ICB Priority Outcomes	Action/s	Timescales	Indicators	Governance
ICB Workstream: Supporting Independence **Leads: Heather Pick (LCC) and Jane Chapman (ELRCCG)**				
HWBS Outcome: Supporting the ageing population **Priority 10: Planning for an ageing population**				
We will support Older People and Adults with health and social care needs to remain independent in their own homes for as long as possible and reduce the number of people accessing nursing/residential care	**Assistive Technology** 1. Explore Telehealth options currently being piloted/delivered by CCGs (including 'Florence' system) along with any further planned approaches to Assistive Technology	September 2013	ASCOF 2a Permanent admissions to residential and nursing care homes per 1,000 population (I 18-64) (ii 65+)	Assistive Technology Project Board
	2. Explore options for Telecare services to be offered as part of Pharmacists Medication Review processes	September 2013		WLCCG Proactive Care Board
	3. Identify and explore any further opportunities to provide integrated Telecare and Telehealth offers	Ongoing (via Assistive Technology Project Board)	Ratio of Permanent Care vs Community Care (local indicator)	
HWBS Outcome: Supporting the ageing population **Priority 12: Improving the management of long-term conditions**				
We will enable people with long term conditions to live longer and healthier lives with a reduced reliance on health and social care services	**Mapping of Self Help Groups** 1. Commissioned Self Help Nottingham to map self help groups operating across the county.	December 2013	NHSOF 2.3i Unplanned hospitalisation for chronic ambulatory care senstive conditions	WLCCG Proactive Care Board ELRCCG Long Term Conditions Board
	2. Identify gaps in services provided by self help groups	March 2014		
	3. Develop a website which signposts GPs to the different self help groups available	2014/15		
	Develop an Integrated Care Model for Long Term Conditions (ELRCCG) 1. Initiate Integrated Care pilot project	January 2013		
	2. Evaluate the pilot	September 2013		
	3. Roll out plan to all GP practices	by April 2014		
	Proactive Care Model (WLCCG) 1. Build and develop a bespoke Risk Stratification tool based on the John Hopkins model (LLR wide)	March 2014		
	2. Implement Integrated Locality Teams to provide flexible, personalised and seamless care.	March 2014		
	3. Build the community offer and support left shift with Multi-Disciplinary Teams, Virtual Wards and Inreach Services.	March 2014		
	4. Develop activity and trajectories for the composite measures on avoidable emergency admissions.	June 2013		
HWBS Outcome: Supporting the ageing population **Priority 14: Improving the Provision of End of Life Care**				
We will place a greater emphasis on end of life care planning and support	**End of Life Care**		NHSOF 4.6 Bereaved carers' views on the quality of care in the last three months of life.	LLR EOLC Working Group
	1. Develop a joint strategic commissioning framework and delivery plan for end of life care	TBC (by EOLC Working Group?)	End of life care (Public Health)	
	2. Implement the actions/objectives arising from the EOL workstream as part of Step-Up Programme (Cross Ref. HWBS priority 11)	As per identified requirements arising from EOL Workstream (as part of Step Up Programme)	% Proportion increase in people dying at home relative to hospital (Local Indicator)	
HWBS Outcome: Supporting the ageing population **Priority 18: Ensuring earlier detection and treatment of Dementia**				
We will ensure the earlier detection and treatment of dementia and support for people with dementia and their carers	**Dementia Services** 1. Review delivery and impact of the Memory Advisory Service to assess the impact on diagnosis rates and early support for dementia patients and their carers.	1. by April 2014	NHSOF 2.6 I Estimated diagnosis rate for people with dementia	Dementia Strategy Group
	2. Identify opportunities to improve dementia referral pathways.	2. March 2014		
	3. Undertake review of current services available for people in latter stages of dementia and their carers	3. June 2013		
	4. Consult on preferred model of service delivery	4. By Autumn 2013		
	5. Implement agreed model of delivery	5. April 2014		
	Dementia Strategy 1. Develop a plan for reviewing and revising the current Joint LLR Dementia Strategy	1. By Autumn 2013		
	2. Establish how the Dementia Strategy will be taken forward post 2014	2. By March 2014		

ICB Priority Outcomes	Action/s	Timescales	Indicators	Governance
ICB Workstream: Step Up / Step Down Care Leads: Tony Dailide (LCC) and Caron Williams (WLCCG)				
