Rutland County Council

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Ladies and Gentlemen,

A meeting of the **HEALTH AND WELLBEING BOARD** will be held in the Council Chamber, Catmose, Oakham, Rutland, LE15 6HP on **Tuesday, 28th June, 2016** commencing at 2.00 pm when it is hoped you will be able to attend.

Yours faithfully

Helen Briggs
Chief Executive

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A G E N D A

1) APOLOGIES

2) RECORD OF MEETING

To confirm the record of the meeting of the Rutland Health and Wellbeing Board held on Tuesday, 22nd March 2016 (previously circulated).

3) DECLARATIONS OF INTEREST

In accordance with the Regulations, Members are invited to declare any personal or prejudicial interests they may have and the nature of those interests in respect of items on this Agenda and/or indicate if Section 106 of the Local Government Finance Act 1992 applies to them.

4) PETITIONS, DEPUTATIONS AND QUESTIONS

To receive any petitions, deputations and questions received from Members of the Public in accordance with the provisions of Procedure Rule 93.

The total time allowed for this item shall be 30 minutes. Petitions, declarations and questions shall be dealt with in the order in which they are received.

Questions may also be submitted at short notice by giving a written copy to the Committee Administrator 15 minutes before the start of the meeting.

The total time allowed for questions at short notice is 15 minutes out of the total time of 30 minutes. Any petitions, deputations and questions that have been submitted with prior formal notice will take precedence over questions submitted at short notice. Any questions that are not considered within the time limit shall receive a written response after the meeting and be the subject of a report to the next meeting.

5) BETTER CARE FUND 2016-2017

To receive Report No. 123/2016 from Mark Andrews, Deputy Director for People and Sandra Taylor, Health and Social Care Integration Project Manager
(Pages 5 - 80)

6) CHILDREN, YOUNG PEOPLE AND FAMILIES PLAN 2016-2019

To receive Report No. 124/2016 from Bernadette Caffrey, Head of Families Support – Early Intervention
(Pages 81 - 94)

7) UPDATE ON EMERGENCY CARE AND THE LEICESTERSHIRE, LEICESTER AND RUTLAND (LLR) VANGUARD

To receive Report No.130/2016 from Tim Sacks, Chief Operating Officer, East Leicestershire and Rutland Clinical Commissioning Group
(Pages 95 - 100)

8) NTDI SEND REVIEW

To receive Report No. 125/2016 from Dr Tim O'Neill, Director for People and Mark Fowler, Head of Learning and Skills
(Pages 101 - 134)

9) NHS QUALITY PREMIUM 2016-2017

To receive Report No. 126/2016 from Yasmin Sidyot, Head of Planning and Stragegic Commissioning, East Leicestershire and Rutland Clinical Commissioning Group
(Pages 135 - 144)

10) INTEGRATING LEICESTERSHIRE, LEICESTER AND RUTLAND (LLR) POINTS OF ACCESS

To receive Report No. 127/2016 from Mark Andrews, Deputy Director for People
(Pages 145 - 228)

11) ANY URGENT BUSINESS

12) DATE OF NEXT MEETING

The next meeting of the Rutland Health and Wellbeing Board will be on Tuesday, 27th September 2016 at 2.00 p.m. in the Council Chamber, Catmose.

PROPOSED AGENDA ITEMS:

1. **HWB: Terms of Reference – review**
   To review/update the TOR for the HWB
   Report from Mark Andrews

2. **Local Safeguarding Children's Board and Safeguarding Adults Board: ANNUAL REPORTS**
   Presentation of the finalised annual report for information and discussion
   Report from Paul Burnett

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DISTRIBUTION
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Mr A Mann	Mrs A Laurie
Dr A Ker	Inspector Gavid Drummond
Mrs H Briggs	Ms J Clayton Jones
Ms J Fenelon	Mr M Sandys
Ms R Dewar	Mr T Sacks
Ms T Thompson	Ms Y Sidyot

OTHER MEMBERS FOR INFORMATION

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REPORT NO. 123/2016

Report to Health and Wellbeing Board

Subject:	**Better Care Fund (BCF)**
Meeting Date:	**28 June 2016**
Report Author:	**Sandra Taylor**
Presented by:	**Mark Andrews**
Paper for:	**Approval**

1. Context, including links to strategic objectives and/or strategic plans:

1.1 This report updates Health and Wellbeing Board (HWB) members on progress with the 2016-17 Rutland Better Care Fund (BCF) Plan and invites them to consider and approve the priority level business plans which will guide implementation in 2016-17. It also sets out a number of questions for discussion.

1.2 The Better Care Fund Plan is a joint health and social care integration programme managed operationally by the People Directorate, in conjunction with East Leicestershire and Rutland Clinical Commissioning Group (ELRCCG), and delivered under the oversight of the Rutland HWB.

1.3 This year's Better Care Fund Plan has significant continuity with the 2015-16 plan, but with adjustments to capitalise on integration progress and learning to date.

Plan approval

1.4 Working to the delayed national timetable, the Rutland 2016-17 BCF Plan was approved by correspondence by the Health and Wellbeing Board on 28 April 2016 for submission to NHS England on 3 May. One change was requested by a HWB member, to the phrasing of the plan's overall objective so its meaning was clearer (Appendix A).

1.5 The plan was submitted on schedule to NHS England on 3 May 2016 and approved in mid May by a regional NHS panel. All BCF plans are going to national moderation, with confirmation of final approval anticipated in early July.

1.6 In the interim, the financial agreement provided for in Section 75 of the NHS Act 2006 has to be finalised for submission to NHS England by 30 June. This agreement between the Council and ELRCCG underpins the management of the pooled fund, setting out how divergence from the BCF plan would be handled. An updated Section 75 Agreement was put to RCC Cabinet on 21 June for Council approval.

1.7 The 2015-16 Rutland Section 75 Agreement was based on a national template, amended and signed following legal advice and input from Cabinet and the ELRCCG Board. The BCF has been in operation for over a year, during which time the Section 75 Agreement has proved fit for purpose. Therefore, the new agreement has only been changed in one aspect: it refers out to the approved plan instead of including details of the programme within the agreement.

Business Case Development

1.8 In contrast to the 2015-16 programme, where the emphasis of reporting and delivery was on a dozen individual schemes within priority areas, the focus of programme steering and reporting in 2016-17 will be at the Priority level, retaining a strategic focus on the three main areas of intervention, plus Enablers:

1. Unified Prevention
2. Long term condition management
3. Crisis response, transfer of care and reablement (hospital inflow and outflow)
4. Enablers

1.9 Priority leads have been identified who have drafted a business plan per priority to operationalise the BCF plan. The business plans are attached as Appendices B, C, D and E for consideration and approval by the Health and Wellbeing Board.

Positioning the programme

1.10 The overall BCF plan, priorities and schemes have been developed to be coherent with the other health and care strategies (current and near future) that include Rutland, notably:

- the LLR Better Care Together Strategy
- the forthcoming Sustainability and Transformation Plan (2017-20) for Leicester, Leicestershire and Rutland,
- the ELRCCG Healthy Communities Plan and
- the RCC Adult Social Care Strategy (2016-20).

1.11 There is further work to do to align aims and activities across these strategies so that change is coherent, duplication of effort is minimised and synergies are achieved, helping to deliver change at pace.

1.12 Many BCF schemes and activities have been continued from 2015-16, so momentum has not been lost in delivery during 2016-17 plan development. For example, the reablement and community health services in scope of the programme have continued to be delivered, as have assistive technology and community agent services.

1.13 Alongside ongoing activity, the programme includes scope to:

a. introduce further activities such as ‘life planning’ schemes under Priority 1: Unified Prevention; and
b. reshape how existing activities are conducted eg. work is underway to integrate community health and social care more tightly, under Priority 2: Long Term Condition Management.

1.14 The BCF programme offers a number of exciting opportunities for Rutland, in terms of what is delivered and how. Among them, it aims to:

a. Develop a **shared view of services and opportunities**, to make it easier for people to identify services for themselves to maintain their own health, or for intermediaries to advise easily and consistently on this. (Priority 1: Unified prevention)
b. Place a greater emphasis on **preventing illness and avoiding falls**, to

extend more people's healthy life expectancy, including by encouraging self care. (Priority 1: Unified prevention)

c. Deliver a **more person centric model of care** which is **coordinated effectively around the individual** and addresses them as a whole person, to include social prescribing alongside health and care services, spanning mental and physical health, and achieving this through new models of delivery. (Priority 1: Unified prevention, Priority 2: LTC management).
d. **Help people to manage better with multiple long term conditions**, including through the expanded use of technology, so they live better and avoid preventable exacerbation that leads to hospital admission (Priority 2: Long Term condition Management).
e. Continue to **support carers in their critical role**.
f. **More consistently avoid delayed transfers of care out of hospital**, which will effectively increase NHS capacity to deliver care, while improving outcomes for individuals who avoid deconditioning and infections. This includes working with patients and their families support good discharge choices (Priority 3: Crisis response, transfer of care and reablement).
g. **Strengthen the patient and service user voice** in evaluation of health and care services and in informing service design and delivery.
h. **Work in an agile way, piloting changes** within Rutland that can be implemented more widely if successful to contribute to the aims of the other health and care strategies that County is part of.

1.15 The late stage of approving the BCF plan means that it is vital that new activities get underway quickly. The Business Plans have been written as soon as possible after plan approval, and aim to put shape on this process but do not yet themselves contain full details of all the schemes or initiatives that will be delivered. Adding further definition here is the next priority.

<u>For discussion:</u>

The HWB has a role in driving and tasking the Integration Executive to deliver against not just the BCF Plan, but the wider integration of health and social care. With this in mind, the Board is asked to consider the following that will inform future Integration Executive work:

a) Which aspects of the new programme does the HWB feel are the most significant to improving the quality and sustainability of health and care services in Rutland?
b) Over the last few months, Rutland has used BCF funding to pilot fresh approaches to avoiding delayed transfers of care (DTOCs). This demonstrates the potential for using the area as an agile test bed for system changes. In which other areas would the HWB like the further potential for this way of working explored?
c) Are there other elements of health and social care integration, outside of the BCF, which the HWB would like to see a greater focus on?

2. Financial implications

2.1 The 2015-16 programme consists of a minimum pooled fund between RCC and ELRCCG of £2.061m, supplemented by £317k of carry forward funding from 2015-16, £200k of which is allocated to one-off projects, with the remaining £117k providing a contingency fund for the programme. Alongside this, there is an RCC capital fund of £186k for Disabled Facilities Grants. Excluding the contingency fund, the value of the programme in 2016-17 is £2.447m. Appendix A provides a summary of how the budget is distributed across the programme's priorities and schemes.

2.2 Many of the programme's activities are ongoing from 2015-16, with personnel or contracts in place and continuing to deliver. In many cases, these ongoing activities will evolve across the programme eg. with the community health and long term social care teams integrating more tightly. Alongside, this, there is c.£340k for new or increased activities, out of a BCF allocation of £2,061k.

2.3 The partnership has agreed to manage £101k of the programme's resources as a risk sharing fund in case emergency admissions reduction targets are not met, as this would lead to additional hospital costs. Last year's targets for non elective admissions were successfully met, and the level of improvement anticipated is similar.

2.4 The Council will continue to manage Rutland's BCF budgets on behalf of the partnership, reporting quarterly to the Section 75 Partnership Board, where budgetary decisions are taken jointly by RCC and ELRCCG guided by the programme's Section 75 Agreement.

3. Recommendations:

3.1 That the HWB:

1. Note progress on finalising and starting to deliver the Rutland 2016-17 Better Care Fund plan.
2. Review and approve the four BCF priority level business plans.
3. Consider the questions set out above.

4. Comments from Integration Executive

The business plans were reviewed by the Integration Executive on 26 May 2016, and this group recommends them for approval.

5. Risk assessment:

Time	M	There are 9 months left in which to deliver a 12 month programme. Some parts of the programme are already in progress, particularly where they follow on from 2015-16 activity. Prompt approval of the business plans or feedback to adjust them will help Priority leads to move forward rapidly with planning and implementation for new elements of the plan.
Viability	L	The 2016-17 BCF programme builds on the partnership developed and progress made in

		2015-16
Finance	M	See *Time* above. There has been confirmation in principle that BCF will continue into 2017-20, but any contracts will still need to be agreed mindful that this is in principle only.
Profile	L	The BCF has a high profile at national, regional and local level and is well integrated as a complementary part of Leicester, Leicestershire and Rutland Better Care Together activity. The HWB will hold both RCC and ELRCCG to account for the delivery of the BCF.
Equality & Diversity	L	The BCF plan will have a positive impact on members of the Rutland community requiring health, care and wellbeing services and opportunities.

6. Timeline (including specific references to forward plan dates):

Task	Target Date	Responsibility
BCF update and business cases presented to the HWB	28 June 2016	Priority Leads
Progress report to HWB including performance report	Forthcoming HWB meetings	Priority Leads

Appendix A. Summary of the Rutland 2016-17 Better Care Fund (BCF) Programme

1. Programme aim and priorities

1.1 The overall aim of the Rutland 2016-17 plan is that:

> *"By 2018 there will be an integrated social and health care service that is well understood by users, providers and communities and used appropriately, has significantly reduced the demand for hospital services and puts prevention and self-management at its heart, which would include building on existing community assets."*

1.2 Alongside enablers activities which help to address barriers to integration, the 2016-17 priorities are: unified prevention services; long term condition management; and crisis response, transfer of care and reablement. Programme governance will be focussed more at the priority level rather than on individual schemes to drive aims more strategically.

1.3 Building on the broadly successful 2015-16 programme, there is substantial continuity in Rutland between the 2015-16 and 2016-17 programmes, including sustaining activities to reduce the burden on acute and hospital care services. However, there will be more emphasis this time on prevention and proactive management of health to sustain individual wellbeing and independence.

2. Budget overview

2.1 The minimum pooled budget available for the Rutland programme in 2016-17 is £2,061k, a small increase on last year's allocation of £2,046k. This is supplemented by £186k of Disabled Facilities Grant and £317k of funding that has been carried forward from the 2015-16 programme, £200k of which has been dedicated to one-off or pilot measures:

Budget	**Amount 2016-17**
CCG contribution	£2,061k
Disabled Facilities Grant	£186k
Carry forward from 2015-16, held by Local Authority - for one-off activities and pilots	£200k
Total plan	**£2,447k**
Contingency Fund – carried forward from 2015-16	£117k

3. Performance metrics

3.1 Performance metrics remain the same as last year, with targets set as follows:

a) Reduction in delayed transfers of care by 5% over last year's targets.

b) Reducing non elective admissions by 2% against predicted levels for the year (with a risk share fund set against this).

c) 83% of people reabled still being at home 91 days after release from hospital.

d) Fewer than 0.36% of the over 65 population entering permanent residential care.

e) A level of hospital admissions due to falls that is no more than 1.66% of Rutland over 65s.

f) A user satisfaction target of 93%.

4. The programme content and structure

4.1 The Unified Prevention priority places a greater emphasis than previously on prevention and self-help, aiming to manage demand for health and social care services more proactively and sustainably into the medium and longer term.

4.2 A broader approach has been taken to long term condition management in 2016-17, going beyond falls and dementia, as this has been identified as a key opportunity to prevent emergency admissions. Work will focus on proactive case management for people with multiple LTCs. GP surgeries (as universal health hubs), community health care and social care will work more closely, reintroducing active case management in which related services 'wrap around' the patient, supporting them in a more tailored and coordinated way. The priority will also aim to build on Rutland Memorial Hospital as an integration hub. An innovation fund has been set up to support the piloting of new approaches to LTC management (eg. through the use of technology). Focussed work will also continue on dementia in particular.

4.3 In terms of hospital inflow, crisis response services will continue, with further work to ensure that they are called upon consistently. Local activities will also be coordinated with the wider LLR Urgent Care Vanguard programme. In common with other BCF areas, prompt hospital discharge will be supported through a local Delayed Transfers of Care Action Plan tailored to Rutland's distinctive local patterns of hospital use. One option being considered, capacity permitting, is 'pre-hab', in which older individuals would receive reablement support prior to planned hospitalisation, to support rapid recovery. Reablement services for people returning home were particularly successful in 2015-16 and will be continued.

5. The priorities and schemes

Priorities and schemes	Lead/ commissioner	Funding
Unified Prevention Schemes		£528k

1. **Coordination and communication:** making it easier for people to identify services and opportunities to support them in remaining well, active and independent.	RCC	£30k
2. **Community prevention and wellbeing services:** Continuing the Community Agents scheme and broadening access to such services, helping individuals to maintain health and independence. Developing community capacity.	RCC	£187k
3. **Life planning – preventative services:** Supporting a range of ongoing and new prevention services including assistive technology and falls prevention.	RCC	£125k
4. **Life planning – Disabled Facilities Grants:** Grants supporting housing adaptations that sustain independence	RCC - DFG Capital	£186k
Long Term Condition (LTC) Management		£898k
5. **Integrated case management for LTCs:** Reintroducing case management approaches to provide 'whole person' responses to managing LTCs.	LCC ELRCCG	£40k £100k
6. **Integrated community health and care services for LTC and high needs**: The heart of the integration programme supporting health and care services to work together on LTC management.	ELRCCG RCC	£405k £113k
7. **LTC management – innovation fund:** Projects supporting integrated ways of working to manage LTCs.	RCC	£55k
8. **Dementia care**: Continuing with dementia services, dementia friendly communities and pathway development.	RCC	£100k
Crisis response, transfer of care and reablement		£936k
9. **Crisis response:** Providing 24:7 local alternatives to hospital where this is not the best response to a health crisis.	ELRCCG RCC	£125k £115k
10. **Transfers of care and reablement:** Driving down delayed transfers of care (DOTCs) affecting Rutland patients via a DTOC action plan. Reablement.	RCC ELRCCG	£561k £135k
Enablers		£85k
11. **Enablers activity:** workforce, data sharing, IT, analytics, etc.	RCC	£34k
12. **Integrated commissioning:** Identifying and progressing coordinated commissioning opportunities.	RCC ELRCCG	£0k
13. **Programme management**	RCC	£51k

A copy of the full BCF Plan is available on request.

Appendix B: Unified Prevention Business Plan

Appendix C: Long Term Condition management business plan

Appendix D: Crisis response, transfer of care and reablement

Appendix E: Enablers

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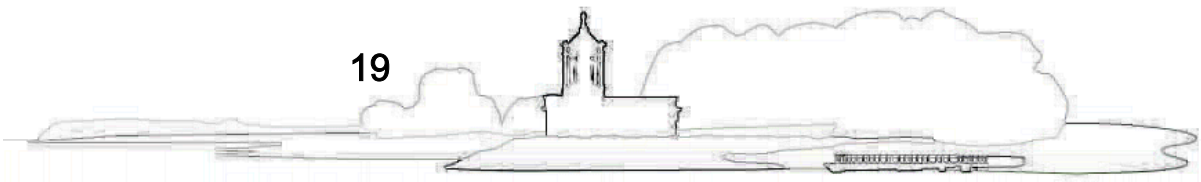
Business Case

BCF Priority: Unified Prevention

Date completed: May 2016

Distribution of this product is UNRESTRICTED

Leads **Local Authority - Trish Crowson**



DOCUMENT CONTROL

Change Control History

Version	Change Summary	Change author	Date
0.1	First draft	Trish Crowson	May 2016
0.2	Second draft (confirmation of leads, alignment of common sections)	Trish Crowson, Sandra Taylor	Juen 2016

Approval Schedule

Integration Executive: 26 May 2016

Health and Wellbeing Board: 28 June 2016

How to briefly describe this Activity to a Service User

“Prevention is better than cure.”

“Helping people to help themselves”

This work includes a range of activities that will help to provide people with information, advice and sources of support, to help keep them both physically and mentally well. For example helping people to keep fit, improve their balance and to access some helping aids which would reduce the likelihood of having a fall. An up to date coordinated information service for public and professionals; support and help in accessing information and services in the community.

1 Description of Priority

Whilst overall life expectancy has been rising in recent decades, the years people spend in good health has changed little. Healthy life expectancy in Rutland (the number of years lived in good health) is similar to the England average for men and better for women – (currently 66.1 years for men and 71.3 years for women) - this contrasts with life expectancy of 81.4 for men and 85.9 for women[i]. The number of older people living with more than one chronic condition has risen by over 10 per cent in the last decade.[ii] This means that a sizeable proportion will be affected by poor health for a significant number of years – requiring additional support and care. It is therefore important to give added attention to prevention and enable people to remain well whenever possible through primary prevention activities, removing risk factors before they have done harm and also using secondary prevention to diagnose disease early and delay its progress. The programme will mean Rutland people will have access to arrange of support early enough to enable them to feel more in control and to live healthier independent lives and stay within their own communities for longer.

1.1 Priority objectives

- To help people live healthier lives
- To help people stay well for longer
- To direct and sign post people and their carers to enable them to help themselves and to manage their own care.
- To ensure people can keep themselves well and know where to go to get information and advice if needed about what is available in their communities.
- More self-sufficient, self-sustaining communities, tackling social isolation
- People feel supported to live independently at home.
- To delay the need for invasive and costly health and social care packages and avoiding hospital and care home admissions
- To reduce the likelihood of people falling and reduce admissions from injuries due to falls
- To increase awareness within Care Homes of how to prevent falls and manage fallers
- To make available equipment and/or adaptations that provide independence and peace of mind for users and carers.

1.2 Key deliverables

Scheme deliverable	Delivery targets
A central, coordinated, easy to use Rutland online health and wellbeing information service providing up to date local information and links to regional and national support; for public and professionals alike.	March 2017 operational and coordinated across partners
New community groups and support networks established and supported to become independent, connected and operating across	March 2017

Scheme deliverable	Delivery targets
a spread of communities in Rutland.	
Community agents and other advice services available in GP practices and in the community offering advice, support and signposting to enable practice staff to focus on more complex care needs.	January 2017
A range of falls prevention projects delivered, evaluated, progress shared and intelligence used to shape new areas for development. To extend skills and knowledge and prevention activities to prevent falls.	Autumn 2017
To identify unmet prevention priorities and opportunities in partnership and put in place projects / schemes up to the value of uncommitted resources.	July 2017
New community prevention & wellbeing service developed through co-design process and commissioned to enable new service to be in place for April 2017	April 2017
Extend the number of people using Assistive technologies to support independence and broaden the range of technologies available to meet differing needs.	Plan in place September 2016
Deliver Disabled Facilities Grants where they are required.	March 2017
A review of Disabled Facilities Grants scheme undertaken and new approach developed to increase impact and appropriateness.	September 2017

1.3 Scheme milestones

Activity	Milestone	Dependency	Responsible	Start	End
Coordination and communication	Develop a coordinated approach to promoting health, wellbeing and prevention information and link as appropriate with programmes such as One You.	Each of the strands of this activity to be taken forward through a task and finish group	Sandra Taylor & Trish Crowson	June 16	March 2017
	Deliver Phase 2 of the Rutland information Service alongside the council website redevelopment		Sandra Taylor/ Trish Crowson & Task group	Sept 16	March 2017
	Development of information platform to better communicate available activities and services (all sectors), including regular usability testing with end users and monitoring via Google Analytics		Sandra Taylor/ Trish Crowson & Task group	Sept 16	*March 2017*

Activity	Milestone	Dependency	Responsible	Start	End
	Undertake an up to date end user focussed needs analysis to identify what information is needed to support unified prevention and self- care			May 16	Sept 16
	Streamline community information/ advice and guidance. access points through commissioning of an integrated prevention and wellness service			June 16	March 17
Community prevention and wellbeing services	Align where appropriate with BCT approaches on prevention (e.g BCT prevention workshop proposals) and making every contact count.		Tracey Webb & Neil Lester	May 16	March17
	Embed changes to ASC prevention and safeguarding team and introduce new monitoring framework		Tracy Webb, Neil Lester and Kelly McAleese		Aug 16
	Steer, review and evaluate falls prevention projects. Identify next steps /develop plan to shape new or adapt or extend projects		Kerry Tobin	July 2016	Dec 16
	Community Agents Scheme to expand community capacity building as well as numbers of individual support in the community across the county		Trish Crowson via Spire Housing/Community Agents	April 16	March 17
	Bring current prevention services together to 'wraparound' Primary Care services	Coordinate with LTC case management – primary care wraparound	Neil Lester &Tracey Webb	August 16	March 17
	Under take Phase 1 of the commissioning of new integrated Community Preventative and Wellness Services, including co-design with stakeholders and potential service users	Subject to suitable bidders participating in the process of redesign and commitment throughout the summer	Karen Kibblewhite	April 16	Sept 16

Activity	Milestone	Dependency	Responsible	Start	End
	Undertake the procurement for integrated Community Preventative and Wellness Services, encompassing mainstream and BCF funded activity	Subject to suitable models and range of services included/ and or commissioned separately	Karen Kibblewhite	Septemb er 16	March 17
Life planning - prevention	Review and identify barriers to use of Assistive Technologies to increase access to and range of technologies available for differing needs. Develop further Assistive technology use within early preventative life planning, identifying barriers to current usage	Need to ensure a consistent process able to cope with staff changes to ensure continued access for individuals	Kerry Tobin and Sarah McCormack	June 16	Aug 16
	Evaluate the Speakset pilot to consider ongoing need and future development		Kerry Tobin		Sept 16
	Ensure Assistive Technology services to meet needs is commissioned whether through integrated service or otherwise	Current contract rolled forward to March 17.	TBC		March 17
	Review current projects and identify any unmet prevention priorities and opportunities in partnership. Put in place projects / schemes up to the value of uncommitted resources.	Effective use of underspend subject to review. Information used to resource short term projects and inform integrated service design outlined below	Trish Crowson/ Kerry Tobin	May 2016	August 16
Life planning - DFGs	Align where appropriate with BCT. Confirm adjusted approach to Disabled Facilities Grants to broaden DFG scope and impact		Neil Lester Kim Sorsky and Sarah McCormack	May 16	Sept 16
	Implement new model of delivery for DFGs and		Kim Sorsky	Jul 2016	March 17

Activity	Milestone	Dependency	Responsible	Start	End
	adaptations		and Sarah McCormack		

1.4 Exclusions

There is some overlap between the Unified Prevention priority and that for Long Term Condition Management. It is anticipated that there will be close coordination between schemes under the two priorities, so that there is not duplication of effort. This is a role of the operational delivery manager.

In general, work on long term conditions and secondary prevention activities including secondary falls prevention is anticipated to be outside the Unified Prevention Priority.

The wider programme of Public Health activities in Rutland will be coordinated with the activities under this priority, but will not come under this umbrella.

The development of the Council's community portal for information and advice is part of this priority, but the wider project to renew the Council's mainstream corporate website is not.

2 Approach

2.1 Operational Readiness

The majority of the projects are underway and learning and evaluation of these will help to determine next steps and developments. Some projects are being reviewed and services may need to adapt or be modified to ensure they meet changing needs or new projects developed. This should be possible within the allocated resources and current staffing levels. For example, it is possible that some straightforward delivery of assistive technology could be mainstreamed into social care business as usual.

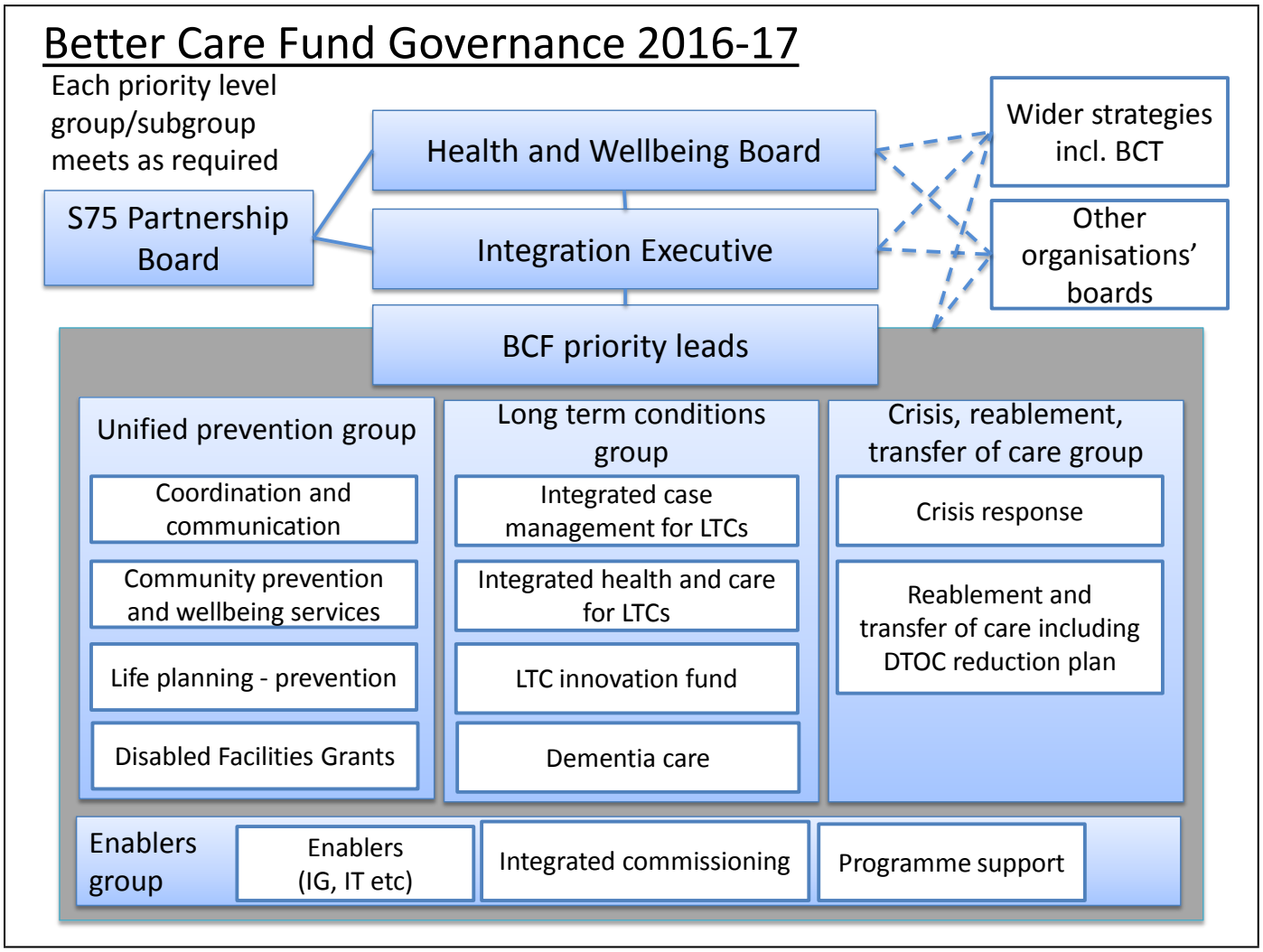
Changes in personnel has resulted in a fall in the use of assistive technology. It is anticipated that once new staff are in place this will increase again. Systems therefore need to be developed to ensure consistency. Adult Social care has introduced a second senior occupational therapist who will be given oversight of this and will take it to the operational teams to embed.

A review of DFG's will be an additional project undertaken with the support from the Long-Term and Review Team Manager and senior OT with coordination by the Operational Delivery Manager. The DFG budget has been increased from £104k to £186k by national government and BCF programmes nationally are considering how they can secure the best impacts from this uplift. Decisions about DFG funding are made relative to the legislation which governs these grants, but national government have indicated that they anticipate innovation in the use of this increased allocation (eg. allowing the purchase of small equipment). A request for more detailed national guidance has been made via the East Midlands Better Care support manager and, in the interim, it will be important to also consider what the options are at a local level.

2.2 Work stream structure

The priority lead will coordinate delivery of this priority, working with scheme leads, stakeholders and providers and using enabler services (IT, commissioning, workforce, etc) as required. The BCF priorities are inter-related, so a priority leads meeting has been established to ensure coordinated progress across the priorities.

Progress across all priorities will be reviewed monthly at the Integration Executive which steers the programme at the more operational level. Information will also be supplied as required to support decision making and plan steering by the Section 75 Partnership Board (quarterly) and the Health and Wellbeing Board (quarterly as required).



2.3 Work stream contribution to key BCF metrics

BCF Metric	Rationale	Likely Impact (significant/ moderate/none/ other)
Admissions to permanent residential and care homes avoided	Services and choices in the community help people retain independence longer	High
People who have had reablement still at home 91 days after release from hospital		N/A
Non elective admissions avoided	Impact of falls prevention projects and prevention activities more generally	Moderate
Delayed transfers of care avoided or reduced	Services and choices in the community help address barriers to returning home from hospital	Moderate
Falls prevention	Impact of falls prevention	High

	projects	
Service user satisfaction	Person centred servcies and choices helping people to achieve their wellbeing aims	High

2.4 Work stream metrics recording

Information being collected	Information collected	Where information is collected / captured/ stored
Communications		
Rutland Information Service – amount of content	Number of community facilities, activities, etc listed on the RIS – detail tbc	Information from the Rutland Information Service Content Management System – Becky Holmes
Rutland Information Service – level of use	Number of visits to website RIS	Use of Google Analytics to monitor website traffic (Google utility on which reports can be defined and run) - Becky Holmes
Community Prevention		
Community Agents activities	Metrics as per each contract in place eg. for Community Agents, number of people supported, measure of progress per individual who has signed out of the scheme, types of services referred on to. New community organisations started. Impact reports where possible – evidence of key BCF metrics having been impacted eg. people returning home from hospital sooner or helped to remain at home.	Monthly performance report sent electronically by providers (Spire Homes) to commissioner
Activities of further prevention services commissioned	Metrics as per each contract in place	Electronic returns to commissioner
Life Planning		
Small projects grants - required information defined per project (currently 3x falls prevention projects)	Agreed outputs per project (eg. number of falls fetes run, attendance levels, satisfaction levels)	Regular interim then final returns from each project to the RCC Falls project lead, reporting on agreed outputs per project, relative to anticipated outputs.
Falls training - activities	Institutions trained, individuals trained, trainee satisfaction	Regular return to RCC Falls lead from trainer.
Falls – FaME exercise project	Reporting as agreed with RCC Falls lead, to include trainers trained, courses run, Individuals trained & how long they remain in the programme/user	Regular return to RCC Falls lead.

Information being collected	Information collected	Where information is collected / captured/ stored
	satisfaction.	
Other prevention projects to be commissioned	Activity, output and impact measures to be agreed and relevant to the aims of the priority.	Regular return by project lead to nominated commissioner/lead.
Assistive technology	Individuals supported, devices delivered, areas of support covered, user satisfaction	Data provided by Provider Spire Homes on relevant solutions delivered.
Technology for care	Speakset pilot project – sets installed, use of sets, service user evaluation, practitioner evaluation.	Some statistics provided on supplier's project interface eg. metrics on call patterns. Evaluation material to be collected and reviewed by project lead.
Disabled Facilities Grants	Sums allocated vs number of projects, types of project.	Data to be managed by nominated RCC DFG lead.

2.5 Work stream performance reporting against metrics

Type of report being prepared (e.g. SITREPS/ RAISE)	**By whom**	**Reporting timeframes**
Summary reports from projects to unified prevention lead to support Integration Executive reporting requirements.	Each project/theme leader or contract lead	Coinciding with Integration Executives.
Contract monitoring reports - Community Agents, Assistive Technology, Speakset, etc	Contract leads	Coinciding with Integration Executives. Monthly.
Google Analytics reports on website traffic	Information Officer	Quarterly.
Falls admissions data.	Public Health - Leics	Coinciding with Integration Executives. Monthly.

