethink, Adult Mental Health

- PCT funded – to look after careers dealing with mental health issues, help to signpost them to receive support.
- Provides support, caring and coping groups.
- Trying to prevent admission to hospitals.
- Provide support groups at Cedar Centre.

Jane Morris – Boulter Crescent Project

- ADHD & ASD support, planning to set up groups in community flat.
- Public Health funding Incredible Editable Project – growing vegetables outside Boulter Crescent for tenants.
- Boulter Crescent available as a venue, free of charge.

Avril Lennox – Health & Leisure O.W.B.C

- Commission funding drawn down to provide a range of physical activity projects across the borough, including Sportivate programme aimed at young people experiencing mental health concerns. In addition to health walks for dementia patients and physical activities for children.

	• Working on retirement project for over 50s and carers. **Age UK** • Provides short respite breaks for people who are caring for an older person with dementia. • Age UK provide a day service for people with dementia that operates in Paddock Street, Wigston. Actively working to ensure that organisation is dementia friendly. This is a combination of training for staff and volunteers, awareness raising –for example, encouraging staff, volunteers and other supported to become Dementia Friends or Dementia Ambassadors, auditing our venues and other infrastructure to ensure e that Age UK are welcoming and accessible to people with dementia and their carers.	
13.	**COMMUNICATION** **Oadby and Wigston Health & Wellbeing Board:** Aim to gather information to create an online information portal for health professionals and members of the public, in order to provide signposting to appropriate local services.	
14.	**DATES OF FUTURE MEETINGS** The Chair confirmed that each HWBB meeting will have a key focus, with the last meeting in April acting as the O&W Annual Health summit to review outcomes and set future priorities. A core list of Members will attend all meetings, with specialist health professionals invited to selected meetings where they can feed into the HWBB 2016/17 priorities based on their specialist area. • **Tuesday 11 October 2016** – Diabetes/Healthy Weight • **Tuesday 10 January 2017** – Substance/ Alcohol Misuse • **Tuesday 4 April 2017** – Annual Health Summit	

THE MEETING CLOSED AT 3.30 PM

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CHAIR

TUESDAY, 11 OCTOBER 2016

Briefing Paper for District Health and Wellbeing Forums

SECTION 1: HEALTH AND CARE

1.1 Transforming Health and Care across Leicester, Leicestershire and Rutland (LLR)

Since 2014 we have been engaged in the Better Care Together Partnership www.bettercareleicester.nhs.uk.

A five year plan has been developed to change the local health and care system so that more care is delivered in community settings in the future, and to reduce the over reliance on hospital care, particularly urgent care.

The Better care Together Programme is led by a multiagency partnership board whose representation includes the Chairs of all 3 Health and Wellbeing Boards in LLR.

During 2016/17 there are some new policy and planning requirements affecting the NHS and Local Government in particular:

- A new place-based five year sustainability and transformation plan (STP) is to be developed by the end of June.
- A digital roadmap for the NHS - setting out how technology across the health and care system will develop to achieve paperless NHS systems, interconnectivity between NHS systems, AND interconnectivity between NHS and social care systems - so that care records and care management is digital and accessible across organisational and professional boundaries.

For our local area, the planning footprint for the STP and the digital roadmap will be LLR. The STP will incorporate work to date on the Better Care Together plan, but will also be expected to cover broader elements, such as the wider determinants of Health and Wellbeing including prevention.

The STP will focus on a small number of system wide priorities in order to make our health and care system sustainable, including financially sustainable in the future.

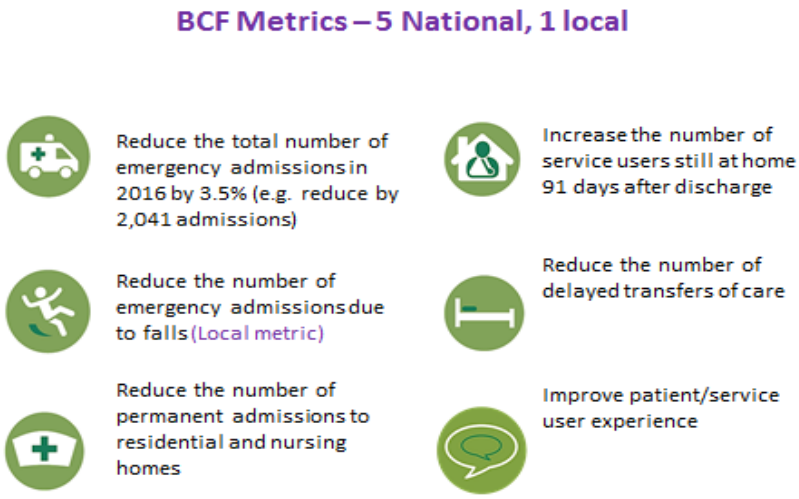
The digital roadmap will build on the existing technological systems already in place in LLR, improving access to a digital shared care record and moving towards a smaller number of NHS IT systems, that have the required interconnectivity.

1.2 Our Integration Programme and the Better Care Fund – Leicestershire

Since 2015 each Local Authority has been required to set out a local plan, approved by the Health and Wellbeing Board, to improve the integration of health and care, and to fund this using a pooled which operates between the Local Authority and the local clinical commissioning groups. This is known as the "Better Care Fund". In Leicestershire in 2016/17 this represents a £39m pooled budget. Each BCF plan must demonstrate how it will deliver to national requirements and plans are assessed against these requirements annually and quarterly by NHS England.

The National requirements of the Better Care Fund are:

1. Delivery against prescribed BCF metrics



(Appendix 1 of the supplementary packet provides a more detail description of each of the metrics)

2. How a proportion of the fund will protect adult social care services;
3. How data sharing and data integration is being progressed using the NHS number *(the NHS number is the unique identifier for each individual which is used on all NHS records);*
4. How an accountable lead professional is designated for care planning/care co-ordination;
5. Delivery of Care Act requirements;
6. How a proportion of the fund will be used to commission care outside of hospital;
7. How seven day services will be supported by the plan;
8. That the impact on emergency admissions activity has been agreed with acute providers;
9. That there is a locally agreed proactive plan to improve delayed transfers of care from hospital;
10. That Disabled Facilities Grant (DFG) allocations within the BCF will be used to support integrated housing solutions including the delivery of major adaptations in the home;
11. Approval of the BCF plan by all partners, assured via the local Health and Wellbeing Board.

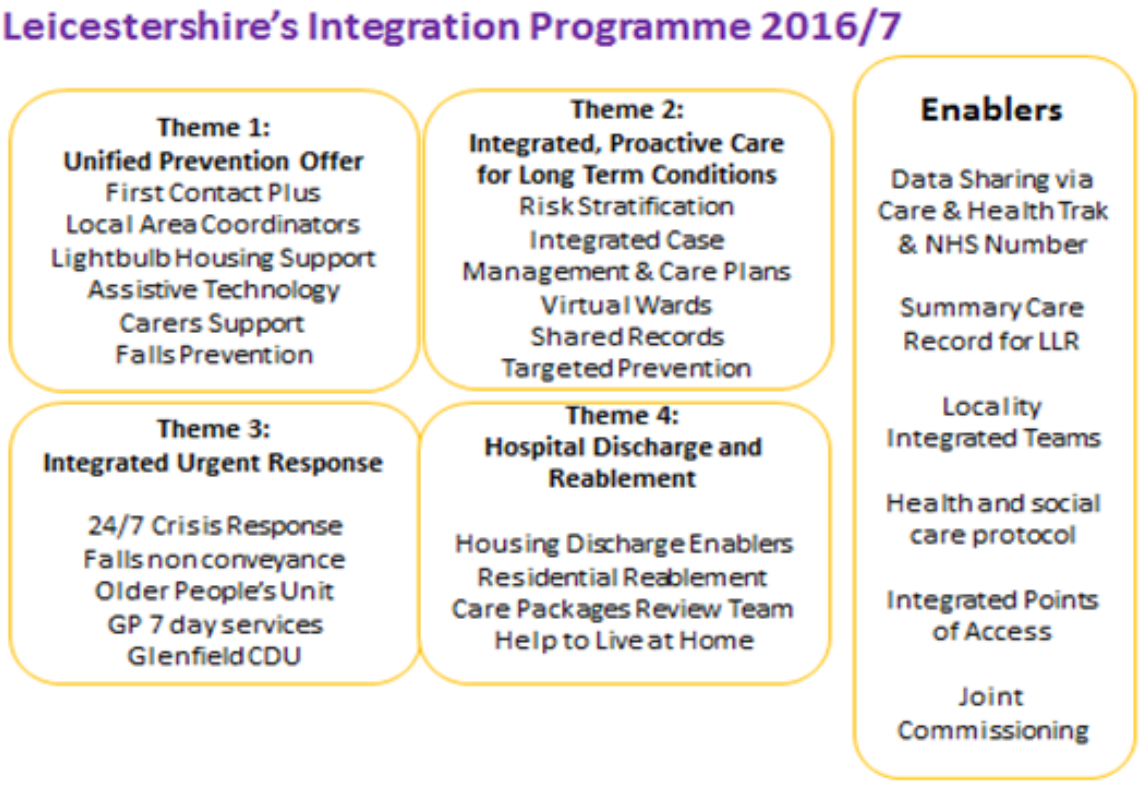
1.3 Overview of the Leicestershire Integration Plan 2016/17

The Leicestershire Vision for Integration is: *We will create a strong, sustainable, person-centred, and integrated health and care system which improves outcomes for our citizens*.

The aims of the 2016/17 the Integration programme are:

1. Continue to develop and implement new models of provision 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: • **LLR five year plan** • **New models of care.**	**5. Manage an effective and efficient pooled budget across the partnership to deliver the integration programme.**	**6. Develop Leicestershire's "medium term integration plan" including our approach to devolution.**

The Integration Programme has four themes, within which individual projects are developed and delivered, and is supported by a range of enablers. The diagram below, which is an extract from the BCF plan, summarises the components.



- **Theme 1** - Unified Prevention Offer - a range of social prescribing interventions, which can be navigated using "First Contact Plus." These include local area coordinators based in communities helping vulnerable people, support to carers, housing solutions, and falls assessment clinics.

- **Theme 2** - Long Term Conditions - is targeted to improving the identification of people with Long Term Conditions with integrated and proactive case management across health and social care.

- **Theme 3** - Integrated Urgent Response - contains schemes targeted to reducing emergency admissions. These include a community based assessment service for frail older people, the crisis response and falls services which provide rapid response and care at home instead of in hospital, seven day services within GP practice, and an improved pathway of care for people at risk of admissions for respiratory and cardiac problems.

- **Theme 4** - Hospital Discharge and Reablement - is targeted to support people to be maintained in the community following a hospital admission, to prevent readmissions, avoid or delay permanent admission to residential care. There is a multiagency plan for sustaining good performance on delayed transfers of care from hospital which includes:
    - Follow up service for home care packages two weeks after discharge
    - Housing offer targeted to improving hospital discharge
    - Improved LTC case management in localities
    - A range of community based care alternative pathways to avoid admission/readmission
    - A new domiciliary care service "Help to Live at Home" being implemented from November 2016.

1.4 Supporting Information for Leicestershire's Better Care Fund Plan/Pooled budget

Our "BCF plan on a page" can be found at Appendix 2 of the supplementary packet. This shows our journey during 2015/16 illustrating some of our key achievements along with a summary of what we are focusing on for 2016/17.

If you would like to read our full BCF plan we have provided this document for your reference (BCF Public Summary) which can be found at Appendix 3 of the supplementary packet

The 2016/17 BCF spending plan, is at Appendix 4.

SECTION 2 – PUBLIC HEALTH AND PREVENTION

2.1 Public Health

A great deal of work is being done to help us save £3m from the public health grant in response to the national reduction in the level of that grant. In addition to work on reducing the spend on health checks, and a switch to an on-line Chlamydia screening service, Public Health are redesigning the smoking cessation service.

There will still be a universal service across Leicestershire, but the intention is that the current face-to-face service will be replaced by one using telephone, text and on-line web chat style support, including the use of Skype. This service is due to be in place by the turn of the year.

2.2 Prevention Review

In February 2016 Leicestershire County Council engaged the consultancy firm Peopletoo, to develop a broad medium term strategy for early help and prevention services to support a new target operating model (TOM) that is efficient, enables the delivery of strategic outcomes and that represents value for money.

The work was completed and resulted in an Early Help and Prevention Strategy, and findings from a review into the current provision of early help and prevention services across Leicestershire County Council.

The strategy encompasses a vision for early help that, by 2018 we will have a comprehensive offer for community based prevention for the citizens of Leicestershire, funded by bringing together all the resources available to Local Councils and partners.

The strategy sets out a clear direction of travel that outlines a more integrated approach across the Council, and indeed Leicestershire, for the provision of early help and prevention activity. The strategy seeks to build upon the good practice and existing strategies of the Council; identifying areas where these can be further developed e.g. the Council's Commissioning and Community strategies. The strategy will deliver savings of just over £3m in the course of the current MTFS.

The strategy also describes the way by which the Council's related assets and services could be refocused on better supporting outcomes through new and modern ways of providing early help and prevention e.g. through greater use of Local Area Co-ordinators.

Governance Proposal and Outline Programme Approach

In order to deliver the implementation plan outlined within the report, it is proposed that the eight workstreams set out in the recommendations of the strategy are configured as a programme. The workstreams are:

- Commissioning
- Information and Advice
- Local Area Co-ordination
- Assistive Living Technology
- Children's centres
- Partnerships
- Communities Strategy

The Senior Responsible Officer (SRO) for this programme is the Director of Public Health as corporate lead.

The lead for member for health within the County council, and chair of the Health and Well Being Board, Mr White CC, will be the lead member for the prevention review.

2.3 BCT/STP Prevention Strategy

Work continues on embedding prevention within Better Care Together and the Sustainability and Transformation Plans of the NHS.

A BCT prevention strategy sets out the need for the NHS to get prevention (the more secondary care focussed areas) within the clinical workstreams like children's and maternity. It also recognises that the role of local government, with districts and boroughs being key in that, on planning, transport, housing, etc will make a real difference to the health of the population.

Rob Howard, consultant in public health, has worked with Harborough, Melton and Blaby Councils on making the most of the potential health gain through developments like Lubbersthorpe and local plans and would welcome other districts using public health expertise in health impact assessment to really improve the health of the population.

SUPPLEMENTARY PACKET

APPENDIX 1 – BCF Metrics

The following table explains the definition of each of the BCF metrics, and the rate of improvement partners are aiming for in each case. Some metrics rely on data produced annually or quarterly, hence the narrative indicates the likely position based on most recent data available.

National Metric (1)	Definition	Trajectory of improvement
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.	The target for 2016/17 has been set at 630.1 per 100,000 based on the 2015/16 target of 670.4 per 100,000 and a 90% confidence level that the trajectory is decreasing. Current performance is on track to achieve the target for 2015/16. As part of the development of a four year adult social care strategy, detailed analysis of this metric has taken place and the target set accordingly. In 2014/15 there were 710.5 permanent admissions per 100,000 people. In 2015/16 this is likely to reduce to 669.6 per 100,000 people.