HWBS Outcome: Supporting the ageing population 11. Maximising independence in older people by improving stroke care and rehabilitation services, preventing falls and reducing preventable hospital admissions				
We will develop an integrated care offer that reduces reliance on acute and long term traditional services, particularly for crisis/emergency situations	**Establish a Step Up Programme** 1. Hold first Step Up Working Group/Scoping Meeting • Agree Terms of Reference and membership • Map existing projects and pathways 2. Develop Project Plan, incorporating the following workstreams as part of the Programme: • Heart Failure • Falls • Nursing Home Support (Cross Ref: JHWS Priority 13/ICB Contracting & Quality Workstream) • End of Life Care (Cross Ref: JHWS Priority 14/ICB Frail Older People Workstream)	August 2013 To be determined as part of Project Plan	NHSOF 3.6i Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services NHSOF 3.6ii Proportion offered rehabilitation following discharge from acute or community hospital NHSOF 3a Emergency admissions for acute conditions that should not usually require hospital admission NHSOF 3b Emergency readmissions within 30 days of discharge from hospital (PHOF 4.11) ASCOF 2c Delayed transfer of care from hospital, and those that are attributable to adult social care PHOF 2.24 Injuries due to falls in people aged 65 and over	Step Up Programme Board Urgent Care Board Better Care Together Board
	Establish a Step Down Programme (Discharge To Assess) 1. Develop and agree Shared Assessment Tool for transfers of care 2. Increase CHS district nursing, mental health nursing and therapy capacity and align intermediate care with reablement and pro-active care, include dementia support to the pathway (Pathway 1) 3. Specify and procure increased nursing/ residential beds capacity , in line with LCC residential reablement pathway. Work with ICS and therapies to support the setting, add on site social care support to move on individuals via increased capacity in reablement provision. (Pathway 2)	March 2014 October/November 2013 October 2013		Better Care Together Step Down Board Urgent Care Board Better Care Together Board
	Integrated Crisis Response Service 1. Pilot ICRS (based on HART service) 2. Investigate integrated additions to the programme during and post pilot service, including: • Single Crisis Response number • Integrated Immediate Care • Link to Community Health Services	August 2013 September 2013		
ICB Workstream: Learning Disabilities Commissioning Leads: Sandy McMillan (LCC) and Jim Bosworth (WLCCG)				
No specific HWBS priority				
We will provide effective, efficient and integrated services for people with Learning Disabilities	**Management of LD Pooled Budget** 1. Establish a Pooled Budget Monitoring Group 2. New Pooled Budget agreement in place 3. Ensure any 100% Health funded Continuing Healthcare cases are removed from the Pooled Budget and returned to Health	September 2013 December 2013 September 2013	ASCOF 1.G Proportion of adults with a learning disability who live in their own home or with their family	LD Programme Board LD Pooled Budget Monitoring Group
	Winterbourne View Concordat 1. Review existing plans and strategies in relation to the Winterbourne concordat 2. Register in place 3. Care Plans reviewed and agreed 4. People will have been moved into appropriate community settings	December 2013 by April 2014 by June 2013 by June 2014		LD Programme Board Winterbourne Sub-Group
	LD Commissioning Plan 1. Produce a learning disabilities chapter for the JSNA 2. Revise existing care pathways and develop a new service specification for assessment and treatment services for people with learning disabilities	by April 2014 by April 2014		LD Programme Board
	Joint LD Self Assessment Framework 1. Set up LLR-wide Multi-Agency SAF Task Group to oversee co-ordination of SAF evidence collection and submission, including access to required data and stakeholder engagement 2. Develop initial draft action plan incorporating range of LD related action plans, including 6 Lives, responses to Winterbourne and a first draft of the LD SAF submission 3. Collate data, evidence and other information for SAF submission 4. Finalise SAF submission for approval by Health & Wellbeing Board (HWB meeting on 5th September 2013) 5. Submit SAF 6. Validation and regional reporting 7. National Reporting and presentations to Health & Wellbeing Boards	by June 2013 by 31st August 2013 June - September 2013 5th September 2013 by 30th September 2013 October - December 2013 January - March 2014		LD Programme Board Multi-Agency LLR SAF Task Group
	Short Breaks 1. Pilot peripatetic Short Breaks service 2. Undertake evaluation of pilot service 3. Consider recommendations from evaluation of pilot to inform commissioning of services	March to August 2013 September 2013 October 2013		LD Programme Board Short Breaks Board
