APPENDIX 1

INTEGRATION EXECUTIVE: 26 APRIL 2016

PROGRAMME DIRECTOR'S HIGHLIGHT REPORT

1. This report provides an update on a range of matters for the attention of the Integration Executive and should be read in conjunction with the Performance and Finance Reports.

Help to Live at Home (HTLAH) Update

2. The PQQ stage has been completed with bidders notified of the outcome on 15th April. ESPO's internal governance and quality assurance panel signed off the PQQ process and outcomes on 14th April.

3. The ITT will commence from the 25th April and applicants will have a period of six weeks to return responses. Final evaluations and award of contracts is scheduled for July 2016, with the new service scheduled to commence in November 2016.

4. The steering group is receiving analysis of the impact of provider bids that did not pass the PQQ and will oversee mitigation plans for any risks arising from this in terms of current provision.

5. Letters have been mailed out to all service users in receipt of a managed domiciliary care service (both local authority and CCG funded) explaining HTLAH and how it may impact upon their service package. A Leicestershire County Council telephone helpline went live on 21st March with 60 calls received in the first week. Two informal service user and family information events have been arranged for 26th and 27th April to explain how the transition arrangements will be managed and to help people to start considering the options available. A media release was issued week commencing 11th April.

6. Good progress is being made across all workstreams preparing for the transition to the new service.

7. A revised timeline has been agreed for the final governance approvals of the HTLAH s75 agreement during May. A draft of the agreement with associated schedules was circulated on the 8th April and has been forwarded to the CCGs' legal advisers for review.

8. A workshop with UHL and LPT has been arranged for 11th April as part of the Operational Dependencies workstream to devise new operational processes across all teams.

Integrated Data: Care and Health Trak Update

9. Representatives from Leicestershire showcased the implementation of Care and Health Trak at the ADASS spring seminar in April.

10. Following approval of CCG MDs to a further 12 months of investment in Care and Health Trak the following activities are underway:

a) Recommissioning the tool with effect from 26th April 2016 for a further 12 months

b) Adoption of additional data sets – out of county acute, NHS 111.

c) Progressing potential inclusion of WLCCG primary care data (pilot)

d) Developing a workplan for the tool in 2016/17 in conjunction with BCT workstreams and the Care and Health Trak Business Intelligence users group.

e) Ensuring a piece of BCT workforce analysis can be undertaken using a data extract from Care and Health Trak.

Integrating LLR Points of Access

11. A presentation was provided at the March Integration Executive which provided an overview of the development of the options and roadmap for the business case.

12. The roadmap outlines the proposed stages including a programme of business readiness for each organisation, co-location opportunities to be exploited with a view to achieving the longer term integration of our adult social care and health call centre offering.

13. The operational readiness will include system and process improvement across all in scope areas, to ensure we have a consistent method of operating, in line with the agreed design principles, to create a baseline from which to co-locate and integrate. It will include:

    a) The operation of all in-scope services under a uniform governance structure for each site.

    b) A revised, clearly communicated service offer.

    c) The implementation of a Performance and Change function.

    d) The start of the standardisation of activities that will drive efficiency in all in-scope areas.

14. The proceeding phases of the project will implement co-location and integration activities, ensuring system resilience and continuous improvement across the complete operation.

15. The draft business case will be presented to the Project Board on 3rd May and be finalised by the end of May.

16. There is a schedule of governance meetings that will then take place, including being presented to each partner’s respective board for approval prior to implementation.

17. Implementation resources are being scoped.

Integrated Community Equipment Service

18. The Demand Management approach, which was brought to the Integration Executive at scoping stage in January, is reaching a conclusion and the outputs will be reported in the next few weeks.

19. Operational delivery within the service has been impacted in recent weeks by two issues - building work and new rotas/terms and conditions affecting staff. These matters are being addressed with the provider.

Health and Social Care Protocol

20. A piece of work has been commissioned to consider the health and social care protocol in the context of changes to the wider domiciliary care contract, with a view to providing an initial report to the Health and Social Care Oversight Board on 2nd August 2016.

Transforming Care Update

21. The Transforming Care Partnership was formally agreed as a function of the BCT LD workstream in December 2015 and will be responsible for the development and delivery of the Transforming Care Plan.

22. Since the update report to the Integration Executive on the 27th February, a second draft of the LLR Transforming Care plan was submitted to the NHS England on the 4th March. Following regional and national moderation the plan has now been assessed as “green” which means that it meets national expectations. A final submission with minor alterations based on feedback was submitted on the 11th April.

Unified Prevention Board (UPB) Update

23. At their April meeting the UPB discussed refreshing their workplan in line with the BCF plan for 2016/17. The UPB discussed the overall vision for integration, the person-centred model of integrated care in localities and how a wrap-around prevention offer is a critical component of this vision.