3 Communication and Engagement

3.1 Stakeholder Analysis

This analysis is illustrative rather than comprehensive. It is useful to note that the Unified Prevention schemes are distinctive in that they involve the widest number and range of organisations who all have a stake in supporting prevention through their interventions, and who may benefit from working together. In addition, the success of this priority depends on the public taking up the opportunities on offer that aim to increase their ability to self manage their wellbeing and extend their healthy lifespan.

Stakeholder Name	How they will impact on the scheme	How they will be impacted by the priority	Communication requirements/methods
Project leads on prevention projects, including providers	Delivering parts of the prevention offer, which in turn will help to increase healthy lifespan of more people in Rutland and reduce some demand for health and social care services.	The priority enables a range of stakeholders to take forward defined projects aiming to increase wellbeing by sustaining health and increasing healthy lifespan.	Regular communication with Unified Prevention lead needed – especially where projects may be experiencing issues. Also communication with each other to coordinate activities – will be assisted by the Communications scheme.
The public who are the target of prevention projects	Participating in the schemes as users eg. users of information about prevention opportunities, finding out how to avoid falls.	Helped to engage more with services supporting their wellbeing and independence.	Communication scheme aims to improve communications with the public about available services. Need two way flow between users and providers.
Better Care Together – relevant workstrands	Undertaking LLR scale actions impacting on prevention locally. Offering learning and ideas to feed into Rutland prevention activities.	Rutland projects can help to inform approaches proposed for LLR eg. for falls prevention and follow up.	Rutland representation on relevant BCT groups, including the frail older people/falls/dementia workstrand.
Providers of prevention services that are not directly under the umbrella of BCF eg. many Active Rutland schemes.	They could help to promote some of the activities supported by the BCF or may assist them eg. through referrals.	There may be opportunities to collaborate with them or to publicise their activities via the communications scheme.	Need to consider how to reach stakeholders beyond those directly involved in the programme.

3.2 Priority Reporting and Communication

Type of communication	Communication Schedule	Communication Mechanism	Initiator	Recipient
Highlight report to Integration Executive	To Integration Executive timetable	Send to H&SC Integration Manager for Integration Executive	Work stream Lead	Integration Executive

4 Risks

4.1 Key Risks

Risk No.	Date Opened	Risk Owner	Risk Description	Probability (High, Med, Low)	Impact (High, Med, Low)
1	May 2016	Project leads	Workforce issues impede the ability to progress project	Med	Med
2	May 2016	Karen Kibblewhite	Where change is via procurement – lack of suitable providers	Low - med	high
3	May 2016	Project leads/ Head of ASC	Ownership of project delivery sits with a number of service and operational leads who need time and ability to ensure effective implementation	Med	High
4	May 2016	Trish Crowson	Life planning - new projects could be slow to come forward, slow progress delaying impact	High	Medium

5 Costs

5.1 Priority Costs

Description	2016-17 (£)
Communications	
Costs to support further development of the Rutland Information Service as a shared public facing communications platform for local services, groups and activities. Spending proposals will be defined during early scoping but may include: usability testing equipment and activities, information officer time eg. for tagging and updating, supplier services, graphics and interaction design, promotion for communication channels.	£30k
Community prevention and wellbeing services	
Community Agents contract and associated subcontracts to deliver wellbeing services	£147k
Additional activity, potentially on a pilot basis, to deliver broader more accessible wellbeing services	£40k
Life planning projects	
Completion of falls projects x 3 supported by grants and falls training (FaME and Speakset projects funded from 2015-16).	£15k
Assistive technology – delivery of contract	£27k
Fund for life planning prevention activities – to cover engagement and planning activities (eg. summits and workshops), evaluation and analysis, follow through projects and/or contracts to deliver services.	£83k
Disabled Facilities Grants (capital)	£186k

5.2 Funding

Funding Source (External - name/Internal)	Confidence rating of funding being provided (H/M/L)	2016/17 (£)
BCF funding *(allocation approved by Health and Wellbeing Board)*	**H**	
Communication	H	£30k
Prevention and wellbeing services	H	£187k
Life Planning	H	£125k
Disabled Facilities Grant	H	£186k
Total Funding	**H**	**£528k**

6 Exit Strategy

It is anticipated that the new integrated Community Prevention and Wellness Services will incorporate a range of projects from the Unified Prevention Programme with clarity about which will be delivered through existing Rutland County Council services, the commissioned integrated service or a coordinated mix of service e.g. online information and advice provided in part through Rutland Information Service in partnership with the new integrated service and liaising with partners including the CCG.

Where contracts are in place for service delivery, these are coterminous with the current programme period. Commitment to these activities beyond 2016-17 will be determined based on future BCF plans and the wider wellbeing services co-production work which will be undertaken in 2016-17.

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[i] Public Health Outcomes Framework Feb. 2016 PHE indicators 0.1i – 0.1ii

[ii] Nafeesa N. Dhalwani et al 2016 http://ijbnpa.biomedcentral.com/articles/10.1186/s12966-016-0330-9

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Business Case

BCF Priority: Long Term Condition Management

Date completed:16/5/16

Distribution of this product is (UN)RESTRICTED

Leads **Local Authority : John Morley**

DOCUMENT CONTROL Change Control History

Version	Change Summary	Change author	Date
0.1	Initial compilation of business case	Emmajane Perkins/ John Morley	10/5/16
0.2	Alignment of common sections	S Taylor	June 2016

How to briefly describe this Activity to a Service User

This priority aims to help people who have one or more long term conditions to stay as well as possible so that their health remains stable and does not deteriorate unnecessarily. This enhances their quality of life and reduces their need for health and care services. This could include by monitoring key indicators, minimising symptoms or reducing their impact, and undertaking reablement to maintain mobility. It is also about giving people the tools to support their own health and wellbeing.

People with several long-term conditions have more complex health and care needs and tend to experience poorer quality of life, poorer clinical outcomes and longer hospital stays. Therefore, this priority also aims to help health and care professionals to coordinate their activities better in support of patients with complex needs. There may be a need for different or enhanced care models targeting this group.

Whilst the majority of those with long term conditions are older people there are other sections of our community who are affected by long term conditions that would benefit from a more coordinated approach to their care and support such as those with learning disabilities, dementia and mental health problems. For our citizens and their families it will mean they have access to a consistent

1 Description of Priority

This scheme is key to the overall objective of the Rutland Better Care Fund Plan 2016-17:

''By 2018 there will be an integrated social and health care service that has significantly reduced the demand for hospital services and puts prevention at its heart."

This objective summarises the main direction of travel nationally for health and social care as highlighted in the Better Care Together, (BCT), strategy to redesign service pathways to support independence and wellbeing, provide services closer to home, reduce hospital and residential care admissions and support the transfer of care back to the community. The business plan is also in line with the LLR/BCT Programme for 2016/2017

A core part of this priority is to build up an integrated community health and social care service that is well coordinated and tailored to local needs

Life Expectancy

Life expectancy in Rutland continues to improve year on year and in the 10 year period from 2000-2002 to 2010-2012 there has been an increase in life expectancy of 1.4 years for men and 2.3 years for women. Life expectancy in Rutland is significantly better than the England average for both males and females at 81.0 years and 84.7 years respectively.4

Healthy life expectancy for 2010-12 is 65.8 years for males and 70.3 years for females. For both males and females, a significant proportion of the population will already be affected by poor health before they reach retirement age.

Health of the population

Keeping people healthy for longer is a key goal. The last few years has seen a steady increase in prevalence of a range of long term conditions – but these are largely preventable and closely associated with a range of lifestyle factors. These include increased levels of obesity, lack of exercise and smoking. 2016 Public Health Outcomes Framework report for Rutland

This unprecedented increase in the older population will lead to increases in the number of people living with long-term conditions.

Whilst the majority of those with long term conditions are older people there are other sections of our community who are affected by long term conditions that would benefit from a more coordinated approach to their care and support such as those with learning disabilities, dementia and mental health problems. For our citizens and their families it will mean they have access to a consistent co- ordinated support system that is responsive to their changing needs, and that they and their carers receive timely and appropriate advice and support. 7 day services will be available in primary care, coordinated by GPs across Rutland, targeted to frail and vulnerable people. Integrated health and care services will be available in Rutland, combining the expertise of adult social care services from Rutland County Council and the community nursing and therapy teams of Leicestershire Partnership Trust, working hand in hand with a cluster of GP practices. Shared care records and care plans will be in place using the NHS Number to help the integrated team manage care more effectively across organisational boundaries

1.1 Priority objectives

This priority addresses the support offered by primary and community health and social care for patients with long term conditions and the frail elderly, including through:

- Enhanced approaches to care management and support planning (building on the care coordinator approach), including anticipating and reducing needs.
- A review of care pathways.
- An integrated system spanning primary care and community based health and care services in and out of hours.
- Consolidating, integrating and extending a number of Rutland's community health based services into one 24/7 service operating across health and social care – to focus on maintaining independence in the community for as long as possible.
- Care services are effectively coordinated around the patient, reducing duplication and increasing effectiveness.

- Service users feel in control of their care.
- Service users feel supported and that their needs are understood.
- Service users are better able to manage their condition(s).
- Service users are able to stay as well as possible for as long as possible.
- To promote social inclusion and utilise community capacity where appropriate
- To enable the development of individual capability in self directing their care and self-managing their conditions
- To enable and support individuals at end of life to be cared for in the place of their choice
- Through enhanced co-ordination and community facilities to assist and support informal carers

1.2 Key deliverables

Scheme deliverable	**Delivery targets**
Everyone with long term care needs that require a health or social care response will be guaranteed a written care plan encompassing health, social and preventative care and the right to access a named coordinator.	Within 6 weeks a detailed plan is available from referral
There will be evidence that patients have been involved in developing the care plan, understand it, and have confidence about who to approach when they need support.	Each plan is personalised Access to information
Supported self-management – people with long term conditions can manage their condition appropriately because they have the right opportunities, resources and support reducing the admission to residential homes.	More people in their home living independently in the community. Wellbeing
Commissioners and providers will work together to use a risk model/register to pro-actively find people at high risk of developing chronic and life threatening conditions and offer them targeted screening and other interventions.	Less non elective hospital admissions
Reduce the number of non-elective admissions to acute hospitals.	BCF metrics achieved

1.3 Scheme milestones

Activity	**Milestone**	**Dependency**	**Responsible**	**Start Date**	**End Date**
Integrated case management	Refresh provision of Integrated Care Coordination service (link from GP to social care for patients identified as with additional needs)	Wider engagement across ELRCCG	Neil Lester	May 16	
	Agree the plan to meet the national condition relating to joint	Dependent on partners	John Morley	June 2016	Sept 2016

Activity	Milestone	Dependency	Responsible	Start Date	End Date
	assessments, care planning and accountable professionals. Case management approach.	engaging			
	Align RCC teams to primary care structures and explore colocation possibility with GP staff and integrate case management	All partners engaging	John Morley	May 16	May 2017
	Develop link worker roles with specialisms such as LD OP across primary care group for specialist input	All partners engaging	John Morley	June 2016	May 2017
	Embedding of senior social work staff attending GP MDT sessions	All partners engaging	Tracey Webb	June 2016	May 2017
	Formulate governance structure for information sharing around NHS number with health colleagues/surgeries.	All partners engaging and national remit	Sandra Taylor	Aug 2016	June 2018
	Establish ASC clinic times within GP practices around Rutland.	Gp buy in and times allocated	Neil Lester	May 2017	Dec 2018
Integrated community care for LTCs and high needs	Incorporate current developments into a new 3 year 'Health and Social care integration plan' To include: • Development of local multi-speciality teams • Models of integrated management and oversight of teams explored and trialled • Permanent model of operational and	Integration across asc & health teams	John Morley	Mar 2017	March 2019

Activity	Milestone	Dependency	Responsible	Start Date	End Date
	management integration delivered				
	ASC teams to adopt Care Management approach to workforce delivery to widen opportunities to recruit operational staff	Availability of suitably qualified and experienced staff	John Morley	Dec 2016	May 2017
	Embed integrated risk stratification for Long term conditions	All partners engaging	Kim Sorsky	SEPT 2016	Mar 2017
LTC management - innovation fund	Agree and deliver projects to trial innovative initiatives that support the management of LTCs (eg. telehealth, condition monitoring, support groups)	Partners engaging	Kim Sorsky	Oct 2016	Aug 2017
Integrated dementia services	Embed provision of Alzheimer's Society person-centred services to individuals with dementia and their carers, helping them to live well	Service user and family engagement	Kim Sorsky	Mar 2016	Mar 2017
	Embed promotion of Alzheimer's friendly communities and high streets	Community involvement	Kim Sorsky	Mar 2016	Mar 2017
	Integrate Alzheimer's Society dementia support workers in Long term and review team	Office space for staff to colocate	Kim Sorsky	Mar 2017	Mar 2018
Care Act - carers	Embed Carers support in Prevention and Safeguarding team	Staff integrated into team	Tracey Webb	Jun 16	Sept 2016

1.4 Exclusions

There is some overlap between the Unified Prevention priority and that for Long Term Condition Management. It is anticipated that there will be close coordination between schemes under the two priorities, so that there is not duplication of effort. This is a role of the operational delivery manager.

2 Approach

2.1 Operational Readiness

The Local Authority 'Memory advisor' role that was established during 2015-16 will be sustained into 2016-17, offering additional support to dementia patients and their carers in navigating health and care services.

Our 2015-16 BCF plan included a care coordination approach which used risk stratification to identify patients with multiple co-morbidities whose evolving heath situation meant that they might benefit from a more rounded response, including potential social care support and wider (eg. medication review, mobility support, benefits reviews etc). Building on this, local partners want to implement a stronger case management approach in 2016-17 which coordinates primary care, community health and social care around target patients more effectively.

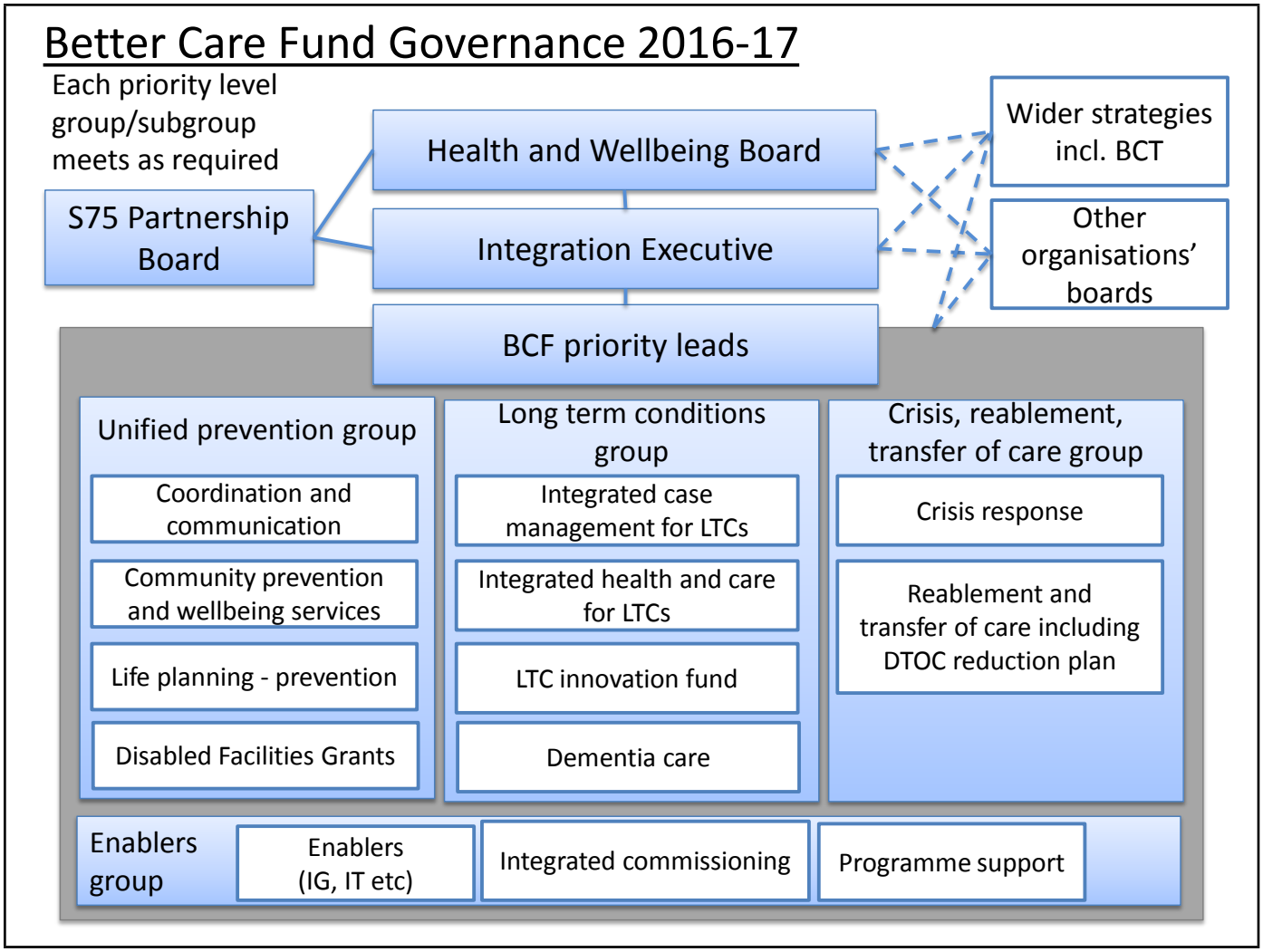
In terms of the model of care ELRCCG continue to focus on the following areas to maximise the benefits for the most vulnerable patients:

- Proactive care planning for all patients at the end of their lives - this would amount to approximately 1% of our population, and as a result increase the number of patients who die in their place of choice
- Proactively work with care homes to improve patient care and reduce unnecessary unplanned admissions
- Combine care for patients with multiple long-term conditions through advanced planning and multi-disciplinary teams (MDT) working to reduce workload and patient visits to practice
- Use of the medicines management team to work on a review of patients relying on multiple medications, medicines reconciliation (i.e. the process of identifying the most accurate list of all medications that a patient is taking), and proactive patient management, as well as improving the quality of prescribing
- Focus on the systems and processes of our healthcare providers to improve the transition towards a primary care model
- A programme of support, advice and education to help GP practices to work closely together.

2.2 Work stream structure

The priority lead will coordinate delivery of this priority, working with scheme leads, stakeholders and providers and using enabler services (IT, commissioning, workforce, etc) as required. The BCF priorities are inter-related, so a priority leads meeting has been established to ensure coordinated progress across the priorities.

Progress across all priorities will be reviewed monthly at the Integration Executive which steers the programme at the more operational level. Information will also be supplied as required to support decision making and plan steering by the Section 75 Partnership Board (quarterly) and the Health and Wellbeing Board (quarterly as required).



2.3 Work stream metrics

BCF Metric	Rationale	Likely Impact (significant/moderate/ none/other)
Admissions to permanent residential and care homes avoided	Enabling people to live independently at home	Significant
People who have had reablement still at home 91 days after release from hospital	Delaying dependency and reduce non elective admissions	Moderate
Non elective admissions avoided	Effective management of one or more conditions and exacerbating factors.	Significant
Delayed transfers of care avoided or reduced	Efficient transfer back into the community with appropriate health and care support to manage conditions.	Moderate
Falls prevention	Support people in managing conditions and sustaining strength/balance. Avoiding medication related falls.	Moderate
Service user satisfaction	Effective engagement of patients	Moderate

2.4 Work stream metrics recording

Information being collected	**At what stage in the patient pathway is the information being collected?**	**Information collected by whom**	**Database on which information is collected / captured/ stored**
ASCOF service user and carer feedback re wellbeing. Service users with control over their daily life. Service users with as much social contact as they would like. Service users and carers who find it easy to get information.	Annually	Adult Social Care	Performance Team
ASC Liquid Logic system referral rate and trends	At referral	Adult Social Care	Liquid Logic
Non elective admissions to acute hospitals	Quarterly	Performance	BCF Metrics
Readmission to acute hospitals within 91 days	Quarterly	Adult Social Care	BCF Metrics
Residential Care placements	Quarterly	Adult Social Care	BCF Metrics
Integrated care coordination and case coordination	TBC	Numbers of patients supported and how (high level)	Regular return by project lead to priority lead. BCF monitoring files.
Posts created or redefined, of which vacancies	n/a	Activity leads	Integrated into priority reporting
Alzheimer's Society services	As required by contract	Dementia care lead	Regular return by project lead to priority lead. BCF monitoring files.
Activities of LTC management projects to be commissioned	TBC	Activity, output and impact measuers to be agreed relevant to the aims of the priority	Regular return by project lead to priority lead. BCF monitoring files.

2.5 Work stream performance reporting against metrics

Type of report being prepared (e.g. SITREPS/ RAISE)	**By whom**	**Reporting timeframes**
Liquid Logic reporting	ASC	Coinciding with Integration Executives.
Contract monitoring reports -	Contract lead	Coinciding with Integration

Dementia services		Executives. Monthly.
Reports from projects/workstrands to Long Term Condition Management lead to support Integration Executive reporting requirements	Each project/theme lead or contract lead	Coinciding with Integration Executives.

3 Communication and Engagement

3.1 Stakeholder Analysis

Stakeholder Name	How they will impact on the scheme	How they will be impacted by the scheme	Communication requirements/methods
Individuals who may require or use the service	Able to contribute to service design	Will require the service to respond in a timely and effective way	Promotion of the service to reassure people that they will get a safe and effective service, that is a better option for them than being admitted to hospital or residential care
Partners (including staff) who will want to refer to services	Need to understand pathways to be able to make use of them appropriately	Will provide an option for them rather than admitting/conveying people to hospital or residential care	Relevant/targeted material to explain pathways, services, referral routes etc.
Existing service staff	Support values and behaviours required to facilitate successful service changes	May affect job roles and responsibilities, work location	Need to keep involved through staff meetings and newsletters and individual supervisions and PDR's

3.2 Scheme Reporting and Communication

Type of communication	Communication Schedule	Communication Mechanism	Initiator	Recipient
highlight report to Integration Executive	To Integration Executive timetable	Send to H&SC Integration Manager for Integration Executive	Work stream Lead	Integration Executive

4 Risks

A contingency reserve has been built up after year 1 from underspends. Any partners experiencing increased activity or the financial consequence of any risk materialising can apply to access the contingency.

The partners recognise that failure of a scheme to achieve targets may have a range of financial impact on others. Given the size of the fund, all partners accept this as risk to be shared equally.

3.1 Key Risks [start by seeing which of the risks in the programme apply]

Risk No.	**Date Opened**	**Risk Owner**	**Risk Description**	**Probability** (High, Med, Low)	**Impact** (High, Med, Low)
1	10/5/16	John Morley	Key partners are not engaged or willing to make the necessary transformation	Low	High
2	June 2016	John Morley	Lack of consensus across partners about changes to be made.	Med	High
3	10/5/16	John Morley	Tools and IT support systems are not able to support transformation	Med	Med
4	10/5/16	John Morley	Staff are not equipped to embrace and deliver change	Med	Med

5 Costs

5.1 Funding

Long term condition management	**£898,000**		**Greater share of funding in 2016-17**
Integrated case management	£40,000 £100,000	Other Carry forward from 2015-16	Funding increased to broaden from care integration to broader case management.
Integrated community care for LTCs and high needs	£405,000 £113,000	Out of hospital services Social care services	The £405k is community health funding. Alongside social care monies to drive health and care integration.
LTC management - innovation fund	£55,000	Carry forward from 2015-16	Investment in schemes and activities supporting long term condition management.
Integrated dementia services	£50,000 £50,000	Social care services Alzheimer's Society	Key & complex area. Needs continuity to deliver sustainable change.
Care Act - carers	£85,000	Care Act monies	As per national guidance, supporting carers.

6 Exit Strategy

It is anticipated that these services could evolve to become a fully integrated mainstream health and social care service that will deliver a range of community based options in line with LLR strategies and national recommendations based on research findings for improving service delivery. This scheme will help to shape and inform how this will best be provided locally.

The Integration Executive will be responsible for shaping the long term sustainability and delivery of these services and determining how integrated they become. This will determine the timescales for any changes. In the meantime there will be some transition costs associated with workforce and service developments and changes alongside maintaining the current services.

This workstream is already part of core service provision and is recurrently funded by ELRCCG. The purpose of bringing it into the BCF is so that greater integration can be achieved between health and social care provision enabling a fully integrated service offer. It is line with the CCG's Community Services Strategy.

As this is core service provision, the intention is not to cease but to deliver this provision in a different way that enables greater integration ongoing.

The aim of this this Project is to transform existing pathways, services and resources into new business as usual activity.

There is £55k of one-off funding for new approaches to supporting long term condition management. Activities will be commissioned to be coterminous with the programme to minimise financial risk and consideration will be given to how those that are successful in improving LTC management could be continued beyond the lifetime of the current BCF programme.

Business Case

BCF Priority: Crisis Response, Discharge and Reablement.

This Priority level Business Case combines two separate workstreams from the Better Care Fund Plan: CRDR1: Integrated Urgent Response and CRDR2 Integrated Hospital Reablement and Transfers of Care

Date completed: 10th May 2016

Distribution of this product is (UN)RESTRICTED

Lead: Local Authority - Emma Jane Perkins

DOCUMENT CONTROL

Change

Control History

Version	Change Summary	Change author	Date
0.1	Initial compilation of business case	Emma Jane Perkins/Neil Lester	10th May 2016
0.2	Second draft including aligned elements	S Taylor	June 2016

How to briefly describe this Activity to a Service User

The aim of this scheme is to prevent admissions to hospital or residential care where avoidable by providing services at home, minimise the length of stay for those who do need to go into hospital and help people to regain their maximum level of independence and wellbeing.

The scheme will also seek to enable timely transfer of care in to the community for Service Users thereby releasing hospital beds.

Reablement helps people to gain or regain the skills necessary for daily living which have been lost through deterioration in health. Reablement ideally takes place in the person's own home but if the person is unable to be at home safely, then an interim bed based facility may be required for part of the programme.

By working closely with our health partners and by putting our resources together, we will have an integrated pathway which supports people more effectively within their own homes. Services will be available seven days a week to enable urgent response to any health / social care crisis.

1 Description of Priority

Indicate business need including strategic/national local contexts and current organisational approach

This scheme is key to the overall objective of the Rutland Better Care Fund Plan 2016-17:

> **''By 2018 there will be an integrated social and health care service that has significantly reduced the demand for hospital services and puts prevention at its heart."**

This objective summarises the main direction of travel nationally for health and social care as highlighted in the Better Care Together, (BCT), strategy to redesign service pathways to support independence and wellbeing, provide services closer to home, reduce hospital and residential care admissions and support the transfer of care back to the community. The business plan is also in line with the LLR/BCT Programme for 2016/2017

An emergency admission to hospital is a disruptive and unsettling experience, particularly for older patients/service users, exposing them to new clinical and psychological risks and increasing their dependency (Glasby 2003; Hoogerduijn et al 2007; Lafont et al 2011). Any delay to transfer from acute hospital care into the community is likely to lead to worse outcomes for older patients/service users.

In addition there is evidence that;

- Shared and comprehensive assessment of needs and personalised care plans, based on shared information and protocols between health and social care partners to address physical, social and psychological needs of patients/service users
- Reablement can enable patients/service users to stay in their own homes for longer, reduce the need for home care and improve outcomes.

The use of acute hospital beds for older patients/service users can be reduced through avoiding emergency admissions and/or reducing excessive lengths of stay.

To enable this to happen, a whole system response is required to ensure a fully coordinated and integrated service is developed, to truly prevent adults and older people from experiencing unnecessarily protracted admissions and for them to have the greatest opportunity for recovery so as to be able to return to their own homes. By bringing our resources together we will establish an integrated pathway which supports people more effectively within their own homes.

We will measure the reduction in 'non elective' admissions, proportion of 65+ year old remaining at home 91 days after discharge from hospital and number of people who are not delayed in hospital.

Services will be available seven days a week to enable an urgent response to crisis. This will include the night nursing service provided by Leicestershire Partnership NHS Trust and an out of hour's social care response provided by Rutland County Council.

Seven day working will be available to enable timely discharge. This will include ICS, an enhanced Reablement service, social work and district nurse capacity to support hospital discharge as well as shared posts to support joint assessments.

This work is also aligned to the BCT project around falls prevention and managing falls and incorporates locally the strategies being developed by this group across Leicester/Leicestershire and Rutland (LLR).

The intention of this piece of work is to consolidate existing activity, ensure clear and appropriate referral routes are in place and ensure practice is evidence based. The scheme will help to deliver more integrated working and inform best value models for the future delivery of these services.

1.1 Priority objectives

- The overall aim of the scheme is to make the pathways between services simple but effective and wherever possible to consider and implement community based care options.
- Care services are effectively coordinated around the patient, reducing duplication and increasing effectiveness.
- Service users are able to stay as well as possible for as long as possible in their own home.
- Reassurance for the service user and their family that there is effective support closer to home reducing likelihood of being admitted to hospital.
- If they do have to be hospitalised, patients return sooner to a community setting/home, rather than being delayed in a hospital bed.
- People can more easily resume their normal lives on their return home, maintaining independence.
- End of life patients are given the choice to remain at home.
- To maximise the capacity within the acute sector for those who really need it.
- To contribute to providing 24/7 services as required.
- To contribute to a reduction in the number of permanent admissions to residential care.
- For services to work in an integrated way that reduces duplication and ensures services are provided in a timely way, are safe, comprehensive and effective and that provide individuals with opportunities to maximise their independence.
- To maximise the involvement of voluntary and community services to contribute to supporting the objectives of preventing hospital or residential care admissions and supporting people to return home and to regain their maximum level of independence following an admission.
- Patients/service users receiving services say they are satisfied with the outcome of the care they receive and have had positive experience.
- To ensure Carers involved in the delivery of these services are satisfied with the experience they receive and the outcomes for the person they care for.
- To demonstrate value for money by continually evaluating the structures and processes and making recommendations for future service models to meet the needs of the Rutland community

1.2 Key deliverables

Scheme deliverable	Delivery targets
Reduce the number of non-elective admissions to acute hospitals..	BCF metrics achieved.

Proportion of 65+ year old remaining at home 91 days after discharge from hospital.	BCF metrics achieved.
Reduction in delayed Transfer of Care (delayed bed days) from Acute Hospitals.	Number of DTOC on sitrep resulting in no reimbursement charges
Timely assessments for Continuing Health Care will be undertaken in the community after discharge once patients have had a period of reablement	Appropriate DST confirmed at panel
Evaluation of this model of integrated working in terms of effectiveness and value for money. Recommendations for future service design.	Validation exercise to be undertaken Oct 2016
To support a 7 day service delivery model which provides broadly consistent service levels by working alongside EDT, ICS, Night Nursing Service and Crisis response in the delivery of out of hours services.	Review performance of the ASC on call process, ICS and Crisis Response Services to highlight systems are in place to evidence comparable service delivery across 7 days
Ensure robust data capture systems are established that allow trends in delayed transfer of care are identified and addressed	BCF Metrics dashboard matches local information
Increased integrated working between health and social care services locally to ensure a seamless transition of care.	Staff are clear about their roles and responsibilities and have positive relationships with colleagues that support the way services are delivered to their patients/service users.
Clear pathway referral routes into services to assist referrers and prevent duplication for services and service users.	Reduction in DTOC numbers.
The service will ensure that the Wellbeing of Service Users is at the forefront of service delivery and that Service users are consulted, where possible, in the care they receive. This is in line with both the Care Act and the Personalisation agenda.	A personalised support plans developed in a person centred way.
In line with the BCF/BCT plans handovers between services will feel seamless and carried out so that the service user feels empowered to manage their ongoing service with choice and control.	Service user feedback/survey

1.3 Scheme milestones

Integrated urgent response

Admission avoidance - Metric 1. Non-Elective Admissions (General & Acute)

Aim	Actions	Start	Finish	responsible
People diverted from acute beds	• Continuing delivery of ICRS crisis response admissions avoidance service in Rutland	Ongoing		Rachel Dewar LPT
	• Integrated work with Peterborough City Hospital (PCH) emergency diversion team to ensure Integrated Care Service is fully utilised	May 2016	June 2016	Neil Doverty
	• The Preventing Avoidable Readmissions Project PARP (2016) being piloted in Leicester City to be analysed to see if it could be used for Rutland patients in PCH & Leicester hospitals (UHL)	May 2016		Srikunar Arun
	• Integrated care coordinator working in Rutland GP surgeries to offer additional support to people identified by GPs as frequently admitted to hospital.	May 2016	Mar 2017	Vicky Hughes
	• Explore ways to facilitate information exchange, including with GPs, to have a complete wraparound approach of the patient. Urgent response needs to be joined up with prevention and LTC management – GP hubs could deliver this.	May 2016	Sept 2016	Neil Lester
	• Work with care homes to raise profile of alternatives to acute response – e.g. ICS/REACH/Crisis response /respite – through the Provider Forum	May 2016	July 2016	Neil Lester

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Patients prevented from ill health that requires acute health service intervention	• Deliver Hub project in GP surgeries	June 2016	Jan 2017	Neil Lester
LD patients diverted from Assessment & Treatment Units	• Develop a Transforming Care Partnership and plan • Introduce an avoidance blue light risk register • Embed Outreach team • Review effectiveness of current respite provision in place	Jun 2016	Oct 2016	Kim Sorsky

Systems to monitor and manage patient flow - Metric 4. Delayed transfers of care from hospital per 100,000 population (average per month)

Aim	Actions	Start	Finish	Responsible
Patients are tracked to ensure they are moved efficiently and quickly through and out of acute to community	• Introduce new systems to monitor patient flow • Analyse metrics used for UHL Vanguard patient monitoring	June 2016 June 2016	July 2016 July 2016	Angie Essom

7 day services - Metric 4. Delayed transfers of care from hospital per 100,000 population (average per month)

Aim	Actions	Start	Finish	Responsible
Discharges taking place 24/7	• MDT staff contracts to include flexible and weekends working if required will also ensure 7 day services could be an option	June 2016	Sept 2016	Rachel Dewar & Emmajane Perkins
	• New EDT arrangements from April 2016 of a new staff team structure for the community care response. Planned care will see the tie up of the LPT ICS and RCC reablement (REACH) services to provide recovery and reablement. The rapid response services will see the tie up of RCC crisis response, LPT rapid response and night nursing service. This will include an out of hours community care worker.	May 2016	June 2016	
	• Align REACH team with relevant LPT sections to integrate in a later part of the plan.	June 2016	Jan 2018	
	• Coordinate activity with Vanguard OOH GP, Urgent care centres & 111 service review	June 2016	Jan 2017	

Enhanced health in care homes - Metric 1. Non-Elective Admissions (General & Acute)

Aim	Actions	Start	Finish	Responsible
Reduce number of people admitted to hospital	• Enhance workforce development through OT/reablement/ provider forum	Mar 2016	Mar 2017	Emmajane Perkins
	• Continue to fund Leicestershire Social Care Development Group (LSCDG) to ensure training and care certification for all staff	April 2016	Mar 2017	
	• Provide Moving and Handling Training	April 2016	April 2016	
	• Review the effectiveness of GP link to homes and implement improvements	August 2016	December 2016	
	• Improve admission monitoring by individual care home			

• Integrated hospital transfer and reablement

• Early discharge planning - Metric 4. Delayed transfers of care from hospital per 100,000 population (average per month)

Aim	Actions	Start	Finish	Responsible
Reduced DTOC Timely and safe discharge	• Refresh analysis of the causes of DTOCs in order that solutions and interventions can be sought. • Ensure case reviews to better understand the opportunities to prevent DTOC and monitor patient flow	June 2016 June 2016	Renew as required Renew as required	Angie Essom
Patient planning for discharge on admission	• Earlier planning for discharge to take place from admission for PCH patients in line with pathway established at UHL.	June 2016	Dec 2016	Angie Essom
Planned care patients arranging to come home even before they have gone to hospital. Mentally prepared.	• Planned pre-hospital engagement for patients	June 2016	Dec 2016	Hilary Fox
Prepare patient for hospital through 'pre-hab' (stronger patient, reduced recovery period, reduced length of stay, less need for follow up support)	• Investigate potential for 'pre-hab' prior to planned admissions	June 2016	Mar 2017	Hilary Fox

Multi-disciplinary discharge team - Metric 4. Delayed transfers of care from hospital per 100,000 population (average per month)

Aim	Actions	Start	Finish	Responsible
Well-resourced MDT hospital discharge team Work in more integrated ways around the patient using voluntary sector/health/social care/private providers	• Recruitment by LPT of a new band 6 nurse, a phlebotomist and technical instructor	June 2016	July 2016	Rachel Dewar Yasmin Sidyot Emmajane Perkins
	• Introduce use of the minimum data/assessment	May 2016	May 2016	
	• Deliver phase 2 of integration: RCC Hospital and Discharge team with LPT health colleagues continues with the start of a system leadership course	June 2016	April 2017	
	• Co-locate the RCC therapist and social workers to. (A proper licence to occupy RMH will need to negotiated involving RCC estates department.)	June 2016	Sep 2016	
	• Alignment of key staff across health and social care in Rutland. Models of integrated management and oversight of teams explored and trialled	June 2016	Dec 2017	
	• Work with GP's to explore primary care involvement as part of discharge planning.	June 2016	Sept 2017	

Home first and discharge to assess - Metric 1. Non-Elective Admissions (General & Acute) & Metric 4. Delayed transfers of care from hospital per 100,000 population (average per month)

Aim	Actions	Start	Finish	Responsible
Safe interim discharge solution to those Non-weight Bearing/Discharge to Assess/Reablement	• Pilot the use of vacant residential home placements to assist in providing interim respite to facilitate discharge from acute back into the community.	Mar 2016	May 2016	Emmajane Perkins Rachel Dewar
	• Train care home staff in reablement	Apr 2016	April 2017	
	• Introduce Pathway 3 (Reablement) project with 60 beds	June 2016	Nov 2016	

	• Agreement of pooled budget/commissioning arrangement or charging/invoice agreement when patient triggers a positive CHC checklist but DST to be completed which may cause a DTOC if not agreed	June 2016	June 2016	
	• Integrated hospital team manage all CHC and social care discharge and care packages from acute to community based/home beds and from community beds to home on an agreed health and social care integrated pathway	June 2016	June 2017	
	• Exploration of incorporation of third sector workforce as a possible step down from REACH (from care to support) and a continued monitoring based on risk of readmission.	June 2016	April 2017	
Develop the market for reablement/domiciliary care providers to ensure patient choice can be accommodated	• Concern over the lack of capacity available in the REACH service and local Domiciliary Care providers needs to be assessed to establish how to increase capacity to meet high level of demand seen at present time	June 2016	Sept 2017	Karen Kibblewhite

CCI

Trusted assessors - Metric 4. Delayed transfers of care from hospital per 100,000 population (average per month)

Aim	Actions	Start	Finish	Responsible
CHC FastTrack is used effectively	• Embed in place in UHL and ensure Arden Gem will accept PCH trusted assessor	July 2016	July 2016	Sue Allen
Patient information is shared to ensure timely and safe discharge	• New Minimum data set paperwork being used by Health/Social care/providers	June 2016	June 2016	Angie Essom Yasmin Sidyot
	• Introduce LiquidLogic ASC case management system	2015	May 2016	

• Focus on choice - Metric 4. Delayed transfers of care from hospital per 100,000 population (average per month)

Aim	Actions	Start	Finish	Responsible
Person centred discharge	• Embed clear patient choice protocol is in place in line with the	June 2016	July 2016	Angie Essom

planned and in place when patient is medically fit to move from acute to community	new NHS national policy guidance			
Patient pathway clear	• Develop pathways 1,2,3,4,5 across both PCH & UHL	June 2016	Dec 2016	Tamsin Hooton
Patients in control of commissioning according to identified need	• Increase awareness and communications of Personal Health Budgets and Direct Payments	June 2016	Sep 2016	Neil Lester
Self funders are supported to prevent DTOC	• Develop further communications around Rutland Rapid Responders for housing repairs	May 2016	Dec 2016	Angie Essom
	• Ensure Coordination by integrated hospital team for all self-funders	May 2016	May 2016	
	• Ensure Assistive technology packages open to self-funders	May 2016	May 2016	
	• Develop further the links with the voluntary sector, for example: linking the Community Agents with discharge	May 2016	June 2016	
	• Improve links between discharge and carers assessments	May 2016	April 2016	

1.4 Exclusions

- There is a wider Vanguard project for Urgent Care which is funding a range of complementary measures. This is also the case for Better Care Together.