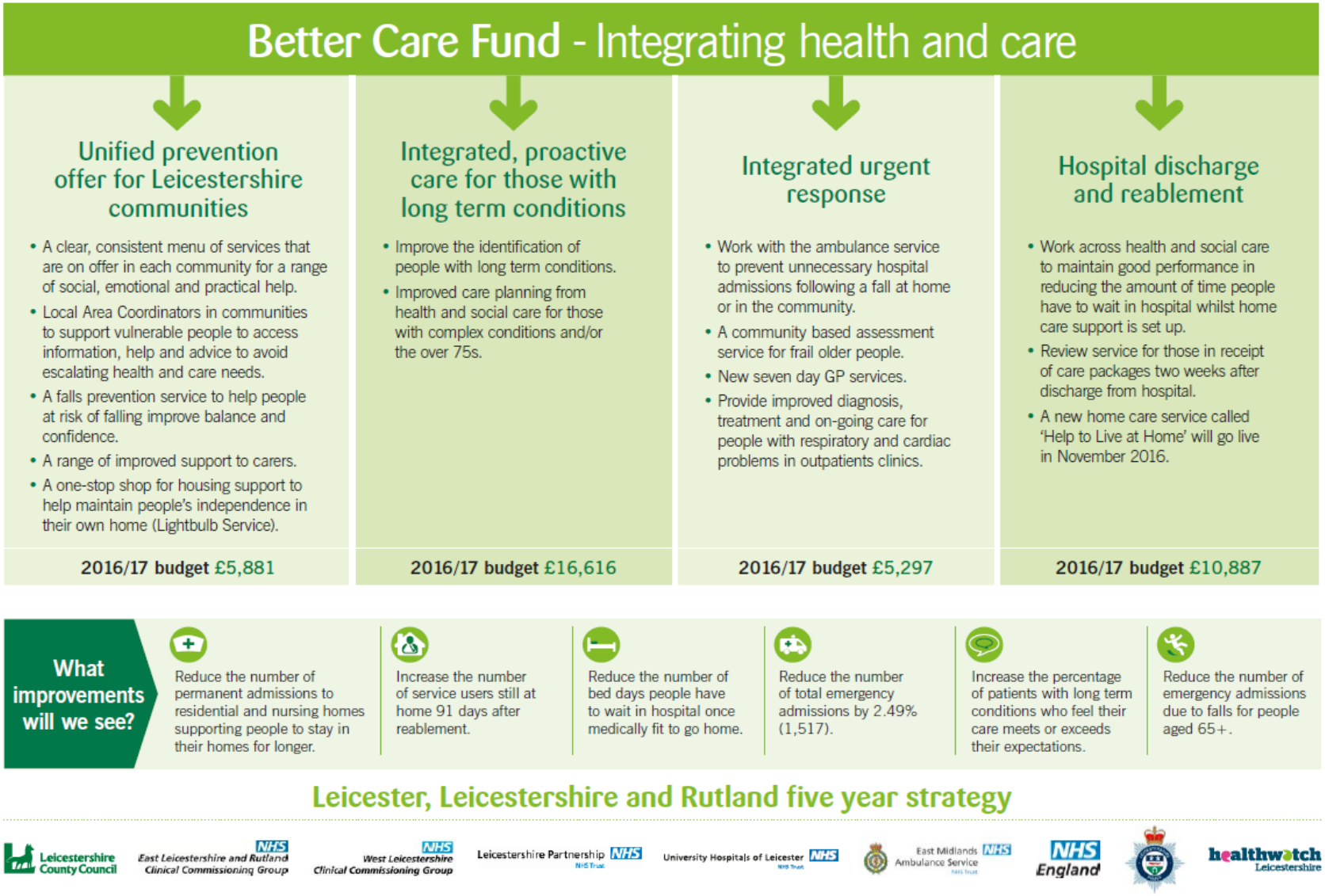
National Metric (2)	Definition	Trajectory of improvement
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	This is a nationally defined metric measuring delivery of the outcome to increase the effectiveness 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.	The target for 2016/17 has been set at 84.2%, based on the expected level of 82.6% being achieved in 2015/16 and a 75% confidence interval that the trajectory is increasing. The lower confidence interval has been chosen to ensure that the target is realistic and achievable. Performance is currently on track to meet the 2015/16 target of 82.0% As part of the development of a four year adult social care strategy, detailed analysis of this metric has taken place and the target set accordingly. In 2014/15 83.8% of reablement service users were still at home after 91 days. In 2015/16 this is likely to reduce to 82.6%. Due to the introduction of a Help to Live at Home scheme planned for November 2016, a conservative target has been set.

National Metric (3)	Definition	Trajectory of improvement
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.	Recent reductions in delays have focussed on interventions in the acute sector. We have therefore set a target based on reducing the number of days delayed in non-acute settings by 0.5%, while maintaining the rate of days delayed in acute settings at its current low level. The targets are quarterly and are 238.0, 233.3, 215.9, 220.7 for quarters 1 to 4 of 2016/17 respectively. As part of the development of a four year adult social care strategy, detailed analysis of this metric has taken place and the target set accordingly. Substantial improvement in the rate of days delayed has been achieved – the annual rate has dropped from 4,753 per 100,000 in 2014/15 to a probable 2,730 per 100,000 in 2015/16.

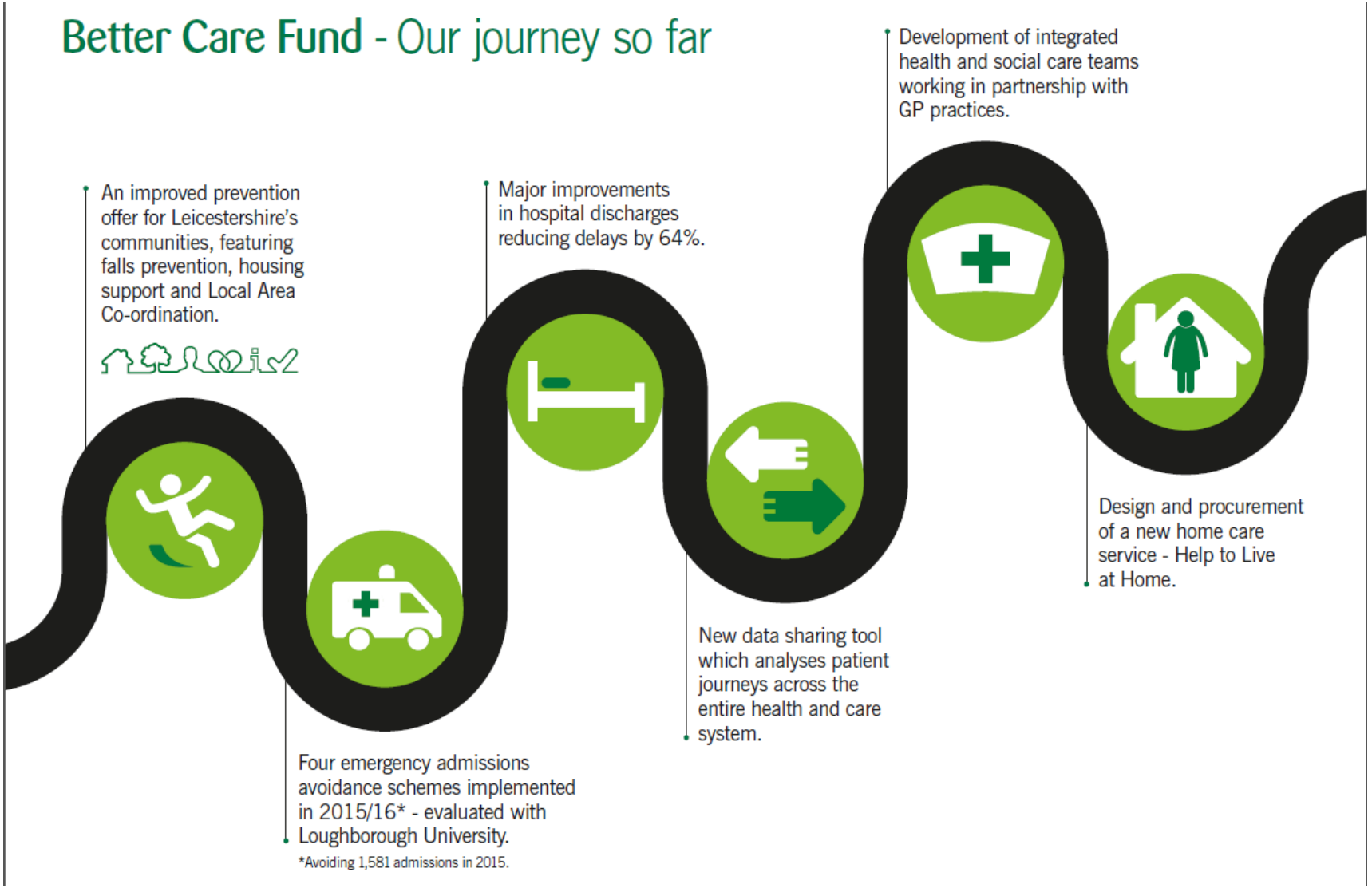
National Metric (4)	Definition	Trajectory of improvement
Non-Elective Admissions (General & Acute)	This is a nationally defined metric measuring the reduction in non-elective admissions which can be influenced by effective collaboration across the health and care system. Total non-elective admissions (general and acute) underpin the payment for performance element of the Better Care Fund.	In 2014/15 there were 58,479 non-elective admissions for Leicestershire residents, In 2015/16 it is likely that there will be 59,957. The proposed target for 2016/17 is 726.38 per 100,000 per month, based on a 2.49% reduction on the probable number of non-elective admissions for patients registered with GP practices in Leicestershire for 2015/16 (allowing for population growth). This equates to no more than 58,836 admissions in 2016/17. This assumption has been aligned with final CCG operational plan targets. All existing admission avoidance schemes have been subject to evaluation in 2015/16, and the results reflected in the development of a trajectory of 1,500 avoided admissions from these schemes in 2016/17.

National Metric (5)	Definition	Trajectory of improvement
 **Improved Patient Experience**	Selected metric for BCF Plan from national menu: - taken from GP Patient Survey: "In the last 6 months, have you had enough support from local services or organisations to help manage long-term health condition(s)? Please think about all organisations and services, not just health." The metric measures the number of patients giving a response of "Yes, definitely" or "Yes, to some extent" to the above question in the GP Patient Survey in comparison to the total number of responses to the question.	It is proposed to set this target at 63.5% for 2016/17 (data will be released February 2017). This is based on the 2015/16 target (data due for release July 2016) and a 2% increase in the number of positive replies. Current performance of 61.6% (January 2016) is below the England average of 63%.

APPENDIX 2 – BCF Plan on a Page



Better Care Fund - Our journey so far



June 2016

Summary document

Leicestershire's Better Care Fund Plan 2016/17

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

SECTION 7: GOVERNANCE OF THE LEICESTERSHIRE BCF PLAN

7.1 Summary of Governance Arrangements

7.2 Assurance for the 2016/17 BCF Plan via the Health and Wellbeing Board

7.3 Measuring the Impact of the Leicestershire Better Care Fund Plan

7.4 Programme and Risk Register for 2016/17

7.5 Equality and Human Rights Impact Assessment

SECTION 8: SUMMARY OF ENGAGEMENT UNDERTAKEN

8.1 Refresh Engagement Activities

8.2 HTLAH Provider Workshops

8.3 Evaluation Study Engagement Workshops

8.4 Microsite Development

SECTION 1: OUR VISION FOR HEALTH AND CARE INTEGRATION

1.1 Our Vision

Our vision remains as set out in our original Better Care Fund (BCF) plan submission in 2014.

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

Our vision in 2014 was built upon four fundamental strategic drivers, two of which are local drivers, and two of which are national, all of which still continue to be fundamental to our integration plans from 2016/17 onwards.

Better care together
Leicester, Leicestershire & Rutland health and social care

Better Care Together 5 Year Strategy: Leicester, Leicestershire and Rutland
www.bettercareleicester.nhs.uk/information-library/better-care-together-plan-2014/

National Voices
People shaping health and social care

National Voices: Principles For Integrated Care
www.england.nhs.uk/wp-content/uploads/2013/05/nv-narrative-cc.pdf

The King's Fund

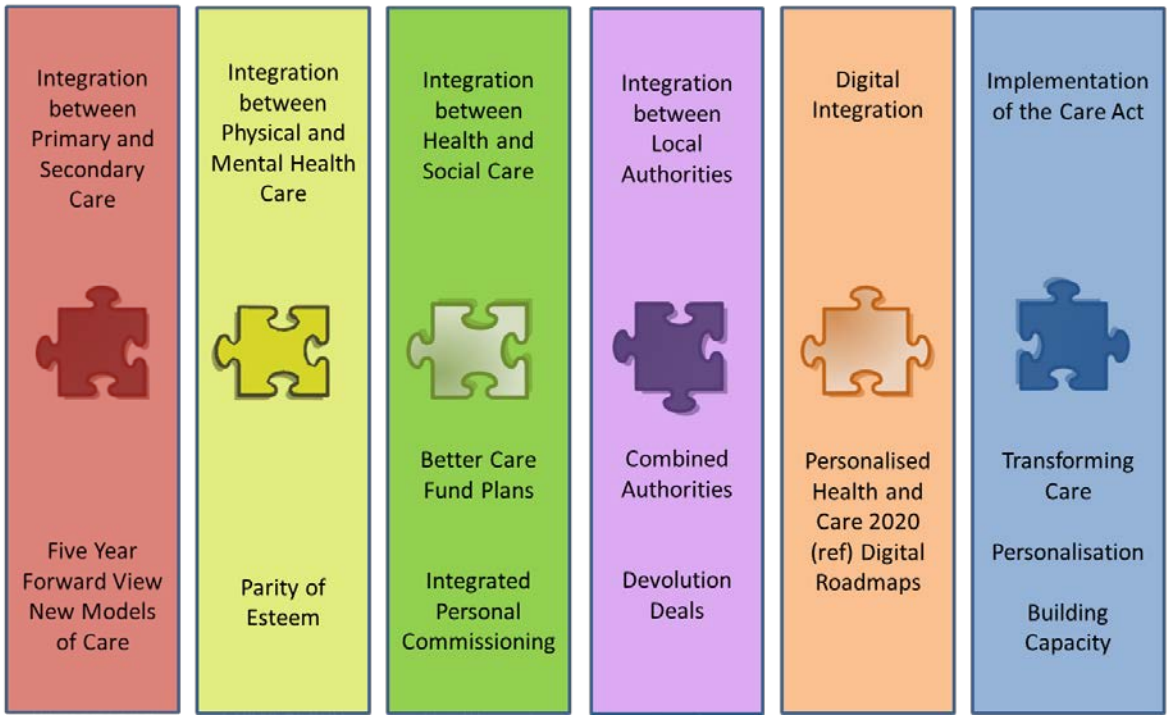
The King's Fund: Integrated, Person Centred Care
www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population

Leicestershire's Joint Health and Wellbeing Strategy
www.leics.gov.uk/healthwellbeingboard.htm

1.2 Policy Developments

Over the last 18 months the policy landscape for health and care integration has continued to evolve. We have developed the diagram below to show the main "pillars" of national policy that are promoting and driving integration, recognising there are many other contributing factors.

How National Policy Developments are promoting and driving integration



During 2016/17 there are some new areas of policy affecting the NHS and Local Government which are referred to in the above pillars diagram – in particular:

- A new place-based five year sustainability and transformation plan (STP). For our local area this will cover the geography of Leicester, Leicestershire and Rutland.
- The STP will incorporate our existing five year strategy for transforming health and care (the Better Care Together plan), but will also be expected to cover broader elements, such as the wider determinants of Health and Wellbeing including prevention.
- Medium term integration plans will be required by March 2017 covering the period 2017-2020.
- Arrangements for combined authorities and devolution deals are also being developed within local government.