24. The work of the group will include defining the model for social prescribing across Leicestershire working with First Contact Plus, District Councils, Local Area Co-ordinators, the Voluntary Sector, and CCG’s.

25. The vision is 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 NHS partners. This will include:

    a) A core menu of preventative services which will wrap around individuals and communities, as an essential component of the model of integrated care.

    b) Prevention will be targeted proactively to specific cohorts of people through social prescribing.

c) Every opportunity will be taken to improve health and wellbeing, support vulnerable people, maintain people's independence, manage demand, and address the wider determinants of health and wellbeing.

d) First Contact Plus will provide the "front door" and navigator for maximising social prescribing.

26. A workshop had also been held in March with relevant scheme leads for social prescribing to start work on the menu of services that will make up the offer. This included initial discussions around using First Contact Plus as a front door.

27. The refreshed workplan for the UPB will be supported by an improved performance framework that will track metrics and outcomes including the impact of social prescribing.

28. There will be some additional workstreams that will work in partnership to provide countywide offers, for example, integrated housing solutions via the Lightbulb Service and a core information, advice and guidance offer.

29. Terms of reference for the UPB will be updated to reflect the above including restructured representation where necessary.

Housing Discharge Enabler Scheme

30. Following a successful recruitment campaign for the Housing Enabler posts working at LRI, Glenfield, General and the Bradgate Unit Hospitals, the following people have been appointed to post:

a) Team Leader Post – Taranjeet Bhaur

b) Housing Enabler – Jackie Hands, Andrew Byron and Amardeep Matharu

c) Housing Related Support – Kyle Richardson and Justin Moulder

31. These roles will become part of the overall Lightbulb Team.

Emergency Admissions Avoidance – Actions to improve performance

32. The combined trajectories for 2016/17 from the six BCF funded avoided admissions schemes total 1,500 avoided admissions, against a target of 1,600.

33. Some in year changes are anticipated due to reviews currently in progress on the design of OPU and Night Nursing services. Also, additional activity is anticipated from two to three additional schemes from CCG QIPP Business Cases which are currently being assessed.

34. The action plan for delivery of avoided admissions in 2016/17 is being finalised. This takes into consideration governance routes for particular schemes, for example the ambulatory (admissions avoidance) pathway for CDU at Glenfield will be governed by the BCT long term conditions workstream.

Older Persons' Unit (OPU)

35. As part of the BCF refresh, it was agreed in January to extend the OPU for a further six months to 30th September 2016 to allow time to test new models through the Frail Older People BCT workstream. Therefore it was timely to consider next steps and generate ideas to optimise utilisation of the service. During January to March a review of patient transport, the ongoing offer and management of follow-ups and workforce, in particular the OPU geriatrician time and therapy input, were reviewed.

36. Outputs of the review have now been implemented and progress will continue to be monitored through the Step Up/Step Down Programme Board.

Integrated Crisis Response Service (ICRS)

37. Within the Better Care Together programme, a wider review of all end of life provision across LLR is being carried out, led by Caroline Trevithick, and will report back in April 2016. A decision was made at the Integration Operational Group in January to continue the night nursing service as-is until the end of life review findings are released, which can then be incorporated into future service model planning.

38. A meeting is planned on 20th April to discuss the night nursing element with LPT. This will include a discussion on current referrals into the service and to identify the cohort of patients that may benefit from the original brief in preparation for the end of life commissioning intentions.

39. A task and finish group has been set up between Adult Social Care and LPT to consider the feasibility and options for integrating the social care crisis response service and the urgent care services within CCHS. A workshop will be taking place mid/end of April to look at the different cases that are coming through the social care crisis response service, Rapid Response in CCHS and EDT and consider how these could be responded to by an integrated service.

40. An update on progress will be provided to the Step Up/Step Down Programme Board in May.

Falls Service

41. A new Falls Project Manager has been appointed and started 7th April.

42. The work encompassing "Falls Prevention" and the "Falls Services" will be ran as a single programme of work to ensure consistency, and that results cover the full pathway of care.

43. The draft workplan has been reviewed and was presented to Integration Operational Group on 14th April for feedback.

44. Due to the change in Project Manager, the task and finish groups were not scheduled as previously expected. As part of current stakeholder meetings the requirements of these workshops is being assessed, with a view to holding them late spring. Current intentions

are that they will discuss and report on the following areas, with results to feed into the revised strategy:

a) a robust referral and triage process for fallers/those at risk of falling;

b) directory of services, and

c) the community falls prevention offer.

45. Funding has now been identified for the new FRAT tool e-learning platform which will be rolled out November 2016. An evaluation of the training previously offered to existing staff, along with the current paper based system will be undertaken.