- There is overlap between aspects of this priority and the priority for long term condition management. Any crossover between priorities will be managed through coordinated working.

2 Approach

2.1 Operational Readiness

The Operational Delivery Manager- Integration & Care Act is now in place with a remit to ensure that strategic decisions taken in both areas are embedded into practice. This role will also enable a conduit to feed back issues faced by teams to senior managers.

The Operational Delivery Manager will act as a liaison between health and social care organisations, including the voluntary sector.

It is anticipated this will allow Rutland County Council to identify any obstructions to discharge pathways/ Service User/Carer support and work in partnership to remove those obstructions.

A Quality Assurance Framework, (QAF), is being compiled which includes an assessment audit tool. This will allow line managers to review performance of staff against the core principles of the Care Act.

A new Social Worker and an Inreach Nurse for Peterborough Hospital are already in place and working effectively. A further Inreach nurse and Technical Instructor are currently being recruited.

There are a number of initiatives currently ongoing such as Preventing Avoidable Admissions and Discharge Planning working groups.

There is now an RCC ‘Out of Hours’ EDT service working in partnership with other agencies to provide support where care and/or social needs are required.

The Rutland ICS has been operational since the 1.9.14 and has accepted a number of referrals with successful outcomes.

The REACH Team has undergone a major re-structure over the past 3 years to develop the role of Co-ordinators and Reablement support Workers. Therapists and a Review Officer are now integral to the Team. Over the past year the Team has developed its role to act as the main Broker of domiciliary care for the Adult Care Team.

The Team is having successful outcomes with consistently over 85% of people discharged from hospital who have received reablement remaining at home 91 days after discharge, and approximately 60% of people requiring no on-going social care at the end of their reablement period. The average time on reablement is 4 weeks. The service is ‘all inclusive’, accepting people considered to have limited potential for improvement but needing the opportunity for their needs to be properly assessed and a package of ongoing care established.

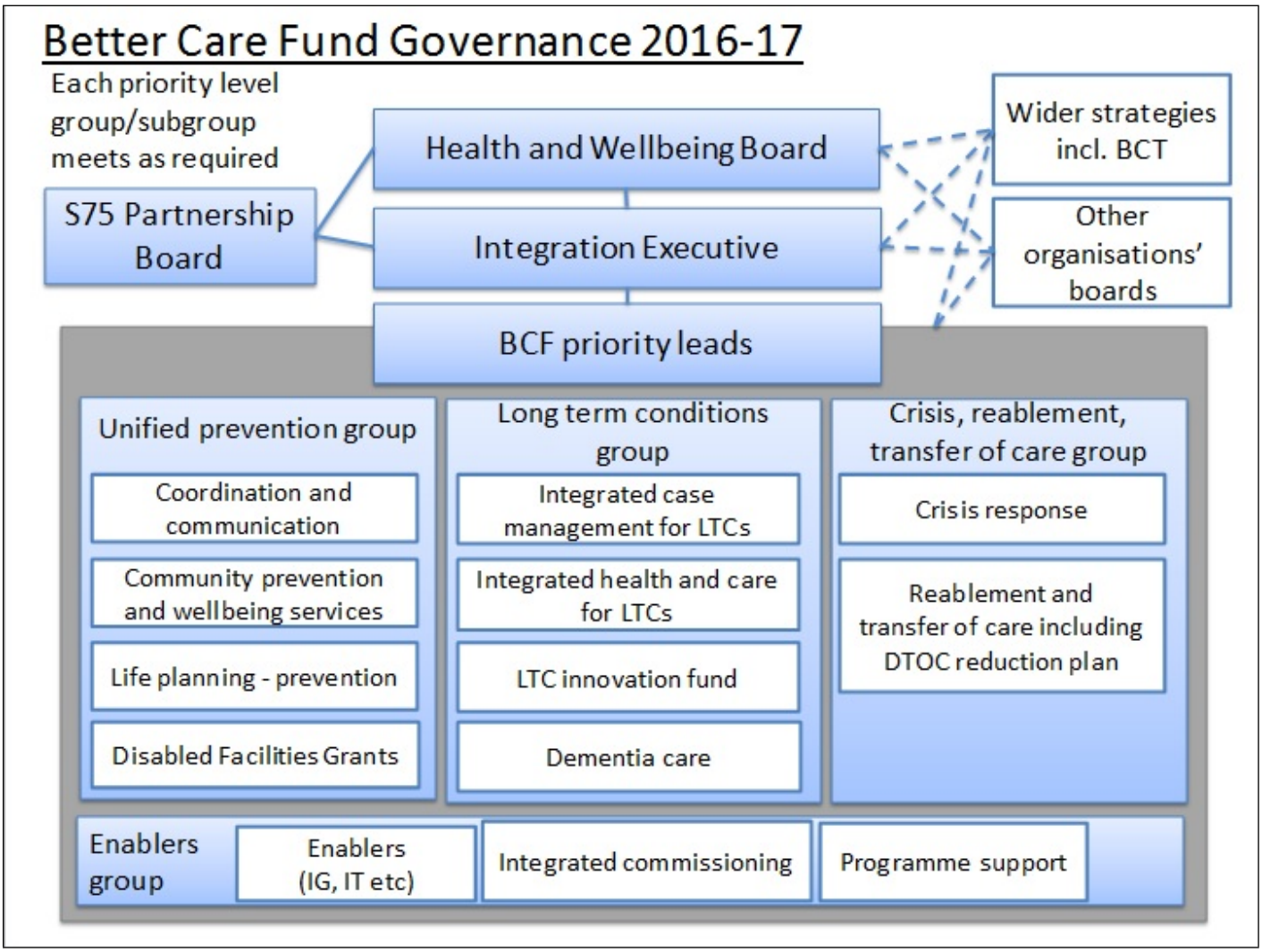
The use of Just Checking has been used by the REACH service to with evidence of positive outcomes, assessment and provision of other assistive technology is regularly utilised.

2.2 Work stream structure

The priority lead will coordinate delivery of this priority, working with scheme leads, partners, stakeholders and providers and using enabler services (IT, commissioning, workforce, etc) as required. The BCF priorities are inter-related, so a priority leads meeting has been established to ensure coordinated progress across the priorities.

This priority is the most focussed on hospital use and must maintain tight coordination with the activities of the wider Better Care Together strategy (frail older people, urgent care and urgent care Vanguard, planned care, end of life, long term conditions.), with the Urgent Care Vanguard and with wider Discharge Steering Groups.

Progress across all priorities will be reviewed monthly at the Integration Executive which steers the programme at the more operational level. Information will also be supplied as required to support decision making and plan steering by the Section 75 Partnership Board (quarterly) and the Health and Wellbeing Board (quarterly as required).



2.3 Work stream contribution to key BCF metrics

BCF Metric	Rationale	Likely Impact (significant/ moderate/ none/ other)
Admissions to permanent residential and care homes avoided	Reduced hospital stays, prompt hospital discharge then reablement help to prolong independence	Significant
People who have had reablement still at home 91 days after release from hospital	Delivering reablement to restore strength/condition.	Significant
Delayed transfers of care avoided or reduced	Main priority addressing barriers to timely transfers of care. Also reducing length of hospital stays.	Significant
Non elective admissions avoided	Crisis response services avoid hospitalisation where appropriate.	Moderate
Service user satisfaction	Effective engagement of patients	Moderate

2.4 Work stream metrics recording

Information being collected	At what stage in the patient pathway is the information being collected?	Information collected by whom	Database on which information is collected / captured/ stored
Collection of 'Live' DTOC statistics to avoid time lag of official DTOC reporting.	Daily	RCC ASC	Sitrep RCC local DTOC monitoring logs
Data relating to Rutland DTOCs (nights, causes, sector, Trust)	Monthly	Arden & GEMCSU	Unify
Local data collection for Reach	Reach Team	At referral, at discharge	Liquid Logic
Local data collection for night nursing service	Night nursing team	ICRS	LPT Database
Customer satisfaction surveys	To be developed jointly with patients ASCOF Letters of compliment	Steering group	

Information being collected	At what stage in the patient pathway is the information being collected?	Information collected by whom	Database on which information is collected / captured/ stored
	and complaints		
Numbers of referrals to Reablement	Start	REACH Admin Information Management team	Liquid Logic
Outcomes of Reablement	End	REACH Admin	Liquid Logic
Number of people remaining at home after 91 days	Monthly	Performance Team	Liquid Logic

2.5 Work stream performance reporting against metrics

Type of report being prepared (e.g. SITREPS/ RAISE)	**By whom**	**Reporting timeframes**
ICRS reports on admissions avoided in crisis	LPT	Monthly
Reablement outcomes	Performance Team	Monthly
'Live' DTOC monitoring	Designated ASC managers	Monthly
Reports to RCC Leadership Team/Elected members	Emma Jane/Neil Lester	As required

3 Communication and Engagement

3.1 Stakeholder Analysis

Stakeholder Name	How they will impact on the scheme	How they will be impacted by the scheme	Communication requirements/methods
People receiving/needing a service and their families and carers. Members	Expectations regarding the level of support they require will determine their	Shorter stays in hospital and/or interventions provided at home or in different settings	Detailed and consistent communication/information given to Service Users and their families/carers.

Stakeholder Name	How they will impact on the scheme	How they will be impacted by the scheme	Communication requirements/methods
of the public.	level of engagement with the service. Feedback on the effectiveness and satisfaction with the services.	closer to home. They will require services to respond in a timely and effective way.	Why the move from acute services Reassurance regarding the level of support/care in the community once discharged. To supply information to all involved to help them understand what Reablement aims to achieve based on their identified outcomes. Promotion of the service to reassure people that they will get a safe and effective service that is a better option for them than being admitted to hospital or residential care. Positive publicity about individual success stories.
Voluntary sector and wider community	To understand how to use preventative services, advice and information systems and universal services to support self-management and wellbeing.	The level of support by the '3rd sector' will grow as new discharge pathways are established. The sector will become an integral part of those pathways providing support in the community	Promote engagement with the sector through a variety of mediums including: • Provider forums • Newsletter • Local Interaction on an ad hoc basis
Partners who will want to refer to the service e.g. GP's, Emergency departments, EMAS, other health and social care services.	Required to understand the options available within the community and to utilise them appropriately	Will provide options for them rather than admitting/conveying people to hospital or residential care Will free up capacity of workers in other teams to deal with new and more on-going cases.	Any changes to processes/pathways to be communicated to all stakeholders Review of service through established working groups.
Members of the REACH Service	Support values and behaviours required to facilitate successful Reablement and service changes.	May affect job roles and responsibilities, work location.	Need to keep involved through staff meetings and newsletters and individual supervisions and PDR's
Intensive Community	Need to work closely with the	May affect job roles and responsibilities	Need to keep involved through regular joint meetings.

Stakeholder Name	How they will impact on the scheme	How they will be impacted by the scheme	Communication requirements/methods
Support Service	Reach team.	and work location.	
Hospitals	Providing appropriate referrals and information using agreed minimum data set and trusted assessments and agreed pathways. Effective partnership working – shared information Able to identify patients at the point of admission who are likely to be difficult to discharge so they can refer early to the discharge co-ordinators. This will allow for the required attention and time to prepare for their discharge.	Will help with speedier and smooth discharges and free up capacity in acute sector. To actively identify people who will require social care and ongoing health support following their acute hospital episode. Benefit from timely and effective discharges to free up beds.	Need to ensure all partners are aware of referral pathways. Collaborative working/understanding to ensure health partners are confident about community services and their ability to provide care/support. Understanding of level of information required by step down facilities and appropriate pathways for them to follow.
Private Domiciliary and Residential care providers	Supporting the principles of Reablement to maintain individual's maximum levels of independence. Sufficient availability to pick up cases efficiently at the end of Reablement or to support cases prior to being ready to commence Reablement.	Will affect the client group they are working with – potentially quicker turnover of some cases and long term cases will be more complex.	Ensure part of RCC commissioning strategy includes a review of provider workforce and training strategy. Contracts to include outcome based 'Key Performance Indicators' to ensure service delivery is in line with expectations.
Hospital Social	Delivery of the	Recognition for what	Supervision arrangements, team

Stakeholder Name	How they will impact on the scheme	How they will be impacted by the scheme	Communication requirements/methods
Worker and in reach Nurse for Peterborough Hospital	service sharing good practice that can be used for other hospitals.	they are doing, direction for future service development.	meetings.
Hospital social Workers for other hospitals and Primary Care Co-ordinator at UHL	Liaise with Link nurse to facilitate best use of step down resources	Have a different profile and resources available to enable them to do their role.	Supervision arrangements, team meetings Establish links with Primary care Co-ordinator to ensure fully integrated with Rutland services.
Team Managers/ Heads of Service	Help with monitoring DTOC through sitreps and escalation meetings.	This reduces demands on their time dealing with delays and fines.	Agreed protocols for managing discharge escalation meeting.
Team Managers/Heads of Service	Tracking of cases using Liquid Logic	Allows supervision of cases to ensure they are not 'lost' or prioritised incorrectly	Heads of service team meeting.
Rutland Memorial Hospital/ICS virtual beds/interim beds for D2A and NWB	Key step down option for those who can't return home immediately.	Increased demand on their service.	Agreed level of referral information from hospital and trusted assessments. Understanding of need to accept referrals and ensure own processes are maximising throughput.
REACH/ICS	Provide support and ongoing assessment and intervention for people when discharged	Increased demand on service. Need to develop capacity and methods so that they can 'pull' people out of hospital as soon as they are ready.	Agreed level of referral information from hospital and trusted assessments. Understanding of need to accept referrals and ensure own processes are maximising throughput.
Other Community based service	Provide support and ongoing assessment and intervention for people when discharged	Business opportunities for independent sector	Promote engagement with the sector through a variety of mediums including: • Provider forums • Newsletter • Local Interaction on an ad hoc basis

3.2 Priority Reporting and Communication

Type of	Communication	Communication	Initiator	Recipient

communication	Schedule	Mechanism		
Highlight report to Integration Executive	To Integration Executive timetable	Send to H&SC Integration Manager for Integration Executive	Priority Lead	Integration Executive

4 Risks

4.1 Key Risks [start by seeing which of the risks in the programme apply]

Risk No.	Date Opened	Risk Owner	Risk Description	Probability (High, Med, Low)	Impact (High, Med, Low)
1	10th May 2016	Neil Lester	External evaluations not having sufficient evidence, due to lack of Rutland focus or lack of referrals to make data viable/statistically significant.	High	Med
2	10th May 2016	Neil Lester	Failure of RCC 'Out of Hours' support to EDT	Med	High
3	10th May 2016	Neil Lester	Failure to establish robust working relationships where these are required to ensure integrated service is consistent and effective	Med	High
4	10th May 2016	Team managers	Wider changes affect the ability of particular partners to contribute to the BCF strategy in the way intended eg. Care Act could affect the number of assessments being requested.	Low	High

5 Costs

5.1 Priority Costs

Include all direct and indirect costs

Description	2016-17 (£)
Integrated Crisis Response	
CCG Posts	£125,000
RCC Posts	£115,000
Transfer and reablement	
CCG Posts	£135,000
RCC Posts	£561,000

5.2 Funding

Funding Source (External - name/Internal)	2016/17+ (£)	Totals (£)
BCF Integrated Crisis Response (ICR)	£240,000	
BCF Hospital Transfer & Reablement (HTR)	£696,000	
Total Funding	£936,000	

6 Exit Strategy

As hospital avoidance schemes begin to have the intended impact on reducing admission to hospital then the number of acute beds and people in acute beds requiring a hospital discharge assessment and planning will reduce. As people's expectations of acute hospitals change and the confidence in community services increases then the pathways out of hospital, for those who do need to be admitted, will become more established. However this change will take some considerable attention and the 'payback' period for the investment is more likely to fit with the BCT timescales of 5 years than the BCF timescales.

However until the culture shift in peoples expectation that acute services are the only health option available for health crisis then the Non elective admissions will be difficult to reduce completely

It is anticipated that these services could evolve to become a fully integrated mainstream health and social care service that will deliver a range of community based options in line with LLR strategies and national recommendations based on research findings for improving service delivery. This scheme will help to shape and inform how this will best be provided locally.

The Integration Exec will be responsible for shaping the long term sustainability and delivery of these services and determining how integrated they become. This will determine the timescales for any changes. In the meantime there will be some transition costs associated with workforce and service developments and changes alongside maintaining the current services.

It should be noted the most significant driver of health needs for the Rutland is the growing older population

In 2013 the total population for Rutland was an estimated 37600 people 8,540 people were estimated to be 65 years and over, and 1,180 were 85 years and over.

The total population is predicted to grow by 10% and is broken down as follows:

- 85 years + growth 227%, 1,100 to 3,600 people.
- 65-84 growth 49%, 7,100 to 10,600 people.
- 0-24 reduce by 4%, 10,400 to 10,000 people.
- Adult population 25-64 reduce by 10% from 18,300 people to 16,400

It is important to recognise that there will also be a 10% decrease in the working age population (25-64 years).

All of the above will have a significant impact on the delivery of health and social care across Rutland

Rutland County Council

NHS
East Leicestershire and Rutland Clinical Commissioning Group

Business Case

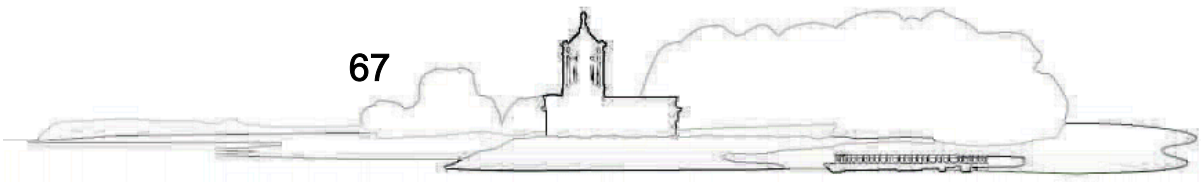
BCF Priority: Enablers

Date completed: May 2016

Distribution of this product is UNRESTRICTED

Leads **Local Authority lead: Sandra Taylor**

Health lead:



DOCUMENT CONTROL

Change

Control History

Version	Change Summary	Change author	Date
0.1	First draft	Sandra Taylor	May 2016
0.2	Second draft (alignment of common sections)	Sandra Taylor	June 2016

Approval Schedule

Integration Executive: 26 May 2016

Health and Wellbeing Board: 28 June 2016

How to briefly describe this activity to a service user

A number of things can stand in the way of health and social care stakeholders working together in more integrated ways for the benefit of patients and service users. This workstrand helps to address those barriers.

This includes:

- **Staff development** eg. understanding how training and recruitment need to change so that the workforce evolves in step with the wider changes to service delivery.
- **Developing information sharing agreements** enabling health and care organisations to share information securely about service users in order to provide them with more seamless services. This must also respect the privacy and rights of individuals, who may withdraw consent for this sharing.
- **Improving case recording systems** so that information can be shared more easily and securely by colleagues with a legitimate need to share.
- **Keeping Better Care Fund stakeholders in the loop** on changes to health and care integration.
- **Health and social care working together to commission services**, rather than purchasing similar services locally from the same pool of providers, with different price structures, service levels, etc.

1 Description of Priority

1.1 Priority objectives

The main aim of this priority is to undertake some of the underpinning work which helps to accelerate health and social care integration and increase the ability for the programme to achieve its objectives more generally, including by helping to address barriers and blockers.

To do this, the Enablers workstrand must to work closely with and respond to the needs of the programme's three substantive priorities.

The main objectives, per strand of activity, are:

- **BCF programme communication:** To ensure that programme stakeholders, including the wider local workforce, are kept up to date with BCF programme aims and progress and the changes the programme is bringing about to health, care and wellbeing services locally.

- **Information Governance and information sharing:** To support stakeholders to undertake confident, lawful information sharing that supports the delivery of more integrated services, including through work on information sharing agreements and assurance frameworks.

- **IT**: To reduce the extent to which IT is a blocker, identifying IT-related blockers to integrated working and supporting Rutland participation in LLR Information Management & Technology (IM&T) projects implementing the LLR digital roadmap.

- **Analytics and monitoring**: To enable programme progress to be monitored using key impact metrics and locally defined output indicators. To use a range of data to generate insights that support the design and delivery of BCF projects. To continue to supply local data to Care & Health Trak and explore the usefulness of this system with decision-makers. To support in-house evaluation of BCF projects and schemes, as required by the national and local BCF governance structures.

- **Workforce development**: To support the identification and implementation of workforce measures that help the workforce to adapt to a changing approach to the delivery of health, care and wellbeing services, ensuring that required posts are filled and that individuals working locally in the health, care and wellbeing sector feel there is career development available to them even in a changing environment. This could include defining workforce actions through workshops, etc, supporting workforce analysis and planning, delivery of direct training programmes and leadership development.

- **Strategy**: To support development of the County's follow-on integration programme for 2017-20.

- **Integrated commissioning:** Commissioning leads to work together to identify commissioning opportunities that could be progressed in a more coordinated or joint way between BCF partners over 2016-18 and to set out a timetable for these procurements. To progress agreed procurements in new ways.

- **Programme management:** To support programme management and reporting.

1.2 Key activities, milestones (stages), deliverables

Actions, Milestones, Deliverables (X = product or deliverable)	Dependencies	Lead	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
BCF Programme approval					X										
Enablers business plan		S Taylor			X										
E1 ENABLERS															
BCF programme communication															
BCF communication plan 2016-17		S Taylor				X									
BCF communications activities	Comms plan	S Taylor													
Information governance and data sharing															
Participate in LLR Information Governance group		S Taylor													
Complete RCC IG Toolkit and understand compliance gap [complete]		S Taylor			X										
Coordinate work to address RCC IG Toolkit compliance gap & submit	Gap analysis IT, IG, ASC inputs	S Taylor													
RCC IG Toolkit compliance obtained		HSCIC					X								
Understand Information Governance gaps for integrated working including Information sharing agreements, training and fair processing adjustments	Working with 3x priorities	S Taylor						X							
Plan to address IG blockers		S Taylor						X							
Embed NHS number into social care/health interface - forms, processes, culture	With users of NHS number														
IT															
Represent Rutland in LLR IM&T activities including digital roadmap planning.	Better Care Together	J Haynes													
Contribute to LLR digital roadmap activities as required	Better Care Together	J Haynes													
Alongside the IG gap analysis, identify IT opportunities to support integration	Working with 3x priorities	S Taylor						X							
Analytics and monitoring															
Continue programme metrics reporting		JHaynes STaylor													
National BCF returns					X			X			X			X	
Support data needs of workstreams		JHaynes STaylor													
Provide agreed data to the Care & Health Trak system & encourage other partners to also do this, as applicable.	Leics BCF programme (system sponsor)	J Haynes													
Introduce Care & Health Trak locally to stakeholders who can use it to inform their decisions		J Haynes													
Review the application & usefulness of Care & Health Trak dashboards locally		JHaynes STaylor								X					
Develop a proposal to increase the learning from service user experience.									X						

Actions, Milestones, Deliverables (X = product or deliverable)	Dependencies	Lead	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Service user insight - implement the agreed approach															
Interim BCF 2016-17 evaluation		S Taylor										X			
Workforce development															
Work with each Priority to identify workforce issues and agree priorities															
Agree workforce development actions including Leadership Development, H&SC Protocol, provider training							X		X						
Coordinate Rutland participation in LLR/BCT workforce development activities	Better Care Together														
Strategy															
Interim evaluation – 2016-17 BCF programme	National timetable and guidance	S Taylor											X		
Strategy – development of the 2017-20 Rutland BCF programme	National timetable and guidance	S Taylor													
E2 INTEGRATED COMMISSIONING															
Use mapping to identify potential areas for cooperation on commissioning and confirm areas where cooperation will take place.	Partner commissioning plans	K Kibble-white					X								
Progress relevant joint or unified commissioning contracts. (May lead to new s75 agreements.)	Joint commission-ing plan	K Kibble-white													
E3 PROGRAMME MANAGEMENT															
Programme management		S Taylor													

1.4 Exclusions

- Developments to IT systems not set out above, unless agreed via governance and affordable within available limits.
- Costs of obtaining NHS N3 secure gateway or equivalent access allowing access to the NHS Demographic Batch Service.
- Mainstream workforce development undertaken by each partner organisation.
- The following elements are addressed under Priority 1: Unified Prevention:
  - Local communication with the public about available services, including via the Rutland Information Service, is addressed under Priority 1: Unified Prevention.
  - The introduction of a new model to commission wellbeing services.

2 Approach

The Rutland BCF Enablers priority consists of actions that are either supporting the whole Rutland BCF programme (eg. programme management, monitoring) or activities being driven

forward to support the programme's three main priorities (eg. use of the NHS number). In some cases, local enablers actions connect out to the parallel Enablers workstreams that are part of the wider Leicestershire, Leicester and Rutland (LLR) Better Care Together (BCT) programme. None of the actions has value in isolation, and they all have a dependency on their connection to the core activities of the local BCF programme.

2.1 Operational Readiness

Some parts of the Enablers priority are continuations of work started in 2015-16, for example ongoing programme management, analytics activities that support the delivery of the overall BCF programme and projects that are underway such as securing NHS IG Toolkit compliance for Rutland County Council. In some other areas, the work to be done in 2016-17 needs to be defined or reconfirmed before it can proceed, for example, confirming where the key Information Governance compliance gaps are that could impede integrated working. In some areas, the level of integration in place in the last programming period may have meant that it was not the right time to address some of these enablers questions. Now that LiquidLogic is in place for Adult Social Care at Rutland CC, for example, the time is right for the next stage of work to fully embed the use of NHS numbers. The prospect of collocation of teams raises the importance of clear information sharing agreements.

- Better Care Fund Programme Communication: a communications plan needs to be developed for the Rutland BCF programme that is tailored to make good use of limited communications resources. It is likely that this will channel messages through to the existing communications channels used by Rutland BCF partners to keep their staff up to date, rather than placing the main emphasis on stand-alone BCF communications.

- Information Governance and information sharing: a stocktake will be done to confirm the real IG gaps that could impede closer working and affect the public's experience of more integrated services. The wider LLR group has progressed information sharing templates that, if applied locally, will allow fast progress in this area.

- Analytics: There are already effective processes in place to track most of the programme's key metrics. Further improvements would be beneficial in tracking local falls data, to supplement the formal falls target which relates to annual Public Health England figures.

- IT: Other than consolidating LiquidLogic for Adult Social Care, there are currently no independent IT actions on the Enablers agenda beyond supporting LLR BCT IM&T actions. This area may require further definition as needs arise.

- Workforce development: There is already an LLR workstream underway for workforce development, including the Health and Social Care Protocol. This workstream will

- Commissioning: Health and social care commissioning activities currently proceed largely separately. If joint or coordinated commissioning opportunities are identified, this will represent a new approach.

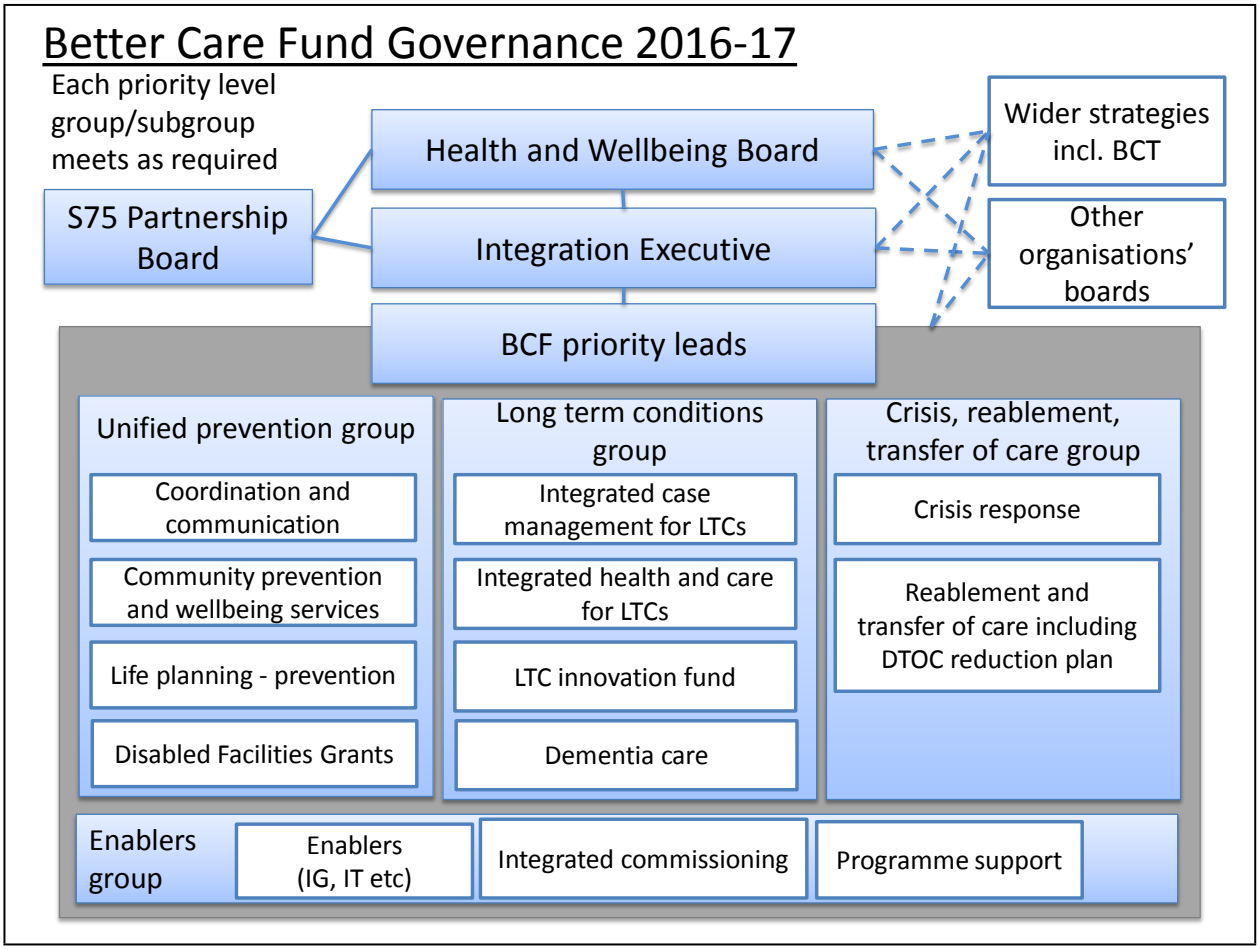
2.2 Work stream structure

The priority lead will coordinate delivery of this priority. The BCF priorities are inter-related, so a priority leads meeting has been established to ensure coordinated progress across the priorities. This will help to tailor Enablers outputs to best support the programme's main substantive change work.

