ANNEX 1 – Detailed Scheme Descriptions

Integrated Urgent Response

Scheme ref no.
IUR
Scheme name
Integrated Urgent Response
What is the strategic objective of this scheme?

Case for change

Our rationale for changing the way urgent care is delivered across LLR over the five year period is based on the following challenges:

Urgent Care Generally

- We are experiencing difficulty achieving national standards and ambitions, e.g. maintaining the four hour A&E target and achieving overall reductions in acute sector activity
- Existing urgent care settings are crowded and uncomfortable
- Navigating the urgent care system is complex and difficult and the varied alternatives to A&E are confusing
- Urgent care services are not well connected to wider community health services/pathways – for example the ambulance service not always aware of elderly frail patients already being case managed by community staff

Frail Older People Specifically

- The number of older people is forecast to rise in the city and county
- Locally too many older people end up in hospital for too long – we need care to be delivered in or close to home
- Too many people end up in services such as residential care instead of going back home with the right changes made to that home to make it a safe environment – we need to support people to be independent
- Not enough services that are joined up to support physical and mental health and wellbeing needs – we need to deliver integrated pathways
- We accept the international and national evidence that integrated care pathways are needed to better support people with complex and multiple needs

Desired outcomes

The outcomes we are seeking to achieve across LLR over the five year period are as follows:

Urgent Care System Generally

- National four hour target consistently met
- More people being treated in the right place – e.g. shift of 25% of A&E attendances (minors) being seen in an urgent care setting rather than an A&E setting by 2018/19
- Improved patient experience e.g. through redevelopment of the A&E department, feedback on satisfaction with alternative community based services
- Simpler urgent care system (for professionals as well as the general public)
- A 25% reduction in emergency department (ED) admissions for chronic diseases through specific interventions for Frail Older People and those with Long Term Conditions
- Less time spent in hospital – 10% reduction in non-elective length of stay for those who still need to be admitted

Frail Older People Specifically

- Improved independence and wellbeing amongst the frail and the elderly as measured by fewer care home admissions
- More older people with agreed and managed care plans
- Fewer older people going into hospital – 15% reduction in admissions
- Reduced delayed discharged and length of stay
- A reduction in readmission rates
- Increased dignity as evidenced through patient surveys
- An increase in the number of people who die in a place of their own choosing
- More older people with agreed and managed care plans

BCF Plan Response to the Urgent Care Case for Change

Leicestershire's BCF plan focuses on providing an integrated urgent response in the community, with clear and effective alternatives to hospital admission. This will be achieved by:

- Providing targeted, integrated community based alternatives for urgent care.
- Targeted specifically to
    - Emergency admissions due to falls
    - Emergency admissions for frail older people
    - Emergency admissions for those with LTCs (see BCF Theme 2)

Overview of the scheme

Please provide a brief description of what you are proposing to do including:

- What is the model of care and support?
- Which patient cohorts are being targeted?

IUR 1 - Integrated Crisis Response

We have identified that a proportion of hospital admissions in Leicestershire can be avoided if we can respond rapidly to crisis situations, such as sudden/temporary changes in the levels of personal care needed at home.

The aim of the Integrated Crisis Response Service is therefore to provide effective short-term support at the point of crisis that will help to maintain someone in their own home.

Appropriate referrals would include;

a) People who have fallen and may be at risk of further falls and require social care intervention to help them avoid an unnecessary / inappropriate admission to hospital or residential care (see also IUR3 below)
b) People who have deteriorated suddenly in their abilities, they will have had appropriate medical intervention but require additional urgent support to maintain them at home. They may have a UTI or acute episode of COPD and as a result be reduced in their normal ability levels. They will be at risk of an unnecessary admission to hospital or residential care.
c) People who require an urgent social care service to assist them to be discharged from hospital emergency departments.
d) People who are at risk of deterioration in their condition / ability / level of independence without urgent social care support.

We have already piloted this approach within adult social care which sits alongside the existing community nursing service resources (day time based support).

The existing social care service has received a total of 884 referrals from 1st September 2013 to 31st July 2014 of which 711 were accepted per the criteria**.**

Of these, 304 referrals came directly from accident and emergency, 116 from intermediate care, 152 from the adult social care customer services centre, and 141 from the promoting independence adult social care team. The interventions of this service are producing approximately 10 avoided admissions per week.