1.3 Key Challenges for the Leicestershire Better Care Fund for 2016/17

Urgent Care	• The demands on the acute care system are the local health and care economy's greatest risk to sustainability. Total emergency admissions in Leicestershire have risen again over the past 12 months. In 2014/15 there were 60,447 non-elective admissions for Leicestershire residents, and in 2015/16 the forecast out turn is 62,432. • Three of the four BCF emergency admissions avoidance schemes implemented in Leicestershire delivered measurable impact on admissions avoidance for specific groups of patients. • The 2016/17 BCF includes new GP 7 day services schemes and a new admissions avoidance scheme targeted to adults with cardio/ respiratory conditions. • Sustaining our good performance on improving delayed discharges from our local acute hospital relies on existing interventions continuing to maintain their impact. • Our plans for 2016/17 focus on improving delayed discharges from acute hospitals outside of the county and from local community and mental health inpatient settings. • A more rigorous implementation plan for falls prevention is being implemented in 2016/17 as part of a new Leicester, Leicestershire and Rutland (LLR) wide falls strategy. • An integrated housing solutions and housing support to deliver measurable health and wellbeing benefits will be a key feature of our workplan in 2016/17, through the development of the Lightbulb Service business case in conjunction with District Councils.
Integrating Data and Technology	• Although progress has been made on data integration using the NHS Number and the Pi Care and Healthtrak tool in 2015/16, further work is needed on the integration of records and data across agencies for direct care and case management in community settings. This will be a focus of the 2016/17 BCF plan in conjunction with the LLR IM&T strategy.
Financial Constraints	• Reduced financial allocations and the scale of financial pressure and savings required across the partnership impact on the ability of partners to commit to new initiatives, unless funds are reallocated between existing commitments, existing schemes are decommissioned or transformation funds can be accessed, especially for delivering return on investment within a one to three year horizon. • Despite this, partners must maintain delivery across the BCF plan metrics and national conditions as well as deliver a medium term

	view of transformation for years three to five. • To do this even more rigour in benefits realisation, with more sophisticated methodologies for predictive modelling and measuring impact will be required and greater alignment will be needed between the local BCF plans, the medium term integration plan (to 2020) and the LLR-wide five year plan/STP. • The 2016/17 BCF plan will include a focus on developing a commissioning framework for integrated commissioning across LA and NHS partners. This will have emphasis on seeking further savings and value for money for joint commissioning, as well as assuring quality and driving further innovation in models of integrated provision.

1.4 Aims of the Leicestershire BCF Plan 2016/17

The aims of the Leicestershire BCF plan have been refreshed in light of the strategic policy context and the work to develop our vision and ambition post March 2016. The revised aims are as follows:

1. Continue to develop and implement new models of provision 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: • **LLR five year plan** • **New models of care.**	**5. Manage an effective and efficient pooled budget across the partnership to deliver the integration programme.**	**6. Develop Leicestershire's "medium term integration plan" including our approach to devolution.**

SECTION 2: LOCAL CASE FOR CHANGE

2.1 Summary Overview of Case for Change Analysis

A number of existing documents provide a consistent analysis of the case for change in the local health and care economy in LLR:

Leicestershire's 2014 BCF submission	The analysis focused for example on the specific needs of older people, the over use of the urgent care system, the improvements still needed in the proactive case management of people with long term conditions (LTCs) and frailty, the problems being experienced with hospital discharge. We considered the case for change and a range of evidence underpinning each theme of our of our BCF plan.
The LLR Better Care Together five year plan	This considers the overall sustainability of our health and care system across a wider geographical footprint and the associated reconfiguration opportunities within LLR, in particular the shift of care from acute to community settings and how improvements in priority care pathways could drive this reconfiguration.
Leicestershire's Joint Strategic Needs Assessment and Leicestershire's Joint Health and Wellbeing Strategy	These documents consider the specific health outcomes where improvements are still needed for the local population in Leicestershire including for example improving mental wellbeing.
Public Health Summary Needs Analysis 2015	This analyses the specific needs of the Leicestershire population in terms of trends in mortality, disease, illness and lifestyle factors using the most recent public health data
The Urgent Care Vanguard Value Proposition	This focuses on the gap between the current model of urgent care operating in LLR and what a redesigned urgent care system based on best practice could deliver.
Population level risk stratification	This shows from April 2015 to December 2015, 44% of all emergency admissions at University Hospital Leicester (UHL) for Leicestershire residents have been for patients aged 70 and over. For those aged 70 and over, length of stay tends to be longer, and admissions for this age group account for 60% of the bed days, and 56% of the health service costs. The analysis also shows the profile healthcare costs of Leicestershire's population with LTCs in the over 70 age group. This shows that most of the costs (63%) for emergency admissions to UHL for those aged 70 and over are for patients with between two and four LTCs. This amounts to over £13.5 million of costs for April - December 2015. In Leicestershire in 2015, almost 62,000 (46% adults aged 65 or over were predicted to have at least one limiting long-term illness (JSNA 2015). Of these, hypertension is the most costly long term condition and 78% of the costs for this condition can be attributed to patients aged 70 and over.

Summary of Customer Insight Analysis that has informed the BCF Refresh	• Service user metrics have been analysed to assess opportunities for improvements in the experience of local people using integrated care and support across settings of care in Leicestershire, including the quality of life score in the Adult Social Care Outcome Framework, support for people with LTCs via the GP survey, and experience of coordination of care and support on discharge from the CQC inpatient survey. • The BCT Frail Older People customer insight survey undertaken in 2015 identified a number of important themes which indicate carers feel unsupported and isolated in our health and care system. • Findings from the engagement with service users undertaken for the introduction of the "Help To Live At Home" domiciliary care services have been used to shape the outcomes and service model. • Findings from the engagement with service users undertaken during the evaluation of the emergency admissions avoidance schemes, with Loughborough University, have been used to shape service redesign within the BCF in 2016/17. • Findings from the customer insight analysis undertaken for the Lightbulb Housing Project are being used to design the service model for the Lightbulb Service business case, which is currently being prepared. • Findings from engagement with service users on integrating customer services points of access across health and care have been used to inform the future options and solutions for an LLR wide operating model.

How the Leicestershire BCF Plan Responds to the Case for Change

There is an ongoing need to focus community based interventions on those with LTCs, frailty and the growing population of the over 70s - to reduce the level of activity and costs associated with acute care in favour of a shift into proactive and preventative care in community settings.

Theme 1 of the Leicestershire BCF (Unified Prevention Offer) provides a range of interventions under the banner of social prescribing including local area coordination to support vulnerable people with low level support to avoid escalating need/demand management, offers a range of improved support to carers and new integrated housing services through the lightbulb project.

Theme 2 of the Leicestershire BCF (Long Term Conditions) is directed to improving the identification of people with LTCs and providing integrated and proactive case management across health and social care.

Theme 3 of the BCF (Integrated Urgent Response) contains seven schemes targeted to reducing emergency admissions by 2.49% in 2016/17. These include a community based assessment service for frail older people, case management for the over 75s including via seven day services, a new falls service to avoid unnecessary admissions for older people,

extends the seven day services offer within primary care and provides an improved ambulatory pathway for people with respiratory and cardiac problems.

Theme 4 of the BCF (Hospital Discharge and Reablement) is targeted to improving reablement and supporting hospital discharge more effectively through:

- A proactive and effective multiagency plan for sustaining good DTOC performance which includes:
    - Follow up service for home care packages two weeks after discharge Housing offer targeted to improving hospital discharge (Theme 1).
    - Improved LTC case management in localities (Theme 2).
    - A range of community based care alternative pathways to avoid admission/readmission.
    - A new domiciliary care service “Help to Live at Home” being implemented from November 2016.

All of which are targeted to support people to be maintained in the community following a hospital admission, and avoid or delay permanent admission to residential care.

SECTION 3: OUR TRACK RECORD OF DELIVERY IN 2015/16

3.1 Progress Achieved by the 2015/16 BCF Plan

The Leicestershire BCF Plan is delivered under four themes. The themes are 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, where applicable.

BCF THEME 1: **Unified Prevention Offer** • 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.	**BCF THEME 2:** **Long Term Conditions** • Integrated, proactive case management from multidisciplinary teams for those with complex conditions and/or the over 75s. • Integrated data sharing and records, for risk stratification, care planning and care coordination.
BCF THEME 3: **Integrated Urgent Response** • Integrated, rapid response community and primary care services 24/7 • Working together to avoid unnecessary hospital admissions, supporting people at home wherever possible.	**BCF THEME 4:** **Hospital Discharge and Reablement** • Safe, timely and effective discharge from hospital, via consistent pathways, reducing length of stay • "Home First" philosophy, focused on reablement and maintaining independence.

3.2 Progress by Theme

Implementation of the integration programme in Leicestershire continues at pace.

The following table is a summary of our achievements to date:

Unified Prevention Offer ✓ Launched Local Area Coordinators in eight localities to support vulnerable people and extend the availability and uptake of our community based assets. ✓ Implemented the Lightbulb Housing Offer with pilots operating across three localities targeted to improving health and wellbeing. ✓ Redesigning adaptation processes with district council partners and designing a new "housing MOT."	**Integrated, Proactive Care for those with Long Term Conditions** ✓ Rolled out integrated locality working between community nursing and social workers so that they 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. ✓ Adopted NHS number onto 94% of adult social care records.
Integrated Urgent Response ✓ Implemented the frail older people's assessment unit at Loughborough Hospital with 540 people referred and 377 avoided admissions between January to December 2015. ✓ Trained 81% of paramedics in the falls risk assessment tool so that an average of 37% people per month are now not conveyed to hospital; but receive care and support at home instead. ✓ Implemented Night Nursing so that our existing Integrated Crisis Response Service can operate 24/7, with 470 referrals and 437 avoided admissions achieved in the Night Nursing service during 2015. ✓ Piloted seven day services in primary care across both CCGs with evaluation findings informing models and admissions avoidance assumptions for 2016 onwards. ✓ Achieved 1,581 avoided admissions from the above schemes between 1st January 2015 and 31st December 2015, against a target of 2,041.	**Hospital Discharge and Reablement** ✓ High impact interventions prioritised for 2015/16 BCF funding for improving DTOC, which ensured we achieved the DTOC target in Q1 (for the first time since 2011) and sustained good performance throughout 2015/16. ✓ Introduced dedicated housing support to acute and mental health inpatient settings to support hospital discharge, (featured in the HSJ in October). ✓ Redesigned domiciliary care service resulting in business case and joint specification for NHS and LA partners to commission a new service with effect from 2016/17.

3.3 Progress with BCF Enablers in 2015

Progress with BCF Enablers in 2015
• Implemented Care and Healthtrak – the new data integration tool for LLR. Care and Healthtrak is now a business as usual tool for measuring the impact of Better Care Together and BCF/integration developments in LLR. • Introduced the safe minimum transfer data set for hospital discharge. • Individual trajectories developed for each of the emergency admissions avoidance schemes with ongoing performance management. • Evaluated the emergency admissions avoidance schemes in conjunction with Loughborough University, Healthwatch Leicestershire and SIMUL8 to inform commissioning intentions for 2016, and with a view to publishing and disseminating our findings and methodology regionally and nationally in 2016. • Emma's story animation published (https://youtu.be/AU8CK-LT3dU) highlighting the approach to emergency admissions avoidance in Leicestershire, featured in the national Better Care Exchange Bulletin. • Social isolation campaign being launched in early 2016. • Integration Stakeholder Bulletins published quarterly featuring our progress and case studies • Work of the Integration Programme promoted via @leicshwb twitter feed.

SECTION 4: OUR PLANS FOR 2016/17

4.1 Our Model for Integrated Care in Localities

New models of integrated care are being designed via co-production and collaboration in Leicestershire, using some important design principles. In summary these are:

a) King's Fund and National Voices principles for Integration

b) Care setting principles per the Keogh review

c) Prevent, Reduce, Delay, as reflected in the Leicestershire Adult Social Care Strategy

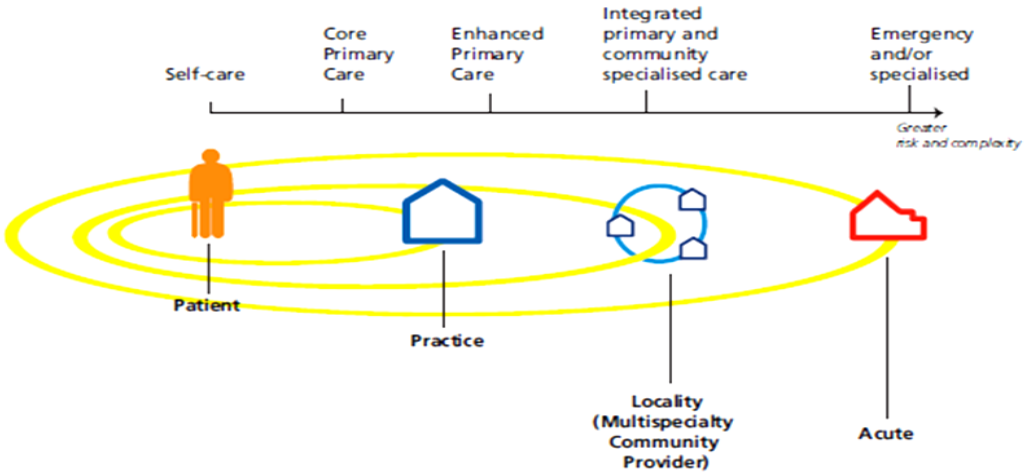
By applying these principles we are designing a new model of integrated care for Leicestershire's localities. During 2015 we have started to put in place the foundations of this model, and during 2016 we will be consolidating it.

The model places the patient or service user at the centre, with the GP as the primary route for accessing care. The GP is also the designated accountable care coordinator for the most complex or vulnerable patients in community settings.

Our model of integration wraps around the patient and their GP practice, extending the care and support that can be delivered in community settings through multidisciplinary working, with the aim of reducing the amount of care and support delivered in acute settings, so that only care that should/must be delivered in the acute setting will take place there in the future.

This "left shift" of activity into community settings is essential for the whole of LLR to deliver a sustainable health and care economy in the future and forms the basis of our LLR-wide five year plan *Better Care Together.*

The diagram below illustrates how the model of integrated care in localities has been designed.



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

- **Multidisciplinary services that are configured on a locality basis and wrap-around clusters of GP practice**. Examples would be our integrated health and care teams who case manage vulnerable people such as those with LTCs or frailty, and our new domiciliary care services, which are being jointly commissioned between CCGs and the Local Authority in 2016, and which will be delivered on a locality basis.
- **Community based alternatives for urgent care**, being implemented in conjunction with the LLR urgent care vanguard, to avoid unnecessary hospital admissions.
- **Ensuring those being discharged from hospital are received safely back into local community services,** with the right level of coordination and planned support to promote reablement and prevent readmission.
- **Shifting demand into non-medical support where appropriate**, providing a broad and consistent range of social and preventative services, such as our housing offer, support to carers, and lifestyle support. The Leicestershire BCF has a whole theme dedicated to co-producing this prevention model, creating a new platform of services which will be consistent and easy to access and navigate for both professionals and the public.

4.2 Our Framework and Workplan for Integrated Commissioning

A new strand of work for the BCF plan in 2016/17 will be to develop an outcomes framework for integrated commissioning with a work plan that focuses on a small number of priorities.

The basis of this framework is outlined in this document.
http://www.birmingham.ac.uk/schools/social-policy/departments/health-services-management-centre/news/2015/02/commissioning-for-better-outcomes-a-route-map.aspx

Through the involvement of local partners in the Commissioning Academy there is already agreement that taking a joint approach to commissioning nursing and residential care placements should be one of the main areas of the work plan in 2016/17.

This will build on the existing BCF funded quality assurance team for this care sector, and lessons learned through our work in 2015/16 to jointly commission domiciliary care services "Help to Live at Home". Other areas of focus area are likely to include: - Integrated Personal Budgets and High Cost Placements for Learning Disabilities. This work will:

- Involve researching other best practice, seeking further opportunities to achieve value for money, improve service user outcomes and quality assurance using a shared outcomes framework.
- Help shape the market and commissioning intentions for integrated provision, improve commissioning intelligence, and how integrated services can be specified and procured across the health and care system.
- Involve improving oversight of all the existing Section 75 agreements within Leicestershire, so they are brought into the governance of the integration programme.