Progress across all priorities will be reviewed monthly at the Integration Executive which steers the programme at the more operational level. Information will also be supplied as required to

support decision making and plan steering by the Section 75 Partnership Board (quarterly) and the Health and Wellbeing Board (quarterly as required).

Within the Council, the Enablers priority will involve its IT, Information Governance, HR and Data teams guiding or participating in activity that will support Health and Social Care integration locally. There is also a dependency across to LLR Better Care Together structures and workstrands.



2.3 Work stream contribution to key metrics

The activities in this priority will not have a direct impact on the programme's key metrics. However, there is scope for indirect impact. For example, workforce actions could help to ensure that people have the skills to prevent falls so reduce emergency admissions. Improved sharing of information could help to speed up transfers of care.

In addition, the activities of the programme will help to feed into the quality of data that is providing the insights into how the programme is performing against the metrics.

BCF Metric	**Rationale**	**Likely Impact (significant/ moderate/ none/ other)**
Admissions to permanent residential and care homes avoided	Enablers supports the effectiveness of other measures	Potential indirect impact
People who have had reablement still at home 91 days after release from hospital	Enablers supports the effectiveness of other measures	Potential indirect impact
Emergency admissions reduced	Enablers supports the	Potential indirect

	effectiveness of other measures	impact
Delayed transfers of care avoided or reduced	Enablers supports the effectiveness of other measures	Potential indirect impact
Falls prevention	Enablers supports the effectiveness of other measures	Potential indirect impact
Service user satisfaction	There is work proposed to improve the insights gained from service users.	Potential indirect impact.

2.4 Work stream metrics recording

Under some activity headings, the work to be done will be specified in the early stages of the 2016-17 programme. This may lead to further specific metrics and targets being identified then tracked.

Information being collected	**Information collected**	**Where information is collected / captured/ stored**
NHS number in use in social care	% of social care records matched with NHS numbers	LiquidLogic
	Number of social care templates using NHS number	LiquidLogic
Information Governance	RCC IG Toolkit compliance	HSCIC website
	Information sharing agreements required, now in place	RCC info sharing agreement log
Metrics	Metrics reported on as required by the programme	BCF programme management filing.
Enablers activities confirmed during plan implementation to support priorities eg. service user feedback mechanism	As agreed per area of delivery.	Returns to priority lead.

2.5 Work stream performance reporting against metrics

Type of report being prepared	**By whom**	**Reporting timeframes**
Overall programme performance reports against key metrics	S Taylor and J Haynes	Coinciding with Integration Executives
Enablers updates	S Taylor and J Haynes	Coinciding with Integration Executives

3 Communication and Engagement

3.1 Stakeholder Analysis

This stakeholder analysis is not comprehensive but illustrates the sorts of interactions and engagement that will be needed around the Enablers activities.

Stakeholder Name	How they will impact on the priority	How they will be impacted by the priority	Communication requirements/methods
Priority and scheme leads.	Confirming what 'Enablers' activity they need to support progress in their area, what blockers they face.	The Enablers work will: provide programme management support to the Priorities, provide data to inform Priority actions, help to address blockers eg. IG issues.	Communication via the Priority leads meetings and Integration Executive.
Information Governance leads in partner organisations.	Helping shared IG solutions to be developed that mean that Rutland's sharing agreements etc are consistent with those used more broadly across LLR. This makes it faster to set up systems and easier for the workforce to comply with them.	Work here means that Rutland's partners will keep step with wider progress in IG framworks and assurance (eg. IG Toolkit compliance). No need for special consideration of Rutland situation or approach.	Enablers Priority lead will attend the LLR IG Leads meetings.
Workforce of involved organisations	The workforce needs information about what the BCF programme and its changes mean to them. They have insights to offer about what workforce interventions would help support change locally.	The programme should help to coordinate pieces of work to improve Rutland as a place to work in health, social care and wellbeing.	BCF communications strand will be designed to reach the workforce. There may be activities that engage the workforce directly, eg. leadership development courses.
BCT IM&T group	The group is developing a digital roadmap for LLR which will help to shape eg. how the summary care record will be accessed by different health and care stakeholders. For efficiency and cost effectiveness, we need to work with this wider programme rather than develop isolated local approaches.	It is possible that Rutland could offer to be a pilot for data and IT integration actions, if relevant partners (RCC, LPT, GPs) were to agree to that sort of approach.	
Better Care Fund Regional Support Team	Setting requirements for how the programme is monitored and evaluated, which will be serviced under the	Potential to feed back local views and experiences to inform national approaches.	Good flow of comms via East Midlands teleconferences, events, BCF online community of practice,

Stakeholder Name	How they will impact on the priority	How they will be impacted by the priority	Communication requirements/methods
	Enablers heading		weekly BCF updates.
Healthwatch	Potential to help inform the approach to increasing learning from service users.	They will receive information about programme activities and performance, they may support user engagement.	Participation on the Health and Wellbeing Board and Integration Executive supports dialogue. Also ad hoc engagement around specific questions.

3.2 Scheme Reporting and Communication

Type of communication	Communication Schedule	Communication Mechanism	Initiator	Recipient
Highlight reports, including progress against milestones	Timed to coincide with Integration Executives	Integration Executive	Priority lead	H&SC Integration Manager
Scheme interim evaluation report	Q3-4	Integration Executive	Priority lead	H&SC Integration Manager
Overview, thematic or proposal papers as required	As set out in the Enablers plan, above, or as requested by Integration Executive, Partnership Board, Health and Wellbeing Board.	Relevant governance structures (Integration Executive, or Partnership Board, Health and Wellbeing Board)	Priority lead	H&SC Integration Manager
Programme level reporting including national quarterly returns	As required by the national BCF team	Templates as supplied by the national BCF team	Priority lead/ H&SC Integration Manager	BCF support team

4 Risks

3.1 Key Risks [start by seeing which of the risks in the programme apply]

Risk No.	Date Opened	Risk Owner	Risk Description	Probability (High, Med, Low)	Impact (High, Med, Low)
1	May 2016	S Taylor	Risk that the work of the Rutland BCF programme is not sufficiently visible to stakeholders and staff, reducing the potential for	Med	Med

Risk No.	Date Opened	Risk Owner	Risk Description	Probability (High, Med, Low)	Impact (High, Med, Low)
			changes to have a speedy impact and be sustained.		
2	May 2016	M Andrews (RCC Caldicott Guardian)	Risk that the RCC cannot secure NHS IG Toolkit compliance because system/assurance work does not proceed eg. due to competing pressures. Could impede health and social care integration and access to data for Public Health prevention activities.	Med	High
3	May 2016	S Taylor	Risk that health and care integration is delayed or impeded by the lack of mutual agreement on Information Governance standards - security policy, information sharing agreements, IG Toolkit compliance.	Med	Med
4	May 2016	S Taylor	Risk that information about service users is shared across organisations when service users do not realise this will happen or have refused consent. Potential Data Protection breach and loss of public trust. NB: Need clear means to manage consent consistently across health and social care.	Med/High	High
5	May 2016	J Haynes	Risk that RCC staff do not adopt the systematic use of NHS numbers as patient identifiers, eg in correspondence.	Med	Med
6	May 2016	J Haynes	Risk that new social care records are not associated with an NHS number, because there is no service usable by the Council to obtain them. [Currently, a mediated solution is in place. Watch.]	Low	Low

Risk No.	Date Opened	Risk Owner	Risk Description	Probability (High, Med, Low)	Impact (High, Med, Low)
7	May 2016	K Kibblewhite	Risk that parallel commissioning of similar services continues locally if coordinated commissioning does not progress – duplication, poor value for money. NB: A scheme has been set up to proactively address commissioning so this does not happen.	Med	Med
8	May 2016	S Taylor	Risk that formal programme metrics for falls and user satisfaction, being annual, provide too little insight into programme performance to tune actions to have the greatest impact.	Med	Low
9	May 2016	S Taylor	Risk that workforce issues impede programme progress.	High	Med

5 Costs

5.1 Priority Costs

Include all direct and indirect costs

Description	2016/7(£k)	Total (£k)
E1 Enablers – estimated allocations		£34k
BCF programme communications	£2k	
Information Governance and data sharing	£3k	
Metrics, intelligence, strategy	£17k	
Workforce development	£10k	
Other	£2k	
E2 Integrated commissioning		£0k
Direct costs	£0k	
E3 Programme management		£51k
Programme management incl on costs and overheads	£51k	

5.2 Funding

Include detail of any potential, or definite, sources of funding. Indicate whether this is likely to come from inside or outside of the BCF approved allocation for this work stream. If external, identify the proposed source.

Funding Source (External - name/Internal)	**Confidence rating of funding being provided (H/M/L)**	**2016/17 (£)**
BCF funding *(allocation approved by Health and Wellbeing Board) :*		
Enablers activities	H	£34k
Programme management	H	£51k
Total Funding		£85k

6 Exit Strategy

The work associated with this scheme is an enabler, and much of it comprises one-off costs. If the programme continues beyond March 2017, there will be a need for programme support and further enablers activity.

Once obtained, there will also be a need to submit an annual return for the NHS IG Toolkit. It is recommended that this is absorbed as a business as usual activity once the standard has been reached.

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REPORT NO. 124/2016

Report to Rutland Health and Wellbeing Board

Subject:	**Children's Trust – Children , Young People and Families Plan 2016 - 2019**
Meeting Date:	**28th June 2016**
Report Author:	**Bernadette Caffrey, Head of Service, Early Intervention (RCC)**
Presented by:	**Bernadette Caffrey**
Paper for:	**Note**

Context

The Rutland Children's Trust through a collaborative partnership approach, supports the development and improvement of services for children and young people 0 – 19 years, including to the age of 25 years for some vulnerable young people. The agreed vision and priorities for the Children's Trust partnership are set out in this Children, Young People and Families Plan (CYPFP) 2016 to 2019. This plan is published by Rutland County Council (RCC) as the lead partner with statutory responsibility to promote co-operation to improve children's wellbeing. Organisations that are key partners within the Rutland Children's Trust have endorsed this plan and are now taking a lead in delivering the key priorities for 2016 – 2017.

There are four key themes identified in the Plan that support the achievement of outcomes for children and families as set out in relevant strategic plans, namely; the LR LSCB Business Plan, Future in Mind – Children and Young People's Mental Health and Wellbeing Transformation Programme, 0 to 19 Healthy Child Programme, School Improvement Strategy, the RCC Participation Strategy and the Child Poverty Strategy. These themes are :

- Keep children well and safe
- Fair Society
- Listening
- Efficiency

A number of priorities for action, (8 this year) are in work areas where there are measurable improvements that can be made and that improvement can be delivered in partnership.

The Children's Trust Board will monitor the progress and achievement of the priority actions. At the Children's Trust Board meeting on the 9th June 2016, lead officers from partner agencies gave an activity and outcomes report to update against progress on the priority actions they are leading. The Board was satisfied with the progress that is being made to date.

Financial implications:

There are no financial implications.

Recommendations:

That the board:

1. Notes the contents of the Children, Young People and Families Plan and especially the priority actions for 2016 / 2017
2. Receives a progress report on the achievement against the priority actions at the November 2016 meeting of the Board.

Comments from the board:

Strategic Lead:	Tim O Neill, Director of People, RCC	
Risk assessment:		
Time	L	The Children's Trust will monitor actions at its meetings twice yearly. Some reporting functions will be tied in to end of year reports such as school achievement. The priorities may change as the Board reviews its successes and areas for development.
Viability	M	Partnership engagement and co- working will be critical to the achievement of some actions
Finance	L	No financial risks to this Plan. It is intended that some activity will seek funding opportunities presented to deliver actions, such as, the Better Care Together (BCT) Emotional Health and Well Being Transformation Plan.
Profile	H	Actions from this Plan support the delivery of key outcomes of other Strategic Plans that are open to internal and external scrutiny, for example, Ofsted inspection for the LSCB Business Plan and external audit process in respect of the Changing Lives Programme.
Equality & Diversity	L	The interventions are intended to meet the needs of all children and their families and especially the most vulnerable.

Timeline:

Task	Target Date	Responsibility
Children's Trust Board to review progress reports against priority actions 2016/17	9th June 2016 and December 2016	B Caffrey
Present for information to the Health and Well Being Board	28th June 2016	B Caffrey
Update Health and Well-Being Board on progress towards achievement	November 2016	B Caffrey

RUTLAND CHILDREN, YOUNG PEOPLE & FAMILIES PLAN 2016-2019

Final Copy

The Rutland Children's Trust through a collaborative partnership approach, supports the development and improvement of services for children and young people 0 – 19 years, including to the age of 25 years for some vulnerable young people. The agreed vision and priorities are set out in this Children, Young People and Families Plan (CYPFP) 2016 to 2019

This plan is published by Rutland County Council (RCC) as the lead partner with statutory responsibility to promote co-operation to improve children's wellbeing (Children Act 2004). Organisations that are key partners within the Rutland Children's Trust and who have endorsed this plan include:

- Rutland County Council
- Leicestershire and Rutland Local Children's Safeguarding Board
- East Leicestershire and Rutland Clinical Commissioning Group
- Leicestershire and Rutland Probation Trust
- Leicestershire NHS Partnership Trust
- Leicestershire Constabulary
- Rutland Early Years Providers, Schools and Colleges
- Leicestershire Youth Offending Service
- NHS Leicestershire and Rutland Local
- Healthwatch
- Rutland Parent Carer Forum
- Rutland Citizens Advice Bureau
- Voluntary Action Rutland

Our Statement of Intent:

"Improve the wellbeing and achievements of children and young people by seamless, integrated provision of services. Our emphasis is on enabling children to be well, safe and succeed first time through high quality provision, preventative action and early intervention."

About our Children, Young People and Families Plan

Our Children, Young People and Families Plan is a summary document of our shared planning to continue improving how we work together. It pulls together our priorities and sets out the direction of work for improving the lives of children and young people over the next three years. The Plan reflects our commitment to supporting children and young people by working with them within their family and their community. The plan will be reviewed on an annual basis.

CHILDREN, YOUNG PEOPLE & FAMILIES PLAN KEY THEMES 2016-2019

KEY THEME 1	KEY THEME 2	KEY THEME 3	KEY THEME 4
Keep children well and safe	**Fair Society**	**Listening**	**Efficiency**

We have identified a number of priorities for action; these are agreed each year and are in work areas where there are measurable improvements that we can make and that improvement can be delivered in partnership. The priorities may change as we review our successes and areas for development:

KEY THEME 1	Priority Areas for Action 2016-17	
Keep children well and safe	**1**	To be assured that Early Help Services are effectively coordinated across the LSCB Partnership and secure outcomes that reduce pressure on child protection and care services (Ref: LSCB Business Plan 16/17)
	2	To champion and support the extension of Signs of Safety (SoS) across the Partnership and secure assurance of the effectiveness of multi-agency processes and working and evidence of positive impact for service users. (Ref: LSCB Business Plan 16/17)
	3	To build community safeguarding resilience and be assured that people; families and professionals, living in the community know how to keep children safe
	4	To enhance the health and well-being of children and young people through improved service integration and the delivery of BCT Better Care Together health targets (Ref: BCT Maternal and Child and 0 to 19 Healthy Child Programme)

KEY THEME 2	Priority Areas for Action 2016-17	
Fair society	**1**	To reduce the development and achievement gap at all key stages – championing children and young people to meet their full potential (Ref: RCC School Improvement Strategy and RCC Inclusion Policy Statement 2015))
	2	To improve economic well-being and reduce child poverty levels in Rutland (Ref: Child Poverty Strategy)

KEY THEME 3	Priority Areas for Action 2016-17	
Listening	**1**	Increase engagement and participation of young people to be active citizens.(Ref: RCC Participation Strategy 2015)

KEY THEME 4	Priority Areas for Action 2016-17	
Efficiency	**1**	To quality assure our practice – through the use of quantitative and qualitative data, engagement of service users, and engagement from front line staff

Appendix 1 – Action Plan

Action 1

KEY THEME 1	Priority Areas for Action 2016-17	
Keep children well and safe	**1**	To be assured that Early Help Services are effectively coordinated across the LSCB Partnership and secure outcomes that reduce pressure on child protection and care services

What difference will it make to children and families?
There is a standard process that can be used by all services, and which is particularly suitable for early assessment as soon as we realise a child and/or family has additional needs. It provides a process through which agencies work together with the family to meet those needs and acts as a bridge for communication between the family and professionals

What are we going to do and how are we going to do it?
Deliver the Rutland Early Help Strategy through integrated working and implementation of the Early Help Assessment (EHAs) and team around the family approach

a) Devise an outcomes framework for early help
b) Review and evaluate local programmes once a year in order to ensure quality, equity and value for money
c) Monitor and manage the performance of delivery plans that support the strategic priorities assigned to the Children's Trust – Children Centre Improvement Plan, Changing Lives Outcome Plans.

Who will lead on this?
Head of Early Intervention RCC

What are the measureable outcomes and targets?

1. 10% reduction in inappropriate referrals to Social Care
2. Increase the average %, (currently 26%) of Social Care Contacts resulting in Early Help Support
3. Increase the % (currently 77%) of Early Help Cases closing with needs met to 80%.
4. 10% increase in the number of external partners completing the Early Help Assessment (EHA) and acting as lead practitioner for the family (Currently 49%)
5. Changing Lives (CL) programme engages 20 new families during 2016
6. Rutland Children's Centre Services receives a good with outstanding elements Ofsted judgement.

Action 2

KEY THEME 1	Priority Areas for Action 2016-17	
Keep children well and safe	**2**	To champion and support the extension of Signs of Safety (SoS) across the Partnership and secure assurance of the effectiveness of multi-agency processes and working and evidence of positive impact for service users.

What difference will it make to children and families?
There is a common and agreed methodology for working with families so we are explicit and consistent in the way we make decisions. There is a transparency of analysis, strong planning and shared goals
The children and families we work with feel knowledgeable about their plan and prepared for their review or conference. Families and professionals knowing what they have to do next.

What are we going to do and how are we going to do it?

a) Work with the LSCB to create a strategy and action plan for implementation of multi-agency delivery of SoS.
b) Support the delivery and evaluation of an LSCB workforce development programme to support effective implementation and improvement through SoS
c) Implement the use of SoS approach throughout the child's journey through early help, CIN, and CP in Rutland, by:

- Revising our Children's Services documentation so it reflects the SoS methodology in Rutland.
- Pilot the use of SoS in case conferences and reviews in Rutland.

Who will lead on this?
Head of Safeguarding and Improvement, RCC

What are the measureable outcomes and targets?

1. 100% of EHAs will use the SoS framework
2. The Voice of the Child (VOC) will be evident in 100% of the EHAs that are quality tested.
3. Implement a new safeguarding Multi Agency Referral Form (MARF)
4. Evidence of SoS methodology in 80% of case supervision in Children's Services in RCC.

Action 3

KEY THEME 1	Priority Areas for Action 2016-17	
Keep children well and safe	**3**	To build community safeguarding resilience and be assured that people; families and professionals, living in the community know how to keep children safe

What difference will it make to children and families?
Support personal choice and control for children and families. Children, young people, parents and professionals know how Rutland keep children safe and what their responsibility is to keep children safe. Early and emerging risk and need is identified and responded to before problems escalate and require specialist interventions.

What are we going to do and how are we going to do it?

a) Building a network of extended families, friends and community support, including volunteering opportunities to create community capacity that support children and young people.
b) The Children Trust as a learning organisation creating naturally occurring networks as we do for families: share our anxieties about families and build confidence in our work with families.
c) Prioritise raising the awareness of professionals and the public in relation to CSE
d) Improve our information sharing and joint working with other agencies about children for whom there are child protection concerns
e) Improve our child protection plans so everyone is clear about what, how, when, and who to take action to keep children safe.
f) Promoting and publicising our early help offer and safeguarding responses

Who will lead on this?
Head of Safeguarding and Improvement and the Head of Early Intervention, RCC

What are the measureable outcomes and targets?

1. Improvement in the application of thresholds and the quality and appropriateness of safeguarding referrals
2. Families and professionals report an improved level of awareness and satisfaction with the early help and safeguarding response.
3. Professionals know and are utilising the professional advice at the front door to children services and the complex cases process and cases are resolved before they escalate to safeguarding concerns

Action 4

KEY THEME 1	Priority Areas for Action 2016-17	
Keep children well and safe	**4**	To enhance the health and well-being of children and young people through improved service integration and the delivery of Better Care Together (BCT) health targets

What difference will it make to children and families?
Young people will have an increased understanding and awareness of mental health and emotional wellbeing tracked using Signs of Safety scaling tools.
Practitioners will report increased confidence and knowledge in dealing with mental health and well-being issues
The resilience and engagement in early intervention of staff in Rutland schools will be improved and measured utilising a resilience framework.
All early years settings will have an increased awareness of good oral health

What are we going to do and how are we going to do it?

a) Improve access to emotional health and well-being support for children and young people in primary and secondary schools, including linking deliverables with BCT streams and promote the primary mental health professional advice line (PAS) for schools.
b) Reduce the gap between targeted Tier 2 and Tier 3 specialist mental health services and support.
c) Understand the availability and pathways to Tier 1 and 2 services in Rutland.
d) Implement a joined-up 0-19 health programme. Design and support the commissioning arrangements of an integrated 0-19 health programme for Rutland which incorporates existing health visiting, school nursing services.
e) Improve the rate of healthy weight children entering reception class to the best in England levels.
f) Increase the access to services for care closer to home for children with complex health needs.
g) Increase awareness of tooth decay and reduce the prevalence of tooth decay in young children. Deliver a training and resource plan to all early years settings aimed at increasing awareness of tooth decay amongst children and parents by March 2017
h) Undertake joint health assessments reviewing packages of care and respite service.

Who will lead on this?
RCC Lead for Public Health

What are the measureable outcomes and targets?
1. Emotional health and wellbeing projects delivered in 2 primary and 2 secondary schools
2. The LLR Early Help Delivery Group successfully bids for transformational funding to deliver Tier 2 targeted emotional wellbeing and mental health support in Rutland and through the Promoting Resilience Delivery Group delivers training and support to Tier 1 universal workforce.
3. 75% of early years settings have accessed dental hygiene awareness campaign and training
4. Tooth decay prevalence in children under 5 is reduced from 40% towards the national levels of (7.9%).

Action 5

KEY THEME 2	Priority Areas for Action 2016-17	
Fair society	**1**	To reduce the development and achievement gap at all key stages – championing children and young people to meet their full potential

What difference will it make to children and families?
(To complete)

What are we going to do and how are we going to do it?

a) Reduce the gap between the achievement and progress of disadvantaged groups (including Service children): and non-disadvantaged by increasing LA influence and support
b) Increase influence on providers through new arrangements, relationships and offer. Esp. integrated support, including early intervention, social care, CAMHS
c) Engage heads/governors in extended programme focused on current performance and vision (strategic events)
d) Agree/facilitate/disseminate strategies with providers
e) Monitor/support pupil premium activity
f) Monitor and challenge gap and inclusion indicators with providers
g) Engage Rutland Teaching Alliance (RTA) actions around disadvantage
h) Ensure system change to stabilise practice re: exclusions; gap reduction. (Forum and alternative provision)

Who will lead on this?
Head of Learning and Skills, RCC

What are the measureable outcomes and targets?

Reduce gaps by 50% in the following GAP indicators:

1. EYFS: Good Level of Development: % of children in Rutland achieving expected level (2) or more in the first 12 Early Learning Goals (ELG) is maintained at 75%
2. Phonics: expected standards

    - KS1: APS
    - KS2: APS; L4 RW Maths
    - KS4: 5 A*-C incl E&M
    - Post 16

3. Reduce exclusions by 50%
4. % of 16-18 year old not in education, training or employment is below 2%.

Action 6

KEY THEME 2	Priority Areas for Action 2016-17	
Fair society	**2**	To improve economic well-being and reduce child poverty levels in Rutland

What difference will it make to children and families?
(To complete)

What are we going to do and how are we going to do it?

a) Implementation of the Child Poverty pledges engaging multi-agency responses to Child Poverty
b) Reduce the impact of the Benefit Reform and delayed introduction of the Universal Credit
c) Influencing commissioning of preventative provision – building capacity in the voluntary sector
d) Implement Phase 2 Changing Lives programme, supporting 20 families during 2016
e) Maintain the work club run by RALS
f) JCP advice sessions delivered in the Library service
g) Deliver maximising income one-to-one sessions, debt pack advice
h) Trial CAB outreach at 1 food bank during the year
i) Implement a benefit take up campaign
j) Implement a life skills (financial management, budgeting course, etc.) for vulnerable young people to support transitions in to independence
k) Promote 2 year old early education funded places
l) Undertake a scoping exercise in the highest 3 priority child poverty areas to ascertain key challenges.

Who will lead on this?
Lead for Rutland Citizens Advice Bureau and the Lead for Child Poverty RCC

What are the measurable outcomes and targets?

1. A 10% increase in the number of vulnerable/targeted peoples accessing advice and support
2. 15% of Changing Lives families achieving employment outcomes.
3. Deliver 3 welfare advice sessions in outreach venues
4. Increase the number of JCP session from monthly
5. 85% of eligible 2 year olds are accessing their Free Early Educational Entitlement place
6. Deliver 3 life skills courses per year for vulnerable young people and care leavers and that these courses being rated as useful / supportive by the participants.
7. To reduce child poverty levels (children in low income households) , currently at 7.1%

Action 7

KEY THEME 3	Priority Areas for Action 2016-17	
Listening	**1**	Increase engagement and participation of young people to be active citizens.

What difference will it make to children and families?

The 'voice of the child' is a golden thread through the early help system.
The needs of Children, Young People and Families in Rutland influence planning for health and wellbeing improvements across all public services.
Services respond to the young people inspections findings inform delivery and changes where required.
Young people are influencing service design and policies.

What are we going to do and how are we going to do it?

a) Involve children and YP in decision making and ensure young people, including the most vulnerable, influence the services they receive
b) Expand Children in Care Council (CICC) activity and ensure consultation on key policies including LAC pledge.
c) Implement the annual take over challenge for young people in November 2016.
d) Support the Youth Council annual campaign for 16/17.
e) Implement 'Make your Mark' 2016 for Young People.
f) Maintain involvement of young people in recruitment campaigns.
g) Maintain Rutland Youth Council (RYC) consultation on key partnership activity.
h) Deliver a coming into care booklet to promote involvement in services and review advocacy model for LAC

Who will lead on this?
Manager Universal and Partnerships, Early Intervention RCC

What are the measurable outcomes and targets?

1. Undertake 4 Young Inspectors service inspections across partner organisations during 2016.
2. Undertake an away day for Children Looked After.
3. 90% return rate for Rutland on National Make Your Mark campaign

Action 8

KEY THEME 4	Priority Areas for Action 2016-17	
Efficiency	**1**	To quality assure our practice – through the use of quantitative and qualitative data, engagement of service users, and engagement from front line staff

What difference will it make to children and families?

Children and families will receive high quality interventions at the right time. Our children's workforce feel supported in their work with families.

What are we going to do and how are we going to do it?

a) Agree a quality assurance and performance framework to evidence impact
b) Create multiagency training and reflective space – implementing the competency framework, peer supervision or action learning sets

Who will lead on this?
LSCB Lead

What are the measurable outcomes and targets?

1. Complete 10 Multiagency audits and quality testing – in Early Help Assessments, Step Up and CSE cases.
2. Complete a localised safeguarding survey or partnership peer challenge annually

REPORT NO. 130/2016

Report to Rutland Health and Wellbeing Board

Subject:	**Update on Emergency Care and the LLR Vanguard**
Meeting Date:	**28th June 2016**
Report Author:	**Paula Vaughan, Deputy Chief Operating Officer, ELRCCG**
Presented by:	**Tim Sacks, Chief Operating Officer, ELRCCG**
Paper for:	**Note**

Context, including links to Health and Wellbeing Priorities e.g. JSNA and Health and Wellbeing Strategy:

Purpose of report

1. The purpose of this report is to update the Board on the Urgent Care Improvement work including the LLR Urgent Care Vanguard, the work being undertaken by ELRCCG and how this impacts on and benefits the patients of Rutland.

Policy Framework and Previous Decisions

2. The national policy framework relevant to the Vanguard includes the Keogh Urgent Care Review and the recent NHS National Commissioning Standards for Urgent Care.

Background

3. In July 2015 the Leicester, Leicestershire and Rutland System Resilience Group successfully submitted a bid to become a national Vanguard site for Urgent and Emergency Care. The Vanguard programme is led by NHS England as a means of supporting local areas to innovate to develop new models of care as outlined in the NHS *Five Year Forward View*.

4. The Vanguard (which is a 6 strand project), forms part of the overall Urgent Care Programme for LLR. The Urgent Care programme is a workstream of Better Care Together, and incorporates work on urgent care inflow demand, acute hospital emergency patient flow and community services to support discharge, as well as having oversight of urgent care system performance, operational resilience and winter/surge planning.

5. In relation to integrated community urgent care, the strand 1 project group is developing plans to test clinical navigation from October 2016, with the aim that a full clinical navigation service is commissioned from April 2017. The clinical navigation service will be complemented by an integrated model of community urgent care which will be developed and implemented for Rutland by ELRCCG.

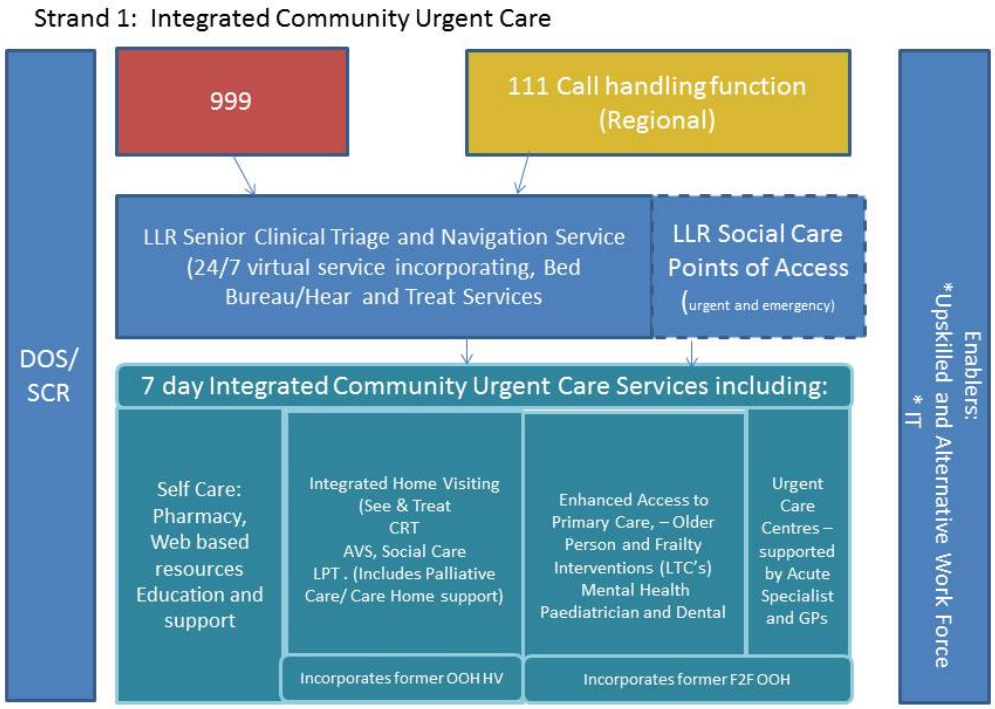
6. The Vanguard project structure means that there will be a degree of variation and local flexibility in the service model across LLR, and therefore ELRCCG have the ability to ensure that the service developed it right for the patients of Rutland.

Proposal

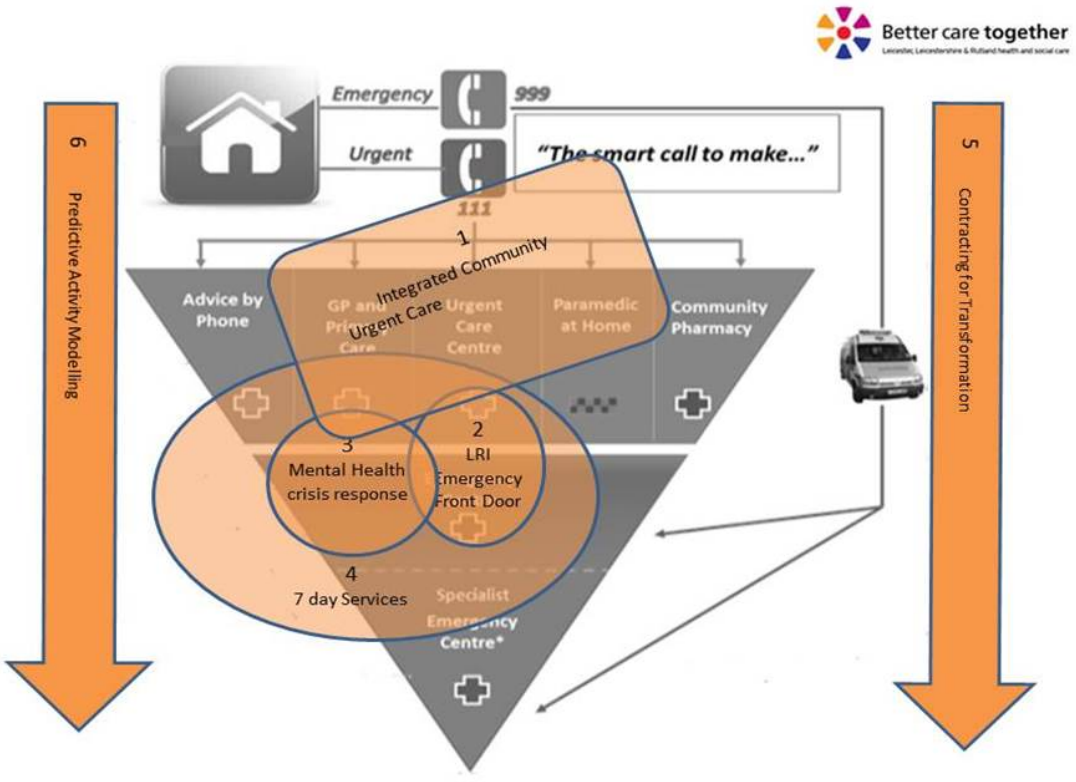
7. The LLR Vanguard is a collaborative change programme including the three LLR CCGs, the three LLR local authorities and the main providers of urgent care across LLR. The aim of the Vanguard is innovate to develop models of urgent care to improve outcomes and patient experience.

For ELRCCG, this provides a unique opportunity to develop flexible and integrated models of care, based on LLR-agreed, sound principles but that are right for our patient population.

8. In essence, the vision is one of delivering integrated urgent care services, putting in place enhanced access to clinical opinion and urgent primary care treatment 7 days a week, reducing the need for ED attendance or a 999 conveyance but also improving accessibility for Rutland patients to care in their direct, local area. Our intention is to model, deliver and commission a consistent and easily intelligible model of urgent care across Rutland, providing 24/7 care in community settings supported by enhanced clinical navigation and an enhanced Acute home Visiting Service (AVS). This new service will be delivered by Strand 1 of the Vanguard project. A summary of Strand 1 is in the diagram below.