Data from the last six months also indicates where capacity of the service has been reached, preventing additional referrals being taken, and this information is part of the ongoing evaluation to establish if further investment should be made to increase the capacity

In the meantime, the approach is being extended with effect from September 2014 to include night nursing cover, so a fully integrated health and care rapid response can be in place.

This means that the service will be able offer short term nursing care for those in crisis, (to avoid admission to hospital or nursing home placement), while the crisis is resolved or a longer term care plan can be arranged.

A trajectory has been developed to show the impact of the combined social care and nursing interventions within IUR1 with effect from September 2014 and the impact of this has been factored into the overall trajectory for reducing total emergency admissions by 3.5%.

IUR 2 - Rapid assessment for older people

We have identified that the immediate capacity needed within this Unit is for approx.1800 older people per year who may need rapid diagnosis, assessment and treatment due to their overall condition changing/deteriorating, and where further investigations are likely to be needed to establish the best course of action.

Usually GPs have to refer these people into hospital in order to evaluate their condition due to the type of diagnostic tests this can involve and/or the need to access a specialist geriatric opinion.

This can have unintended consequences such as resulting in an admission, a longer hospital stay than necessary and/or followed by difficulties/delays in discharging them back to their usual place of residence, particularly if their care needs have changed.

Between April and June 2014 we analysed the options to improve this care pathway and developed a business case based on our findings. As a result we have agreed to implement a new community based rapid assessment service for older people.

This will be called the *Frail Older Person's Unit* and will be accessed in the first instance at Loughborough community hospital, operating on an outpatient basis. A multidisciplinary team including medical, nursing and social care professionals will see up to 20 patients a day in this service once fully established.

The aim of this service is that by following a clinical protocol for the type of patients to be referred and by having access to diagnostics and specialist advice on site, a minimum of six of every 10 patients referred could return to their usual place of residence.

In each case there will be a clear set of decisions about any adjustments needed to their ongoing care/care plan, including good communication direct with their GP and the integrated locality based health and social care.
A trajectory has been developed to show the impact of the new frail older person's unit with effect from October 2014 and the impact of this has been factored into the overall trajectory for reducing total emergency admissions by 3.5%.

IUR3 - Falls

We have identified that approximately 15,000 people in Leicestershire call East Midlands Ambulance Service (EMAS) as a result of a fall each year. Approximately 7,000 of these calls result in a patient being conveyed to hospital and approximately 2,000 are admitted as result of an injury due to a fall. This data is based on a primary treatment code, so will not take into account a fall as a secondary diagnosis reason. There are a number of additional patients who will be admitted to hospital, having originally been conveyed as a result of a fall but their admission code will be different as this will classify the treatment they receive e.g. stroke, respiratory problems.

Our aim is to ensure we provide an integrated, seamless pathway across all settings of care, for people who are at risk of a fall, or who have experienced one or more falls. With the older population increasing, there is a need to develop alternative ways of delivering a service for frail older people which includes a variety of elements such as rapid access to clinical intervention, and access to community services or equipment that improves quality of life and allows people to remain independent/living at home. By working with EMAS and Leicestershire Partnership Trust we will change the pathway of care for people who fall in Leicestershire and offer them a rapid response in the community. This will assess the need for hospitalisation, and if this is not required, offer any treatment or follow up support that may be needed in their usual place of residence instead.

The project has three main elements and a full implementation plan is currently in development;

- EMAS emergency response to patients that have fallen,
- End to end review of the falls pathway;
- Prevention pathway and early intervention.

In other health and care economies it has been demonstrated that community based alternatives to admission can be implemented which prevent a significant proportion of these unnecessary hospital journeys and admissions.

The expected level of non-conveyance is estimated to rise by 20% (once the training for paramedics has been undertaken and an increased capacity within the Single Point of Access has been implemented. This is based on evidence from Northamptonshire, Derbyshire and Nottinghamshire where the alternative pathway has already been successfully implemented. From this data we have been able to estimate the number of emergency admissions that can be avoided in Leicestershire to be approx. 338 admissions per annum.

A trajectory has been developed to show the impact of the falls service with effect from January 2014 and the impact of this has been factored into the overall trajectory for reducing total emergency admissions by 3.5%.