The performance of all of the following pooled budgets will be assessed quarterly in the Integration Finance and Performance Group, which includes representatives from Leicestershire County Council and the County CCGs:

- BCF Plan Section 75/pooled budget;
- Community Equipment Section 75/pooled budget;
- Learning Disabilities Section 75/pooled budget;
- Help to Live at Home (domiciliary care) Section 75/pooled budget (from November 2016).

SECTION 5: DELIVERY OF THE BETTER CARE FUND NATIONAL CONDITIONS

5.1 Maintaining Provision of Social Care Services

Within the BCF plan we have confirmed a number of investments where specific types of packages of care and other social care services were protected. In the 2015/16 BCF plan this totalled £16m of the £38m pooled budget and in 2016/17 this totals £17m of a £39.4m BCF pooled budget.

Leicestershire County Council is required to make a total of £78m budget savings between 2016-20. The Council recognises the need to protect adult social care and has allocated £23m for demographic growth pressures over the next four years. The Council is sourcing a higher proportion of savings from non-Adult Social Care Council services to mitigate some of the service reductions that would need to be made otherwise.

The protection identified within the BCF plan does not resolve all aspects of the increased demographic pressure, nor does it address the 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.

The table below summarises the packages/activity type and investment levels that have been agreed for 2016/17 in order to protect Adult Social Care in support of the BCF plan.

Service Area	Description	Risk if not protected / protection reduced	2015/16 Protected Amount £000's	Other Adjustment £000's	2016/17 Protection £000's
Nursing Care Home Packages	Ongoing provision of c300 nursing care packages enabling these high dependency service users to remain safely in stable placements.	Service user needs not adequately met which could result in a deterioration in condition and admission to hospital and or need of more costly services.	3,361	0	3,361

Home Care Services	The provision of home care services to vulnerable adults is a cost effective way of meeting service user needs in their own home and helps to maintain their independence in the community. Demand for this service is increasing as more community based services are being commissioned. The funding ensures the delivery of c740,000 hours of home care to 1,420 service users.	Service users are not adequately supported in the community which may result in the need for more costly services, for example residential care. Unmet needs could have an impact on a service user's health needs leading to additional demands on primary, community or acute health care services.	10,312	432	10,744
Residential Respite Services	Ongoing provision of residential respite care for c20 service users per week. This service provides support to carers of service users with complex and challenging needs, giving them a break from their caring responsibilities.	Increased risk of carer breakdown which could result in the need to provide more costly services to support service users that would otherwise be undertaken by the carer.	743	0	743
Social Care Assessment and Review	Dedicated social work teams based across Leicestershire and in acute hospitals to ensure that service users and carers are assessed or reviewed in an appropriate timescale ensuring that needs are identified and, where appropriate, services are commissioned to meet outcomes.	Reduced capacity in this area may result in delays in assessing service user needs which could adversely impact on DTOCs. Reductions in review staff may mean that areas of over commissioning are not identified which would result in capacity issues in the market place.	1,640	0	1,640
Increased demand for Nursing Care Placements (New for 2016/17)	Demand growth in nursing placements equivalent to 750 bed weeks.				238
Increased demand for Community Based Social Care Services (New for	Leicestershire has an ageing population and as a result, greater numbers of residents are in need of support from Adult Social Care. This allocation will				300

2016/17)	allow for a provide community based support for an additional 40 service users to enabling them to remain safely in their own homes, reducing the likelihood of admission to permanent residential care.				
			16,056	**432**	**17,026**

5.1.1 Progress on Implementation of the Care Act

The Care Act 2014 introduced significant changes to Social Care legislation in April 2015. The changes implemented included the introduction of a national eligibility threshold; a new duty to carry out assessments for all carers regardless of the level of care provided, and an expanded role in market shaping. Responsibilities were also broadened to include assessments and support for adult prisoners and people in approved premises as well as the introduction of a universal deferred payment scheme.

All the required statutory requirements were implemented in April 2015, and a post implementation review has been completed confirming compliance with the Act.

Further changes were due to take effect from April 2016, namely the introduction of a cap on charges payable by service users; an increased threshold before service users start paying and free social care to anyone entering adulthood with a disability. Due to their significant cost, at a national level, these changes have now been postponed until 2020.

5.1.2 Leicestershire's Care Act Allocation

Local Authorities have received confirmation of their specific allocation from a national investment of £138m for the implementation of the Care Act in 2016/17. This forms one of the elements of the overall BCF financial envelope for each Authority and its partners.

We have identified our proportion of the £138m for the implementation of the Care Act which equates to £1.39m for Leicestershire and this has been incorporated and applied to the BCF plan.

5.2 Seven Day Services across Health and Social Care

There is a national requirement to deliver against a set of ten clinical standards for seven day services (7DS) www.nhsiq.nhs.uk/media/2638611/clinical_standards.pdf which NHS organisations are expected to meet by 2017.

The standards include delivery of 7DS improvements within acute settings including diagnostic availability, and delivery of improvements in 7DS across other system wide settings such as primary, community mental health, and social care.

These developments aim to improve clinical outcomes and patient experience, reduce the risk of morbidity and mortality, and provide consistent NHS services across seven days. Specifically the following outcomes are intended to be delivered as a result of implementing the ten standards:

- Reduced admissions
- Reduced variation in:
    - Length of stay by day of week
    - Mortality by day of week
    - Re-admittance by day of week
    - Access to diagnostics

- Reduced delays in clinical decision making
- Reduction in decompensation especially for the elderly
- Reduced risk especially for longer lengths of stay e.g.; falls, infection rates.

5.2.1 Local Progress

University Hospitals of Leicester (UHL) is an Acute Trust Early Implementer for 7DS, and the LLR health and care economy is one of the national Urgent Care Vanguard sites.

An active programme of work is in place to address the standards, both in terms of the contractual delivery of specific clinical standards within UHL and delivering a redesigned, resilient health and care system on a seven day basis across organisational boundaries and settings of care.

The governance route for assuring this delivery is via the LLR System Resilience Group and the LLR Urgent Care Board.

Services commissioned via local BCF plans are already contributing to the progress being made across LLR on 7DS. A number of specific BCF investments were made in 2015/16 within the Leicestershire BCF in order to strengthen the provision of 7DS such as:

- The acute visiting service in primary care;
- Seven day services pilots in primary care in ELRCCG and WLCCG;
- Extended opening hours in primary care in ELRCCG and WLCCG;
- 24/7 integrated crisis rapid response services – across LLR;
- Adult social care seven day support to hospital discharge.

The impact of these is measured via BCF performance metrics for emergency admissions and delayed transfers of care, as reported quarterly to NHS England.

The LLR Urgent Care Vanguard is the vehicle for establishing a more comprehensive and resilient seven day service across the health and care system. The Vanguard work programme has been designed in line with achieving the national clinical standards and the new model of urgent care per the NHSE five year forward view.

Within the LLR Vanguard Programme, workstream four focuses specifically on the delivery of 7DS and workstream one focuses on Integrated Urgent Care in the Community. Together these workstreams will coordinate the delivery of 7DS developments spanning acute primary, secondary, social care and mental health care.

5.3 Better Data Sharing between Health and Social Care based on the NHS Number

5.3.1 NHS Number as the Consistent Identifier

The NHS number has been adopted on all Adult Social Care records in Leicestershire where a successful match has been possible (94%) via the NHS matching service (MACS). Good preparations have also been made for the switch over to the new Demographics Batch Tracing Service Bureau (DBSB) due to the imminent cessation of the MACS service. The adoption of the NHS number has been a key dependency for the implementation of Care and Healthtrak – see further detail on this development below.

5.3.2 Data Sharing

During the preparations for the original BCF submission in 2014, we assessed our local approach to data sharing and benefited from the "how to" guides, workshops and webinars provided by the national BCF team which explored the information sharing purposes, national policy, legislative and IG issues, and encouraged local areas to seek solutions to the numerous challenges and barriers these issues present.

In Leicestershire we recognised the need to take a strategic approach to solving two key barriers to delivering our vision for health and care integration:

a. System level data sharing across health and care - for population level stratification, and tracking patient journeys and outcomes.

b. Records sharing at the point of care delivery, including for care coordination and care planning.

We are using the Leicestershire BCF as the lever to address item a, and are working with the LLR wide IM&T group to progress item b.

5.3.3 Implementation of Care and Healthtrak

During 2015/16 the Leicestershire BCF led the local implementation of Care and Healthtrak, a third party product from Pi Ltd. This tool was procured in April 2016 to provide a psuedonymised analysis of patient journeys across the health and care system. Implementation of this tool has been led via the Leicestershire BCF on behalf of the LLR health and care economy.

The tool was launched in October 2015 http://www.lsr-online.org/launch-event---14-october-2015.html. The tool includes two years of historical activity and costing data which is then updated routinely monthly from existing commissioner and provider systems within the NHS and Local Authorities.

Care and Healthtrak offers bespoke dashboards, costing analysis and source data for workforce analysis for the workstreams within the BCT programme across LLR.

26 members of the business intelligence teams in LLR have been trained to use the system with individuals assigned to partner organisations and BCT workstreams.

Dashboards and bespoke analysis are now being produced to analyse trends in how patients are using the health and care system and the impact of changes that are being made, such as the introduction of new elements of the urgent care system.

The PI Care & Health tool provides extensive data sharing between health providers and social care across LLR, using pseudonymised NHS number as the unique identifier. All appropriate information governance controls are in place.

Following agreement by LLR partners to continue with investment in the tool for a further 12 months, a workplan for the priority business intelligence activities for 2016/17 is currently being developed which will provide analysis in support of the BCF plan, the overarching Better Care Together programme and the LLR Urgent Care Vanguard.

In Q1 and Q2 of 2016/17, we will be pursuing the addition of NHS 111 number data sets, adoption of the NHS number for children's social care records, the supporting Leicestershire Families Service and the Lightbulb Housing Service.

In Q3 of 2016/17 we will also be working with our new domiciliary care providers who will be coming on stream in November 2016 to ensure their activity data can also be identified with the consistency of the NHS number.

Technology Developments

The LLR IM&T Group are in the process of developing a Local Digital Roadmap to define the IM&T strategy for LLR. This will be completed by June 2016. Key focus areas for 2016/17 aligned to the roadmap are:

- Interoperability of systems across health and care partners so that data can be shared for direct care delivery;
- Development of summary care records;
- Population data analysis;
- System wide efficiencies to improve integrated working;
- Better Care Together Clinical Workstreams.

The main priority of the LLR IM&T group in 2015 has been to develop a system wide summary care record (SCR) which can be viewed across NHS partner organisations through a web based solution called the MIG. In 2016/17, further scoping will consider which is the best platform for achieving SCR across NHS and Local Authority settings.

5.4 Case Management

Both CCGs in Leicestershire have developed case management in the community with locality based nursing and social care teams working hand in hand with General Practice.

A proactive, integrated approach is followed where the individual and the health and care team work together to agree the support needed to manage their condition and identify the specific help they need. A care plan is developed, with primary, community and social care based support planned around the patient, carer and family, using standard shared care plans. Care plans “step up” care when needed to support through a period of crisis or increased need and “step down” care when the person stabilises or needs decrease.

A named accountable GP is responsible for ensuring the creation of the personalised care plan and the appointment of a care co-ordinator.

In 2016/17 BCF we move into an even greater level of ambition for integrated care in the community. This will integrate the offer beyond core primary care, community nursing and social care to encompass other wraparound preventative and social prescribing components such as housing support, domiciliary care and local area coordination.

5.5 Impact of the BCF Plan on Providers

Approval of the BCF plan by all partners, including agreeing the impact on providers is an essential part of the governance associated with the Leicestershire Integration Programme.

In section 8 (p40) of this document there is a summary of all the engagement undertaken in the process to prepare the BCF plans for 2016/17.

It should be noted however that co-production with providers and with Healthwatch is a key feature of how we deliver our integration programme on a daily, weekly and monthly basis.

The impact of the BCF emergency admissions schemes on capacity planning and contract negotiations with our local acute provider have been shared transparently and feedback has been sought specifically from their Executive/Clinical management team on the assumptions for 2016/17.

The impact of the trajectory for emergency admissions for the BCF related activities is that 1,517 admissions are to be avoided by the BCF schemes in 2016/17 which represents a 2.49% reduction.

Evaluation and lessons learned from implementing the initial four emergency admissions avoidance schemes in 2015 have been shared proactively with NHS providers.

Risks to delivery of the BCF including the risks to delivery of the emergency admissions trajectory within the urgent care system have been reflected in the Integration Risk Register.

Impact on other providers (community services, social care, housing) have also been quantified in terms of investment levels, specification and delivery requirements including refreshing KPIs and trajectories where applicable. The governance at project level and via the Integration Operational Group is designed to ensure the lead commissioner in each case has enacted the contractual requirements.

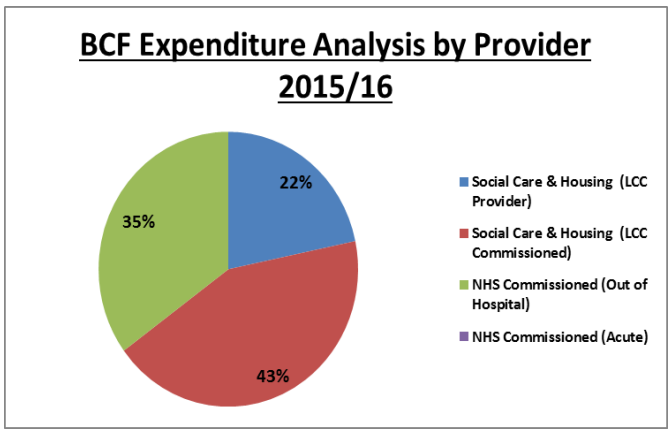
In terms of the impact of Disabled Facilities Grant allocations the BCF plan confirms the commitment to passport a £1.7m DFG allocation to Districts Councils for 2016/17, the same as the arrangement in 2015/16. The additional £1.3m DFG allocation which replaced the social care capital grant within the BCF is being retained within the BCF pooled budget. This is because it is already committed on a range of essential services that benefit all partners and the communities they serve, including elements of housing related support (for example assistive technology and the housing discharge support schemes at the Bradgate Unit and Leicester Royal Infirmary). The position will be reviewed following consideration of the Lightbulb Business Case with District Councils later in 2016.

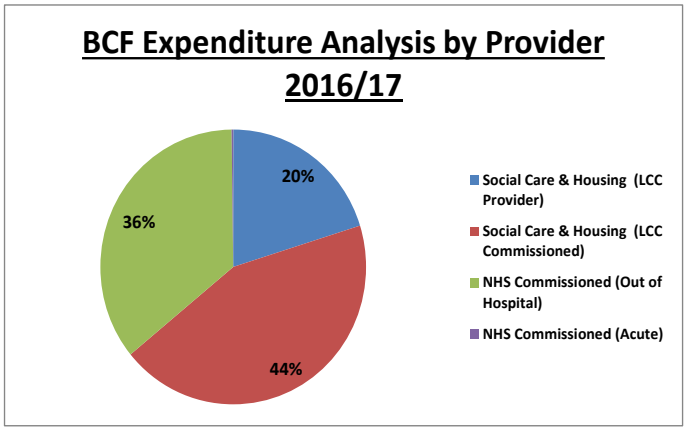
5.6 Agreement to Invest in Out of Hospital Services

The detailed spending plan at Appendix 1 demonstrates the breadth of the Leicestershire BCF plan in investing in services out of hospital. This includes not only NHS community services and social care services but a range of prevention services such as carers support, First Contact plus, housing support and Local Area Coordination.