9. The diagram below shows the structure of the Programme, overlaid against the elements of the Keogh Review.



10. The integrated community urgent care model is still in development but there are some areas where the strategic direction and some of the supporting detail is fairly clear. This document outlines that strategic direction, concentrating on those areas which would have specific implications for the services currently provided by urgent care providers.

Introduction of Clinical Navigation

11. The service will be led by a senior, local multi-disciplinary team. We aim to have in place a trial model of clinical navigation by October 2016, which would be evaluated and rolled out from April 2017. We are currently testing different elements of clinical navigation to establish how this service is best operated and staffed, aiming to increase the number of patients whose needs can be dealt with without a 999 conveyance or ED attendance. We envisage that clinical navigation would absorb at least some, if not all, of the telephone advice provided by out of hours doctors and the nurse clinical triage capacity within 111. We have already given notice of our intention to commission a local clinical navigation model distinct from the 111 call handling function in our procurement of NHS111 as part of the recent regional procurement.

Integrated Community Urgent Care Offer

12. The Vanguard programme has developed a set of principles to guide the design of integrated community urgent care services which will guide the development of detailed plans for the service model to be in place from April 2017. The ELRCCG approach to this will take into account population needs of Rutland, the local geography and the existence of current physical assets including the active Urgent Care Centre at Rutland Memorial Hospital.

Timeline

13. In relation to integrated community urgent care, the Strand 1 project group is developing plans to test clinical navigation from October 2016, with the aim that a full clinical navigation service is commissioned from April 2017. The clinical navigation service will be complemented by an integrated model of community urgent care. ELRCCG will take forward plans to develop and test local service models that are in line with the needs of our population.

Strand 1 Implications for Rutland Patients

14. The provisional of an integrated community based urgent care service will build on existing services including the currently active Urgent Care Centre at Rutland Memorial Hospital.

15. A comprehensive service which uses the assets already in place (Out of Hours GP services, primary care services and the urgent Care Centre) will be accessed via an integrate Single Point of Access (SPA), helping the patients of Rutland access the right service at the first point of contact.

16. The SPA will being Health and Social care together for Rutland patients, helping each patient access the right support for them as an individual.

17. The Clinical Triage service and Navigation Hub, supported by an enhanced AVS will improve accessibility for Rutland patients.

Financial implications:

The implications raised by the service design will be addressed through the Vanguard and BCT

Recommendations:

That the board:

1. Receive and note the update from ELRCCG

Comments from the board: (delete as necessary)

Strategic Lead:	

Risk assessment:

Time	L/M/H	M – Newly commissioned service to be implemented by April 2017
Viability	L/M/H	H
Finance	L/M/H	H
Profile	L/M/H	H
Equality & Diversity	L/M/H	H

Timeline: April 2017

Task	Target Date	Responsibility
Finalise Urgent Care Offer as part of Vanguard Strad 1 workstream for ELR patients (including Rutland)	September 2016	Paula Vaughan, ELRCCG
Procurement of new service model for ELR patients (including	March 2016	Paula Vaughan, ELRCCG

Rutland)		
Implementation of Community Based, Integrated Urgent Care Service Model as part of Vanguard Strand 1 workstream	April 2017	Paula Vaughan, ELRCCG

Agenda Item 8

Report to Rutland Health and Wellbeing Board

Subject:	**A review of commissioning of services for children and young people with learning disabilities who challenge services in Rutland conducted by NDTI.**
Meeting Date:	**28 June 2016**
Report Author:	**Mark Fowler**
Presented by:	**Tim O'Neill**
Paper for:	**Note**

Context, including links to Health and Wellbeing Priorities e.g. JSNA and Health and Wellbeing Strategy:

As part of a regional collaborative approach to system improvement in SEND, Rutland agreed to participate in a piloted review of SEND provision. Conducted by the National Development Team for Inclusion, the review took place on 31 March and 1 April 2016.

The review focused upon services to children who have learning difficulties and who also pose a challenge to the services provided for them. A range of stakeholder and providers were involved in the review, including parents, children and professional staff from schools, public sector and voluntary agencies. Two NDTI reviewers led the process which lasted two days. One day was spent in Rutland interviewing stakeholders and reviewing services; the second involved feedback to service heads. The review timetable is attached in Appendix A.

Given the late notice of the review, the parents, children and staff are thanked for their willing and helpful contribution.

The full text of the review is in the attached report. The key findings are shown below.

A presentation on the contents of the report will be made during the meeting. An initial response to the report will be included in the presentation; a formal response to the findings will follow.

Financial implications:

There are no financial implications in the report itself.

The recommendations may be implemented in a range of different ways and to varying degrees. The means chosen and scope of implementation will have financial implications. Once a full response has been prepared, the financial implications will be made explicit and recommendations identified.

Recommendations:

That the Board:

1. Note the contents of the report.

Comments from the board

Strategic Lead:	Tim O'Neill

Risk assessment:		
Time	L/M/H	L
Viability	L/M/H	L
Finance	L/M/H	L
Profile	L/M/H	M
Equality & Diversity	L/M/H	H
Timeline (including specific references to forward plan dates):		
Task	**Target Date**	**Responsibility**

NDTI presentation report to HWB v2 140616
Based on: *NDTI presentation report to SMT v2 170516*; Ppt presentation: *SEN review NDTi report presentation v1 170516; Rutland Report March Final.*

Appendix A: Timetable of Review

Commissioning services for children and young people who challenge Rutland Programme 31st March/1st April 2016

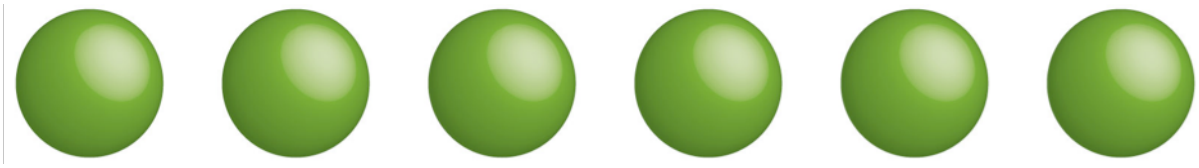
	Team Member 1 Sue Turner, Wytchley Room		Team Member 2 Pat Bullen, Alstoe Room
Day One 9.00 – 9.30	**The Rutland Context** Meet Mark Fowler , HOS Learning and Skills, Bernadette Caffrey HOS Early Intervention People Directorate	9.00 – 9.30	**The Rutland Context** Meet Mark Fowler , HOS Learning and Skills, Bernadette Caffrey HOS Early Intervention People Directorate
9.30 – 10.00	**Key commissioners** - Public Health, Sue Beech CCG Designated Medical Officer (**TBC**)	10.- 10.30	**Vol Sector/Carers** ADHD Solutions - unable to attend but happy to take a call after 2.30pm on 0116 2610711 or 07552 277282
10.00- 10.45	**Strategic Focus Groups** – SEND and Inclusion Leads, Ed Psych, AH Lead, Transitions Lead	10.45 – 11.15	**Family Centre./Sunflower** Debbie Sowter/Nicola Harries
11.00 – 11.30	**Healthwatch – Emotional Health and Well Being** Dr Ann Williams	11.30 – 12.00 12.00 – 12.20	**Parent /Carer Voice Group** Kirstin Wallace and David Chesman Amanda Hana
		12.30 to 13.00	**Management Information /Data** SEND Lead and HOS L&S
13.00 – 13.30	**CCG Commissioner** Telephone Conference call Mel Twaites Associate Director Children and Families Services LLR CCGs.	13.00 – 13.30	**CCG Commissioner** Telephone Conference call Mel Twaites Associate Director Children and Families Services LLR CCGs.
	Lunch Break **Case presentations**: Focus group with front	14.30 – 16.00	Lunch Break **Meetings with commissioned**

	Team Member 1 Sue Turner, Wytchley Room		Team Member 2 Pat Bullen, Alstoe Room
14.30 – 16.00	line practitioners Case 1. LE (F Douglas) Case 2. T&M Twins (C Hogg) Case 3. HG (L Hawkes) Case4. HH (J Phillips) Case 5. AB (S Jones) Case 6. DD(F Douglas) End of day preliminary analysis	14.30 15.00 15.30	**services/providers** Kim Quigley Inclusion Manager Casterton Business Enterprise Bianca McGregor SENCO UCC Robin Lee, Wilds Lodge End of day preliminary analysis
Day Two 9.30 - 11.00	**Hot Desking Room 2** Final Analysis DCS/HOSs Feedback meeting		**Hot Desking Room 2** Final Analysis DCS/HOSs Feedback meeting

National Development Team for inclusion

A review of commissioning of services for children and young people with learning disabilities who challenge services in Rutland

31st March and 1st April 2016



National Development Team for Inclusion

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Contents

1 Background and Introduction

1.1 Following the investigation into the abuse at Winterbourne View, there has been a cross government commitment to transform care and support for people with learning disabilities and/or autism whose behaviour challenges services[1], including behaviour that can result in contact with the criminal justice system. Transforming care is about building community capacity as well as reducing inappropriate hospital admissions, and in October 2015 a service model was published describing what good services and support should look like[2]. Services for children and young people are included in the model. In order to support the implementation of the model for children and young people, NHSE funded a number of projects. This review contributes to a project to develop a rapid review framework for services supporting children and young people who challenge.

1.2 NDTi already have an evidence based review tool for adult services for people who challenge, developed from the commissioning guide written by NDTi for the Department of Health to support implementation of the Mansell report. For further information see: www.ndti.org.uk/publications/ndti-publications/commissioning-services-for-people-with-learning-disabilities-who-challenge- The review uses the seven broad areas of commissioning consideration set out in the guidance. Following consultation with young people, families and commissioners we adapted the review and are piloting it in five sites. At the end of the pilot we will:

[1] Challenging behaviour' is a way of describing a range of behaviours which some people with learning disabilities may display to get needs met. Behaviours may include:
Hurting others (e.g. hair pulling, hitting, head-butting)
Self-injury (e.g. head banging, eye poking, hand biting)
Destructive behaviours (e.g. throwing things, breaking furniture, tearing things up)
Eating inedible objects (e.g. cigarette butts, pen lids, bedding)
Other behaviours (e.g. spitting, smearing, repetitive rocking stripping off , running away)
The above is taken from the Challenging Behaviour Foundation website. For further information see: www.challengingbehaviour.org.uk/about-us/about-challenging-behaviour/what-is-challenging-behaviour.html

[2] Local Government Association, ADASS & NHSE (2015). Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition. See: https://www.england.nhs.uk/learningdisabilities/natplan/

- adapt the tool based on feedback from the sites
- Write a report for national publication highlighting key themes and good practice examples
- Write a report for each pilot area setting out our findings

1.3 This report sets out our findings from our review in Rutland, undertaken on the 31st March by Pat Bullen, NDTi associate and Sue Turner, Learning Disability Lead at the NDTi, using the draft review framework. We met with commissioners, managers, clinicians, social workers, education providers and families as well as reviewing documentation and other information provided at our request. At the end of the review an initial verbal feedback was provided to Tim O'Neill, Director for People and Deputy Chief Executive, Mark Fowler, Head of Service, Learning and Skills, and Bernadette Caffrey, Head of Service, Early Interventions. This report is a more detailed outline of our conclusions.

1.4 The feedback and report is structured round the seven broad areas of commissioning consideration in the original commissioning guidance. We have taken the view that these commissioning principles are equally valid for children and young people's services, and have also signposted to the new service model and guidance as appropriate. Each section briefly summarises what the guidance identified as being indicators of effective practice and then discusses what we found through the review process. Each section also includes recommendations and these are also summarised in the conclusion.

1.5 We wish to emphasise the limitations of this review. It is a pilot, and designed to provide an overview of issues, rather than a detailed service review. It does not claim to be definitive or fully accurate in terms of all the detail. It is not a review of the quality of services. Its aim is simply to provide an external overview of key commissioning issues and challenges in order to offer a framework for action that we hope you will find useful. We are very grateful for enabling us to pilot the review in Rutland, and appreciate the amount of work it took to organise in challenging timescales. With more time, there would have been other people/services it would have been good to talk to, but I hope we have captured the main points.

2. Vision and Values

2.1 Good practice guidance:

Commissioners start from a commitment to the principles of 'an ordinary life' and this is shared and understood by others. People ensure they understand the evidence base around services for children and young people with behaviour that challenges, and work in partnership with children, young people and families to deliver that vision. Commissioners accept there may not be quick results and support providers and families through difficult times – not giving up at the first signs of difficulty.

2.2 We found very clear statements about inclusive education in Rutland County Council's commendably short policy statement. The recognition that inclusion is a human rights issue was also refreshing and unusual. There was clear evidence that practitioners sought inclusive options where possible.

2.3 There was a strong focus on Preparing For Adulthood (PFA) in Rutland. This was evident in discussions with practitioners who regularly made reference to increasing young people's independence, and gave examples of practical steps they were taking to do this. It was noted that the small size of Rutland, where children, young people and families are known to practitioners who also work closely together, may help. Having a 'People's Directorate' is a related factor which could also enable people to have a common culture and understanding of purpose.

2.4 We found evidence of a clear focus on outcomes in Rutland, both in the paperwork and through our discussions. The SEND plan detailed outcomes, actions and milestones, and practitioners talked about outcomes, particularly in relation to increasing independence and opportunities for young people. For example we were told that discussions with colleges focused on PFA 'not just courses'.

2.5 We were given examples of outcomes based on feedback from children, young people and families. For example, the work with FE to tailor responses and thus improve independence. Also individually tailored support to meet the needs of children and families. For example, one young child did not meet the criteria for

additional funding as both parents worked, but to enable the parents to work and meet the child's needs, funding was found for support at nursery costing £170 less per day than a placement at Parks.

2.6 There was a good understanding of the need for early identification of children who may need extra support, and a good system in place to ensure this happened. We were told that health staff were very good at referring children at a young age, and integrated reviews at year two have recently been implemented and are good at picking up on needs. There was evidence of a timely and flexible response to young children and families when needs were identified.

2.7 As well as evidence of flexibility, we found a 'can do' culture in the county. Practitioners went out of their way to meet children and families' needs, and were creative about finding ways to provide the right support.

3. Leadership

3.1 Good practice guidance:

Commissioners are actively involved in service development, championing new ways of working and supporting leaders from all organisations who are innovators and take planned risks. Strong clinical leadership exists that is committed to the vision set out above, and works in partnership with social care.

3.2 There was evidence of good engagement with portfolio holders, and the governance of SEND goes to the Education Performance Board, which includes members, senior offices and the public, and from there through scrutiny to cabinet. Thus there was a clear thread of accountability, with progress towards outcomes monitored. Commissioners were ambitious about delivering high quality services in Rutland, and we noted the aim to be 'the best'.

3.3 Local authority commissioners demonstrated a good understanding of the issues for children, young people and families in Rutland. The small size of the country facilitates this, but nevertheless commissioners were supportive of practitioners and enabled flexibility. Parks school also noted the support they have received from the local authority. The CCG commissioner worked across Leicester, Leicestershire and Rutland, and although in theory services based in Leicester should cover Rutland, in practice this did not seem to be the case, and knowledge about what happened in Rutland was more general.

3.4 It is early days regarding links with the Health and Wellbeing Board, although we were told there are now opportunities to raise the profile of children and young people as there is a new chair and a focus on developing the work of the board.

3.5 There was evidence of positive risk taking happening in practice, and a great deal of flexibility in services to meet individual and family need, but there was no policy to support this. While a culture of positive risk taking is far more important than a policy, having something in writing can be supportive of practitioners.

Recommendations

- As discussed, raising the profile of children and young people with SEND at the Health and Wellbeing Board has the potential to enable a wide ownership of the issues and could lead to actions to address the wider health inequalities children and young people with SEND experience. A report summarising research into the health inequities experienced by children with learning disabilities can be found here: www.ihal.org.uk/publications/313899/The_determinants_of_health_inequities_experienced_by_children_with_learning_disabilities Although the focus is on children with learning disabilities, the issues raised are also of relevance to other children with SEND. The report includes specific recommendations for Health and Wellbeing Boards.

- We recommend developing a joint positive risk taking policy to support practitioners, which could be used as a vehicle to help with the development of a shared understanding about what you are trying to achieve. The importance of positive risk taking is one of the 'golden threads' that runs through the service model. However the models we could find are mainly for adult services. SCIE has some guidance on positive risk taking: http://www.scie.org.uk/publications/ataglance/ataglance31.asp

- TLAP also have some general guidance on risk and personalisation: http://www.thinklocalactpersonal.org.uk/_library/Resources/Personalisation/TLAP/Risk_personalisation_framework_West_Midlands.pdf

- Newham are considering developing specific guidance for their children and young people's services, and may well be prepared to share.

4. Relationships

4.1 Good practice guidance:

Strong relationships and a 'no-blame' culture between organisations are important. Children, young people and families are at the centre of decision-making. Local authority, NHS commissioners and education share responsibility, use resources jointly and have strong relationships with providers – getting beyond simplistic tendering processes when choosing providers. Providers and clinicians work closely together - using each other's expertise with trust and respect.

4.2 There was evidence of very positive partnerships and relationships across the county, including between the local authority departments, parents and carers support groups and schools/providers. For example, where social care identified needs within a group of young people with ASD, some with behaviours that challenge, the Aiming High team were able to commission the voluntary organisation, Family Centre, to develop and deliver a short cookery course to develop independent living skills. A local Secondary school was also able to work with the school nurse to develop a short course to support young people within the school to manage exam-related anxiety, based on observation that more young people with additional needs were likely to display either behaviour that challenges, or to self-harm, in the lead up to the exam period.

4.3 Parents reported that there are several types of support and routes to support across the county. Excellent support is provided by the formal SEND Information, Advice and Support Service- RIASS (Rutland Information Advice and Support Service). One parent whose son experiences a range of challenging behaviours, described feeling marginalised even with other parents of children with SEND, because her son's difficulty in being with and around people caused changes to his behaviour. Over his 15 years in Rutland, she described RIASS as being the one continued source of support to her.

Parents and carers can also access support from Sunflowers, an excellent voluntary group, with volunteers having a wealth of expertise, and who themselves

identify that they could provide even more support to families of service personnel, who are located outside of the Oakham area. Sunflowers is clear that its mission is to support parents and carers, enabling them to have access to friendships and support alongside other parents/carers with children with additional needs.

Sunflowers links well with Family Centre, which again, has enormous expertise within its volunteer ranks. Both Family Centre and Sunflowers are excellent examples of the Council's ambition to harness social capital and local community knowledge within the commissioning strategy.

4.4 There are some excellent relationships with schools, though variation exists which is beyond the influence of the LA.

Uppingham Community College has developed a flexible graduated response to meeting individual needs, working well with the LA and with CAMHS. One community liaison nurse, whose role has been recognised within the 'National Positive Practice in Mental Health' awards in October 2015, works with the school to develop both group and individual support work, including conference calls, as the geography of Rutland within the LLR partnership (Leicester, Leicestershire and Rutland) means that most major health provisions are within the larger neighbouring LA areas rather than within Rutland itself.

Casterton Enterprise College has employed its own counselling service to support young people with mental health needs and/or behaviour which challenges.

Schools described networking as good, and local knowledge of the 'right' people to liaise with when challenges do occur, as a major strength. For example, LA staff are able to reach into schools and meet with them within a day or two of challenges occurring.

However, a third secondary school did not have such an inclusive culture. One parent described his son's repeated fixed term exclusions from the school, based on incidents such as a failure to make appropriate eye contact with a teacher, when his son's ASD diagnosis explicitly noted that this was a real obstacle for the student concerned. The LA noted that the school has an enhanced resource for students with additional needs, though the criteria for admission was unclear, and the relationship between the LA and the academy was clearly less effective than those described above.

The LA noted that it needed to do more to support the work of SENCOs in schools, and has arranged a summer term full day of training/briefing with SENCOs to develop the EHC Pathway with greater clarity and effectiveness.

4.5 The culture within children's and adults services is hugely enhanced through two attributes:

- The People's Directorate working across children and adult services, and reporting into one Director;
- The geography and size of Rutland- there was a distinct 'small is beautiful' attribute to the locality, and relationships are very positive across the LA. The geography, though, mitigates against the level of health resourcing within its' borders, as the majority of resources for health providers and commissioners, are within the connected health regions of Leicester and Leicestershire.

Possibly because of the above, although there was evidence of good joint working with health in early years, this tends to tail off as children get older. There was a lack of joined up commissioning with health in Rutland and health was largely absent from EHCP processes.

The positives of working across child and adult services are apparent in groups such as the Transitions Operational Group (TOG) which identifies young people from year eight onwards who may require social care services or who may have SEND or challenging behaviours. The group includes housing, and reference was also made on more than one occasion to employment, which we thought was very positive. The group enables planning across the transition gap. Schools work with LA services to identify such young people requiring a commissioning focus.

4.6 Despite the good work outlined in sections above, families of children with SEND still need more support. They can often locate a person who can enhance their navigation of the Local Offer, but some fall through the gaps. One parent described a very difficult predicament where his son did not receive a diagnosis from CAMHS, as it appeared to 'sit' on the system for up to a year, affecting his son's ability to access appropriate services and support, although generally a needs led approach was described.

Recommendations

- We were told that an event was being planned for school SENCOs and HTs in the summer, It would be helpful if strategic level working were part of the agenda

- Gloucestershire set up a family peer support network that has been positively received and has had a positive knock on effect with regard to participation and co-production. This may be of interest. A summary can be found here: www.ndti.org.uk/publications/ndti-insights/insights-24-gloucester-challenging-behaviour-strategy

5. Service Model

5.1 Good practice guidance:

Using person centred approaches, services are jointly designed by all partners– including the young person, their family and future providers. Clinical leadership is consistently available and non-aversive techniques drive staff practice.

5.2 We identified a range of individual person centred approaches, such as the commissioned Aiming High activities and the secondary academy graduated responses to meeting needs, which indicate the ability of the LA to deliver excellent person and family centred support. However we wondered if the EHCP process could be more person centred? It was noted that the views of the family are gathered through 'our story', that young people were asked for their views, and that advocates were available post 16 if it is felt that the young person's voice may get lost. All this is very positive but the process seemed to be foremost, whereas some areas have used the introduction of EHCPs as an opportunity to embed person centred planning at the forefront.

5.3 The offer of health services was desribed as a bit of a lottery for families as services are commissioned from outside of the county, which means that what is available in one area isn't necessarily available in another. For example, although one mental health nurse went 'above and beyond,' some families reported that they had to travel to Leicester to access CAMHS, 25 miles from home, creating huge obstacles to access.

5.4 The local offer is developing, but was not thought to be entirely helpful to families at this point. It was more of a directory of services, and most parents we spoke to had not used it. However, the Local Offer as embodied by the LA staff, and some health partners, is very accessible, well known and for some services very joined up.

5.5 There was a lack of understanding from parents about the implications of the Mental Capacity Act. One parent reported concerns about her 18 year old son, and

felt that her concerns were not heeded, as he appeared to have mental capacity- yet he has left his volunteering role and dropped out of community activity since living alone/independently.

5.6 Educational psychology input to schools was noted as developing, with a recently newly commissioned service. Delays in assessment were reported by some schools, but not all. Schools experienced health services as being inflexible. CAMHS had made an error with one student noted in a section above, delaying his initial diagnosis by one year; a second diagnosis wrongly described him as having 'OCD' when it should have read 'ADHD'- his and his parents confidence in CAMHS were understandably dinted.

5.7 There was evidence of non aversive approaches in Rutland, We were told that ADHD solutions work closely with schools regarding behavioural strategies, and there are drop in sessions that families can access. There is also a consistent approach with children and young people who have autism. However it was less clear that there was a consistent approach across education, other providers and families regarding behaviour that challenges generally.

5.8 There was evidence of excellent early intervention and support available to families. Families talked about the Parks provision for children aged 2 to 5 years; the positive impact of the two year old health check, and the support of Sunflowers and the Family Centre. There was some concern that families outside of the Oakham conurbation may be unable to access some services, though drop ins had begun on a monthly basis for example, serving the Cottesmore military base. The Early Years focus from the LA officer for SEND enables an individual tailor made approach to support and intervention packages.

5.9 The problems regarding transition are known and the Transitions Operational Group- TOG- ameliorates the transition to adult life.

The LA is keen to develop their Preparing for Adulthood offer to families, with external support. Ensuring that information from EHCPs is used to inform commissioning could help.

A People's directorate ensures that children are more effectively transferred to appropriate adult services within the LA. This is not the case for children's transfer to adult health services.

5.10 The work carried out by Healthwatch Rutland to first identify that mental health was an overwhelming problem for children and young people in the county, gather further information and then put a plan of action in place, all with the young people concerned was commendable. While the work doesn't specifically address the

needs of the group of children and young people this report is about, developing a culture where mental health and wellbeing are seen as priorities can only be of benefit to all.

5.9 The Youth Inclusion Support programme, which was described as the step before Youth Offending was another positive initiative, and although we didn't have detailed information about this, one of the case studies demonstrated a positive impact. One route into assessment and treatment services is via court diversion, and this is not an uncommon scenario for people with mild learning disabilities who then have a reputation for life, so diverting them before they come into contact with the criminal justice system is important.

Recommendations

- The EHCP process could be reviewed within the SEND review, to ensure that the flexibilities regarding a person centred approach are understood and implemented at several levels, including within schools.
- The Local offer on the ground is one of the better examples seen by the review team. It is worth looking at other local offers to develop further ideas. Rutland has many very positive Local Offer attributes which further publicity such as a Local Offer live event could enable to reach a wider range of families. Wiltshire and Hampshire's Local Offer is thought to be good: www.wiltshirelocaloffer.org.uk/ & www.hantslocaloffer.info/en/Main_Page We also though Leeds was good: www.leeds.gov.uk/residents/Pages/Leeds-Local-Offer.aspx
- More work could be done to raise awareness of the Mental Capacity Act with parents, utilising current networks/mechanisms such as the RIASS- Rutland Information, Advice and Support Service, and the Local Offer. For young people with learning disabilities the introduction of a health check at the age of 14 also presents an opportunity.
- Adopting one non-aversive method of working with children and young people with learning disabilities who may harm others or themselves is important to maintain consistency within education, other services and the family home. Positive Behaviour Support is an evidence-based approach that should be considered. Evidence from Bristol indicates that PBS is most successful with children when consistently applied both at home and at school. For further information see the positive behavioural support example in Paving the Way: www.challengingbehaviour.org.uk/learning-disability-files/Paving-the-Way.pdf

6. Skilled Providers and Staff

6.1 Good practice guidance:

Skilled providers and support staff are essential, with positive, enabling approaches that looked outwards to the local community. Providers are selected because they actively wanted to work in partnership with children, young people and families and have a demonstrable willingness to keep going in difficult times. They can also demonstrate genuine senior management involvement in service delivery, responsiveness to clinical advice and no use of casual, agency staff.

6.2 Workforce turnover is lower in Rutland than elsewhere, and staffing is largely stable and effective, though leaders note some challenges with recruitment at the most senior levels, and are concerned to succession plan effectively, particularly as a cohort of staff are due to retire at roughly the same time.

6.3 There was some clear evidence of skilled providers and innovative practice, which could be shared and developed. For example, schools with effective graduated responses, and the Teaching School Alliance within the county could be commissioned to develop the knowledge of the EHC Pathway and person centred approaches which schools could develop within the Pathway. There was also a tiered response from SALT services.

6.4 Parents said that there was a lack of understanding in the workforce about autism and behaviour that challenges. Professionals have the expertise, but it may not be harnessed across the whole area. For example, Educational Psychologists knowledge regarding ASD and attachment, can make a massive difference to schools and providers in developing appropriate strategies for enablement and support. As currently configured, EPs may not able to deliver this across children's services.

Recommendations

- A professional development approach for behaviour, ASD pathway and attachment, could be developed across Educational Psychology and LD and mainstream CAMHS, potentially delivered through the Teaching School Alliance (TSAs) within the county. This could include core and traded offers of training and CPD for schools, settings and colleges.
- Family leadership – an element of person-centred approaches- could further enhance the potential of families to be supported to promote wider outcomes including employment pathways for young people with additional needs and behaviour which challenges.

7. An Evidence Base

7.1 Good practice guidance:

'Commissioners have developed, with providers, an outcomes framework and a costing analysis to help them understand and evidence what progress people are making at what financial cost'.

7.2 Information on costs was available and is clearly utilised to improve services. The work of the placement Panel within education has strong elements of joint commissioning, clearly across education and social care, and across children's and adult services, but health is not present at the Panel, providing only written reports.

7.4 There is some evidence of children moving from primary schools directly to specialist SEMH placements in the county. The Principal of an independent provider believed this to be related to an increased concern from primary schools, of children with additional needs having their end of Key Stage 2 results impact upon the standards agenda within schools. In five years, he has seen Rutland's take up of places increase from zero to 15.

The use of Rutland College, to develop more bespoke approaches to meeting individual needs, and develop more pathways for young people with SEND, also indicated a developing approach to commissioning local services. However LA staff were concerned about the impact of changes to college structures which could adversely impact upon inclusive pathways.

7.5 We were told the Transforming Care Strategy that includes Rutland has been quite 'adult' in focus, although children and young people are now included. Some of the services designed to support children and young people with challenging needs, such as the children's learning disability team linked to CAMHS and based in Leicester, were theoretically supposed to cover Rutland, but this did not seem to be the case on the ground.

7.6 Some of the referrals from GPs into CAMHS and other services appeared to be a bit 'random'. Although some of this may be due to where people live, practitioners did not think this was the whole reason. Practitoners had to deal with this on an ad

hoc basis with GPs, whereas a more strategic approach through the CCG may be more effective.

Recommendations

- Useful work could be done with primary schools to reduce out of LA placements, which could include working with the independent SEMH provider to develop support within mainstream schools for children and young people.
- More work could be done with LLR to develop a more active role of commissioners within the implementation of the EHC pathway and Panel, and to consider how LLR can better reach families in need within their own localities, including a more inclusive service coverage of Rutland and better communication with GPs

8. Other Commissioning Actions

8.1 Good practice guidance:

Other important commissioner actions include; up front investment to ensure skills and resources are in place at an early stage; there are flexible ways of choosing providers; flexible contracting systems that could respond quickly to changes in people's needs; creative use of continuing healthcare criteria; and shared financial risk between commissioners and openly aiming for reduced costs over time – but only based on evidenced improvements in children and young people's lives'.

8.2 There were no young people with Personal Health Budgets in Rutland and we were told that eligibility for Continuing Health Care (CHC) is set very high in LLR. A number of applications have been made and turned down, although it seemed as if applications were more likely to be successful when the young person reached adulthood.

8.5 Personal Budgets in education, through the EHC Pathway, are also a work in progress. Examples from In Control, and links to the EHC Panel, could be harnessed to develop a joint understanding for families and professionals of the potential use of PBs to support choice and control.

Recommendations

- We suggest promoting and increasing the uptake of personal health budgets to improve outcomes for children and young people with particularly complex needs. A learning network is free to join: http://www.personalhealthbudgets.england.nhs.uk/index.cfm
- Developing a shared understanding of the potential use of education Personal Budgets within the EHC Pathway, could support more local commissioning of services.

9. Summary of recommendations and conclusions

9.1 We found many strengths in Rutland, including some excellent good practice, a clear values base and outcomes focused commissioning. The strong focus on PFA was particularly noticeable, although early intervention and prevention services were also very good. The small size of Rutland may have facilitated positive working relationships and a flexible and can-do attitude, but much credit should also go to the staff for this. The geography of Rutland and organisation of services are more of a drawback in terms of the level of health input, which becomes more problematic as children get older.

We are very grateful to the commissioners in Rutland for opening themselves to scrutiny by ourselves. We are also grateful to the professionals who spoke to us and most especially to the parents we met and who shared what were sometimes some very difficult personal experiences.

9.2 Specific examples of good practice we would like to write up for the national report are: Aiming high short breaks; Support to parents and Flexible personalised commissioning.

9.3 All the recommendations are set out below for ease of reference:

- As discussed, raising the profile of children and young people with SEND at the Health and Wellbeing Board has the potential to enable a wide ownership of the issues and could lead to actions to address the wider health inequalities children and young people with SEND experience. A report summarising research into the health inequities experienced by children with learning disabilities can be found here: www.ihal.org.uk/publications/313899/The_determinants_of_health_inequities_experienced_by_children_with_learning_disabilities Although the focus is on children with learning disabilities, the issues raised are also of relevance to other children with SEND. The report includes specific recommendations for Health and Wellbeing Boards.

- We recommend developing a joint positive risk taking policy to support practitioners, which could be used as a vehicle to help with the development

of a shared understanding about what you are trying to achieve. The importance of positive risk taking is one of the 'golden threads' that runs through the service model. However the models we could find are mainly for adult services. SCIE has some guidance on positive risk taking: http://www.scie.org.uk/publications/ataglance/ataglance31.asp

- TLAP also have some general guidance on risk and personalisation: http://www.thinklocalactpersonal.org.uk/_library/Resources/Personalisation/TLAP/Risk_personalisation_framework_West_Midlands.pdf
- Newham are considering developing specific guidance for their children and young people's services, and may well be prepared to share.
- We were told that an event was being planned for school SENCOs and HTs in the summer, It would be helpful if strategic level working were part of the agenda
- Gloucestershire set up a family peer support network that has been positively received and has had a positive knock on effect with regard to participation and co-production. This may be of interest. A summary can be found here: www.ndti.org.uk/publications/ndti-insights/insights-24-gloucester-challenging-behaviour-strategy
- The EHCP process could be reviewed within the SEND review, to ensure that the flexibilities regarding a person centred approach are understood and implemented at several levels, including within schools.
- The Local offer on the ground is one of the better examples seen by the review team. It is worth looking at other local offers to develop further ideas. Rutland has many very positive Local Offer attributes which further publicity such as a Local Offer live event could enable to reach a wider range of families. Wiltshire and Hampshire's Local Offer is thought to be good: www.wiltshirelocaloffer.org.uk/ & www.hantslocaloffer.info/en/Main_Page We also though Leeds was good: www.leeds.gov.uk/residents/Pages/Leeds-Local-Offer.aspx
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- Adopting one non-aversive method of working with children and young people with learning disabilities who may harm others or themselves is important to maintain consistency within education, other services and the family home. Positive Behaviour Support is an evidence-based approach that should be considered. Evidence from Bristol indicates that PBS is most successful with children when consistently applied both at home and at school. For further information see the positive behavioural support example in Paving the Way: www.challengingbehaviour.org.uk/learning-disability-files/Paving-the-Way.pdf

- A professional development approach for behaviour, ASD pathway and attachment, could be developed across Educational Psychology and LD and mainstream CAMHS, potentially delivered through the Teaching School Alliance (TSAs) within the county. This could include core and traded offers of training and CPD for schools, settings and colleges.

- Family leadership – an element of person-centred approaches- could further enhance the potential of families to be supported to promote wider outcomes including employment pathways for young people with additional needs and behaviour which challenges.

- Useful work could be done with primary schools to reduce out of LA placements, which could include working with the independent SEMH provider to develop support within mainstream schools for children and young people.

- More work could be done with LLR to develop a more active role of commissioners within the implementation of the EHC pathway and Panel, and to consider how LLR can better reach families in need within their own localities, including a more inclusive service coverage of Rutland and better communication with GPs

- We suggest promoting and increasing the uptake of personal health budgets to improve outcomes for children and young people with particularly complex needs. A learning network is free to join: http://www.personalhealthbudgets.england.nhs.uk/index.cfm

- Developing a shared understanding of the potential use of education Personal Budgets within the EHC Pathway, could support more local commissioning of services.