The key to success for this service is for all agencies to work consistently to an agreed protocol for people who fall and to ensure that local community services have the capacity to respond rapidly to provide any follow up that may be needed.
The urgent response for falls is only part of the falls prevention pathways which will be supported by a medium term falls prevention approach which is covered in BCF Theme 1.

IUR4a – 7 day services in Primary Care: West Leicestershire CCG

WLCCG has allocated funding of £180k to support early implementation of 7 day services though a number of locality based pilots with effect from Q3/4 2014/15. This forms part of the CCG's investment of £5 per head of population to support practices in transforming the care of patients aged 75 or older and reducing emergency admissions. This is being supplemented by an additional £170k identified via the Better Care Fund recognising the impact this development will have on achieving integrated care and support on a 24/7 basis across Leicestershire's communities.

The approach has been clinically led and extensively tested at GP locality meetings during and at a Protected Learning Time event in May.

WLCCG practices feel strongly that routine access to appointments over the weekend period will not address some of the biggest challenges faced by our health economy, e.g. the extra support needed for elderly and vulnerable patients.

As described within the JNSA[1] both the number and proportion of the population in Leicestershire over 65 and over will continue to increase from the estimated 115,100 (17.6%) in 2010 to 151,100 in 21.2% in 2020. This shift in our local population requires a flexible and responsive service to address the forthcoming changes in health care needs locally.

We know that our ageing population are susceptible to a number of long term conditions such as Osteoarthritis, cardiac failure, chronic airways disease as well as minor conditions that impact on their health. The King's Fund report *Making Health Care Systems Fit for an Ageing Population* (The Kings Fund 2014) highlights the need to transform services for older people and shift towards care co-ordinated around the full range of the individual's need, rather than based around single diseases.

Analysis of local activity data shows that between March 2013 and February 2014 there were 17,523 A&E Attendances and 14,026 hospital admissions from West Leicestershire CCG patients aged over 65 years. Nearly one fifth (19%) of admissions were due to sign and systems with no formal diagnosis, followed by diseases of the circulatory system 16% and diseases of the respiratory system 14%.

The four pilot schemes aim to develop a local and sustainable approach to seven day working for primary medical care and test out models of care that meet the needs of our elderly and vulnerable patients. Particular emphasis is placed on ensuring the pilots integrate with community based care to avoid unnecessary admissions to hospital. The pilot schemes aim to:

- Ensure seven day access to primary medical care services for patients identified at high risk of admission to hospital particularly on a Saturday and Sunday.
- Utilise registered patient lists and GP knowledge to identify appropriate patients.
- Identify and target the most vulnerable through anticipatory care planning and proactive review.
- Provide greater continuity of care and adherence to care plans during weekend periods.
- Support housebound patients offering medical care and assessment prior to the winter
- Support for care homes and other institutions who are heavy users of OOH services
- Be locally led by GPs who understand current pathways and able to integrate with existing health and social care community based services

KPIs are in the process of being established, however an indication of the measures the pilot schemes will be evaluated against is provided below:

[1] Leicestershire's Joint Strategic Needs Assessment 2012

- Reduction in emergency admissions at weekend periods and on Mondays
- Reduction in A&E attendances at weekend periods and on Mondays
- Reduction in A&E attendances / admissions from care homes on a Saturday and Sunday.
- Reduction in call volume to OOH, EMAS and 111
- Utilisation of established weekend clinic capacity with salaried doctor /ANP/paramedic in the form of either telephone consultation / face to face appointments / home visits
- Integration with community based health and social care services.
- Audit of evaluation of intervention made by the service
- Feedback from GPs, ECPs, Care homes and patients on the pilot
- Audit of prescribing undertaken by the scheme

A trajectory has been developed to show the impact of the service on emergency admissions avoidance and the impact of this has been factored into the overall trajectory for reducing total emergency admissions by 3.5%. However it should be noted that the KPIs for this service will not be targeted solely to emergency admissions avoidance.

The evaluation will ultimately consider:

- the impact of the different models, including on emergency admissions avoidance
- preferred local model(s)
- plans for wider scale roll out

These outputs will inform a business case proposing future developments aligned to the local primary care strategy (the latter is currently in the process of being developed - expected October 2014).