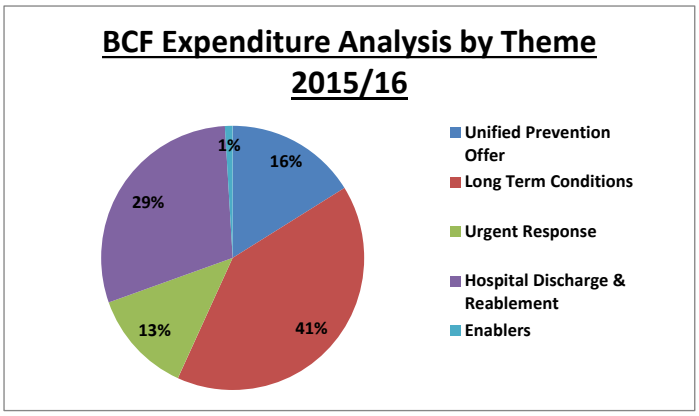
The proportion of the plan invested in out of hospital services is illustrated in the following pie chart with a comparison chart provided for 2015/16:

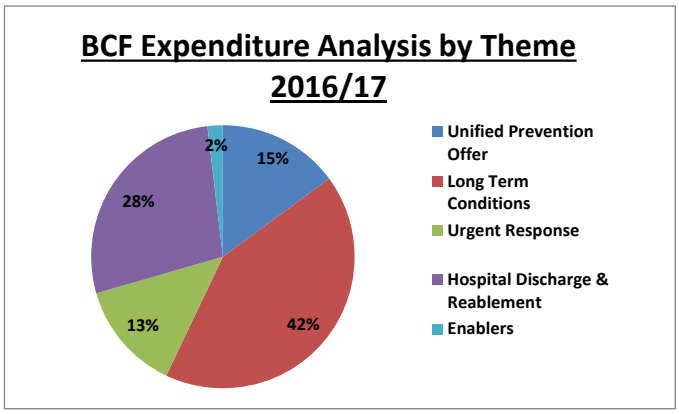
Analysis of Expenditure by Provider	2015/16	2016/17
	£'000	£'000
Social Care & Housing (LCC Provider)	8,438	7,942
Social Care & Housing (LCC Commissioned)	16,790	17,298
NHS Commissioned (Out of Hospital)	13,638	14,102
NHS Commissioned (Acute)	0	78
	38,866	**39,419**





Analysis of Expenditure By Theme	2015/16 £'000	2016/17 £'000
Unified Prevention Offer	6,266	5,881
Long Term Conditions	15,824	16,617
Urgent Response	4,930	5,298
Hospital Discharge & Reablement	11,479	10,887
Enablers	367	737
	38,866	**39,419**





The charts demonstrate the Leicestershire BCF plan 2016/17 has again achieved a good balance between adult social care protected spend and NHS Commissioned out of hospital services.

As performance on emergency admissions remains extremely challenging in LLR and we achieved only 70% of the admissions to be avoided by the four schemes in 2015, we have agreed a local risk pool will still be needed for 2016/17.

The risk pool for 2016/17 has been set at £1m, based on 70% performance across the schemes for 2016/17.

5.7 Agreement on Local Action Plan to reduce Delayed Transfers of Care (DTOC)

In January 2015 the Leicestershire Health and Wellbeing Board received a comprehensive report about DTOC performance in the context of the poor performance of the urgent care system at that time.

The report analysed the reasons for the poor performance and provided an overview of the system wide action plan being implemented and governed by the LLR Urgent Care Board. The LLR Urgent Care Action Plan had activities organised into three themes; inflow, flow and outflow.

The outflow section of the plan focused on discharge routes out of hospital and incorporated a number of the key interventions which were already being prioritised and invested in by

partners through the implementation of the 2015/16 Leicestershire BCF plan. These included:

- Alignment of BCF interventions into the new, five (rationalised) discharge pathways for LLR.
- Introduction of the safe minimum transfer data set.
- Improvements to social care seven day working on acute sites.
- Implementation of housing advisers within hospital discharge teams on acute sites.
- Systematic review of all care packages two weeks post discharge by expert review team.
- Pilot sites for residential reablement pathways.
- Introduction of a new non weight-bearing pathway.
- Improvements to CHC pathways (discharge to assess).
- Re-commissioning of Leicestershire's domiciliary care services (joint commissioning NHS and LA partners – new service called "Help to Live at Home".

During the BCF refresh for 2016/17 the following elements were used to consider our DTOC plans for 2016/17:

- Best practice from the East Midlands DTOC Guidance Event.
- The new national definitions, guidance and high impact changes for DTOC and self assessment toolkit.
- Performance analysis and benchmarking information including specific analysis on performance on non-acute sites and out of county acute sites.
- Evaluation of the housing discharge enabler.
- Benchmarking information as at December 2015.

Other activities included:

- Confirming commissioning intentions for 2016/17 on the basis of the impactful changes made in 2015/16.
- Engaging with health and care voluntary sector partners.
- OJEU notice for our new domiciliary care service.
- Organisational development programme for integrated health and social care teams operating in localities, where case management for planned and unscheduled care is now delivered to joint operating models.
- Implementation of the new community equipment service.

5.7.1 Discharge Developments for 2016/17

- The LLR Integrated Points of Access review will result in a business case by April 2016. It is anticipated this will provide further opportunities to integrate the response of the local workforce to urgent care and planned care including discharge support. The technological aspects of this integration are intended to provide new tools for scheduling and capacity management across the community based workforce.

- The introduction of the MIG (viewing technology for sharing the summary care record) will bring additional benefits for discharge planning, care coordination and admissions/readmissions avoidance.

- On May 5th 2016, an LLR Discharge Summit is being held to consider further opportunities to improve local performance.

- During the autumn of 2016 there will be a planned transition into the new domiciliary care services ("Help to Live at Home"). Good practice in reviewing care packages at two weeks has been incorporated into the new model of care and the new providers will be receiving induction into localities so they integrate effectively with other parts of the local health and care system including community based preventative support.

- During 2016/17 further joint commissioning activities are planned between LA and NHS partners, specifically in relation to care and nursing homes placements and falls prevention.

- During 2016/17 our Lightbulb housing offer, which is currently being piloted, is likely to roll out across Leicestershire, bringing a new one stop-shop for housing related support such as aids and adaptations, home maintenance, home safety and affordable warmth. The Lightbulb housing offer will also adopt the successful hospital discharge enabler staff into the new service.

- An LLR workforce strategy and supporting workforce analysis is currently being developed by Better Care Together, and this is a key dependency for the Leicestershire BCF plan as detailed in our risk register.

- The introduction of Care and Healthtrak in 2015 has resulted in a new set of dashboards which allow greater interrogation of patient journeys across the whole health and care system including social care components. The impact of DTOC interventions can be evaluated through this tool with effect from January 2016.

5.7.2 DTOC Target for 2016/17

Using all the analysis outlined above we have concluded that the performance improvements achieved in 2015 have been driven by focussed delivery of interventions in the acute sector, and we now need to turn our attention to delays that are generated at non-acute sites.

Our approach to target setting for 2016/17 is therefore to set a target to maintain the good performance in the acute sector and apply a 0.5% improvement across non-acute delays. This has also been reflected in CCG operating plans.

Sustaining LLR wide DTOC performance operationally and strategically will continue to be a high priority across all partners, with high levels of commitment to improve performance further in 2016/17, in particular in relation to length of stay and delayed transfers of care across community hospitals, mental health sites and out of county acute sites.

5.8 Better Care Fund Metrics – Our Targets for 2016/17

The following table explains the definition of each metric, and the rate of improvement we are aiming for in each case. Please refer to the NHSE BCF Planning Template, Appendix 2 for the more detailed metrics analysis.

National Metric (1)	Definition	Trajectory of improvement
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.	The target for 2016/17 has been set at 630.1 per 100,000 based on the 2015/16 target of 670.4 per 100,000 and a 90% confidence level that the trajectory is decreasing. Current performance is on track to achieve the target for 2015/16. As part of the development of a four year adult social care strategy, detailed analysis of this metric has taken place and the target set accordingly. In 2014/15 there were 710.5 permanent admissions per 100,000 people. In 2015/16 this is likely to reduce to 669.6 per 100,000 people.

National Metric (2)	Definition	Trajectory of improvement
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.	The target for 2016/17 has been set at 84.2%, based on the expected level of 82.6% being achieved in 2015/16 and a 75% confidence interval that the trajectory is increasing. The lower confidence interval has been chosen to ensure that the target is realistic and achievable. Performance is currently on track to meet the 2015/16 target of 82.0% As part of the development of a four year adult social care strategy, detailed analysis of this metric has taken place and the target set accordingly. In 2014/15 83.8% of reablement service users were still at home after 91 days. In 2015/16 this is likely to reduce to 82.6%. Due to the introduction of a Help to Live at Home scheme planned for November 2016, a conservative target has been set.

National Metric (3)	Definition	Trajectory of improvement
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.	Recent reductions in delays have focussed on interventions in the acute sector. We have therefore set a target based on reducing the number of days delayed in non-acute settings by 0.5%, while maintaining the rate of days delayed in acute settings at its current low level. The targets are quarterly and are 238.0, 233.3, 215.9, and 220.7 for quarters one to four of 2016/17 respectively. As part of the development of a four year adult social care strategy, detailed analysis of this metric has taken place and the target set accordingly. Substantial improvement in the rate of days delayed has been achieved – the annual rate has dropped from 4,753 per 100,000 in 2014/15 to a probable 2,730 per 100,000 in 2015/16.

National Metric (4)	Definition	Trajectory of improvement
 **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.	The proposed target for 2016/17 is 726.38 per 100,000 per month, based on a 2.49% reduction on CCG plans submitted to Unify 2. This equates to no more than 58,836 admissions in 2016/17 for people registered with Leicestershire GP practices. This assumption has been aligned with final CCG operational plan targets. In 2014/15 there were 58,479 non-elective admissions for Leicestershire residents, In 2015/16 it is likely that there will be 59,957. All our admission avoidance schemes have been subject to evaluation in 2015/16, and the result have fed into the development of the trajectory of 1,517 avoided admissions from these schemes in 2016/17.

National Metric (5)	Definition	Trajectory of improvement
 **Improved Patient Experience**	Selected metric for BCF Plan from national menu: - taken from GP Patient Survey: “In the last 6 months, have you had enough support from local services or organisations to help manage long-term health condition(s)? Please think about all organisations and services, not just health.” The metric measures the number of patients giving a response of "Yes, definitely" or "Yes, to some extent" to the above question in the GP Patient Survey in comparison to the total number of responses to the question.	It is proposed to set this target at 63.5% for 2016/17 (data will be released February 2017). This is based on the 2015/16 target (data due for release July 2016) and a 2% increase in the number of positive replies. Current performance of 61.6% (January 2016) is below the England average of 63%.

Local Metric (6)	Definition	Trajectory of Improvement
Injuries due to falls in people aged 65 and over	This is a locally defined metric measuring delivery of the outcome to reduce emergency admissions for injuries due to falls in people aged 65 and over.	It is proposed that this target is set at 1,742.9, based on holding the number of admissions for injuries due to falls steady for the 65-79 age group (a reduction in the rate per 100,000 from 678.9 to 664.0) while lowering the rate per 100,000 for the 80+ age group from 7,919.1 to 7,523.1 (this equates to 25 fewer admissions in the year despite the increase in population) The latest published data (2014/15) shows Leicestershire as having a directly standardised rate significantly better than the England average for the whole age 65+ cohort and for the separate 65-79 age group and the 80+ age group.

The BCF Plan for 2016/17 will involve delivery of the following elements:

I. Continuation of the business as usual components of the BCF plan. This includes all our designated "protected services" across adult social care and NHS provision.

II. Implementation and further evaluation of the following components of the BCF plan per the table below.

Appendix 3 provides a high level scheme overview with mapping to BCF national conditions and metrics, Leicestershire BCF Themes, and LLR's Better Care Together Programme Workstreams.

5.9 What will our Health and Care System look like as a result of the changes planned in 2016/17?

Long Term Conditions, Frailty and Dementia

- Central to the development of the local multi-speciality community provider model, integrated health and care teams will be available in each locality, combining the expertise of adult social care services from Leicestershire County Council and the community nursing and therapy teams of Leicestershire Partnership Trust (LPT), working hand in hand with GP practices.

- Via primary care, people with LTCs will have their risks assessed and their care plans coordinated by the integrated health and social care team in their locality. They will benefit from:-

    - Electronic care plans.
    - A designated accountable professional for their care.
    - A new prevention offer which will target social prescribing interventions such as housing support, carer support, assistive technology and local area coordinators to support vulnerable people and help them remain as independent as possible in the community for as long as possible.

- People with heart failure and atrial fibrillation will benefit from improvements to case management to reduce premature mortality and the risk of stroke.

- People with long term respiratory and cardiology conditions will be supported to remain in the community rather than being admitted to hospital through the development of a new ambulatory pathway in conjunction with Glenfield Hospital and primary care.

- Seven day services will be available in primary care, coordinated by GPs across Leicestershire localities. This will be targeted in particular to frail and vulnerable people, those with complex and multiple long term conditions and those at the end of life.

- Through LLR's digital road map, further interoperability between IT systems will be achieved to enable shared care records and care plans, using the NHS Number as the consistent identifier to plan and deliver person centred care more effectively across organisational boundaries.

Integrated Urgent Care

- LLR's urgent care system will be redesigned in line with the models of care proposed by the Vanguard project, with the BCF focused particularly on:

    - Improving and streamlining points of access into the health and care system on a 24/7 basis.
    - Delivering a number of the alternative pathways to avoid hospital admission.

- 1,500 emergency admissions will be avoided in 2016/17 through improved urgent care pathways funded by the Leicestershire BCF, which include integrating pathways between the ambulance service, NHS Trusts, locality teams and GP practice across on a 24/7 basis.

Hospital Discharge and Reablement

- We will continue to limit delayed bed days despite a 0.69% population growth. This will be achieved by reducing the number of delayed bed days in non-acute settings by 0.5% and maintaining our good performance on acute sites. Without this focus we would see 102 additional delayed bed days per year.

- 3,500 people will benefit from the new domiciliary care service for Leicestershire "Help to Live at Home" which will focus on reablement outcomes, and maintaining independence.

- We will continue to reduce the numbers of people aged 65 and over needing hospital care after a fall, despite a 2.48% increase in this population. Instead more people will receive care at home and there will be a new LLR wide approach to falls prevention. We aim to achieve no increase in the number of emergency admissions for injuries due to falls in the 65-79 age group, despite an increased population. For the 80+ age group we plan to lower the number of similar admissions by 25, despite growth in the population.

- Fewer people will be permanently admitted to residential or nursing care, due to improvements to the care and support they can receive at home.

Unified Prevention and Social Prescribing

- Our unified prevention offer will describe a clear, consistent menu of services that are on offer in each community, with First Contact Plus as the coordinating "front door" for accessing a range of social prescribing solutions.

- 2,900 carers will benefit from enhanced information and health and wellbeing support, including via assessments provided under the Care Act.

- 240 vulnerable people per year will be supported by Local Area Coordinators operating in Leicestershire's communities, to help them make the most of what's on offer on their doorstep.

- A new integrated housing service "Lightbulb", operating across District Councils will offer a one stop shop and housing "MOT" where practical expertise and support for people needing aids, equipment, adaptations, handy person services and advice on energy efficiency/affordable warmth can be delivered.

Other Benefits

- Leicestershire people will experience significant changes in how care is planned and delivered, feel confident in community based services, and report improvements in their overall experience of integrated care and support.

- By reconfiguring services and investing in community alternatives, improving delayed discharges, reducing emergency admissions, and creating enhanced locality based services, we can confidently reduce the overall number of inpatient beds in Leicestershire, at key intervals in line with the five year plan.

- A new outcomes framework for integrated commissioning will support partners to take a joint approach to value for money, quality assurance and service user outcomes. This will deliver improvements during 2016/17 in areas such as nursing and care home placements, as well as inform our joint commissioning priorities for 2017/18.