46. The management of the falls in care homes pilot is currently on the reserve list for BCF funding, and will continue to be evaluated further along with other potential schemes based availability of funding and agreed priorities.

7 Days Services in Primary Care

47. **WLCCG** – The service has been operational since the beginning of 2016. Trajectories have been agreed. Avoided admissions are now being reported directly from the HCPs and represent clinical judgement.

48. **ELRCCG** – The initial pilot is for six months and will cover four GP practices. The Croft Medical Centre went live on 6th Feb 2016, the Glenfield Surgery went live on 27th Feb and the Latham House went live on 12th March. Meetings are taking place to look into the logistics for the fourth practice. And the information governance and IT requirements that will need to be fulfilled. Avoided admissions for February have exceeded the target and work continues to evaluate effectiveness and determine future targets.

Ambulatory Pathways on CDU (Glenfield Scheme)

49. A presentation was provided to the Step Up/Step Down Programme Board on 14th April on the CDU Glenfield Rapid Assessment Clinic Test Cycle Week which took place from 14th to 18th March.

50. During the test cycle week the rapid assessment clinic was available between 10am and 8pm with the last patient triaged to clinic at 6pm. Two GPs and a dedicated cardiac specialist nurse where involved.

51. Phase two proposals include:

a) An eight week extended pilot from mid-May to early June.

b) May include weekends so has been costed as a seven day service by eight hours per day.

c) Increased GP presence in triage to identify more patients suitable for same day discharges.

d) Greater integration with GP teams and Intensive Care Support to reduce length of stay in CDU and facilitated discharges.

e) Detailed analysis of outcomes, sustainability and cost effectiveness.

f) Estimated cost is £60k (total across both county and city) to include GP costs, non-recurrent IT start up and project management.

52. Further work on trajectories for avoided admissions and other issues raised in the meeting are to be reviewed between meetings. Governance for the delivery of the scheme will be via the BCT long term conditions workstream.

Charnwood Integrated Urgent Care Testbed

53. Within WLCCG a task and finish group is being set up to lead on the design, testing and delivery of an integrated urgent community and primary care model in the Charnwood locality. This is part of a wider piece of work across each individual CCG across LLR, where each federation will be testing a particular area.

54. The scope of the programme will focus on testing an integrated community urgent care service. This will pick up a number of urgent care schemes that are funded through the BCF plan.

Communications and Engagement

55. Work is progressing on the new Leicestershire Health and Care Integration website. The name has now been confirmed – www.healthandcareleicestershire.co.uk. Content for the web pages is being created and with the initial content on the site ready for 25th April.

56. We have updated the Better Care Fund plan on a page for the refresh submission.

57. The letter and leaflet for the next phase of Help to Live at Home communications has now been distributed to Leicestershire County Council and CCG service users. A press release was issued week beginning 11th April. Two service user information events have also been arranged for 26th and 27th April.

58. The @LeicsHWB twitter now has 286 followers.

59. Content has been drafted for the next edition of the stakeholder health and care integration bulletin including a focus on how prevention services can help GP practices and their patients:

a) First Contact Plus – progress in 2015 and case studies on how the service is being used by GP practices.

b) Lightbulb – a GP view of the housing pilot in Hinckley.

c) Improvements in hospital discharge – what progress has been made and what are the next areas to tackle.

d) The vision for integrated health and care in Leicestershire localities.

60. We are currently working on communications to showcase the SIMTEGR8 evaluation work at national conferences and through academic channels etc.

61. An article has been developed for the Barwell and Hollycroft GP surgery newsletter to promote the Lightbulb programme.

62. We have also developed a leaflet to give out in GP practices where we are running Lightbulb pilots to promote the drop-in session.

63. A refresh 2016/17 BCF communications plan is currently being drafted.

Key Risks

BCF Programme Level Risks

64. The schemes contributing to the achievement of the reduction in emergency admissions are not currently achieving the required trajectory – this has been refreshed for the 2016/17 delivery plan in line with the national guidance.

65. The action plan to address the utilisation of schemes continues and is being monitored by the Step Up/Step Down Programme Board in order to continually assess the confidence level in schemes meeting the required target and will feature as part of review of the trajectories for each scheme and the decisions required for the 2016/17 refresh.

66. Financial pressures affecting all partners means delivery of the BCF plan will be even more challenging than in 2015/16.

67. If our BCF refreshed plan or national quarterly submission templates highlight that we are not satisfactorily meeting any of the national conditions or metrics for the BCF, our plan could be escalated via NHS England depending on the identified risk.

68. The escalation process ultimately leads to the ability for NHS England to use its powers of intervention provided by the Care Act legislation in consultation with DH and DCLG.

Recommendations

69. The Integration Executive is asked to:

- Note the contents of the report.
- Provide any feedback and challenge to the programme team concerning the matters raised.

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