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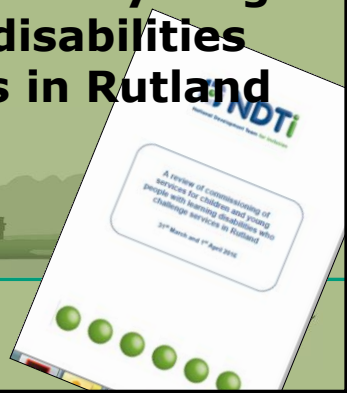
Rutland County Council

NDTi: A review of commissioning of services for children and young people with learning disabilities who challenge services in Rutland

Overview



SUMMARY

"...many strengths, including some excellent good practice, a clear values base and outcomes-focused commissioning. The strong focus on PFA was particularly noticeable…early intervention and prevention services, also very good. …positive working relationships and a flexible and can-do attitude; much credit to the staff for this. Geography a drawback in level of health input, which becomes more problematic as children get older."

Rutland County Council

Good practice case studies

These will be written up for national publication:

- Aiming High short breaks
- Support to parents
- Flexible personalised commissioning

Rutland County Council

Vision and Values

- Good: inclusive intention
- Emphasis on PFA
- Clear focus on outcomes – SEND plan
- Outcomes based on feedback from children, families
- Good solutions; early identification
- "Can do" culture

Leadership

- Good: thread of accountability; portfolio holders; governance; public and Scrutiny – "aim to be the best"
- Commissioners; good and value flexibility; problem with CCG
- Positive risk taking; good flexibility; need policy on this
- Need to raise profile SEND at Health & Wellbeing Board

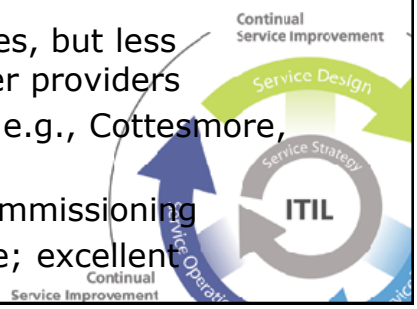
Relationships

- V positive partnerships & relationships (departments, parents, carers, e.g., Aiming High; family centre; secondary school
- Good support & info to families RIASS; Sunflowers;
- Council ambition to harness social capital
- Schools; more varied. Schools saw networking with right people locally; strength
- Need to support SENCos more
- Small is good; tails off as children get older
- TOG good
- SEND families need more support

Rutland County Council

Service Model

- Individual person-centred approaches good BUT could EHCP be more person-centred?
- Health; a lottery
- Local offer developing – is a directory; Ed Psych developing (delays)
- Non-aversive approaches; yes, but less consistent in education, other providers
- Excellent early intervention, e.g., Cottesmore, youth inclusion support
- Need EHCP info to inform commissioning
- Healthwatch mental initiative; excellent



Rutland County Council

Skilled Providers and Staff

- Staff turnover low; stable
- Skilled providers and innovative practice, use TSA on EHCP training?
- Parents' view; lack of understanding of autism and behaviour challenges amongst staff, e.g., use Ed Psychs with schools
- Need prof dev't approach for ASD, pathway and attachment; use ED Psych and LD, CAMHS and TSA to arrange

Rutland County Council

An Evidence Base

- Cost info was available; used to improve services. Placement panel has strong elements of commissioning, but no health
- Concern that near end KS2 children are removed
- Concern at pathways once college moves
- Random referrals from GPs to CAMHS
- Need to reduce primary placements
- Engage LLR in EHCP

Rutland County Council

Other Commissioning Actions

- No personal health budgets in Rutland
- Personal budgets in EHC – "work in progress"
- Need to increase this

SUMMARY

"...many strengths, including some excellent good practice, a clear values base and outcomes-focused commissioning. The strong focus on PFA was particularly noticeable…early intervention and prevention services, also very good. …positive working relationships and a flexible and can-do attitude; much credit to the staff for this. Geography a drawback in level of health input, which becomes more problematic as children get older."

REPORT NO. 126/2016

NHS
East Leicestershire and Rutland
Clinical Commissioning Group

HEALTH AND WELLBEING BOARD

REPORT OF EAST LEICESTERSHIRE & RUTLAND CCG

NHS QUALITY PREMIUM 2016/17

Purpose of report

1. The purpose of this report is to provide H&WBB with information on specific indicators that relate to the Quality Premium 2016/17 and confirm specific indicators, where choices have been made in agreement with NHS England.

Link to Better Care Together

Workstream	Relevance	Workstream	Relevance
Maternity, neonates, children and young people		Mental health	✓
Long term conditions	✓	Frail and older people	✓
Urgent care	✓	Planned care	✓
Learning disabilities		End of life	

Policy Framework and Previous Decisions

2. East Leicestershire & Rutland CCG Operational Plans 2016/17.
East Leicestershire & Rutland CCG Commissioning for Value Packs

Background

3. The Quality Premium for 2016/17 has been published, and is intended to reward CCGs for improvements in the quality of the services that they commission and for associated improvement in health outcomes. This premium will be paid to CCGs in 2017/18, and covers a number of national and local priorities. Monies will be awarded for the achievement of the following:
    - Improving anti-biotic prescribing in primary care 10%
    - Cancer diagnosed at early stage 20%
    - Increase in the proportion of GP referrals made by e-referrals 20%
    - GP Patient Survey 20%
    - Three local measures 30%

    There are also a number of NHS Constitution indicators that will also impact on the Quality Premium. Monies will be deducted for non-achievement. These are:

    - Referral To Treatment incomplete - 92% standard
    - Maximum four hour waits for A&E departments – 95% standard
    - Cancer 62 Day Wait – 85% standard
    - Maximum 8 minutes responses for Category A (Red 1) ambulance calls – 75% standard

    There are choices and decisions that Health & Wellbeing Boards should be made aware of. The choice of these indicators will be submitted, with the agreement of NHS England, on 29th April 2016. Given the timeframe of information being supplied by NHS England this is the first opportunity the CCGs have had to submit to H&WBB.

Proposals/Options

4. There are a number of indicators that CCGs are able to choose as part of their Quality Premium. It should be noted that at the time of writing this paper (15th April 2016) these are subject to confirmation by NHS England.

    The H&WBB members are asked to support the following:

    3 Local Priorities:

    - Cancer - % of lung cancers detected at an early stage (1 or 2)
    - Mental Health - Access to IAPT services: People entering IAPT services as a % of those estimated to have anxiety/depression
    - Mental Health – Reported numbers of dementia on GP registers as a % of estimated prevalence

    Improving the early detection of Lung cancer will have an impact on improving outcomes for Potential Years Life Lost (PYLL).
    ELRCCG recognise the need to focus on Parity of Esteem. Increasing IAPT referrals is critical to maintaining people accessing the service and serving the population of ELRCCG, and the service has been proactive in disseminating information to the public, community groups and voluntary organisations.
    Improving early diagnosis and treatment of people with dementia continues to be a key priority for ELRCCG.

As in previous years, the three local priorities will be reported to the ELRCCG Quality & Performance sub group as part of the monthly Performance report.

Consultation/Patient and Public Involvement

5. *N/A*

Resource Implications

6. *N/A*

Timetable for Decisions

7. *N/A*

Conclusions/Recommendations

8. H&WBB are asked to support the options made by ELRCCG in Section 4.

Background papers

https://www.england.nhs.uk/resources/resources-for-ccgs/ccg-out-tool/ccg-ois/qual-prem/

Circulation under the Local Issues Alert Procedure

N/A

Officer to Contact

Yasmin Sidyot Head of Planning & Strategic Commissioning East Leicestershire & Rutland CCG 0116 295 6768 yasmin.sidyot@eastleicestershireandrutlandccg.nhs.uk	

List of Appendices

A) UNIFY submission for ELRCCG

Relevant Impact Assessments

Equality and Human Rights Implications

9. N/A

Crime and Disorder Implications

10. N/A

Environmental Implications

11. N/A

Partnership Working and associated issues

12. WL CCG, LCCCG, UHL, EMAS, LPT & Rutland County Council, Leicestershire County Council

Risk Assessment

13. N/A

Planning Round 2016/17 - Quality Premium

V1.0

Please select your CCG:

Select CCG: NHS EAST LEICESTERSHIRE AND RUTLAND CCG - 03W

CCG Details:

CCG Name: NHS EAST LEICESTERSHIRE AND RUTLAND CCG
CCG Code: 03W

Quality Premium Notes

The local element of the 16/17 Quality Premium (QP) focuses on the RightCare programme, with CCGs expected to identify three measures from their Commissioning for Value (CfV) packs, each worth 10% of the QP. In selecting the local indicators CCGs and Regional Teams (local offices) should refer to the 16/17 QP guidance on the QP website. CCGs will need to work with their NHS England Regional Team (local office) to agree the local indicators for the QP scheme, and the levels of improvement needed to trigger the award.

CCGs and Regional Teams (local offices) will be required to submit an assessment of performance on the local measure in **September 2017**, therefore CCGs and Regional Teams (local offices) should select indicators where data will be available that will allow them to make a robust assessment of performance. Appendix 3 "Identification of RightCare metrics" of the QP guidance contains an assessment of the timeliness and suitability to inform indicator selection.

CCGs should select from the dropdown list of 80 indicators contained in Appendix 3. Where the CCG and Regional team (local office) feel there is an alternative indicator from the wider RightCare set that will bring greater benefit, then this could be used instead, subject to robust and timely data being identified.

To complete this return CCGs should:
1) Select from the drop down list the relevant metrics for local measures 1, 2 and 3. Each metric from Appendix 3 of the guidance is listed, numbered 1-80, and number 81 is "other".
   Where "81-other-other" is selected a text box will appear that should be completed with the indicator design and source of data for assessment.
2) The CCG should provide detail of the level of improvement agreed with the Regional Team for each measure.

This information will be stored in Unify, and used to populate a template that will be issued to CCGs and Regional Teams (local offices) in September 2017, so that CCGs and Regional teams can carry out a local assessment of performance to be submitted to the National Team.

How to upload this template:

Once you have completed the workbook and saved it onto your hard drive, please upload your data into Unify 2.
To do this, login to Unify2 http://nww.unify2.dh.nhs.uk/unify/interface/homepage.aspx

[If you are a CSU acting on behalf of a CCG and have logged in using a CSU account, at this point you will need to follow an extra step before continuing - see CSU Guidance. If logged in as a CCG, continue to step below]

Once logged in click on 'Data collection & management'
.....then 'NON DCT Home Page'
...and select the Upload option for the return '**PlanQPC**'

Then click 'Browse' and select (or drill down to) the location of the completed workbook on your hard drive (the file path will be displayed below)

CSU Guidance:

If you are a CSU acting on behalf of a CCG and have logged in using a CSU account you will first need to 'impersonate' the CCG for whom you are uploading the template

- In the top right corner of the screen, click where it reads 'You are signed in as xxx as XXX COMMISSIONING SUPPORT UNIT'
- Select the correct CCG from the organisation dropdown list
- Click 'Impersonate'
- Follow the remaining steps above, from 'Once logged in click on Data collection and management'

Further Information:

For queries related to this template and its submission to Unify2 please email PAT@dh.gsi.gov.uk

CCG Code:	CCG Name:
03W	NHS EAST LEICESTERSHIRE AND RUTLAND CCG

Validations
All Questions Completed
Character Limits Passed

TEMPLATE READY FOR UPLOAD

Quality Premium Local Measure 1

Please select a measure from the drop down below

7 - Cancer - % of lung cancers detected at an early stage (1 or 2)

QP Local Measure 1 - Locally agreed target

Please provide the agreed level of improvement - 704 characters remaining.

Currently 21% of all identified lung cancer cases are detected at Stage 1 or 2. In 2012 this level was 24%. Therefore suggested target is to stretch to 25%. This equates to an extra 8 patients (44 Stage 1 & 2 in total)

This data will be available annually from the Cancer Commissioning Toolkit

Quality Premium Local Measure 2

Please select a measure from the drop down below

37 - Mental Health - Access to IAPT services: People entering IAPT services as a % of those estimated to have anxiety/depression

QP Local Measure 2 - Locally agreed target

Please provide the agreed level of improvement - 567 characters remaining.

Stretch target to achieve 15.5% of the total number of people who have depression and/or anxiety disorders by the end of March 2017. The number of people accessing the service should be 4277 to achieve this during 16/17 which represents an increase of 511 from levels in Jan 16. It represents an increase of 137 patients from the national target of 15%.

This is reported monthly from ArdenGEM BI team, using national data systems.

Quality Premium Local Measure 3

Please select a measure from the drop down below

36 - Mental Health - Mental Health - Reported numbers of dementia on GP registers as a % of estimated prevalence

QP Local Measure 3 - Locally agreed target

Please provide the agreed level of improvement - 745 characters remaining.

Target to achieve 68% of estimated dementia prevalence (65+ Only). The number of people diagnosed (65+) should be 3127 by the end of March 17, this is an overall increase of 383 patients from Feb 16 levels. This is reported monthly using data from HSCIC.

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REPORT NO. 127/2016

Report to Rutland Health and Wellbeing Board

Subject:	**Integrating LLR Points of Access**
Meeting Date:	**28th June**
Report Author:	**Mark Andrews**
Presented by:	**Mark Andrews**
Paper for:	**Approval**

Context, including links to Health and Wellbeing Priorities e.g. JSNA and Health and Wellbeing Strategy:

The purpose of the report is to inform members of the Committee of the Business Case which has been developed for Integrating LLR Points of Access across health and social care partners. Members are asked to support the overall vision and direction of travel as set out in the business case (Appendix A).

The development of the LLR Better Care Together Five Year Plan has highlighted the need to consider how single points of access across LLR could be simplified and reconfigured in support of demand management and the "left shift" so that professionals and service users make the best use of the most appropriate service in the most appropriate setting of care, and that the information and signposting provided is responsive and consistent with local pathways.

The Integrating LLR points of Access project group, with representation from NHS and Adult Social Care services (and broader local authority services e.g. first contact) from across LLR, was set up to the scope of this work in the context of the future model of urgent care for LLR and the national context for redesigning urgent care which is a key priority from NHS England's Five Year Forward View.

The overall aims of the Integrating LLR Points of Access project are to:

- To deliver high quality, citizen centred, integrated care pathways, delivered in the appropriate place and at the appropriate time by the appropriate person, supported by staff/citizens
- To reduce inequalities in care (both physical and mental) across and within communities in LLR
- Support the improvement of health and wellbeing outcomes for citizens across LLR
- To optimise both the opportunities for integration and the use of physical assets across the health and social care economy
- Support the achievement of more appropriate use of health, social and community services
- Services to be accessible to as many people as possible within the community
- All health and social care organisations in LLR to achieve financial sustainability, by adapting the resource profile where appropriate
- To improve the utilisation of our workforce and the development of new capacity and capabilities where appropriate, in our people and the technology we use.

Current Position

LLR has various single points of access that provide support to the health and social care service provision. These include separate customer service call centres for each of the Local

Authorities and a number of general and specialist customer call centres with Health settings. Each “SPA” currently operates separately, and in very different ways.

Operationally, it is recognised that there is an opportunity to deliver a more consistent, targeted service to both customers and professional by integrating our approach across existing points of access.

The model proposed in this business case has been designed to support the new urgent care system for LLR which is being developed as part of the local Vanguard site. The new urgent care system will feature improved clinical triage. This business case demonstrates the opportunities to integrate existing “SPAs” so that the infrastructure supporting the urgent care system, including supporting the new clinical triage systems, can be as integrated as possible for both professionals and patients in the future.

Business Case

This business case outlines how these objectives can be achieved through implementing a new Target Operating Model (TOM). It also examines the associated activities, costs, benefits, risks and mitigations that will be involved in delivering this new, more integrated way of working.

This business case has been developed within the context of current levels of performance, the strategic direction of the in-scope services, aligned to the Better Care Together (BCT) Five-Year Plan and the Vanguard - Workstream 1 programme. In summary, the document details the following:

- An integrated TOM for Health and Adult Social Care (ASC) points of access across LLR
- A proposed approach and business case to achieve implementation of integrated services
- A financial appraisal of the current service delivery model versus the recommended TOM for Health and ASC including implementation costs, realisable financial and non-financial benefits
- The associated change activities required to deliver the overarching aims and objectives of the programme
- Risks, Issues and Constraints associated with a programme of this scale across multiple organisations and the mitigating actions

The business case finds that there are significant advantages of moving to a single uniform way of operating, at a single or much reduced number of sites and under one management structure. At a high-level these are:

- Realisable savings that may be achieved through rationalisation of the management structures, teams and facilities that undertake contact centre activities in Health and Adult Social Care
- Savings that can be achieved through more effective ways of working in the teams that execute service requests
- A more effective, responsive and better experience for the recipients of the services (professionals, patients and service users) and
- Better information on which to make LLR wide decisions on demand management and targeted interventions

It is recognised that there are a number of challenges of moving to this model and the approach outlined in the business case seeks to address these through risk mitigation and

effective programme management. The challenges are as follows:

- Each of the organisations involved, both politically and organisationally will want (or be able) to move at different speeds towards the optimal solution
- The ability to integrate the ways of working and the technology that supports it
- To be able to design and implement a cost effective approach that can effectively support the varying demographics across the LLR region

These challenges create a number of risks that will need to be mitigated and actively managed through the life of the programme if the LLR vision and the benefits are to be achieved. These major risks are:

- The organisations involved may not be able to reach agreement on progressing through the implementation phases
- The overall benefits may be diluted as the timelines for benefit realisation become extended and the economies of scale of running a concertinaed implementation phase are reduced
- The timelines for the IT integration and the Vanguard projects may have a material impact on the progress on this project.
- As this level of integration has not been achieved before, the LLR system may not have confidence to move at the pace required to deliver the benefits identified in the business case

The business case, the approach that this phase of the programme has taken and the recommended implementation approach seeks to address these risks by:

- Ensuring that there is a commonly understood and agreed set of aims, objectives and Design Principles that are aligned to the LLR overall vision. This has created a framework to guide the programme though the design and implementation phases
- Developing a set of reasonable assumptions that will allow the programme to move through each of the phases with known, unknown and managed risk
- A phased implementation approach to standardise and optimise the ways of working across all the organisations involved to drive out savings early in the programme to help build credibility and confidence.
- The baselining and collection of more detailed, comparative information in the early stages of the programme. This, in conjunction with the detailed design stages, will allow the stakeholders to make the integration and co-location decisions in the later stages of the project and within the context of the framework.
- Ensuring there is a detailed co-design stage at the start of the transition stage to both support decision making and start the engagement of the operational teams, service users and patients in the change
- Ensuring that the programme strategies that will support the change e.g. benefit management, stakeholder management, change and communications are developed and co-designed early in the project.
- Ensuring that there are activities within the programme and in the operational teams that facilitates the collection of standardised data to allow the organisations to make good decisions over the 30-month programme period and beyond.
- Ensuring that the key programme resources with the necessary skills and capacity, from across the in scope organisations are identified early by undertaking a skills and capacity assessment to determine any skills gaps and plan for sourcing alternative programme resources if required.

The approach taken in developing the business case provides the foundation for the next stage of the programme, as it was designed to engage the teams who will have responsibility for delivering the model and to begin the process of involving the wider Health and ASC services and stakeholder groups. These teams are an integral part of the proposed changes. Their intellectual capital, combined with 4OC's experience, has been used to co-design the proposed future TOM and the method for delivery, and hopefully, in the process has cemented their commitment to the upcoming changes.

Financial implications:

Resource Implications

At this business case approval stage in the project, no funding is being requested from individual organisations. The current phase of the project (business case preparation) has been funded from Vanguard monies allocated to the Leicestershire BCF for this purpose. The LLR wide Project Board have agreed to recruit a temporary Programme Manager to ensure the pace and momentum around this project is maintained. The costs for this support are being funded from the same source of funds.

The LLR points of access project board will provide a further report on the resource implications of the implementation of the programme in due course.

These requirements depend on the outcome of the business case approval stage and the number of partners across LLR who participate in phase 1 (and future phases).

Recommendations:

That the board:

The Business Case will be presented to management teams and boards across health and social care partners in the forthcoming months. The report recommends supporting the overall vision and direction of travel as set out in the business case attached.

Management teams and boards from across the partnership are being asked to consider the following recommendations:

a. Support the overall vision and direction of travel as set out in the business case attached.
b. Make a recommendation to the Board to support the commitment to enter into phase one of the programme (operational readiness and standardisation across existing call centres)
c. Agree to participate in a further strategic gateway/decision point once this standardisation has been achieved, whereby organisations will determine their entry into to the next stage of integration (phase 2).
d. At this business case approval stage in the project, no funding is being requested from individual organisations. The current phase of the project (business case preparation) has been funded from Vanguard monies allocated to the Leicestershire BCF for this purpose. The LLR wide Project Board have agreed to recruit a temporary Programme Manager to ensure the pace and momentum around this project is maintained. The costs for this support are being funded from the same source of funds.
e. The LLR points of access project board will provide a further report on the resource implications of the implementation of the programme in due course.
f. These requirements depend on the outcome of the business case approval stage and the number of partners across LLR who participate in phase 1 (and

future phases).		
Comments from the board: (delete as necessary)		
Strategic Lead:	Mark Andrews	
Risk assessment:		
Time	L/M/H	
Viability	L/M/H	
Finance	L/M/H	
Profile	L/M/H	
Equality & Diversity	L/M/H	
Timeline:		

Task	Target Date	Responsibility

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Integrating LLR Points of Access

Full Business Case

Status: Final

Prepared by: 4OC

Version 1.0

Date 11 May 2016

Table of Contents

1. Executive Summary

1.1. Background

The Leicestershire County, Leicester City and Rutland County Councils (LLR) Better Care Together Five Year Plan highlighted the need to consider how points of access across LLR could be simplified and reconfigured in support of demand management and the "left shift". The reason for this is so that professionals and service users make the best use of the most appropriate service in the most appropriate setting of care, and that the information and signposting provided is responsive and consistent with local pathways.

There are key drivers for this change. These are detailed in the Better Care Together Five Year Plan and are summarised below:

- The need to reduce waiting times by providing transparent and accessible data and advice about health and services
- The need to manage the impact of a predicted skills shortfall by effectively managing the workforce, through different ways of working and better supporting technology
- The need to meet rising demand for health and social care
- The need to drive better value for money and achieve financial sustainability
- The need to deliver integrated care by optimising the use of estates, ensuring care is provided in appropriate cost effective settings, reducing duplication and eliminating waste

In addition, there is a requirement to improve patient outcomes, especially those that deliver better patient centered care. It is anticipated that the approach outlined within this business case will help to address the following key statements from the 'National Voices, A Narrative for Patient Centred Care', (May 2013):

- I am always kept informed about what the next steps will be
- The professionals involved with my care talk to each other
- When I use a new service, my care plan is known in advance and respected
- When I move between services or settings, there is a plan in place for what happens next
- I know in advance where I am going, what I will be provided with, and who will be my main point of professional contact
- If I still need contact with previous services/professionals, this is made possible

1.2. Business Case Summary

This business case outlines how these objectives can be achieved through implementing a new Target Operating Model (TOM). It also examines the associated activities, costs, benefits, risks and mitigations that will be involved in delivering this new, more integrated

way of working. This document has been developed within the context of current levels of performance, the strategic direction of the in-scope services, aligned to the Better Care Together (BCT) Five-Year Plan and the Vanguard - Workstream 1 programme. In summary, the document details the following:

- An integrated TOM for Health and Adult Social Care (ASC) points of access across LLR
- A proposed approach and business case to achieve implementation of integrated services
- A financial appraisal of the current service delivery model versus the recommended TOM for Health and ASC including implementation costs, realisable financial and non-financial benefits
- The associated change activities required to deliver the overarching aims and objectives of the programme as detailed in *Section 5*
- Risks, Issues and Constraints associated with a programme of this scale across multiple organisations and the mitigating actions

The business case finds that there are significant advantages of moving to a single uniform way of operating, at a single or much reduced number of sites and under one management structure. At a high-level these are:

- Realisable savings that may be achieved through rationalisation of the management structures, teams and facilities that undertake contact centre activities in Health and Adult Social Care
- Savings that can be achieved through more effective ways of working in the teams that execute service requests
- A more effective, responsive and better experience for the recipients of the services (professionals, patients and service users) and
- Better information on which to make LLR wide decisions on demand management and targeted interventions

It is recognised that there are a number of challenges of moving to this model and the approach outlined in the business case seeks to address these through risk mitigation and effective programme management. The challenges are as follows:

- Each of the organisations involved, both politically and organisationally will want (or be able) to move at different speeds towards the optimal solution
- The ability to integrate the ways of working and the technology that supports it
- To be able to design and implement a cost effective approach that can effectively support the varying demographics across the LLR region

These challenges create a number of risks that will need to be mitigated and actively managed through the life of the programme if the LLR vision and the benefits are to be achieved. These major risks are:

- The organisations involved may not be able to reach agreement on progressing through the implementation phases
- The overall benefits may be diluted as the timelines for benefit realisation become extended and the economies of scale of running a concertinaed implementation phase are reduced
- The perception that those organisations that have more of a 'speed challenge' are reluctant to make changes and that those that can move faster are seeking to 'take over'
- The timelines for the IT integration and the Vanguard projects may have a material impact on the progress on this project
- As this level of integration has not been achieved before, the LLR system may not have confidence to move at the pace required to deliver the benefits identified in the business case

This business case, the approach that this phase of the programme has taken and the recommended implementation approach seeks to address these risks by:

- Ensuring that there is a commonly understood and agreed set of aims, objectives and Design Principles (see Appendix 1) that are aligned to the LLR overall vision. This has created a framework to guide the programme though the design and implementation phases
- Developing a set of reasonable assumptions that will allow the programme to move through each of the phases with known, unknown and managed risk
- A phased implementation approach to standardise and optimise the ways of working across all the organisations involved to drive out savings early in the programme to help build credibility and confidence
- The baselining and collection of more detailed, comparative information in the early stages of the programme. This, in conjunction with the detailed design stages, will allow the stakeholders to make the integration and co-location decisions in the later stages of the project and within the context of the framework
- Ensuring there is a detailed co-design stage at the start of the transition stage to both support decision making and start the engagement of the operational teams, service users and patients in the change
- Ensuring that the programme strategies that will support the change e.g. benefit management, stakeholder management, change and communications are developed and co-designed early in the project
- Ensuring that there are activities within the programme and in the operational teams that facilitates the collection of standardised data to allow the organisations to make good decisions over the 30-month programme period and beyond

- Ensuring that the key programme resources (as detailed in Section 5.5.3) with the necessary skills and capacity, from across the in scope organisations are identified early by undertaking a skills and capacity assessment to determine any skills gaps and plan for sourcing alternative programme resources if required

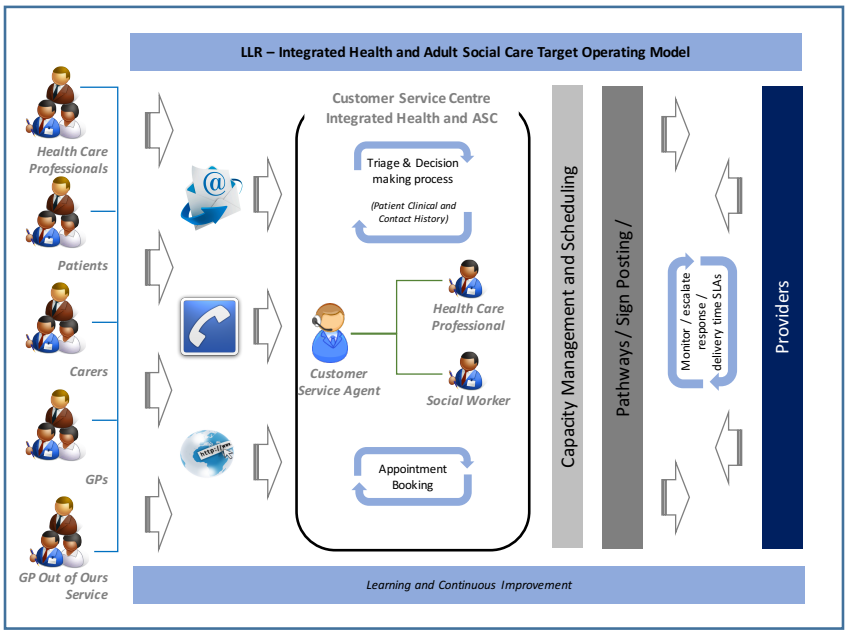
The approach taken in developing this business case provides the foundation for the next stage of the programme, as it was designed to engage the teams who will have responsibility for delivering the model and to begin the process of involving the wider Health and ASC services and stakeholder groups. These teams are an integral part of the proposed changes. Their intellectual capital combined with 4OC's experience have been used to co-design the proposed future TOM and the method for delivery, and hopefully, in the process has cemented their commitment to the upcoming changes.

The data gathering and co-design phases of the development of this business case have been characterised by a high degree of openness and enthusiasm from across all the in-scope services. There is an acceptance across the Health and ASC services of the need for change against a backdrop of increasing pressure to manage demand, reduce waste and associated cost in the system.

1.3. A New Operating Model

Figure 1 below outlines the proposed end-vision operating model for the Integrated Points of Access for LLR. To achieve this end state, the business case outlines a phased approach to implementation, building upon the work that has already been done and ensuring that the current services are working effectively and have been sufficiently aligned ahead of initiating any deeper integration.

Figure 1 - Future Target Operating Model for LLR Integrated Health and ASC



1.4. Proposed Approach

Section 5 outlines further detail on a potential approach for the phased implementation. It is anticipated that, based on the level of complexity (including the interdependencies) of the programme, the total programme could be delivered over a maximum of a 30-month period.

The phasing and the overall timeline will need to be finalised through detailed programme planning at the start of the mobilisation phase (and subsequently refined as part of detailed co-design activities in Phase 1) and managed through the implementation phases. The business case also outlines the critical features of a successful change programme of this nature as well as the skills required to execute it, the cost of implementation and the risks that need to be managed.

1.5. Financial Appraisal

It is estimated that implementation of the recommendations could save £4.3m at a cost of £2.2m over 5 years. In order to provide a like for like assessment we have assumed no growth in demand for service across the system. The recommendations within this report will provide an infrastructure that will allow the area to address growth more cost effectively.

There are a number of assumptions that underpin the calculation of the cost and benefits, further detail of these can be found in Section 7 – Financial Assessment. At a high-level these are:

Costs

- The changes will be delivered over a 30 - 36 month timeframe
- Costs are split, broadly equally, between programme management, change management and technology costs
- Technology costs have been scaled back from original assumptions on the basis that the existing investment in case management and telephony solutions will be leveraged for the future solution
- We have assumed the programme will be run through a consolidated programme team, through existing governance arrangements
- We have provided an indicative cost breakdown by organisation, pro-ratad against the benefits profile with some smoothing to allocate costs to smaller organisations where benefits are low due to the overheads associated with the implementation of best practice

Benefits

- The benefits profile is based on savings over a five year period from the start of the project
- Most savings are headcount based, through a more efficient set of services, driven by scale, automation and implementation of best practice
- We have assumed a level of non-cashable savings (£0.5M) for deskpace reduction which is relatively marginal compared to overall savings. This is also based on a reduction in the number of locations from over 8 to 2
- We have assumed a single management team with a standard management span of control which yields a contribution to the savings profile (almost 20%)

These changes will need to be underpinned by a Quality and Performance framework that will have sufficient management controls to identify service delivery issues and service user outcomes and to plan for continuous improvement initiatives that will ultimately enhance the commissioning of quality services.

1.6. Non-Financial Benefits

In summary the following non-financial benefits will be achieved by implementing the recommended TOM:

- Multi-skilled workforce serving Health and ASC services across LLR
- Improved experience for service users and professionals alike
- Consistent approach to service delivery and application of standards and pathways
- One single view of the service user/customer journey
- Reduction in failure demand across the system
- A professionalised, well equipped and confident workforce at the point of access for Health and ASC services
- Greater job satisfaction and reduction in attrition rates and associated costs (although these have not been a measured in the financial assessment), which have been highlighted as an issue across services
- Time saved by professionals no longer having to progress chase individual cases
- The collation of structured and timely data that will allow informed decision making at a local and system level

1.7. Enabling Future Benefits

This approach to the implementation of the programme is predicated on building capacity and capability across the existing Health and ASC teams (i.e. the teams that manage the calls into the services only). The programme provides an opportunity to develop, at system level, the in-house capability to deliver complicated system change programmes, as this delivery is likely to be one of many.

Developing structured and standardised ways of working in operational areas and across programme and change management will allow for easier integrations in the future. As part of the implementation of this programme, the processes and service costs will be baselined allowing the LLR system to better understand the impact of any future decisions they will need to make.

As this programme may lead the integration of technology, this experience can and should be used in other programmes. It is critical that a structured programme is mobilised with the right level of resource and experience to deliver this business case and the associated change management activities. (see Appendix 2 – Why Programmes Fail).

Another major benefit from the approach is the systematic collection of data, which will allow for the redesign of pathways, identify failure demand at a system level quickly and provide evidence for further investment.

What has not been quantified at this stage are the benefits for those who use the service and the impact this may have on patients and service users. It is anticipated that there will be significant time saved through users no longer having to chase service requests. The collection of data that informs the design of services could create additional efficiency benefits across the LLR system.

The impact of this implementation should also increase service resilience as there are currently multiple single points of failure (across the system) as service knowledge is retained in individuals' heads. As part of the baselining and data collection, it is recommended that further analysis of these benefits is examined.

2. Introduction and Background

Within the Leicestershire Better Care Fund (BCF) plan submitted in September 2014, the Leicestershire partners identified the need to consider further developments in relation to Points of Access specifically within the County as part of the joint vision of integration. This included reviewing options for the integration of the various existing Points of Access and Customer Service Centres across the Health and ASC economy.

Since the BCF plan was submitted, the development of the LLR Better Care Together Five Year Plan also highlighted the need to consider how Points of Access across LLR could be simplified and reconfigured in support of demand management and the “left shift”. The reason for this is so that professionals and service users can make the best use of the most appropriate service in the most appropriate setting of care, and that the information and signposting provided is responsive and consistent with local pathways.

2.1. Project Aims and Objectives

The overarching aim of the programme is to deliver a business case outlining options and recommendations for a new Target Operating Model (TOM) for integrated Health and ASC across the various Points of Access within LLR. The approach focused on positive engagement with key stakeholders from across the Points of Access in the scope of the programme, the co-design of ideas and solutions and clear and open paths of communication.

It is important to note that the programme focused on how service users and professionals accessed services and pathways (i.e. the 'front door') and not the delivery of services across partners.

The overall aims of the Integrating LLR Points of Access programme are, to:

- Support the delivery of high quality, citizen-centred, integrated care pathways, delivered in the appropriate place and at the appropriate time by the appropriate person, supported by staff/citizens
- Support the reduction of inequalities in care (both physical and mental) across and within communities in LLR
- Support the improvement of health and well-being outcomes for citizens across LLR
- Optimise the opportunities for integration and the use of physical assets across the health and social care economy
- Support the achievement of a more appropriate use of health, social and community services
- Ensure that services are easily accessible through appropriate access channels to as many people as possible within the community

- Support the drive for financial sustainability across all health and social care organisations in LLR, by adapting resource, as a result of the new model, where appropriate
- Improve the utilisation of the in scope workforce and develop new capacity and capabilities, in our people and the technology we use

2.2. Project Scope

The following seven Points of Access were included in the original project scope:

- Leicester City, Single Point of Contact
- Leicestershire County, Customer Service Centre
- Public Health Leicestershire County Council, First Contact Plus
- Rutland, Customer Service Team
- LPT CHS, Community Health SPA
- LPT AMH, Adult Mental Health SPA
- LLR Wide, Bed Bureau

As the project progressed, the Leicester City Incident Crisis Response Service (ICRS) was added to the scope of the project through a formal change control process approved by the Project Board, increasing the number of in-scope Points of Access to eight.