- The benefits of the Care and Healthtrak data sharing tool will be embedded as business as usual, and will inform impact analysis for the STP, BCT workstreams, including the LLR Vanguard and BCF delivery.

SECTION 6: BCF PLAN FUNDING SOURCES, SPENDING PLAN AND OUR APPROACH TO RISK SHARING

6.1 Financial Context

The BCF refresh for 2016/17 has involved a comprehensive review of the proposed spending plan for 2016/17. Partners have considered the overall pressures within the BCF spending plan, the level of investment needed to meet the BCF metrics and national conditions, including the ongoing requirement for a risk pool for emergency admissions and the impact of the unexpected DFG allocation increase. These discussions have taken place in the context of wider financial pressures affecting all partners in the health and care system, plus the need to balance priorities within a complex planning environment and a health and care economy which continues to face significant sustainability risks linked to the over use of acute care.

This BCF refresh process has identified a number of new areas of investment for 2016/17. This has been achieved by maximising the use of the reserve from 2015/16 and the main categories of additional investment are as follows:

- Investment in further emergency admissions avoidance interventions and seven day services improvements.
- Increasing the level of adult social care protection to sustain DTOC performance and mitigate (in part) demographic/demand pressures.
- Securing ongoing investment for DTOC related schemes (e.g. the housing discharge pilots have been funded recurrently from the BCF).

The process to refresh the BCF spending plan has confirmed the following:

- That partners will continue to pool the required minimum BCF level of funding in 2016/17 which is £39.1m.
- Additional contributions above the required minimum BCF level of funding total £0.3m.
- That a risk pool of £1m (for emergency admissions performance risk) will be applied to the fund in 2016/17.
- That a contingency reserve of £1m will be applied to the fund in 2016/17.
- That the investment in adult social care protection within the fund will be increased from £16m to £17m.
- That £1.7m of the 2016/17 DFG allocation will be passported directly to Districts for DFG delivery.
- That £1.3m of the 2016/7 DFG allocation will be utilised within the financial envelope of the BCF pooled budget to drive medium term housing solutions redesign by agreement with District Councils.

6.2 Confirmation of the Source of Funds for the Refreshed BCF Plan

Better Care Fund Funding Comparison 2015/16 to 2016/17				
Funding Source	2015/16 £	2016/17 £	Movement £	Movement %
Minimum Contributions				
East Leicestershire & Rutland CCG*	15,187,000	15,559,591	372,591	2.5%
West Leicestershire CCG*	20,073,000	20,476,926	403,926	2.0%
Social Care Capital Grants	1,344,000	0	-1,344,000	-100.0%
Disabled Facilities Grants	1,739,000	3,067,448	1,328,448	76.4%
	38,343,000	39,103,965	760,965	2.0%
Additional Contributions				
Additional Contribution (Reserve funding)	504,800	128,248	-376,552	
Additional LA Contribution - Programme Management	0	50,000	50,000	
Additional Reserve Contribution - Integrating Points of Access	0	137,000	137,000	
	504,800	315,248	-189,552	
Total BCF Funding	**38,847,800**	**39,419,213**	**571,413**	
* Inclusive of Care Act Funding (including non-recurrent element in 2015/16)	1,893,000	1,388,000	-505,000	-26.7%
Health and Social Care Integration Reserve at start of the financial year	5,758,000	4,374,000	-1,384,000	-24.0%

6.3 Our Approach to Risk Sharing

Partners already have in place an agreed risk sharing agreement for the BCF and have agreed that a risk pool will apply to the emergency admissions metric in 2016/17.

Based on our performance in 2015/16 and the refreshed trajectories we have developed for admissions avoidance in 2016/17 we have placed £1m in the risk pool for 2016/17.

The £1m pool will be released into the fund or retained by CCGs based on quarterly performance and forecast outturn against the emergency admissions trajectory associated with the BCF emergency admissions schemes.

Recommendations on the treatment of the risk pool are assessed quarterly by the Integration Finance and Performance Group, with ultimate approval and assurance via the Integration Executive and the Health and Wellbeing Board.

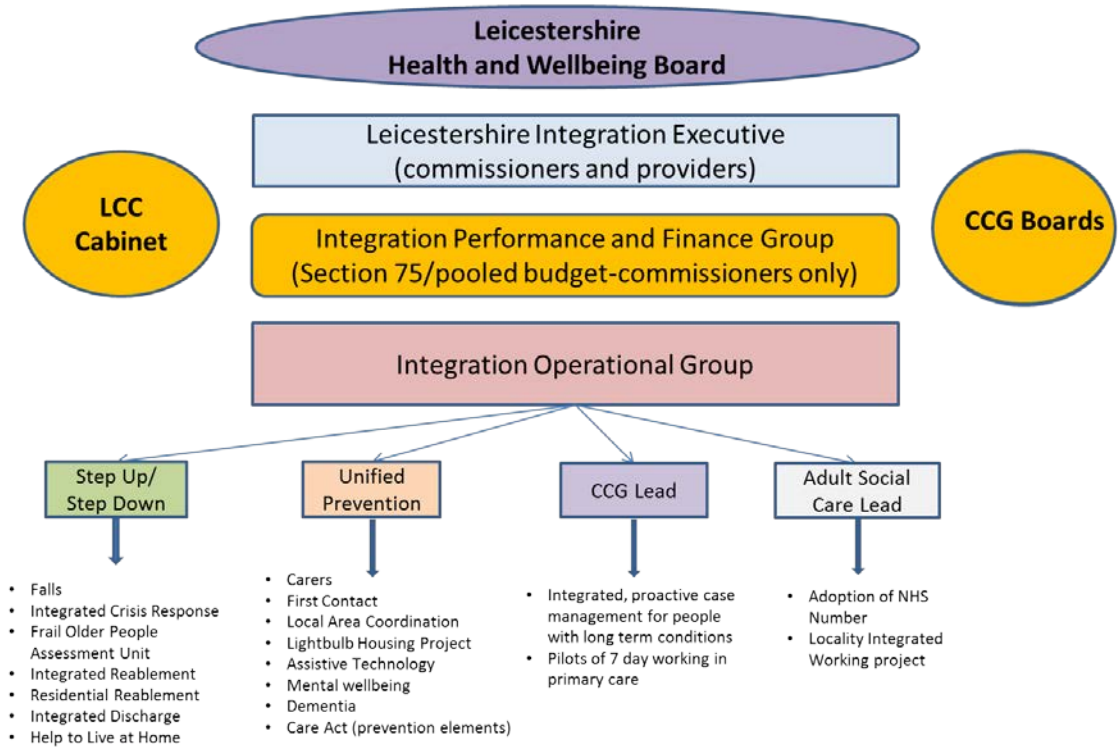
During the prioritisation process for the 2016/17 BCF plan a number of new schemes have been agreed as the next joint priorities for investment from the BCF, subject to business case assessment/approval. If monies are released from the risk pool into the BCF plan in this year these items will be ready for immediate consideration.

SECTION 7: GOVERNANCE OF THE LEICESTERSHIRE BCF PLAN

7.1 Summary of Governance Arrangements

The Leicestershire BCF has a well-established and effective programme governance structure. The structure is designed to ensure that there is co-production, transparency and pace in delivering our vision for integration. The structure ensures that providers and commissioners co-produce solutions and take joint accountability for decisions and delivery. The structure also ensures that statutory decision making is respected and the appropriate bodies are involved in decision making per the scheme of delegation.

The diagram below shows the governance structure for Leicestershire's Integration Programme. The programme structure incorporates the BCF in its entirety plus some other related elements in our integration programme such as the recommissioning of domiciliary care.



The Health and Wellbeing Board meets six times per year. The Board is ultimately responsible for approving and delivering the BCF plan and sets the overall strategic direction.

Since February 2014, the Health and Wellbeing Board has delegated the day to day delivery and oversight of the integration programme to the Leicestershire Integration Executive, which meets monthly. This is an officers group at Director level comprising representatives from local NHS partners, the LA, Districts Councils and Healthwatch.

The Integration Executive supports and advises the Health and Wellbeing Board with respect to the vision, aims, and pace of the programme per national and local policy and strategic context; provides the infrastructure to support assurance of the section 75 agreement, ensures stakeholder engagement and joint leadership and accountability at senior level, and makes recommendations to the Health and Wellbeing Board concerning prioritisation and resourcing the integration programme including the detailed spending plan for the BCF.

The Integration Operational Group meets monthly and comprises of senior operational managers from the same partner organisations. This group coordinates the day to day delivery of the individual projects and services within the BCF within the approved spending plan, produces the Integration Executive's finance and performance analysis reporting on a monthly basis, ensures delivery of the individual milestones within projects and the programme as a whole, assesses and addresses policy developments at an operational level, ensures matrix working and resourcing across organisational boundaries within individual projects, and directs the engagement plan between the integration programme and the structure and governance arrangements of all partner organisations as well as the communications and engagement plan with wider stakeholders, including the public.

The functions, duties, and delegation in terms of decision making are reflected in the terms of reference for the groups operating at the respective tiers of the programme governance structure diagram, with terms of reference updated and refreshed at least annually.

7.2 Assurance for the 2016/17 BCF Plan via the Health and Wellbeing Board

The Health and Wellbeing Board received a presentation and an interim report on the BCF refresh at its meeting on January 7, 2016 (http://politics.leics.gov.uk/ieListDocuments.aspx?MId=4630 item 251.

At their meeting 10th March 2016 Board meeting, the Board received further assurance on the progress of the BCF plans and associated submissions. The Board approved that remaining work required be completed by the Integration Executive http://politics.leics.gov.uk/ieListDocuments.aspx?MId=4631 (item 5).

At their meeting on 5th May, the Board received the final BCF Submission for assurance http://politics.leics.gov.uk/ieListDocuments.aspx?MId=4632 (item 282)

7.3 Measuring the Impact of the Leicestershire Better Care Fund Plan

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 in Annex A and B of the BCF policy framework 2016/17.

   (www.gov.uk/government/uploads/system/uploads/attachment_data/file/490559/BCF_Policy_Framework_2016-17.pdf) – see also summary metrics table.

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

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

d) Monthly, locally via the Leicestershire Integration Executive Programme performance dashboard providing performance summary across the whole programme/metrics (example at Appendix 4).

e) 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.

f) Via specific evaluation activity– for example clinical audits, independent evaluations, academic studies. During 2015/16, we conducted an evaluation and research study in conjunction with Loughborough University and Leicestershire Healthwatch. This evaluated our four BCF emergency admissions schemes. Findings are being disseminated regionally and nationally during 2016/17. A second phase of our evaluation has also been planned, using funds allocated from national and regional BCF support monies.

7.4 Programme Plan and Risk Register for 2016/17

Our Programme Plan and Programme Risk Register have both been refreshed for 2016/17.

A high level programme plan can be seen at Appendix 5.

The programme level risk register is reviewed operationally and strategically at regular intervals as part of the routine work of the Integration Executive and Integration Operational 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 also summarises key risks on a monthly basis.

The main risk affecting delivery of the BCF plan in 2016/17 is as follows:

- A risk that we are unable to deliver against the national metrics for the BCF – specifically due to failure to reduce the rate of total emergency admissions.
- This may result in the need to release monies from the BCF risk pool and escalation of our performance via NHS England quarterly BCF assurance returns.

7.5 Equality and Human Rights Impact Assessment

In January we completed an impact assessment for the BCF which has been approved through Leicestershire County Council's governance processes – a copy of the documentation can be found at this weblink.
www.leics.gov.uk/better_care_fund_overview_ehria.pdf

SECTION 8: SUMMARY OF ENGAGEMENT UNDERTAKEN

8.1 Refresh Engagement Activities

There has been extensive engagement undertaken within the BCF programme throughout 2015/16. The table below focuses on the detail of activities between December 2015 and April 2016 evidencing how the BCF refresh has been undertaken, with the engagement of all stakeholders.

Date	Purpose	Audience
4th Dec 15	Briefing on BCF progress, and progress with developing the Lightbulb Housing Offer	Members Briefing to Oadby & Wigston Borough Councillors
4th Dec 15	Briefing on BCF progress, and progress with developing the Lightbulb Housing Offer	Members Briefing to Coalville District Councillors
7th Dec 15	To review and shape joint commissioning intentions across partner agencies	HWB Board Annual Development Session on Commissioning Intentions
8th Dec 15	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17	WLCCG Corporate Management Team
8th Dec 15	Engagement to jointly review the performance of the BCF emergency admissions avoidance schemes January – December 2015	University Hospitals of Leicester Executive Management/Clinical Director Team
10th Dec 15	Evaluation of BCF delivery in 2015/16 including using the national BCF assessment tool.	Integration Operational Group Meeting
10th Dec 15	Briefing on BCF progress, and progress with developing the Lightbulb Housing Offer	District Council's Joint Chief Executive's Meeting
14th Dec 15	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17	ELRCCG Corporate Management Team
15th Dec 15	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17	Integration Executive meeting
17th Dec 15	Briefing on BCF progress and progress with developing the Lightbulb Housing Offer	Members Briefing to Hinckley & Bosworth Borough Councillors
17th Dec 15	Briefing on BCF progress and progress with developing the Lightbulb Housing Offer	Members Briefing to Blaby District Councillors
4th Jan 16	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17	WLCCG Corporate Management Team

7th Jan 16	Presentation on planning guidance and approach to BCF refresh/emerging priorities to seek feedback from the H&WB Board	Health & Well Being Board
11th Jan 16	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17	ELRCCG Corporate Management Team
12th Jan 16	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17	WLCCG Corporate Management Team
14th Jan 16	Further evaluation of BCF delivery in 2015/16 to inform the refresh including using the national BCF assessment tool.	Integration Operational Group Meeting
14th Jan 16	Multiagency session to set scale of ambition for national BCF metrics for 2016/17	Review of Emergency Admissions and DTOC targets and scheme trajectories
20th Jan 16	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17	A&C Departmental Transformation Delivery Board
22nd Jan 16	Briefing on BCF progress, emphasis on developments for Local Area Coordination and the Lightbulb Housing Offer	Hinckley & Bosworth Borough Council Health & Well Being Board
26th Jan 16	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17	Integration Executive Meeting
28th Jan 16	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17	Leicestershire County Council's Transformation Delivery Board
1st Feb 16	Review progress with Care and Health Trak implementation and agree commissioning intentions for 2016/17	LLR (NHS and LA) Chief Officers' Meeting
2nd Feb 16	Sharing good practice from Leicestershire BCF and capturing good practice from other parts of the West Midlands	West Midlands Regional BCF Network meeting
8th Feb 16	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17	ELRCCG Corporate Management Team
8th Feb 16	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17	WLCCG Corporate Management Team
9th Feb 16	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17	UHL Executive Team Meeting
10th Feb 16	Board Development Session - System Leadership for planning and delivery of health and care integration/health and wellbeing outcomes	Health and Wellbeing Board

11th Feb 16	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17	Integration Operational Group Meeting
11th Feb 16	Sharing good practice from Leicestershire BCF and capturing good practice from other parts of the East Midlands	East Midlands Regional BCF Network meeting
23rd Feb 16	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17 Assurance for BCF national submission on March 2nd	Integration Executive
26th Feb 16	Detailed review of BCF spending plan for 2016/17 and further prioritisation Decision on Risk Pool levels for 2016/17	Integration Finance & Performance Group
28th Feb 16	LLR Better Care Together prevention workshop – to scope the strategic approach to prevention across the programme including the contribution of the prevention components delivered within the BCF	BCT Stakeholders from across LLR
8th Mar 16	Briefing on BCF progress in 2015/16 and refresh plans for 2016/17	Voluntary Action Leicestershire Health & Social Care Forum
14th Mar 16	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17	ELRCCG Corporate Management Team
14th Mar 16	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17	WLCCG Corporate Management Team
17th Mar 16	Review of BCF submissions materials including draft narrative	Integration Operational Meeting
21st Mar 16	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17	LPT Executive Team Meeting
29th Mar 16	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17 Assurance for BCF national submission on March 21st	WLCCG Extraordinary Board Meeting
29th Mar 16	Assurance on BCF delivery 2015/6 and BCF refresh progress for 2016/17 Assurance for BCF national submission on March 21st	Integration Executive
30th Mar 16	Scrutiny of performance in 2015/16 and refreshed plan for 2016/17	Health & Overview Scrutiny Meeting
31st Mar 16	Assurance on plan completion and submissions	LCC Transformation Delivery Board
4th Apr 16	Engagement on BCF and briefing on devolution/combined authorities	NHS England Executive Team Meeting

11th Apr 16	Assurance on final BCF submission for April 25th	ELRCCG Corporate Management Team
11th Apr 16	Assurance on final BCF submission for April 25th	WLCCG Corporate Management Team
12th Apr 16	Engagement on BCF delivery 2015/6 and BCF refresh progress for 2016/17	Leicestershire Partnership Trust Community Health Service Divisional Management Team meeting
13th Apr 16	Engagement on BCF delivery 2015/6 and BCF refresh progress for 2016/17	EMAS Senior Management Team
13th Apr 16	Assurance on final BCF submission for April 25th	A&C Departmental Transformation Delivery Board
14th Apr 16	Assurance on final BCF submission for April 25th	Integration Operational Meeting
14th Apr 16	Engagement on BCF delivery 2015/6 and BCF refresh progress for 2016/17 with particular emphasis on prevention theme of BCF	Leicestershire Fire Service Executive Board
19th Apr 16	Assurance on final BCF submission for April 25th Approval of final submission as delegated from Integration Executive	Integration Executive
20th Apr 16	Routine (Quarterly) all Member Briefing – will include engagement on BCF delivery and other LLR wide health and care activities (e.g. STP/Better Care Together)	Leicestershire County Council's All Member Briefing – Health & Care Integration

8.2 HTLAH Provider Workshops

The following is a summary of the engagement undertaken with domiciliary care providers and service users during the development of the specification and commissioning approach for our new model of domiciliary care "Help to Live at Home" (HTLAH).