	Transitions 1. Develop a joint strategy for Transitions 2. Establish Transitions Sub-Group and agree governance arrangements 3.Develop and deliver training for CYPS/A&C staff around Transitions 4. Ensure NHS develop clear Transitions processes, with dedicated Transitions leads identified to progress joint commissioning arrangements; guidelines for Continuing Healthcare and ensuring Health Action Plans are incorporated into Person Centred Reviews 5. Develop a clear and transparent multi-agency Transitions protocol	June 2012 March 2013 April 2014 - June 2014 Timescale TBC February 2014		LD Programme Board Transitions Management Board Transitions Management Group Transitions Sub-Group

ICB Priority Outcomes	Action/s	Timescales	Indicators	Governance
ICB Workstream: Personalisation Leads: Tony Dailide (LCC) and Caron Williams (WLCCG)				
No specific HWBS priority				
We will ensure that Adult Health and Social Care service users have choice and control and access the right support in the right place at the right time	**Integration of health and social care personal budgets** 1. Investigate current position with regards to implementation of Personal Health Budgets with GEM 2. Identify future plan for roll out of PHBs, including integration with Personal Social Care Budgets (with particular reference to CHC cases) 3. Explore options for integrating PHB's with Personal Social Care Budgets for wider range of services/conditions	August 2013 by April 2014 Ongoing	ASCOF 1c Proportion of people using social services who receive self-directed support, and those receiving direct payments	TBC
ICB Workstream: Contracting & Quality (Including Continuing Healthcare) Leads: Sandy McMillan (LCC), Dave Briggs (ELRCCG) and Caroline Trevithick (WLCCG)				
HWBS Outcome: Supporting the ageing population Priority 13: Ensuring care homes adhere to the highest standards of dignity and quality				
We will use resources effectively and efficiently to ensure a long term, integrated and sustainable care system can be created, which can support people now and in the future	**Develop Business Case to explore integrated approaches to contracting and quality for Continuing Healthcare** • Complete final analysis of shared contract database • Review best practice and evidence base • Complete comparison on contractual terms • Complete process mapping for procurement • Determine the level of integration to be achieved and which local authorities are involved • Explore options for the establishment of a virtual integrated strategic commissioning function for CHC • Explore options for developing a fully integrated service and how this may fit with emerging vision for commissioning to meet Leicestershire Together priorities	by Autumn 2013	NHSOF 4.9 Improving people's experience of integrated care ASCOF 4A The proportion of people who use services who feel safe ASCOF 4B The proportion of people who use services who say that those services have made them feel safe and secure	CHC Management Board
ICB Workstream: Cross-Cutting Principles Leads: Sandy McMillan (LCC) and Sandra Whiles (Blaby DC)				
Carers	**Implement Carers Strategy 2012-15** 1. LCC/CCGs to work together to increase understanding of carers needs and issues including the need to identify carers; Build on current systems to embed the identification and onward referral of carers in primary medical care 2. Carers to lead the development of a Carer's Charter 3. Continue and increase funding for the Carers Support Grant for young and older carers 4. Consider feasibility of pooled Personal Budgets and Personal Health Budgets 5. Implement new Carer Health and Wellbeing Service working with CCGs 6. Develop training around stress management/coping strategies for Carers utilising Health Transfer Monies	by April 2014 (subject to Project Board approval - Sept 13) by Autumn 2013 Ongoing by December 2014 Ongoing March 2014	ASCOF 3B Overall satisfaction of carers over social services ASCOF 3C Proportion of carers who report that they have been included or consulted in discussion about the person they care for ASCOF 3D Proportion of people who use services and carers who find it easy to find information about services	Carers Project Board
Housing	**Identify any specific housing related barriers/issues impacting on the identified actions for each Workstream and address via Housing Services Partnership Board**	30th September 2013		Housing Services Partnership
Engagement	**Identify and implement relevant engagement mechanisms for the actions for each Workstream**	Ongoing		

37

This page is intentionally left blank