2.3. Approach

The following section summarises the approach undertaken by 4OC and LLR resources to achieve the agreed project aims and objectives.

2.3.1. Stage 1 - Mobilisation

The Mobilisation stage took place over a two-week period and was used to complete detailed planning and preparation for the subsequent stages of project delivery. This was achieved through a combination of:

- Meetings with the Project Sponsor and key stakeholders
- Clarifying project aims, objectives and expected outcomes
- Agreeing project governance
- Identifying key stakeholder groups and individuals
- Identifying existing information to be considered as part of the project analysis and recommendation stage, for example, Vanguard - Workstream 1

Key Outputs

- Updated Project Plan
- Project Governance

- Stakeholder Engagement Plan
- Situation Analysis
- Case for Change

2.3.2. Stage 2 – Information Gathering

The Information Gathering stage took place over a two-month period. During this stage, 4OC worked closely with key stakeholders to get a clear understanding of the existing services delivered across Health and ASC customer service centres within LLR. The team completed site visits to the Points of Access and partner organisations to understand and map the following:

- Current services delivered across Points of Access, including Pathways
- Service delivery models and high-level business processes
- IT systems and infrastructure across Points of Access
- Partner relationships
- Demand for service
- Access Channels

In addition to the above, 4OC facilitated two co-design workshops with representatives from the identified stakeholder groups to discuss and agree options for a rationalised service delivery model across the existing Points of Access and capture individual/group ideas for an integrated operating model. The workshops were well attended by representatives at all levels across the stakeholder groups, including service users, and the programme team received very positive feedback from those who attended (see Appendix 3 for a summary of workshops).

Key Outputs

- High-level Customer Journey Maps for current service across multiple Points of Access
- Value Chain analysis detailing key activities and outcomes that informed the high-level options appraisal (see Appendix 4)
- Technology Maps for multiple Points of Access
- Service Demand Analysis across all services
- Target Operating Model Options
- Updated Risk, Assumptions, Issues and Dependencies (RAID)

2.3.3. Stage 3 - Analysis and Recommendation

The Analysis and Recommendation stage took place over a one-month period. This stage of the programme focused on detailed analysis of the information gathering stage, predominantly the value chain and strategic options appraisal, together with

recommendations for the Points of Access Target Operating Model (TOM) aligned to the overarching LLR vision for integrated services.

Key Outputs

- TOM Strategic Options Appraisal (see Appendix 5)
- Preferred list of ICT products to support the TOM
- Draft Business Case with recommended approach
- Draft implementation Roadmap

2.3.4. Stage 4 - Review

The review stage of the project presented the SRO and project board with an opportunity to review the outline business case and implementation roadmap as recommended by the project team. The business case and implementation plan were refined and updated as part of this process based on the feedback received.

Key Outputs

- Refined Business Case
- Implementation Plan and Roadmap

2.3.5. Stage 5 – Close Out

A workshop will take place with the Project Board to handover the final version of the business case and implementation plan.

Key Outputs

- Close Out Report

3. LLR Health and ASC - Target Operating Model

Leicestershire County, Leicester City and Rutland County Councils (LLR) have a range of Points of Access that provide help and support to the Health and ASC service provision including, assessment of need, signposting and responding to service requests. These Points of Access include disparate customer service/contact centres for each of the Local Authorities and a number of general and specialist customer service/contact centres within the Health settings.

Although the 'customer journey' and high-level business processes are relatively generic across these Points of Access, all of the existing services operate separately and in different ways, with little information sharing across services and visibility of service user outcomes.

3.1. Issues with the existing TOM

There are a number of operational issues with the existing services, which are discussed further below. These issues have been grouped in to three categories: People, Business Process and Technology.

3.1.1. People

- Staff, in some cases, do not have the necessary internal support materials to enable them to deliver a responsive and effective service. (For example, standard operating procedures (SOPs), up-to-date business processes, policies and procedures)
- Ambiguity exists amongst staff as to the service offer across points of access. For example, SLA and KPI management as opposed to service user focused contact. In this case, some staff prefer to ignore call handling times/targets and provide the service user with a positive and quality engagement to determine the most appropriate action to take based on their needs which increases the overall process time
- Staff feel that they don't have access to the relevant knowledge and information to effectively manage contacts into the services and therefore assess users' needs effectively and sign-post to relevant services
- In some instances, staff circumvent the agreed business process and approach it in the way that 'they see fit'. For example, the detailed ASC assessment process is inconsistently completed introducing duplication of effort and elongating the overall business process time

3.1.2. Process

- All services operate differently and to different business process and standards, which may not have been documented either in business process format or SOPs. In

some cases, these are not up-to-date or reflective of the current service offer

- There is evidence of manual workarounds to support business processes where there is no supporting system, for example schedules of work for mobile staff and rostering systems for internal service staff
- There is variability as to how the services capture data and undertake resolution

3.1.3. Technology

- The services are telephony centric and have various telephony solutions deployed that provide varying levels of MI that may be used to manage the service effectively in terms of demand management
- There are five different systems used to capture customer contact, manage referrals and capture sign-posting information which are not currently integrated. This results in duplicate service user records and lack of end-to-end visibility of the customer journey and outcomes
- Services rely on outdated technology to receive referrals into the service, for example, faxes
- Operations do not have the capability to schedule work according to team capacity either within an organisation or into multidisciplinary teams
- Lack of systems functionality, sophistication and integration means that performance management and all aspects of quality, including measuring effectiveness of pathways and outcomes, cannot be achieved nor services improved

3.2. Service Specific Findings

Table 1 below summarises some key findings from the site visits to the Points of Access as part of the information gathering stage of the project. These are presented as 'what works well' and 'what doesn't work so well'.

It is important to note that initiatives are underway within individual organisations to address some of the issues presented below (what doesn't work so well).

Table 1 - Summary of Key Findings per Point of Access

Ref	Point of Access	What works well	What doesn't work so well
1	Leicester City – Single Point of Contact	▪ Excellent, experienced team with a 'can do' attitude ▪ Initial triage completed by team Support Worker to identify the reason for the call and either sign-post as the caller isn't eligible or transfer	▪ Focus on service user experience means that SLAs and KPIs and service demand may not be managed effectively ▪ Lack of SOPs and supporting information that supports

Ref	Point of Access	What works well	What doesn't work so well
		to a duty worker for further assessment to a social worker if they already have a case ▪ Focus on service user experience ▪ Home visits, pre-screening and assessment to ensure best use of staff time and minimise wasted visits ▪ Pending implementation of an on-line portal that may enable channel shift (to be rolled out across County and Rutland)	service delivery ▪ Manual spreadsheets and workarounds to manage staff capacity and work allocation ▪ Assessment forms are completed manually on the site visit and then re-keyed to the Liquid Logic system meaning duplication of effort and increased process time ▪ Lack of multi-skilled staff
2	Leicester County – Customer Service Centre	▪ Good contact centre infrastructure including accommodation and lay out, telephony and Liquid logic system ▪ Teams are well structured with health care professionals co-located in the call handling teams to support initial assessment and sign-posting ▪ Multi-channel contact centre with telephony, email, and web contacts ▪ Broad and deep service offering ▪ Good management of SLAs and KPIs ▪ Staff get good experience and build in-depth knowledge of Adult Social Care services ▪ Strong Management team in place	▪ Limited multi-skilling and assessment ▪ Staff over-assess callers because of the above ▪ The website and external collateral is not fit for purpose and therefore channel shift is difficult to achieve, increasing the level of phone contact and ultimately the cost of service delivery ▪ There is a high volume of calls from professionals in terms of progress updates ▪ Although SOPs are in place they tend to be out of date and aren't always followed correctly ▪ The service is seen as a recruiting ground for ASC and staff turnover may be a little high
3	Public Health Leicestershire County Council – First Contact Plus	▪ Strong and focussed management team ▪ Well skilled and experienced operation team with a 'can do' attitude ▪ Good location on the Leicestershire County campus ▪ Currently managing the requirements gathering and design of an on-line portal for providers and service users ▪ Process in place to measure	▪ Disparate systems to manage information ▪ Manual process for receiving referrals (pdf) recording the information manually and then entering in the system, duplication of effort

Ref	Point of Access	What works well	What doesn't work so well
		outcomes (although not automated)	
4	Rutland - Customer Service Team	▪ Small knowledgeable customer service team managing all contacts to the Council ▪ F2F offering for service users ▪ Good local knowledge of services for sign-posting ▪ Good website to promote self-care and sign-posting ▪ First Contact Bus for outreach	▪ The number of repeat calls made to the centre ▪ Currently in the process of configuring and implementing Liquid Logic, which will be a different instance of the system currently deployed at County CSC and Leicester SPOC
5	LPT CHS – Community Health SPA	▪ Good Contact Centre principles in place ▪ Strong management team ▪ Focused and knowledgeable staff ▪ Good management information available to resource the centre appropriately and manage SLAs and KPIs effectively	▪ No capacity planning and scheduling tool to effectively allocate work to remote locality teams which results in failure demand i.e. repeat calls ▪ Layout of current centre, separate rooms, not a standard call centre layout ▪ Receive a large number of faxes from GPs ▪ Noisy operating environment ▪ System navigation issues in terms of the number of clicks to process/access information
6	LPT AMH – Adult Mental Health SPA	▪ Operations is co-located with clinical professionals allowing case consultation to be undertaken ▪ The RIO case management system and telephony solution provides significant amounts of management information	▪ Small operation with on average 2 operators in place. ▪ Call lengths are long and convoluted as RIO often does not have patient information which keeps HCPs on the phone fro significant periods of time
7	LLR Wide – Bed Bureau	▪ Small, focused and knowledgeable team ▪ Co-location in the hospital means that they can contact professionals for advice and guidance ▪ Good controls in the system to minimise risk particularly around ambulance bookings	▪ Small, cramped office located on the hospital site ▪ No telephony system producing meaningful MI ▪ MI collated manually ▪ Disparate systems to manage referrals and booking to appropriate hospital for in-chair triage ▪ Rely on manual systems to get

Ref	Point of Access	What works well	What doesn't work so well
			up-to-date information as to bed availability ▪ GPs tend to send faxes ▪ SOPs are out of date and require updating
8	Leicester City - ICRS	▪ Co-location of the ICRS service in the Neville centre with partners from Mental Health, Community, Therapy ▪ Services are co-located and leads from each service are in constant dialogue to manage the service effectively ▪ Joint assessment visits (holistic assessments) to assess user needs and ensure that they get the right care ▪ ICRS has a service delivery success rate of 75% i.e. 75% of service users do not require any further intervention or hospital admission ▪ The team use a robust capacity planning tool Staff Plan (Advance Health Care) which pushes the itinerary to operational staff	▪ As with other services, the service manages disparate systems causing duplication of effort ▪ Lack of SOPs and supporting process material although this is work in progress

3.3. Proposed Target Operating Model (TOM)

The proposed TOM for Health and ASC Points of Access aligns to the original vision for a co-located and integrated Health and ASC service delivery model. The proposed model has been co-designed with key stakeholder groups across the Health and ASC setting including:

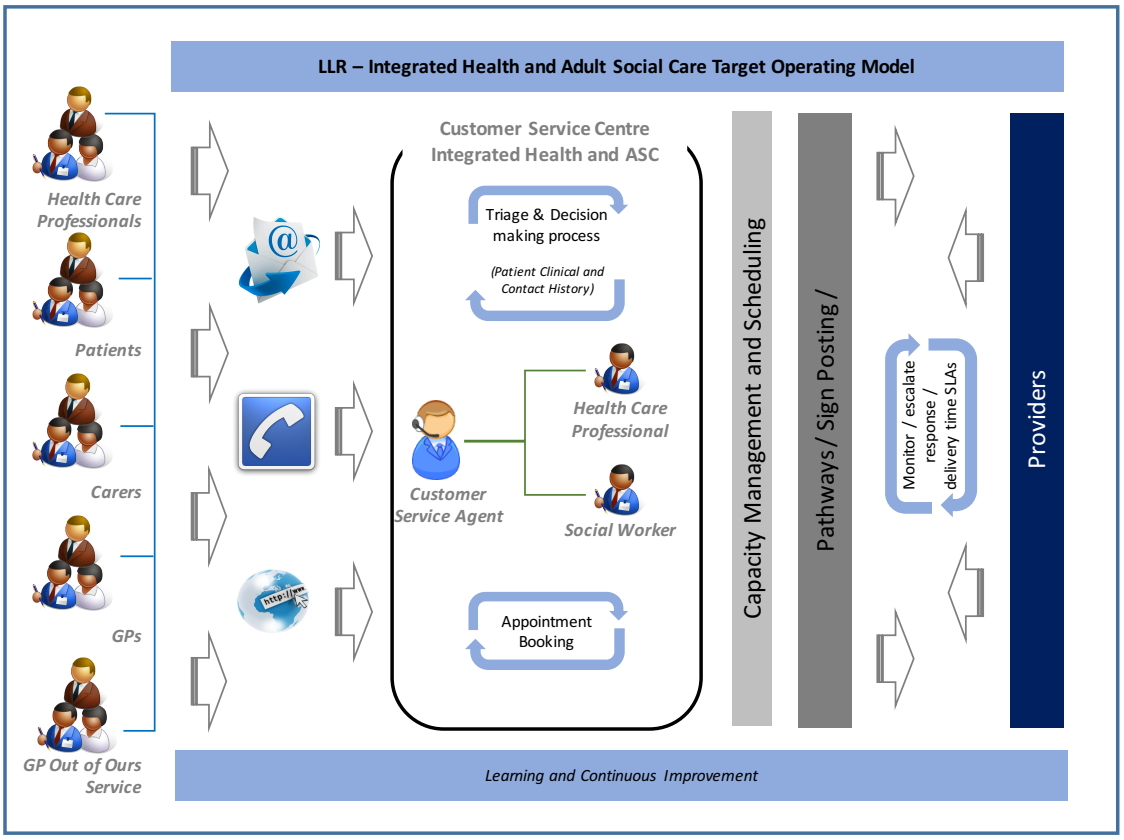
- Heads of Service
- GPs
- Vanguard representatives
- Contact Centre Managers
- Members of CCGs
- Frontline staff including call handlers
- Service Users
- Representatives from 111

Iterations of the proposed TOM have been presented to the Project Board and subsequently

approved. **Figure 2** below illustrates the proposed TOM and this section will elaborate on the following:

- The shared vision for integrated service delivery across Health and ASC services
- TOM Features
- Implications
- Rationale

Figure 2 - Future Target Operating Model for LLR Integrated Health and ASC



There is a clear vision for the service in the longer term that is based on:

- Either one or a significantly reduced number of co-located facilities that provide a single or reduced number of points of access to Health and Social Care services across LLR
- A high-performing operation that provides timely response and feedback on a wide variety of access to services
- A single repository for interactions from across LLR generating quality management information that can be used to inform continuous improvement and support decision making regarding the evolution of services
- Generating granular data that can be used to identify and flag early indications of critical care requirement
- A shift towards community defined services
- A community of professionals creating appropriate pathways for individuals

- A digital self-service offering for professionals and service users alike
- Improving outcomes for service users and patients

3.4. Proposed TOM Features

- A primary focus on providing a single point of access for professionals into the resources that execute a defined set of services in the LLR system
- The principles and capability will be extended to support patient facing activities
- Where possible, the process of service request and notification of service progress and completion will be automated
- Non-value adding work will be removed and transactional activities will be automated
- Validation and pre-population of information in the assessment process
- E-referral processes
- Operators will have access to a shared record, initially based on information from SystmOne and Liquid Logic
- Workflow updates will notify progress of activities
- There will be standard ways of working and managing performance
- Operating agreements will be in place at transition points
- There will be a single number to access multiple services
- Where possible resolution will be at the first point of contact
- There will be shorter call times driven by business process and system automation
- A method of capturing data to drive improvements and support system and potentially clinical decision making or interventions

3.5. Implications

- There should be a single management structure in each site, operating to the same standards
- Processes should be co-designed and shared between the sites
- Consistent operating processes and performance measures should be in place, as well as clearly defined transition points and service levels
- There should be a single service governance for each site with membership from each of the service provider groups and from the CCGs
- SystmOne would be used as the single source of interactions, but where a transaction involves social care, the details would be replicated within Liquid Logic
- Technology solutions would be integrated to reduce the level of double keying
- SystmOne would be configured to generate outputs that would allow the generation of Management Information and Business Intelligence
- The introduction of a capacity planning and scheduling tool will improve the interface between the contact centres and operation delivery, therefore complimenting existing mobile working solutions/technology and ultimately

reducing failure demand

- Staff should be seconded into the service to reduce complexity, maintaining Terms and Conditions

4. Alignment to Vanguard

4.1. Background

There are a number of programmes that are underway across LLR that have or could have an impact on the shape of the eventual solution being proposed. The most significant of these in terms of dependencies is the Vanguard programme and, in particular, the Urgent Care workstream, Workstream 1 as well as the LLR IM&T programme.

Vanguard, Workstream 1 are developing a new model of primary and intermediate care for the LLR system to align with the re-procurement of the 111 service. Following a period of engagement with key stakeholders, the Vanguard team have arrived at a draft operating model that contains aspects of the service being proposed through the Integration of LLR Points of Access.

To co-ordinate the design of these services, it was agreed that the Vanguard team would be included in the governance structures for this programme and have attended all programme boards. There have also been a set of design workshops to generate an holistic picture of the two proposed operating models to ensure consistency of vision and approach.

The design workshops for the Integration of LLR Points of Access programme have consistently promoted the need for increased levels of clinical support to the triage processes involved. The Clinical Triage Hub model being proposed by the Vanguard team provides a strong match to this requirement. To this end, we have jointly recognised the interdependencies between the programmes of work.

Work is ongoing to ensure a strong alignment of the Design Principles for the programmes and to capture and define in a formal manner the interdependencies that will need to be managed through implementation as the programmes are agreed. As an example of requirements for co-ordination the need for a consistent and co-ordinated IM&T strategy to support the implementation of these programmes has been identified and further engagement planned.

4.2. Options for Alignment

Although engagement has been positive and the programmes could continue to progress through the current governance structures, it is likely that as each programme progresses there will be increasing levels of interdependency and mutual risk that will need to be managed.

Another option is for the two programmes of work to develop a more formal joint

governance model to provide a single focus for management of activities, risk and dependencies.

5. Programme Implementation Approach

This section details the approach to implementation of the integrated Health and ASC model across LLR.

5.1. Phased Approach

The business case advocates a phased approach that takes into account the constraints within the LLR system and the practical realities of integrating at this scale. This phased approach allows some benefits to be realised early in the implementation and begins to build quality data and relevant information that can be used to inform decision making for the integration and co-location phases of the programme.

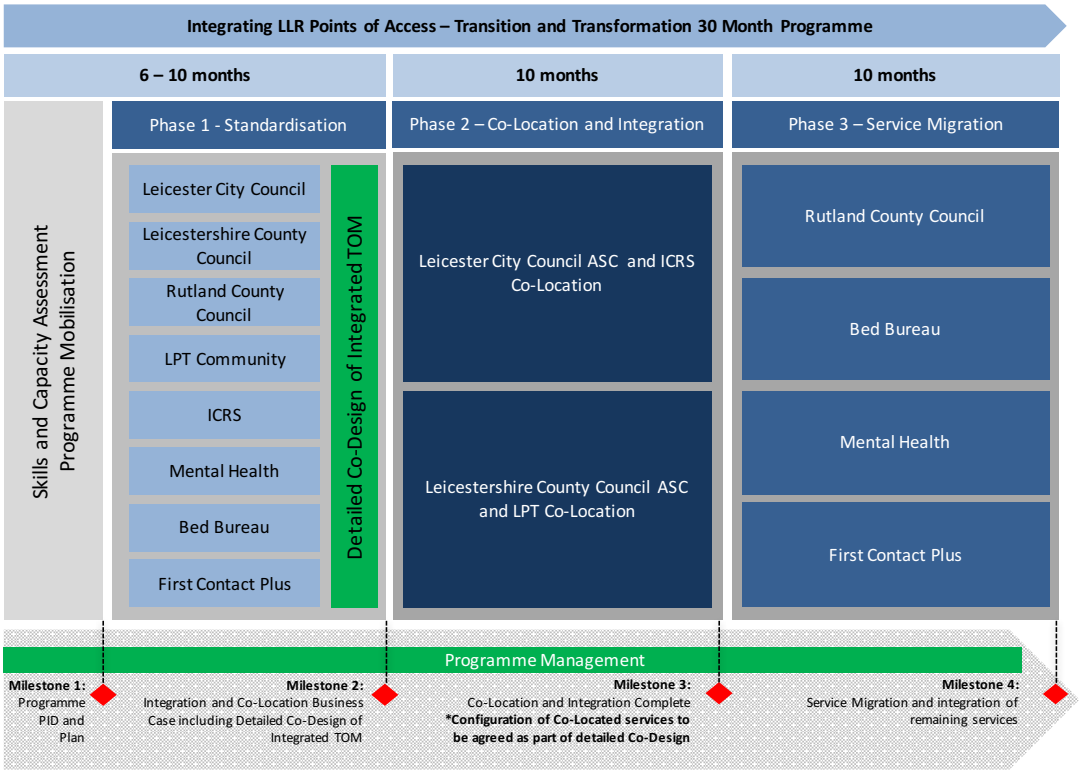
The approach has a number of staged phases as illustrated in **Figure 3** below. The implementations should be managed through a dedicated Programme Team to provide consistency and to ensure that the specialist resources undertaking the activity are used effectively. In addition, it will be important that the detailed design is co-designed with the service delivery teams, patients and service users as part of Phase 1 – Standardisation, to ensure that the solutions are workable and to cement commitment to the change.

The Roadmap in **Figure 3** is for illustrative purposes and outlines what can reasonably be achieved given the constraints, the risks that need to be managed and deliver the anticipated outcome and financial benefits. It highlights the potential phasing of the programme over the anticipated timescale of 30 months and the potential timescales per phase as well as key milestones and outputs.

The Roadmap will undoubtedly be reconfigured as the standardisation and co-design work commences and the detailed planning starts to take place. This will have an impact on the shape and timing of the integration and co-location activities and final shape of the Target Operating Model.

It should however be noted, that any changes to the assumptions contained within this business case will have an impact (positive or negative) on the costs, benefits and timelines. As outlined in this document, there will need to be an actively managed impact assessment process as part of the programme management of the implementation to allow the system to make informed decisions about any material changes to the assumptions in this business case.

Figure 3 - LLR Integration Roadmap



5.1.1. Programme Mobilisation

There will need to be a series of mobilisation activities prior to the commencement of the implementation phases these are as follows:

5.1.1.1. Setting up the Programme

- The drafting of the Project Initiation Document (PID), the programme plan and cost model in order to baseline all programme activities that will need to be measured
- The further development of the roles and responsibilities required
- The further development of the risks, issues, assumptions and dependencies (RAID) log
- The setting up of the programme board to manage the implementation phases
- The approval of these documents by the Programme Board

5.1.1.2. Skills and Capacity Assessment

A capacity assessment should be completed to establish what availability there is within the teams to participate in the programme of work and how this then can be managed on a day-to-day basis. This assessment will allow decisions on what additional resources may be required and how these can be sourced. It should be noted that if external resource is

required, time will need to be added to the programme plan for the procurement process.

There will be a requirement to undertake this assessment prior to detailed mobilisation activities. In addition, a decision will also need to be made from where the programme team is managed and which organisation hosts it and who has the bandwidth to manage the resources.

5.1.1.3. Set up of Programme Management Office (PMO)

There will be a requirement to have experienced and skilled resources to plan and manage the implementation activities, through the agreed governance in the programme. As part of this programme of work the key resources are defined as, Programme Manager, Programme Support and Change Manager (see *Section 5.7.1* – key programme roles).

Consideration should be given to seconding operational personnel into the team to develop capability for the later stages of the programme to reduce reliance on external resource. Consideration should also be given to utilising the existing skills within the PMO functions of the three councils and LPT.

The programme team should manage the following:

- The agreed governance controls, including programme boards and reporting
- The stakeholder engagement strategy and plan
- The relationship with the Vanguard programme of work (Workstream 1)
- Benefit identification, measurement and tracking including any associated risks that may hinder benefits realisation including an action plan to mitigate these
- The change strategy and plan including the communication approach and plan
- An impact assessment process to determine the impact to programme timelines, costs and deliverables that may result on the back of any requests for change
- Risks, Assumptions, Issues, Dependencies (RAID) and Mitigating strategies and actions
- Interdependencies between this programme and other programmes in the LLR system including Vanguard and IM&T
- The design of the Target Operating Model (TOM) and underpinning operating procedures based on the original agreed Design Principles, including business user requirements
- The undertaking of an assessment of organisational or digital readiness to assess the maturity of each of the organisations' change capability

5.1.1.4. The Set up of a Perfromance and Change Function

This will ensure that there are the skills within the system that can effectively plan and manage the change activities throughout the implementation phases. This function will also be responsible for identifying, prioritising and implementing additional change initiatives in the Business as Usual (BAU) operational environment.

5.1.2. Phase 1 – Standardisation

This phase of the programme will focus on system and process improvement across all in-scope areas. The aim is, before integration starts, to have a common and consistent method of operating, in line with the agreed Design Principles, which will make integration easier and potentially less costly as there should be a reduced requirement for bespoke IT configuration. The activities in this phase include:

Business Process Re-design (BPR): This will ensure that the business processes and standards that underpin the services, where possible, only undertake value adding work (non-value adding activities will be removed). It will also ensure that the operational processes are documented and Standard Operating Procedures (SOPs) and performance metrics are put in place to support the staff in their roles.

Requirements Definition: This activity will feed the technology workstream in the programme to ensure that any systems reconfiguration accurately reflects the redesigned business processes, business rules and policy and procedures. This activity and associated outputs (business user requirements) are critical to the successful design and implementation of the optimum TOM.

Benefits Identification and Management: The programme should develop an agreed process for benefit tracking and management for the entirety of the programme. A baseline exercise should be undertaken at the start of the implementation phase and a measurement method agreed. It should be noted that through this programme there will be achievable financial and non-financial benefits across the system, not only in the 'front door' of service provision. It is envisaged that users of the service will also be able to measure the benefits of the changes proposed under this implementation.

The development of the Estates Strategy: The estates strategy and plan will feed into the benefits realisation strategy. This activity will quantify the financial benefits associated with a rationalised call centre estate across the LLR system. In addition, the strategy should recommend an approach to estates management for these functions in the future.

Detailed Co-Design: In parallel to the standardisation phase a detailed co-design workstream should run to develop the optimal approach for integration and co-location.

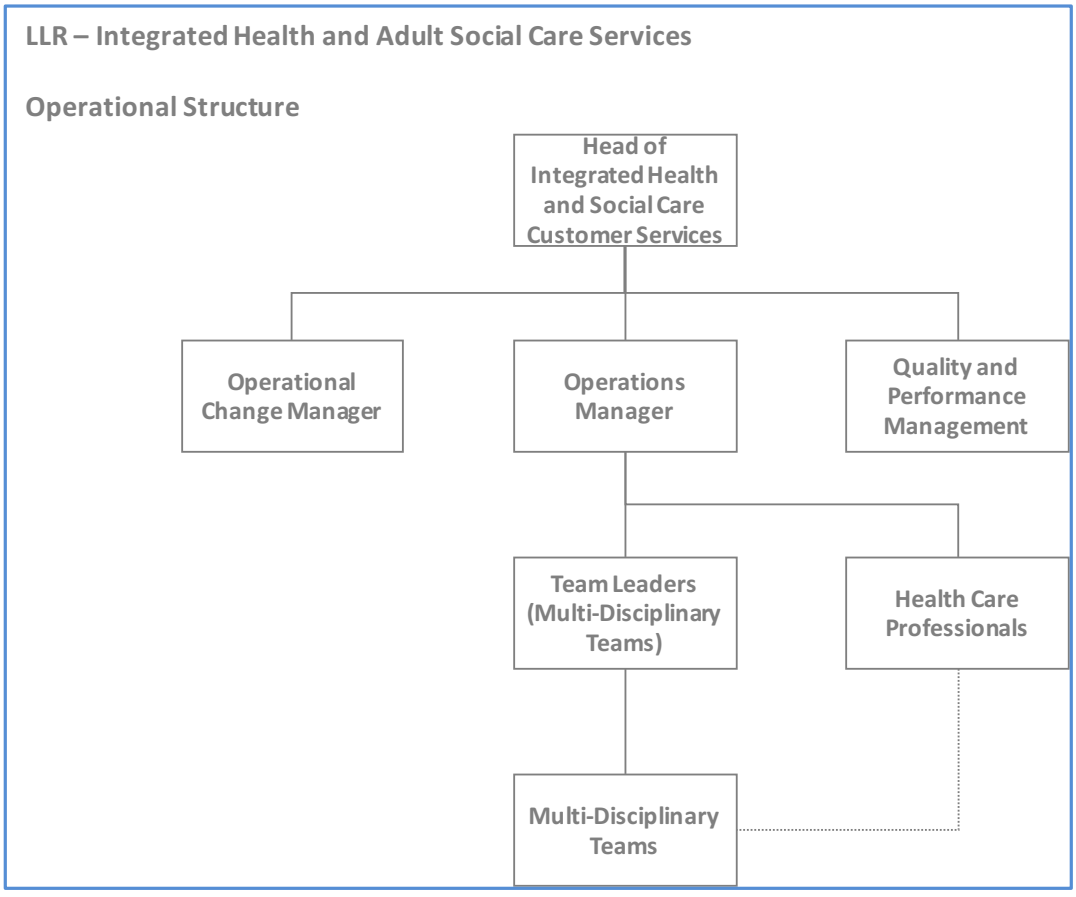
This phase should result in the production of a more detailed business case to allow the programme board to make decisions of the configuration and phasing of the integration and co-location activities, based more robust assumptions on costs, benefits, risks and mitigations.

5.1.3. Phase 2 – Integration

Following approval of the detailed business case and development of the implementation plan the co-location and integration activity can commence. The business case outlines the areas that at this stage of analysis would appear to be more straightforward to integrate at this early stage. This recommendation is also based on the knowledge that there are already existing working arrangements in the system.

One Governance Structure: A uniform management structure should be designed in the detailed design phase and agreed as part of the detailed business case approval. Once the services are co-located, this structure should be refined and improved to ensure that the aims and objectives of the service integration are met. The structure will reflect the roles and responsibilities of all staff in the services. An example structure is illustrated below:

Figure 4 – Integrated Health and Social Care Structure



Management Events: This activity relates to the design and implementation of management events that provide the management team with the necessary controls to monitor and measure the performance of services and teams. These controls include the reporting mechanisms required to highlight service performance. It also includes the management governance meetings to discuss underlying business issues and plan for corrective and preventative action, the outcomes of which will feed into the quality and performance management framework.

Multi-skilling: Once the above has been implemented and embedded, the management team can start the process of light touch multi-skilling of teams. This may initially take the form of job shadowing and joint assessments so that resources in the services get an understanding of the business processes and outcomes. This approach is currently deployed by the Leicester City, ICRS team and the co-located Health and Community services at the Neville Centre.

ICT Configuration and Integration: Reconfiguration and integration of ICT as well as procurement of any additional ICT (i.e. a capacity management system) will run in parallel with the above activities. This will be based on the business user requirements documented in Phase 1 of the programme as well as the agreed Design Principles (see Appendix 1 for the agreed Design Principles).

5.1.4. Phase 3 – Service Migration

Phase 3 addresses the phased migration of the remaining, now standardised Health and ASC customer services across the LLR system to the locations that have been agreed in the detailed business case. By this stage of the programme those services that have already been co-located will have benefited from the implementation of standardised and best practice business processes and new ways of working.

Financial and non-financial savings will have been realised and the new entities will have achieved proof of concept, which in turn will improve confidence in the new integrated ways of working. This in turn will make the migration of the remaining services less contentious and significantly easier to incorporate into the new TOM.

The migration will be planned and take into account the operating priorities of each of the remaining services at the time of service migration.

5.2. Timelines

Based on 4OC's experience of similar sized Transition and Transformation programmes, we anticipate a 30-month programme of work to achieve the agreed aims and objectives

aligned to the shared integration vision across stakeholder groups. This delivery would be split as follows:

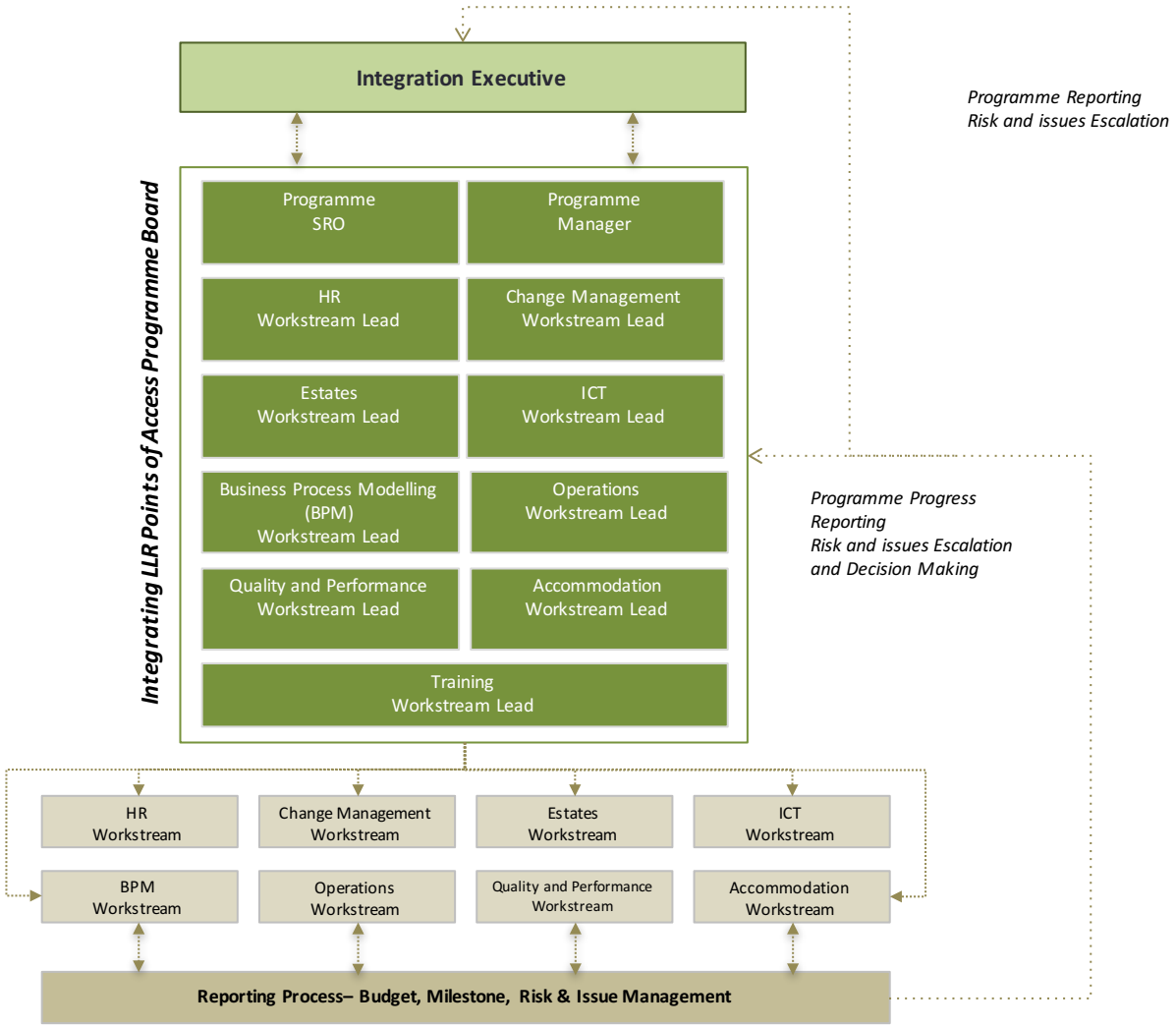
- Operational Readiness – 6-10 months
- Integration Phases – 10 months
- Service Migration – 10 months

It is likely that, during detailed planning for the later stages of the implementation, the programme timings may move as new information is produced.