Date	**Purpose**
2nd/6th Feb 2015	Two market engagement events were undertaken, providing an opportunity to explore with both existing and prospective Service Providers the benefits and challenges of the range of strategic options considered in the development of this business case. 112 participants attended the events from 61 organisations. The February 2015 engagement events were supplemented by an online questionnaire that was made available to all delegates (including those unable to attend facilitated events) with the aim of: • Helping the programme in understanding if there are different views on the options from small and large providers • Contributing to informing feasibility of implementation of the options

	• Helping to develop the approach to support market readiness for the new way of working, including gauging provider interest in the proposed options.
13th/19th May 2015	Two further events were held May 2015 to explore the delivery of Reablement through the independent sector, commissioning for outcomes and developing the role of providers in coordinating support for individuals from community resources and assistive technology. These events provided an opportunity to appraise the Market of the delivery model under development, compared and contrasted to the current model, and supported the development of the new model utilising the knowledge and expertise of the Market. Topics discussed were: • Reablement in practice; Assistive Technology; Social Capital and developing community resources. • Outcomes commissioning: the current market experience; delivering to outcomes, putting the service user/patient at the heart of support planning
30th July/5th Aug 2015	Two market engagement events were undertaken in July and August 2015, providing an opportunity to explore with both existing and prospective Service Providers the benefits and challenges of the chosen strategic options considered in the development of this business case. These engagement events included live voting to ascertain the market view of chosen strategic options. This was supplemented by an anonymised survey of indicative bidding intentions against the 18 draft lots across 7 localities. This was made available to all delegates with the aim of: • Helping the programme in understanding if lots are commercially viable and likely to attract bids in the procurement phase • Contributing to informing the development of the provider delivery model as part of the Full Business Case • Helping to develop the approach to support market readiness in respect of Lead Provider, Sub-contracting and Consortia arrangements
22nd/24th Sep 2015	Two market engagement events were undertaken in September 2015 facilitate informal provider networking and information sharing opportunities.
10th/11th Dec 2015	Two events held to give providers an update on HTLAH Procurement process and progress; Continuing Healthcare (CHC) requirements; Introduction to the Abridged Joint Service Specification and Service elements and rates. The sessions were facilitated with: • Table top discussions • 'Ask the Audience' Voting
11th Feb 2016	A bidders day event was held to launch the PQQ

8.3 Evaluation Study Engagement Workshops

The following illustrates the multiagency stakeholder workshops and service user engagement workshops held to evaluate our four emergency admissions schemes within the Leicestershire BCF plan 2015/16. These were part of our research and evaluation study completed in conjunction with Loughborough University and Leicestershire Healthwatch

Date	Aim	Scheme
11th Sept 15	Stakeholder workshops – to review the computer simulation of the patient pathway for each intervention; test scenarios about future improvements to the scheme; and make recommendations of future actions to the Integration Programme.	Integrated Crisis Response Service – Night Nursing Service
11th Sept 15		Older Persons Unit
29th Oct 15		7 Day Services in Primary Care
29th Oct 15		Rapid Response Falls Service
10th Nov 15	User workshops – to review a computer simulation model of the service; to engage patients with the process of avoiding emergency admissions; and to explore ways of measuring patient satisfaction.	Integrated Crisis Response Service – Night Nursing Service
10th Nov 15		Older Persons Unit
2nd Feb 16		Rapid Response Falls Service

In addition to the above engagement activities we publish regular editions of our stakeholder bulletins – 2015 editions can be found at this
www.leics.gov.uk/healthwellbeingboardnews#hcibulletins

8.4 Microsite Development

Due to the upgrading of Leicestershire County Council's website, new arrangements are being made to create a health and care integration microsite. This will become the new location for our integration programme communications and engagement product which have previously been located on historical pages of the Leicestershire Health and Wellbeing Board. This microsite will also hold all BCF related materials from 2014 onwards.

www.healthandcareleicestershire.co.uk/health-and-care-integration/health-and-care-integration-newsletters/

APPENDICES

Appendix 1 BCF Spending Plan 2016-17

Appendix 2 NHSE BCF Planning Template

Appendix 3 BCF Schemes Mapping Table

Appendix 4 Integration Executive Performance Dashboard May 2016

Appendix 5 Integration Programme Plan

Better Care Fund Spending Plan 2016/17

Ref No.	Resubmission BCF Scheme Heading	West Leics CCG £'000	East Leics & Rutland CCG £'000	Leics County Council £'000	Integration Reserve	Total £'000
UNIFIED PREVENTION OFFER						
UPO1	First Contact Plus	92,707	70,509	0	0	163,216
UPO2	Carers Services:					
	Care Act Support Pathway	257,872	196,128	0	0	454,000
	Carers Health and Wellbeing Service	93,720	71,280	0	0	165,000
	Specialist Support to People with Dementia & Carers (Memory Support Service)	181,006	137,667	0	0	318,673
		532,598	405,075	0	0	937,673
UP03	Local Area Co-ordination	14,802	11,257	263,941	0	290,000
UPO5	Assistive Technology:	0	0	950,200	0	950,200
UPO6	Integrated Housing Solutions:					
	Disabled Facilities Grants	0	0	1,739,307	0	1,739,307
	Hospital Discharge - Housing Enablers	0	0	114,000	0	114,000
		0	0	1,853,307	0	1,853,307
UPO7	Protected Prevention Services:					
	NHS - LD Short Breaks	588,000	256,000	0	0	844,000
	Social Care - Residential Respite Services	421,797	320,803	0	0	742,600
		1,009,797	576,803	0	0	1,586,600
UPO9	Supporting Leicestershire Families (April 16 to September 16)	57,000	43,000	0	0	100,000
UNIFIED PREVENTION OFFER TOTAL		**1,706,903**	**1,106,645**	**3,067,448**	**0**	**5,880,996**
LONG TERM CONDITIONS						
LTC1	Integrated, Proactive Care (Risk Stratification & Care Management):					
	Proactive Care Model (WLCCG)	540,000	0	0	0	540,000
	Integrated Care Team (ELRCCG)	0	430,000	0	0	430,000
		540,000	430,000	0	0	970,000
LTC3	Improving Quality in Care Homes:					
	Quality Improvement Team	176,818	134,482	0	0	311,300
	Safeguarding Team	108,999	82,901	0	0	191,900
		285,818	217,382	0	0	503,200
LTC4	Protected LTC Services					
	Social Care - Nursing care packages	1,908,821	1,451,779	0	0	3,360,600
	Social Care - Home Care Services	6,102,592	4,641,408	0	0	10,744,000
	Social Care - Growth in Community Based Services	170,400	129,600	0	0	300,000
	Social Care - Growth in Nursing Care Home Services	135,575	103,113	0	0	238,688
		8,317,388	6,325,900	0	0	14,643,288
LTC5	Health and Social Care Protocol Training	58,115	44,201	0	0	102,316
LTC6	LTC QIPP Investments	229,000	168,700	0	0	397,700
TOTAL LONG TERM CONDITIONS		**9,430,321**	**7,186,183**	**0**	**0**	**16,616,504**
URGENT RESPONSE						
IUR1	Integrated Health & Care Crisis Response (ICRS):					
	Night Nursing Element	601,020	486,500	0	0	1,087,520
	Social Care Element	320,920	244,080	0	0	565,000
		921,940	730,580	0	0	1,652,520
IUR2	Rapid Assessment for Older People:					
	Loughborough Frail Older People's Unit	500,000	0	0	0	500,000
	Loughbourough Urgent Care Centre	390,000	0	0	0	390,000
	Integrated Community Health	0	563,000	0	0	563,000
	Care Home Support (Pressure Sores)	0	54,000	0	0	54,000
	ANPs Physical Health Assessment (MHSOP Patients)	0	77,000	0	0	77,000
	Care Home and Community Inreach Support (MH)	0	82,000	0	0	82,000
		890,000	776,000	0	0	1,666,000
IUR4	Weekend Working Service (WLCCG)	427,500	0	0	0	427,500
	Acute Visiting Service (WLCCG)	851,000	0	0	0	851,000
IUR 6	Integrated 7 Day Community Care (with additional AVS capacity) - ELRCCG	0	622,500	0	0	622,500
IUR5	Ambulatory Care on CDU - Glenfield Hospital	44,304	33,696	0	0	78,000
TOTAL URGENT RESPONSE		**3,134,744**	**2,162,776**	**0**	**0**	**5,297,520**
HOSPITAL DISCHARGE AND REABLEMENT						
HDR1	Residential Reablement	92,584	70,416	0	0	163,000

Ref No.	Resubmission BCF Scheme Heading	West Leics CCG £'000	East Leics & Rutland CCG £'000	Leics County Council £'000	Integration Reserve	Total £'000
	Hospital to Home	40,896	31,104	0	0	72,000
	Intermediate Care	313,000	267,000	0	0	580,000
HDR2	Protected Reablement Services:					
	NHS - Reablement	2,419,000	1,713,000	0	0	4,132,000
	NHS - Intensive Community Service	951,000	870,000	0	0	1,821,000
		3,370,000	2,583,000	0	0	5,953,000
HDR3	Improving Mental Health Discharge:	154,263	117,326	0	0	271,589
HDR5	Protected Hospital Discharge Services					
	NHS - Step Down	300,000	229,000	0	0	529,000
	NHS - Assertive InReach	208,000	184,000	0	0	392,000
	Expansion of Assertive Inreach	0	0	0	0	0
	Social Care - Assessment and Review	803,272	708,368	0	128,248	1,639,888
		1,311,272	1,121,368	0	128,248	2,560,888
HDR6	Help to Live at Home:					
	Hospital Discharge Care Packages Review Team (to Oct 16)	136,774	104,026	0	0	240,800
	Community Based Review Team (from Nov 16)	97,696	74,304	0	0	172,000
	HTLAH Transitional Costs (TBC)	0	0	0	0	0
	HTLAH - Pathway 2 Case Management	0	211,500	0	0	211,500
	Back Office Support	23,667	18,000	0	0	41,667
	CCG Reablement	185,000	141,000	0	0	326,000
		443,137	548,830	0	0	991,967
HDR7	Non Weight Bearing Pathway (Pathway 3)	48,507	36,893	0	0	85,400
HDR9	Social Care DST Workers	118,712	90,288	0	0	209,000
TOTAL HOSPITAL DISCHARGE AND REABLEMENT		**5,892,371**	**4,866,225**	**0**	**128,248**	**10,886,844**
ENABLERS						
EN01	Programme Leads and Support:					
	Programme Lead - Falls Strategy	17,229	13,104	0	0	30,333
		17,229	13,104	0	0	30,333
	Programme Support (Main)	107,361	81,674	50,000	0	239,035
	Programme Support (Finance)	31,537	23,986	0	0	55,523
	Programme Support (Transformation BP)	20,710	15,751	0	0	36,461
	Programme Support (Lead Analyst - H&SC Integration)	28,456	21,643	0	0	50,099
	Programme Support (Communications)	8,605	6,545	0	0	15,150
EN01	Programme Leads and Support	196,669	149,599	50,000	0	396,268
EN02	Care Act Enablers:					
	Independent Mental Health Advocacy	45,638	34,710	0	0	80,348
	Veterans GIP	9,883	7,517	0	0	17,400
		55,521	42,227	0	0	97,748
EN03	IT Enablers - PI Caretrak	39,760	30,240	0	0	70,000
	IT Enablers - MicroWebsite	3,408	2,592	0	0	6,000
		43,168	32,832	0	0	76,000
EN04	Service Enablers: Integrated Points of Access	0	0	0	137,000	137,000
TOTAL ENABLERS		**312,587**	**237,762**	**50,000**	**137,000**	**737,349**
	Total Expenditure	**20,476,926**	**15,559,591**	**3,117,448**	**265,248**	**39,419,213**

Joint Health and Wellbeing Strategy 2017 - 2022

Mike Sandys, Director of Public Health

Background – Board Requirements

- Complement but not duplicate existing plans
- Provide clarity of shared vision and ambition
- Focus on a few key priorities that require a partnership approach
- Support good health and wellbeing through maximum impact and reducing inequality
- Enable the shift to prevention and early intervention
- Include the aspiration to embed 'health in all policies'
- Based on evidence of local need
- Use an iterative process

Process to date

Leicestershire County Council

Research

- Issues from the review of the previous strategy
- Evidence of need, gaps and recommendations for action from the Joint Strategic Needs Assessment 2015
- Performance below the national average or where there could be higher ambition
- Sustainability and Transformation Plan and Better Care Together

Engagement

- Health and Wellbeing Board Development session with the LGA
- Meetings with individual members of the Health and Wellbeing Board and Joint Health and Wellbeing Strategy Steering Board

Drafting

- Vision and Principles to capture a new way of working
- Outcomes
- Priority objectives
- Recommended approach to delivery

Shared Vision and Board Principles

There is a consensus that the Health and Wellbeing Board needs:

- More effective collaboration to get the best outcomes and use of resources

- A joint vision and shared aims and ambition

- To take a proactive approach to the issues and where progress is not on track

Suggested Outcomes

1. The people of Leicestershire take responsibility for their own health and our communities inspire and enable good choices for all;

2. Children and young people are safe and free from harm and are supported by families and others to reach their full potential;

3. People plan ahead to age well and stay healthy and older people feel they have a good quality of life;

4. People know how to take care of the mental health and wellbeing of themselves and their family

5. The gap between health outcomes for different people and places has reduced;

Outcome 1

The people of Leicestershire take responsibility for their own health and wellbeing

We will:

Work together to build health into the local environment and support communities to help themselves

Encourage and support people to stay well and target the most vulnerable and at risk

Work together to keep communities safe and free from harm

Outcome 2

The gap between health outcomes for different people and places has reduced

We will:

Improve our understanding of the most vulnerable and at risk within the Leicestershire population

Use evidence to improve the targeting of activity to reduce health inequality between people and places

Improve outcomes for people with special educational needs and disabilities

Outcome 3

Children and young people are safe and free from harm and are supported by families and others to reach their full potential

We will:

Ensure the best start in life for children and their families

Work proactively in partnership to keep children and young people safe and free from harm and sexual exploitation

Support those families identified as most troubled to become self-sufficient and resilient

Prepare and support children with complex physical and mental health needs, and their families, as they move between child and adult services

Outcome 4

People plan ahead to age well and stay healthy and older people feel they have a good quality of life

We will:

Plan for the ageing population, particularly their housing needs

Improve the diagnosis and management of long term conditions

Maximise independence of older people and work with communities to help them stay connected

Enable older people in Leicestershire to keep well and healthy with a focus on the needs of the increasing number of frail elderly people

Outcome 5

People know how to take care of the mental health and wellbeing of themselves and their family

We will:

Provide positive mental health promotion through improved coordination and collaboration

Increase the early detection and treatment of children and young people with mental health and wellbeing needs

An approach to delivery - rationale

- Existing Strategy does not cover delivery in detail
- Performance framework is large and due for review and refocus
- Terms of reference require 'rate of progress'
- Opportunity to capture existing joint working against priorities and highlight gaps
- Provides partners outside the Board to see how the issues are being addressed

Timetable

- Update on progress to Health &Wellbeing Board on 7th July
- Gain approval for wider engagement end July
- Final approval of Joint Health and Wellbeing Strategy on 15th September 2016
- Draft a 'delivery plan' during wider engagement process with all partners
- Develop the performance framework in consultation with partners

Discussion

- What is your initial reaction to the Outcomes proposed and the suggested priorities?