IUR4b 7 Day Services in Primary Care; East Leicestershire and Rutland CCG

The BCF allocation for 2014/15 (£129k) to pilot the seven Day services with the Syston, Long Clawson & Latham House and Melton Mowbray (SLAM) locality practices with effect from October 2014.

The pilot area covers The Jubilee Practice, Syston, the County Practice, Syston, Long Clawson & Latham House, Melton Mowbray incorporating 64,000+ patients which are all sited within East Leicestershire and Rutland CCG.

In 2015/16 the £300k available will be used across the CCG to support the Urgent Care Hubs (currently under procurement/tender) and formalising the Coordinated CHS vision linking into Integrated Care and delivery of the Primary Care Operational Plan as part of the Better Care Together programme.

Some of the aspects below will be **delivered across 7 days** (these are highlighted below). The goal is to prevent unnecessary attendance and admission to the acute hospitals. The pilot will work in conjunction with other healthcare professionals including community nurse teams, pharmacists and the out of hours service.

Key to a successful pilot outcome will be:

- Patient Education
- Practice Education
- **Utilising community facilities – e.g. Care Homes**
- **Home visiting – review this work across the area and see where other services, such as the out of hours service, could support it.**
- **Developing an area wide approach to dealing with patients over 75 years during out of hours, to prevent unnecessary admission to hospitals.**

- Develop a falls response service.
- Integration of IT systems.
- Integrate services within primary care – these would include services that support the management of long term conditions, community nursing services and others.
- Enhance the pathway interface between primary and secondary care to prevent unnecessary referrals and hospital admissions
- Enhancing the current provision to include other methods such as virtual MDT clinics.
- Build a new HUB around the current MIAMI service and link in the procurement of the new urgent care service

Project outputs:
Below are the expected outputs from the pilot:

- Better patient education and ability to self-manage where appropriate, with improved access to a variety of community-based educational resources.
- Utilisation of social media as a source of patient education accessible via a portal, practice websites or the internet.
- Matching patient access demand to service capacity Monday to Friday and providing a comprehensive MIAMI service to the population of SLAM at the weekends and on bank holidays.
- Using the right services at the right time with a tier approach to community-based healthcare provision.
    - Optimisation of patients health and wellbeing
    - Improved access to the primary healthcare team electively,
    - Improved communication between service providers involved with all levels of community-based health and social care,
    - Improved care of patients with long-term conditions
    - Increased breadth of community-based healthcare services utilizing existing service providers (including local libraries, the voluntary sector etc.)
    - Optimisation of management of care home patients.
    - Increased community diagnostics,
    - Correct utilisation of virtual hospital beds and community hospital in-patient provision.
- Improved patient awareness of out of hours service provision and clarity on when, how and where to access care. We need to be mindful that we do not offer a triplicate OOH service i.e.111, Urgent Care Centres and Practice provision, as this is costly and confusing for the patient.
- Maintaining continuity of care for patients with their GP during core hours.
- Utilising existing volunteer groups to support patients.
- Trialling more innovative ways to collect information from the patients in order to process their requirements more efficiently
    - Electronic prescribing – e.g. online pill check information
    - Travel data site to fill in forms with pop up information sheets

Monitoring/Evaluation/Assurance:
The following will be used in conjunction with the practices to evaluate the proposal:

- Friends and Family Test Results
- Patient/PPG Evaluation
- Report from each stage of pilot with final conclusive report
- Attendances at A&E
- Emergency hospital Admission
- Patient contact with 111 and OOH medical services.
- Levels of demand on the service

- Waiting time of patients seen in comparison to A&E waiting times.
- Website: evaluate usage stats e.g. video watches, links used, leaflet views
- Number of Skype calls/email advice taken daily
- Patient Experience Surveys
- Project leads to provide monthly updates on usage and use key performance indicators to drive improvement
- Attendance at ELRCCG/ locality meetings, to share outcomes/ discuss future service redesign/ pathway redesign

IUR5 – Glenfield Hospital Admission Avoidance

This project is currently under development and will have a full business case and trajectory agreed prior to implementation.