- How can the local health forums be effectively linked to the work of the Health and Wellbeing Board?

- What is the role of the local health forums in delivering the Health and Wellbeing Strategy?

Improving Mental Health in Our Local Community

Phoenix Therapies and Training

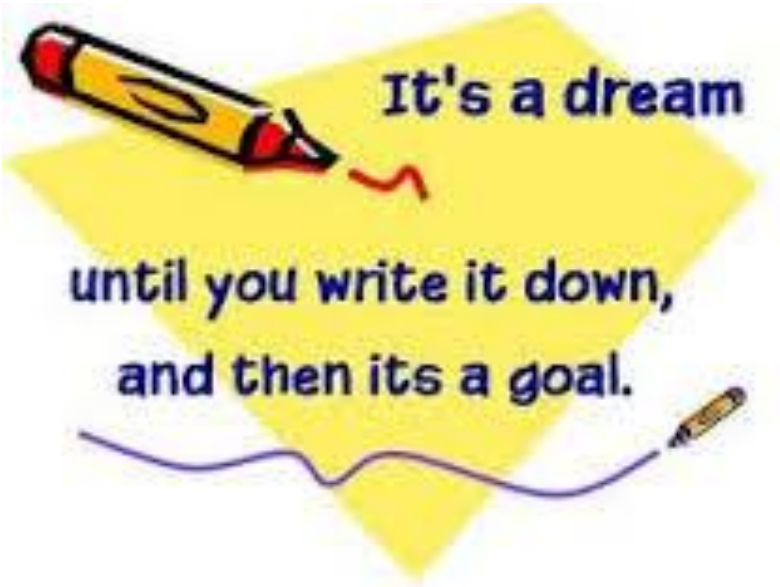
Empowering people to reach their full potential

What Do Phoenix Do?

- Deliver specialised early intervention community health services throughout the Midlands (2012).
- Preparation for Work and Take the Weight of Your Mind
- People learn new life skills to deal with the day to day stresses of life.

We teach the four main life skills that people need to be well.

- How to manage stress
- How to create and maintain a healthy self-esteem
- How to maintain positivity
- How to achieve goals



Clients so far....

EUROPEAN SOCIAL FUND

jobcentreplus

LASS
Responding to the challenges of HIV & AIDS

newdawnnewday
Transforming the lives of women, families and communities

Hope - control - opportunity

people's health trust

Oadby & Wigston Borough Council

Leicester City Council

framework
opening doors to homeless and vulnerable people

LCiL
Empowering Disabled People

bipolar UK

Our clients suffer from ……

- Stress
- Depression
- Agoraphobia
- Post traumatic stress disorder
- Bereavement
- High blood pressure
- Insomnia
- Social isolation
- Bi polar

What's Unique About Us?

- We bridge the gap between people needing statutory mental health services and people having assess to them.

- We prevent people from needing statutory services because they learn to manage their own mental health.

- We offer the benefits of peer mentoring and professional training simultaneously.

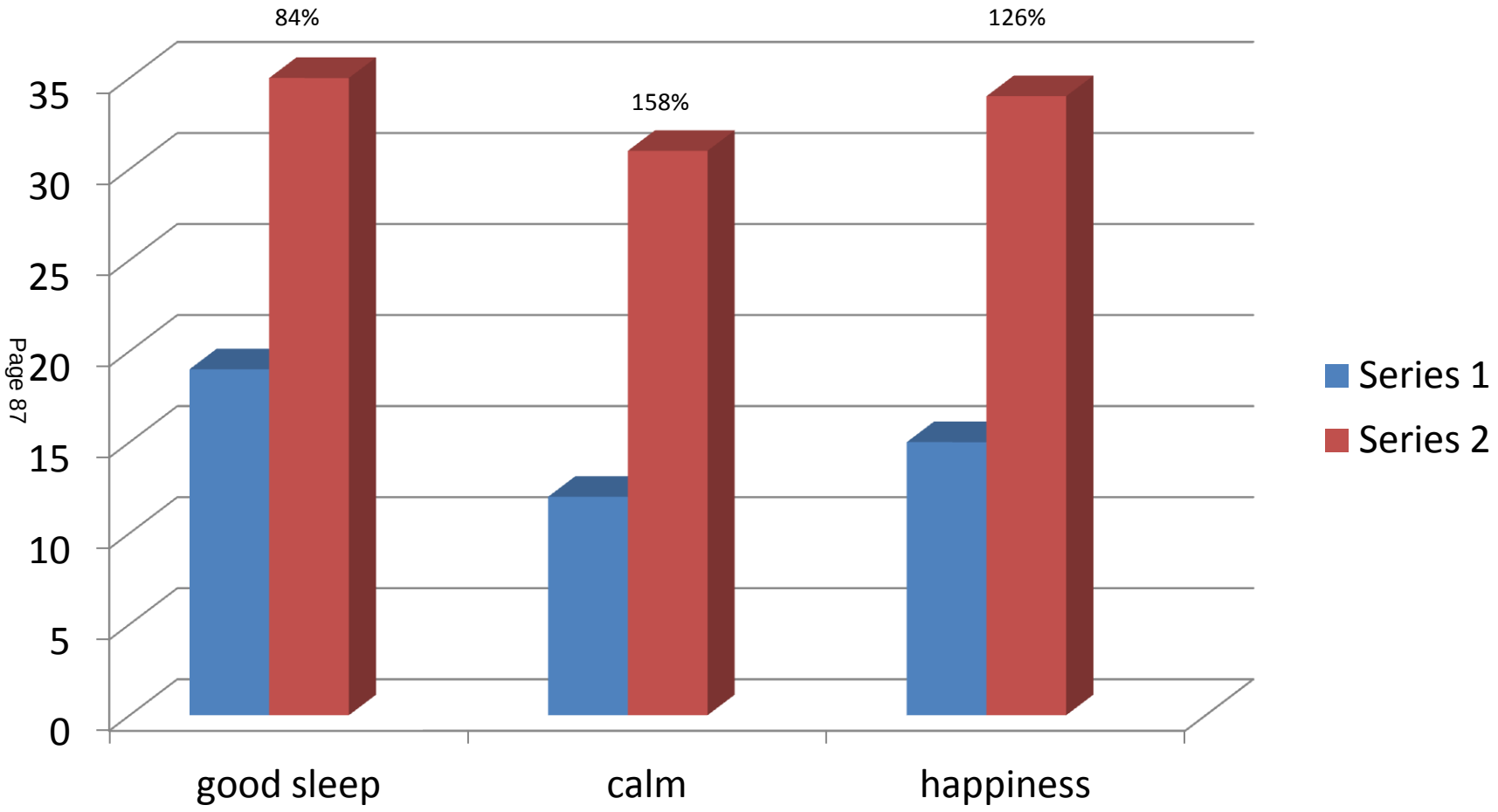
Benefits for Oadby and Wigston

- Improve wellbeing of the community.
- 81% of learners experience an improvement in emotional health, positivity and confidence.
- (source 2012-2014 monitored by ESF and LCC)

People feel healthier and the community saves money

- Reduces need for statutory services and benefits.
- *“ When my husband died I was at the GP’s about 3 times a week. After attending group training with phoenix my panic attacks stopped and I no longer needed to see my GP.”*
- Nanette Mooney June 2014

Take the Weight of your Mind - Wigston



Saving money

- It is estimated that improved early intervention services could save the NHS up to £38 million per year.

The Proposal- Phoenix is the Bridge

- We support people who currently need help with their mental health and are not getting it.

- Research is completed on the outcomes and cost effectiveness of our work.

Proposal A

- You identify the GPs with the longest waiting lists for IAPT services.
- We work with these people.
- “Suicides are rising and 75% of people needing help are not receiving it”
- Guardian 13 Feb 2016

Proposal B

- We work with referrals on the waiting list for the Cedar Centre services.

- The average maximum wait time for a community mental health team appointment is 30 weeks.
- Guardian 13 february 2016

Leicestershire Partnership NHS
NHS Trust

Proposal C

- We do both
- Cost £1700 per programme

Questions ?

Why?

- The average maximum wait time for a community mental health team appointment is 30 weeks.
- Guardian 13 february 2016

- “The human cost is unacceptable and the financial cost is unaffordable.”
- Paul Farmer, chief executive Mind

Why?

- The Government's ' Putting People First' paper recognises that

- " effective peer support is essential in the transformation of adult social care."
- (Dept of Health 2010)

Why?

- Mental illness causes 15 % of the country's disease burden but received just 5 % of total health research spending.

- Suicides are rising and 75% of people needing help are not receiving it
- Guardian 13 Feb 2016

More People Work and the Community Saves Money

- ***£100,250** has been saved a year because our learners became well enough to go to work again.

- *New economy Manchester – unit costs 12/13
- Phoenix outcomes June 2012-july 2014 monitored by European Social Funding

The community becomes stronger

- *66% of your learners experienced reduced social isolation because they went into further study, volunteering or work.

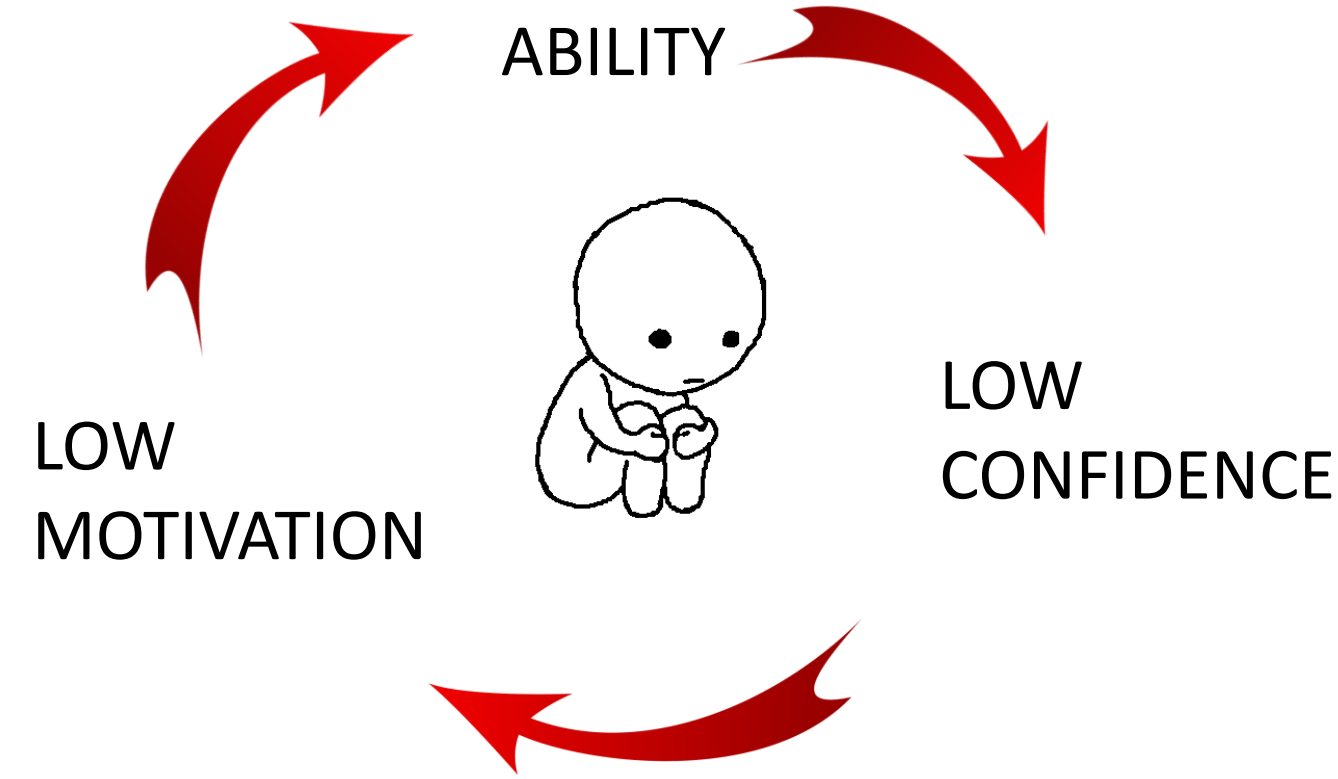
- * monitored by ESF 2014

Lives are Saved and the Community saves Money

- **£66,750** has been saved by our services by supporting 11 people with suicidal thoughts in the community
- ***" Without Phoenix I wouldn't be here today or what I am now."***
- Mehmoodah Peshiman 2014

How Do we do This?

- We show people how to break the negativity cycle.



And Hop On The Cycle of Confidence

STEP 1
PRACTICE
THE SKILLS

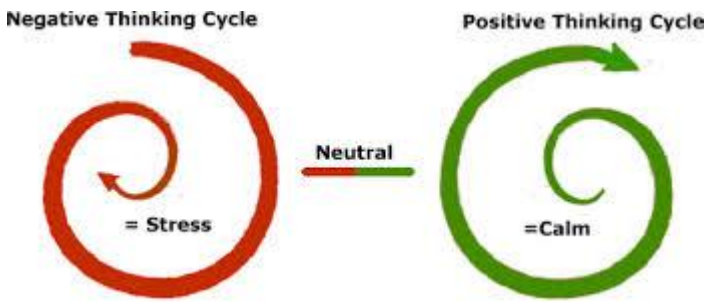
STEP 2
APPLY THEM
EFFECTIVELY

STEP 3
ASSESS THE
RESULTS

STEP 4
MODIFY
AS
NEEDED

Topics We May Cover.

- Our courses are bespoke. Here are sample of potential topics



Testimonials

"This was the best course I've ever been on". Harprett The Recovery College 2016

" I learnt to believe in myself. If you can believe in yourself others can too." Penny Bigley 2013.

"The change in these guys has been amazing" Dave Price Framework 2015

"I feel good more than I feel bad. Anyone can change it just takes time." Gina Azziz June 2013

"This is a very successful project, with the progress of learners outstanding." Jon Ashworth MP July 2013