The delivery chain
Please provide evidence of a coherent delivery chain, naming the commissioners and providers involved

IUR1 – Integrated Crisis Response Service
The social care element of the crisis response service is delivered directly by Leicestershire County Council.
The health element is:

- Commissioned by East Leicestershire and Rutland CCG and West Leicestershire CCG
- Commissioned to Leicestershire Partnership Trust

IUR2 – Rapid Assessment for Older People
The Older Person's Unit will be:

- Commissioned by East Leicestershire and Rutland CCG and West Leicestershire CCG
- Commissioned to Leicestershire Partnership Trust

IUR3 – Falls
The falls service will be:

- Commissioned by East Leicestershire and Rutland CCG and West Leicestershire CCG
- Commissioned to East Midlands Ambulance Service

IUR4 – 7 day services in Primary Care

This service is being piloted across both East Leicestershire and Rutland CCG and West Leicestershire CCG.

IUR5 – Glenfield Hospital Admission Avoidance

A business case is currently being developed for this scheme.

The evidence base
Please reference the evidence base which you have drawn on

- to support the selection and design of this scheme
- to drive assumptions about impact and outcomes

Local Evidence	National Evidence
Scale of opportunity to avoid emergency admissions: **LLR 5 year Strategy June 2014**	**Scale of opportunity to avoid emergency admissions:** Quality Watch, The Health Foundation, Nuffield Trust: Blunt, I (2013) 'Focus on preventable

Based on • LLR Mckinsey Report 2013 • EMPACT Utilisation Review 2013 • Interqual Report 2014 • National BCBV benchmarking data These collectively demonstrated the opportunity to avoid 13 of 100 emergency department admissions per day and achieve a 25% reduction in converted admissions from emergency department. Evaluation report of the acute visiting service (6 Month pilot), 2010. Commissioned by the North and South Charnwood Commissioning Group. LLR Admission Avoidance Detailed Report - Emergency Department.	admissions: trends in emergency admissions for ambulatory care sensitive conditions, 2001 to 2013' The King's Fund: Purdy S (2010) 'Avoiding hospital admissions: what does the research say?' 'Focus on preventable admissions: trends in emergency admissions for ambulatory care sensitive conditions, 2001 to 2013' **Blunt 2013**, QualityWatch, The Health Foundation, Nuffield Trust Making our health and care systems fit for an aging population. **The Kings Fund 2014**. http://www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population Includes a section on rapid support close to home in times of crises. The King's Fund: Naylor et al, 2013. Transforming our health care system. Ten priorities for commissioners. [Available online at http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/10PrioritiesFinal2.pdf]. Making best use of the Better Care Fund Spending to save? **The Kings Fund 2014.** http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/making-best-use-of-the-better-care-fund-kingsfund-jan14.pdf. Summarises the key evidence on primary prevention, managing ambulatory care-sensitive conditions (which account for 15.9% of England's emergency admission in 2009/10), falls, intermediate care, re-ablement and rehabilitation, managing emergency activity, discharge planning and post-discharge support, mental and physical health needs and delivering integrated care. Living Well With Dementia: a national dementia strategy, 2009 https://www.gov.uk/government/publications/living-well-with-dementia-a-national-dementia-strategy
Interventions for Falls and Frailty **LLR 5 year Strategy June 2014** Based on • LLR Mckinsey Report 2013 • EMPACT Utilisation Review 2013 • Interqual Report 2014 • • National BCBV benchmarking data **Admissions Analysis by HRG, 2013/14 -** analysis focused on admissions due to falls, carer breakdown, housing issues, and other social care factors to identify where BCF interventions could have maximum effect	**Interventions for Falls and Frailty** Campbell et al (2013) Northamptonshire Crisis response service, Source LGA: 'Integrated care evidence review, November 2013' Falls: the assessment and prevention of falls in older people. **NICE CG161**. http://www.nice.org.uk/Guidance/CG21 **Economic case for investing in falls prevention**: Fracture prevention services: an economic evaluation' (Department of Health, 2009) A study by **Tian et al (2013),** 'Exploring the system - wide costs of falls in older people in Torbay', used patient-level linked datasets to explore the health and social care costs for patients in the year before and after a fall. It showed that in the 12 months

Frail Older People's Outline Business Case, June 2014 including the **EMAHSN Sparkler 2014** - academic review of evidence base to examine the impact of assessing and treating FOP outside of acute setting on emergency admissions http://www.nottingham.ac.uk/emahsn/documents/sparkler-2-v4--sp2v1-final-noisbn-21-7-14.pdf **The Director of Public Health Annual Report** (NHS Leicestershire County and Rutland, Leicestershire County Council and Rutland County Council, 2012). Indicates that frailty rather than age is an important indicator for poorer outcomes in older people. http://www.leics.gov.uk/dphannualreport.pdf **EMAS Analysis** mapping the opportunity of the Northamptonshire Falls/Crisis response for Leicestershire's population, July 2014 **Leicestershire JSNA** chapter on older persons, including frail older people 2012: http://www.lsr-online.org/reports/leicestershire_joint_strategic_needs_assessment_jsna_2012_full_length **Leicestershire's Health & Wellbeing Strategy** [Available online at http://politics.leics.gov.uk/Published/C00000135/M00003397/AI00033271/$FFAppendixD.doc.pdf]. **Falls Service Review – Paper 2 – March 2013. Brian Joplin.** Includes outline business case and recommendations on various service options. **Project Brief: Addressing falls that result in attendance at A&E and/or admission to hospital, as part of the frail elderly pathway** Includes national and local background to falls in the background section.	after a fall, community care costs increased by 160%, social care costs by 37% and acute hospital costs by 35%. Making our health and care systems fit for an aging population. **The Kings Fund 2014**. http://www.kingsfund.org.uk/publications/making-our-health-and-care-systems-fit-ageing-population Includes a section on rapid support close to home in times of crises. The role of GPs in personalised care of older people is set out in the Government policy Transforming Primary Care: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/304139/Transforming_primary_care.pdf Intermediate care for frail older people: **NHS Benchmarking (2013)** http://www.nhsbenchmarking.nhs.uk/partnership-projects/National-Audit-of-Intermediate-Care/year-two.php Living Well With Dementia: a national dementia strategy, 2009 https://www.gov.uk/government/publications/living-well-with-dementia-a-national-dementia-strategy
Integrated Crisis Response Service Crisis response Service (ASC only) Activity Summary 2 Sept 2013 - 31 July 2014. David Stanton. Includes referral rates / Referral Sources / referral outcomes	Based on other studies Salford PCT Investment £600k = savings £1m to £3m http://www.wales.nhs.uk/sitesplus/documents/829/Salford%20rapid%20reponse%20ppoint%20presentation.pdf Bristol. Investment £2.8m. Benefits £4.3m (£3.6 health, £0.7 social care) http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&frm=1&source=web&cd=11&cad=rja&ved=0CDkQFjAAOAo&url=http%3A%2F%2Farms.evidence.nhs.uk%2Fresources%2Fqipp%2F29511%2Fattachment&ei=53_rUvOIDeSS7Qb0roHgBg&usg=AFQjCNFcpHbdEzTKT7g9ogY0csqt5tQuoA
7 days services in primary care Paper to the Integration Executive on 24 June 2014 on PROGRESSIN WLCCG. Data within the Activity section	

Investment requirements
Please enter the amount of funding required for this scheme in Part 2, Tab 3. HWB Expenditure Plan

Impact of scheme
Please enter details of outcomes anticipated in Part 2, Tab 4. HWB Benefits Plan
Please provide any further information about anticipated outcomes that is not captured in headline metrics below

Feedback loop
What is your approach to measuring the outcomes of this scheme, in order to understand what is and is not working in terms of integrated care in your area?

The Integrated Urgent Response will be measure by:

- Reducing the total overall number of admissions to hospital.
- Reducing the total number of admissions due to falls.
- Contribution to bed capacity reductions in the acute sector
- Reducing the number of admissions to residential and nursing care
- User Experience
- (insert reference to any clinical audit/statistical process control/evaluation etc.)

What are the key success factors for implementation of this scheme?

- Clinical expertise to develop the model of care
- Robust business cases
- Effective impact assessment
- Clear KPI's and evaluation approach
- Realistic trajectory for implementation
- Recruitment timelines
- Risk mitigation plans
- Clear project management and SRO roles
- Performance management of delivery via the Integration Executive
- Relationship management and joint leadership across agencies
- Maintaining alignment with the 5 year plan
- Relationship management between County, City and Rutland BCF.

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