5.3. Programme Governance

Figure 5 below illustrates the programme governance structure, detailing key roles and alignment to the Integration Executive.

Figure 5 - Programme Governance Structure



5.4. Change Approach

The challenge in this programme will be to drive the change while ensuring that there is no increased risk and minimum disruption to current service delivery. The following section outlines the key elements of a successful change approach that will ensure there are sustainable changes in behaviour, systems, processes, organisations and job roles, that are designed around the needs of the community that is being served.

5.5. Decision Making

The change and programme approach should allow managers throughout the programme to make decisions based on good information. As the detailed design of the solution emerges, it should provide them with the flexibility needed if new information or issues arise. The programme governance should provide a clear mandate to the programme to achieved the aims and objectives.

The programme manager should set up the programme to ensure that this happens. The time spent planning, engaging with stakeholders and engaging in detailed co-design with staff and users should not be underestimated. It will be essential that a programme manager who has experience of delivering this level of change across multiple organisations is sourced to drive the programme.

It will be vital that the senior stakeholders be clear about the relative priorities and that they support staff and professionals with the decisions they will face as to whether to engage and execute the change. Those involved in the programme must be given head-room and support so that they can properly engage in managing the change and that their managers in turn must be properly informed and equipped to allow them to do that. The programme manager must support the senior stakeholders by providing them with quality and timely information to make those decisions.

5.6. Co-Design

The Design Principles agreed at the outset of this programme and documented in this business case should provide the framework for the detailed co-design phases throughout the implementation. It is essential that during the design, planning and implementation of the programme these principles should be constantly referenced to check that the programme is not designing out the intent articulated by the principles. The process of co-design of the case for change provides senior managers and staff with a level of comfort that they are making controlled decisions.

Co-design with those who operate the services and with service users and patients is essential. The associated effort and costs involved are often overlooked in programmes and

are a contributing factor as to why programmes fail. The detailed co-design must engage staff in meaningful and cost effective activities that contribute to the overall aims of the programme so that they can recognise their contribution. It also provides a solid foundation on which to build communication and engagement plans.

Co-design provides a vehicle for gaining a common understanding of the aims of the programme, the definitions used and what they really mean along with absolute clarity on what people are required to do. This gives individuals and teams the time to work through and process the words being used into the associated actions and, most importantly, it allows them to recognise what it means to them and the people they interact with. It also ensures that best use is made of all available expertise and experience in the development of robust and sustainable solutions. It makes staff, professionals and patients feel that they are making a contribution to the change and not having change done to them.

This phase should also take into account any previous work or engagement with patients and service users to reduce the amount of rework.

5.7. Experienced Programme Management

This programme will need to be led by an experienced programme manager who has a successful track record of delivering change programmes that have produced measurable results. They should have specific experience of delivering change across departmental/budgetary/organisational boundaries, and be able to demonstrate how their approach has supported the decision making in the programme.

The programme manager should establish the programme in such a way that the programme team is made up of a combination of experienced programme skills and resources seconded from the operational areas so that capability and capacity can be developed to manage subsequent programmes in LLR system, reducing reliance on external agencies. The methodology used should ensure that those engaged in delivering the programme have their skills increased as a direct result of being involved. The ability to plan, manage interdependencies, work with stakeholders and communicate effectively are key skills in any job and involvement in this programme should measurably improve these skills.

5.7.1. Key Programme Roles

The key roles for the overall programme have been identified and are listed in **Table 2** below together with responsibilities, skills and experience.

The key PMO resources that have been identified for this programme are:

- Programme Manager
- PMO Support
- Change Manager

The above roles equate to c. 27% of the total programme spend of £1.8m and reflect the level of leadership required to deliver a programme of this scale and complexity.

Table 2 - LLR Integration Programme - Key Roles

Phase	Total Programme Costs by Phase	Costs
Standardisation	Programme Resource Costs	*£621,000*
	Transition Technology Costs	*£82,600*
Integration	Programme Costs	*£871,200*
	Technology Costs	*£300,000*
Service Migration	Service Migration Programme Costs	*£323,300*
	Service Migration Technology Costs	*£75,000*
Total Costs		**£2,273,100**

Ref:	Role	Responsibilities	Skills and Experience
1	Programme Manager	- Manage the Transition and Transformation Programme of Work - Governance arrangements including programme controls - Creating and managing the programme plan on a day-to-day basis - Budget Management - Reporting to the Programme Boards - RAID Management	- A Minimum of 8 years experience of managing complex programmes of work - Certification in one or more project / programme management methodologies, for example Prince II, Agile or Managing Successful Projects (MSP) - Ability to work well under pressure and to tight deadlines - Able to manage / priorities complex and multiple programme activities - People management
2	PMO Support	- Planning - Bookings - Reporting - Document configuration and management	- A minimum of 3 years of experience of managing PMO activities on complex programmes of work - Ability to work under pressure and to tight deadlines to achieve overall programme objectives and deliverables - Knowledge of one or more project / programme management methodologies, for example Prince II, Agile or Managing Successful Projects (MSP)
3	Change Manager	- Change Strategy - Change Plan - Communications - Stakeholder Engagement	- Extensive experience of managing change workstream on complex programmes of work - Knowledge of Change Management Methodologies, for example Kotter - Ability to communicate effectively at all levels within the programme governance framework - Experience of benefits realisation methodologies / management
4	Estates Workstream Lead	- Develop estates strategy in-line with the programme aims and objectives - Estates rationalisation - Lease negotiation	- Experience of estates rationalisation activities as part of a complex programme of work - Excellent communication and negotiation skills - Excellent business and financial acumen
5	Business process Design Workstream Lead	- Business process Modelling Strategy - Business Process Modelling - Implementation of Integrated TOM - Business User Requirements gathering aligned to the agreed Design principles and redesigned business processes	- Experience of Business Process modelling as part of a large programme of work - Knowledge of one or more BPM methodologies such as Business process Re-engineering and lean - Excellent workshop facilitation and tools and techniques
6	Operations Workstream Lead (inc. SOPs)	- Develop the Service offer - Standard Operating Procedures - Alignment to Quality and Performance	- Strong Operational experience in terms of managing operational resources, including budgets, people business process - Strong understanding of business process improvement and how this translates in to the day-to-day operating environment to realise efficiencies - Ability to own and manage the operational outputs of a complex programme of work
7	Quality and Performance Workstream Lead	- Develop the Quality and Performance Management Framework - Develop the continuous improvement approach including outcome measures - Develop the approach to the maintenance of the Directory of Services	- Experience of managing the design of quality and performance frameworks to achieve operational effectiveness as well as drive best practice activities and behaviours - Knowledge of best practice quality and performance management frameworks and methodologies
8	Accommodation Workstream Lead	- Work with the Estates workstream lead to determine the configuration of co-located sites - Ensure that the integrated sites have adequate equipment and facilities that support integrated working	- Experience of relocating services to alternative facilities as part of a complex change programme of work - Experience of managing all aspects of accommodation reconfiguration including the transfer of all necessary hardware and work station assembly - Technical infrastructure design and configuration

5.8. Training

The programme will need to have a workstream responsible for training. A training needs analysis will be required to identify the most effective means of ensuring staff have the

capabilities to apply the new operating model to their roles. The approach to staff training will be identified through this activity, ensuring staff are engaged in a way that best meets their needs. The training material should be developed to provide a resource that staff can use on an ongoing basis, and which can be redeveloped alongside any future changes.

5.9. Performance Measures

A key part of the design phase of new ways of working will be the development of a series of indicators demonstrating how those new ways of working are contributing, directly or indirectly, to the aims of this programme. It is vital that these indicators do not contradict or work against what is being measured or managed in people's day jobs.

In addition, it will be important to ensure that the measures are supported by policies in HR, training, patient safety, etc. There should be a 'golden thread' of metrics running from the aims of the programme, through the outcomes frameworks in each organisation to the new ways of working. There should also be metrics which measure the service user and patient experience.

5.10. Impact Assessment

Throughout the design phases of the programme, each proposed change will inevitably have an impact on the activities of the current operation. These impacts must be understood and made visible so that the programme, sponsors and politicians can make informed decisions on whether to proceed with the changes. These impacts should be articulated in terms of risks, accompanied by a set of proposed mitigations, costs and benefits and timescales. This process should be completed under the programme disciplines brought by the programme manager.

Part of this process should be a review of other change initiatives running concurrently to identify the most appropriate interfacing/resource usage. The programme should be aware that organisations have a finite capacity for change and that the same key resources will often be engaged in other change projects across the LLR system. Change fatigue is a real phenomenon that exhausts and confuses people and organisations. This will firstly need to be understood and then managed so the timescales for delivery are planned properly.

5.11. The Development of Change Strategies

The approaches to change, communication, engagement, testing and training should be developed by the programme team, who must ensure that they reflect the existing policies (and/or have a process to vary policy if required) across the system. HR, communications

and IT teams should be involved in the detailed design phases to prevent delay or rework in the latter stages of the programme.

5.12. Change Planning

Below are detailed the key components of a good change strategy and plan:

Communications: A communication strategy and plan should be drafted as part of the detailed planning phase of the programme. The strategy should consider the following:

- Each organisations' communication strategy, if applicable, in terms of what types of communication is deemed to be effective
- The media available and accessible to the programme to communicate effectively across individual organisations
- Language and tone used to communicate consistently across the individual organisations in-scope of the programme
- A detailed communication plan with assigned owners, aligned to key programme milestones and deliverables including scheduled events to communicate progress (e.g. roadshows)
- Alignment to the agreed stakeholder engagement strategy

Stakeholder Engagement: The level of stakeholder engagement in the implementation phase should not be underestimated. This is a complex delivery in a complex Health and ASC system. In order to develop this business case, there has been up to 30 days of effort in stakeholder engagement alone, from the programme board members and the 4OC team. It was also estimated that the time spent on stakeholder engagement in the development of the Better Care Fund plans exceeded this.

It is critical that this time is planned properly and the extent to which stakeholders are expected to be involved is communicated early and as clearly as possible. This is key in ensuring that key stakeholders are comfortable with the decisions that the programme will ask them to make.

6. IM&T Requirements and Approach

There has been a significant amount of activity to understand the current issues and plans the surround the ICT architecture across services. The following sections examine these issues, which have informed the implementation approach outlined in this Roadmap.

6.1. Current Landscape

6.1.1. Lack of Interoperability

There is a lack of interoperability with the business systems currently deployed by the services across Health and Adult Social Care (ASC). The services are therefore unable to exchange or share information that would improve service delivery for service users and health care professionals alike. For example, a single view of the service user history across a range of Health and ASC services may improve decision making and future signposting to relevant services.

6.1.2. Inability to produce Meaningful Management Information

There is currently no consistent or structured approach to capturing service user information at the point of care. This results in multiple care records in multiple systems across services as well as variations of management information that requires further manipulation to be meaningful. This issue is compounded by the maintenance of manual records to support service delivery.

6.1.3. Lack of Business Intelligence

Overall, the services lack the ability to produce business intelligence from the systems in terms of recording patient outcomes post care intervention. This in turn means that the services are not able to identify and continue the commissioning of effective pathways, execute a continuous improvement approach to service delivery and maintain an up-to-date directory of services.

6.1.4. Asset and Resource Optimisation

Asset and resource optimisation is not achieved within the current structure. There is a reliance on manual workarounds to assign work items and appointments as well as work schedules across teams and across localities, for example, in community nursing. This in turn means that there is a lack of visibility of teams' activities and potentially increased resources and therefore increased cost to support this.

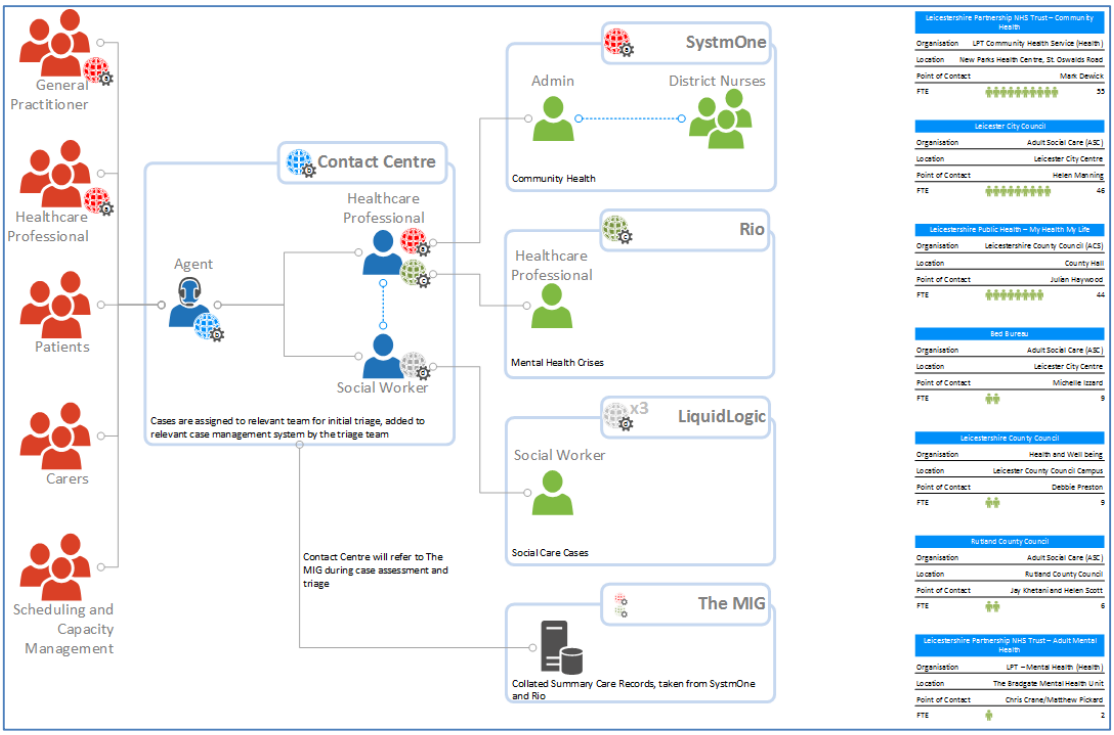
6.1.5. Progress of Assessment and Care Provision

Although there are plans to introduce online portals for health care professionals and the public, including within Leicester ASC and First Contact plus, there is no mechanism for professionals and service users to receive notifications as to the status of progression through the process. This results in increased contact to the services for progress updates and high levels of failure demand management.

6.2. Proposed architecture

The proposed architecture for the integrated Health and ASC Point of Access is illustrated in **Figure 6** below:

Figure 6 – Proposed Architecture for Integrated Health and ASC Point of Access



The architecture required will have the following features:

- Telephony solution that interoperates with the solutions used within EMAS, 111 providers and the other providers in the LLR health and social care system
- The ability to support warm handovers of end users between the relevant subject matter experts within the system
- Provision of web-based and app-based front end to service requests supporting single sign on and a security model
- Case management solution that allows the capture of information, the sharing of case notes, the development of care plans and the provision of notes back to primary care

- The ability to trigger service requests and track status of requests across the case management solutions across the system, particularly Liquid Logic in social care
- Capacity management planning and resource scheduling tool to support the most appropriate allocation of work within the provider base and remotely to reduce failure demand and improve service delivery
- The generation of management information to support the efficient and effective delivery of services

6.3. Solution Requirements

Solution Requirements for the architecture to be put in place for an integrated point of access will include:

- Consolidated record for service users and referrers
- Feedback on requests to the shared summary record for service users and to primary care records
- The provision of status for each service request
- Contact centre functionality and reporting
- Ability to transfer records from one operator to another in near real time
- Call scripting and knowledge management to support more efficient processing
- Highlight patient history including previous referral patterns
- Record, time stamp, track and manage requests for Unscheduled and planned Care services
- Highlight potential breaches of service levels
- The provision of Management Information and Analytics that support:
- A set of reporting metrics and analysis tools that will allow the business to manage its performance, meeting and surpassing the organisation and patient expectation as well as to engage with partners to drive channel shift and support internal transformation initiatives
- The development of data from the service that will allow the development of internal continuous improvement and to support organisational decision making
- The development of a Self-Management capability via the implementation of an on-line portal

6.4. Information Governance

There will be a significant challenge around data and information security for the integration programme particularly the challenge of sharing data between the in-scope organisations across Health and ASC.

The principles of information security require that all reasonable care is taken to prevent

inappropriate access, modification or manipulation of data affecting service user records.

The Information Governance frameworks for both Health and ASC services will be identified early in the Standardisation phase of the programme. The co-design activities will therefore consider these frameworks and requirements when developing the detailed design of the integrated Health and ASC TOM.

6.5. Areas of Risk and Potential Mitigations

Technology and integrations are likely to generate a high level of risk to the delivery of the programme. The programme has been structured in a way that reduces dependency on integration and to drive savings out of operational best practice. However, in order to achieve the operating model described, significant changes will need to be made to the systems landscape across LLR.

The risks identified during the analysis phases include:

- Data inconsistency across systems. The way data is captured and the varying standards applied to data capture, make it difficult to share information across service resulting in a risk that operational efficiencies will be hard to achieve
- The mitigation to this risk is included within the activities in Phase 1 with a focus for staff on the design of consistent master data across services. This will require a degree of data cleansing and configuration within the existing case management solutions, and completion of a universal data dictionary, which is allowed for within the timescales and costs
- Solution resilience
- Each of the services provides an important component of the overall functioning of the Health and Social Care system for LLR. Consolidating technology solutions, while delivering many benefits, also increases the risk that a systems outage will impact the system on scale, generating concern about the approach and progress of the programme
- The mitigation to this risk involves a clear focus within the programme requirements, Design Principles and solution design on ensuring resilience and fault tolerance is built in to all proposals and that stakeholders are briefed on these aspects of the eventual solution
- Information Governance is always a challenge in multi-agency environments and there is therefore a risk that a solution design does not adequately allay concerns across the organisations involved. This could impact the implementation timescales for the technology solution in Phase 2 increasing the cost of the programme and potentially negatively impacting the benefits through efficiencies
- The mitigation to this risk involves building upon the work achieved through the LLR IM&T BCT Enablement Group and the in place Data Sharing Agreement. The

development of any solution designs that relate to information and sharing of data will be impact assessed with the relevant IG representatives across the LLR provider base

6.6. Capability and Capacity

The following highlights the capabilities required in developing a new architecture including:

- The solution providers and their ability to deliver requirements
- The bodies of expertise in each of the organisations associated with the systems used
- The requirements for significant levels of change over the coming years
- The development of this capability to support functions such as ILPoA

7. Financial Assessment

7.1. Introduction

The analysis team, on behalf of the programme board, have reviewed each of the services through staff and management interviews, staff shadowing, data collection and follow up meetings as well as financial analysis, to form a view of the operational structures, operating model and efficiency and effectiveness in order to generate an informed view of a future operating model and a level of potential savings.

They have also undertaken a number of workshops with practitioners, frontline staff, local management and executives in order to ascertain the shape and approach to develop an integrated point of access for the LLR Health and Adult Social Care system. From these activities we have identified an incremental approach to the development of an integrated service that the services involved and the programme board feel is an appropriate and deliverable means of generating the objectives for this business case.

A key deliverable of the business case approach was to to identify areas of potential savings and to identify the cost of development of the agreed solution. Our findings indicate that there is scope for financial and cashable savings that can be delivered in a structured way through the three distinct phases identified in Section 5, which are the:

- Standardisation Phase
- Integration Phase
- Service Migration Phase

We believe, supported by the findings of the workshops, that an 'in-place' process improvement exercise, undertaken at the outset would best prepare the services for integration. This activity would in itself yield significant savings against our benchmarks for public service delivery functions. We have identified the high-level costs and expected benefits for this first phase, as outlined later in this section.

The second phase of activities, Integration, will focus on the larger areas of service delivery across the system. This in turn lays the groundwork for a wider integrated point of access for Health and Adult Social Care services. The savings delivered through this integration are based on a set of reasonable assumptions relating to a level of achievable technology integration and increased levels of self-service and automation.

We have provided an estimate of expected costs and benefits/savings for this phase, as outlined below. We recommend that additional analysis be carried out through the first phase, as detailed requirements should be developed to support the validation and refinement of the assumptions made within this document.

The third phase of activities, Service Migration, involves the integration of the remaining services across the system into the the integrated hub or hubs created in the Integration phase. We envisage additional services being introduced over the following months as the technological prerequisites for integration are met.

This programme provides the foundation for a broader integration and we have estimated the potential costs and savings for the current in-scope services. It should be noted that there remains an opportunity to deliver additional savings and to provide a more rounded service for health and social care, including young people, for professionals in other organisations and areas of service delivery within the system.

Finally, we have developed a proposed financial governance approach to ensure that both the constituent organisations and the overarching Better Care Together programme can exercise managed control over investment decisions.

7.2. Expected savings and sources

There are five primary sources of financial savings that have been profiled within the business case, which are described within this section. Savings have been modelled based on assumed efficiencies that could be achieved through reported transaction volumes, staffing numbers, hours of service and recommended management structures. The savings have been identified against each phase of the programme for the services that are in-scope.

We have assumed savings arising from the reduction in staff and management numbers, but we have not factored in redundancy costs. We have assumed that the reduction in numbers can be achieved through natural attrition given the reported levels of staff turnover in the current services.

7.2.1. Process Efficiencies

Our analysis has shown that the in-scope services are run on a professional basis and there are pockets of best practice. Consolidating these approaches and applying best of breed management techniques across all the services will yield efficiencies. In particular, our analysis has identified resource planning, performance management, continuous improvement techniques and the standardisation of processing as contributory factors in the delivery of savings.

7.2.2. Channel Shift

There are some examples of good practice in the use of on-line approaches to facilitating

service requests that could further reduce the level of manual processing and intervention required across the services if applied consistently throughout the service.

Although good progress is being made in the reduction in use of paper and fax, there are still relatively high levels of service requests being triggered by paper based forms.

7.2.3. Reduction in failure demand

Across all services there was evidence of activity being generated and undertaken that yielded few positive outcomes. Examples include chase calls for non-appearance of staff or for status updates. There were a number of instances where there were high levels of service requests that resulted in no further activity being generated, particularly around adult social care.

There was evidence of considerable chase activity to other delivery areas within the system being undertaken by the services in scope. The root causes for this chase activity included communications breakdowns in process and unidentified implications of roster changes.

7.2.4. Management efficiencies

We have assumed a management span of control metric based upon extensive experience across a range of public sector contact centre and administrative services. Through the delivery of Process Improvements and later through the integration of services, we have identified savings amongst the management and team leader cohorts as the metrics associated with this span of control are achieved.

Some of the existing services suffer from a lack of scale and variety of spans of control which has lead to the entire system having more management roles than in best practice operations. As the approach moves towards co-location and consolidation, we have identified savings relating to the reduction of management roles.

By contrast, for this type of service delivery, there are some roles that are notably absent. When the operations are consolidated, we recommend that these should be put in place as they support best practice working in a service that is a front door. These roles include Quality and Information Management, Change Management and Training. We have factored these roles in to the future organisation shape and have included the associated costs as additional cost against the overall savings. We believe that these roles are essential in supporting an agile service at this scale.

7.2.5. Property Rationalisation

During the Integration and Service Migration phases, there will be the opportunity to reduce

deskspace demands across a number of buildings for the constituent organisations. We envisage that the future operating model would best be supported by at most two locations, a reduction from the eight currently in operation.

We have identified a saving through migration to existing properties within the combined estate and the reduction in demand for floorspace. The degree to which these savings are could be claimed as cashable is currently being reviewed.

7.3. Other notes

It is important to note that any reduction in demand that we have allowed for are relevant only to the services in scope. We have made no assumption for the impact (in terms of effort reduction) for the 'back office' services that underpin the points of access. We would recommend a parallel process be undertaken to review delivery processes in light of the recommended changes by the transformation teams within each organisation.

The team have assumed conservative estimates for savings. In reality we would expect the delivery of greater efficiencies than those described.

7.4. Savings Assumptions and justification

The smaller services included within the scope of the business case tend to have less associated overhead. The efficiencies identified above therefore have a more marginal impact at this scale and as a result we have not included any potential savings in these cases. These services include Rutland County Council and the ICRS service provided out of City Adult Social Care.

For the remaining services we have made the following assumptions:

7.4.1. Leicestershire County Council - CSC

We have assumed a reduction in failure demand across the service through an effective community and professional engagement campaign to ensure a higher level of appropriate referral. We have assumed a resulting 10% reduction in contact demand.

We have assumed a 5% reduction in effort through a review of the processes in place within the service. Average effort per case is over 35[1] minutes currently providing scope for implementation of standard procedures to free up time. For this service we have assumed no channel shift savings.

[1] It should be noted that this includes contact and administrative time

7.4.2. Leicester City SPOC

We have assumed a reduction in failure demand across the service through effective community and professional engagement campaign to ensure a higher level of appropriate referral. We have assumed a resulting 10% reduction in contact demand.

We have assumed a 5% reduction in effort through a review of the processes in place within the service. Average effort per case is over 70[2] minutes currently providing scope for implementation of standard procedures to free up time.

For this service we have assumed no channel shift savings.

7.4.3. First Contact Plus

Analysis of the contact data provided by the service reflected a greater cross-community age profile for this service than the other services. It also indicated a lower level of repeat calls, whether to chase progress or to raise subsequent service requests. To this end we have made a very low estimate for improvement in failure demand and have assumed a 1% reduction.

Based on a review of the contact data provided, we believe that the service could benefit from a review of process and the identification and definition of standard operating procedures. The training and application of these processes would lead to an estimated 5% reduction in effort across the service.

7.4.4. Leicestershire Partnership Trust - SPA

The review of this service with management and staff and the analysis of the data provided from SystmOne allowed the team to develop a profile of activity undertaken within this service. The structure of the service is split between contact centre staffing and administrative staff that are co-located with front-line staff. The scope of this review has included contact centre functions only.

The identified savings are associated with call handling and processing of both e-referrals and paper-based referrals. It should be noted that there is a large degree of interdependence between these functions and the change programme would need to manage these interdependencies from a process design and organisational change perspective.

[2] Based on the data provided to the team from the case management solution

Reported high levels of repeat calls per service request (e.g. Where's my Nurse) and the level of outbound calls would indicate high levels of failure demand. The root causes are likely to be working practice issues that will require significant change programme effort to resolve and an investment in solutions to better support a peripatetic workforce. We have estimated a 10% reduction in processing demand for the Point of Access. We have also costed for solutions in this space to facilitate new working styles.

Review of the data extracted from SystmOne indicates that there are improvements in data collection that could drive process revision and reduction in effort for the Points of Access. We have assumed a 5% reduction in effort through the development and implementation of revised standard operating procedures and a revised quality and performance framework.

We have also assumed additional improvement in the migration towards increased e-referral, which will require professional engagement and training. We have estimated a conservative 5% reduction in handling activities through this approach.

7.5. Phasing of the savings

Tables 3 and 4 below, identify the savings associated with each phase of delivery. For the Operational Readiness phase this is identified by constituent organisation. For the subsequent phases, the savings have been identified for the integrated service.

Table 3 - Phasing of Savings

Phase	Saving
Benefits by phase	
Phase 1	2,647,050
Phase 2	913,528
Phase 3	794,566
Total	4,355,144

Table 4 - Phasing of Savings over time

Phase	16/17	17/18	18/19	19/20	20/21	21/22	Total
1	-	487,323	664,531	664,531	664,531	166,133	2,647,050
2	-	86,902	254,347	254,347	254,347	63,587	913,528
3	-	17,901	234,691	240,877	240,877	60,219	794,566

7.6. Cost of Implementation

7.6.1. Phasing of delivery

We have developed a model that captures the costs associated with the three phases of

activity defined within the implementation section of this document as illustrated in **Table 5** below. Following feedback from the wider team we developed a best case and worst case scenario in order to model these costs. The variables used included:

- The duration of the phases - in particular the length of time associated with phase 1
- The level of backfill required for operational roles in order to mitigate the effect of secondments of key staff into the programme team
- The level of change management resource applied to the costs in order to support the move to new ways of working

For the purposes of costings for this business case it was agreed that a mid-point would be used between the best case and worst case scenarios.

Table 5 - Programme Costs by Phase

Phase	Total Programme Costs by Phase	Costs
Standardisation	Programme Resource Costs	*£621,000*
	Transition Technology Costs	*£82,600*
Integration	Programme Costs	*£871,200*
	Technology Costs	*£300,000*
Service Migration	Service Migration Programme Costs	*£323,300*
	Service Migration Technology Costs	*£75,000*
Total Costs		**£2,273,100**

7.6.1.1. Standardisation Phase

This phase is intended to allow individual services to prepare for the joint working across LLR, to identify and implement common approaches to service improvement, to identify larger programmes of change as part of consolidation and to mitigate the risks associated with a move to an integrated service.

The teams will be supported through the provision of subject matter experts in the areas of business process redesign, organisational change, training and communications. The programme team will also focus on defining the next phase of activities to the next level of detail.

The scope of the operating model design improvements will include:

- Development of standard operating procedures that are co-designed and shared across services
- The development of common customer contact standards with similar service levels across service
- The identification of common working practices and engagement with staff to agree these practices across LLR

- The introduction of revised working practices that allow improved performance including:
  - A revised structure with standardised spans of control
  - A performance management framework that supports staff to achieve team targets
  - The introduction of "management events" to allow team leaders, managers and staff to review ongoing performance, recommend future changes and discuss the pending implementation of small and large changes. This phase accounts for close to 25% of the overall spend planned for the programme. The bulk of the activity will occur in the financial year 2016/2017, with savings delivered in the following financial year.

The plan purposefully avoids including technology development through this phase, reducing costs and shortening the timescales for implementation and benefit delivery. **Table 6** below summarises the spend by quarter profile.

Table 6 - Spend by Quarter

Phase	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1	Total	%'age
1	245,200	287,275	119,375	55,750	-	-	-	-	707,600	26%

7.6.1.2. Integration Phase

The second phase of change will focus primarily on the development of large centres of best practice for the delivery of an integrated point of access for services. This will be based on a twin track approach of multi-disciplinary case activity and the development of the required technology underpinnings. The following will be in scope for this phase:

- The development of two sites within the geographical area, which will host state of the art contact centre functions providing site resilience
- The development of common pathways in association with the planned Clinical Triage Hub and other clinical services within the system to support the right-shift of care away from emergency and unplanned admissions
- The development of shared care and case records that enhance the visibility of patient centred activity across the system
- Improvements in the the visibility of the status of planned patient activities (in order to reduce the levels of failure demand)
- Increased levels of e-referral and online self-service for health care professionals
- Improved capacity management, both for the contact centre services but also within the operational delivery realm, through better co-ordination, planning and underlying software tools

From an organisational perspective, the scope of this phase covers Leicestershire County and Leicester City Adult Social Care contact centres and LPT Community Services SPA.

This phase accounts for close to 60% of the profiled spend for the programme and involves the bulk of the spend on technology. The spend is spread over the 16/17 and 17/18 financial years on a 40/60 basis as illustrated in **Table 7** below.

Table 7 - Spend by Quarter

Phase	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1	Total	%'age
2	-	54,300	155,250	285,250	316,550	226,650	107,550	32,850	1,178,400	55%

7.6.1.3. Service Migration Phase

This final phase is designed to build on the practices and infrastructure delivered through Phase 2, drawing in a wider range of services from across the system developing towards a more comprehensive point of access for services.

The scope of this phase is similar to phase 2 but includes the following services within the scope:

- Rutland County Council Adult Social Care
- Leicestershire County - First Contact
- LPT - Mental Health Crisis team
- UHL - Bed Bureau
- Leicester City – ICRS service

It should be noted that there are a number of other services that will be included within the scope of this phase but which have been excluded at this stage due to technology change requirements.

This phase accounts for 20% of the overall spend. This spend of approximately £400k is spread between the financial years 17/18 and 18/19, as illustrated in **Table 8** below.

Table 8 - Spend by Quarter

Phase	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4	18/19 Q1	Total	%'age
3	-	-	-	-	-	25,975	94,175	104,750	366,750	20%

7.6.2. Split of costs between organisations

We have identified a split of costs between organisations in **Table 9** below on the basis of the potential financial benefits of undertaking the integration of points of access. However

for organisations with smaller points of access benefits may be close to zero or negative, therefore we have smoothed out the effect.

Table 9 – Cost by Organisation

Point of Access	% of benefits	Phase 1 Costs	Phase 2 Costs	Phase 3 Costs	Total Costs
CSC (County)	22%	£ 154,792.00	£ 334,628.57		£ 489,420.57
SPOC (City)	23%	£ 161,828.00	£ 349,838.96		£ 511,666.96
First Contact Plus (County)	8%	£ 56,288.00		£ 138,539.13	£ 194,827.13
SPA (LPT)	27%	£ 189,972.00	£ 410,680.52		£ 600,652.52
Bed Bureau	5%	£ 35,180.00		£ 86,586.96	£ 121,766.96
Rutland County	5%	£ 35,180.00		£ 86,586.96	£ 121,766.96
ICRS (City)	5%	£ 35,180.00	£ 76,051.95		£ 111,231.95
Mental Health Crisis (LPT)	5%	£ 35,180.00		£ 86,586.96	£ 121,766.96
Total		**£ 703,600.00**	**£ 1,171,200.00**	**£ 398,300.00**	**£ 2,273,100.00**

7.7. Financial Governance

This section will deal with the financial governance for the delivery of the integration programme. The team recommend the following principles underpin the management of finance during the delivery phases of the programme:

- That for the first phase of delivery, as defined in the implementation plan, and for those elements of subsequent phases that precede the development of an integrated service under one management structure, financial governance is undertaken by the constituent organisations for the in-scope services
- The funding for the implementation of the changes described, as well as a contribution to the overarching programme management, will be prorated across the organisations in scope. For the first phase and until there is a single entity in place to manage an integrated delivery of service, the associated benefits will accrue to these organisations
- The financial governance for each organisation will include the business case submission for capital and revenue funding for the programme and the management of subsequent MTFS, QIPP or similar business planning as a result of planned savings
- Subsequent funding to support technology integration and further integration of services will be sourced through constituent Better Care Funds and national technology funding initiatives.
- Efficiencies associated with these later phases will be used to re-invest in change initiatives for integrated services across the system

For subsequent phases of investment, where investment is being made for a single entity (the integrated service) a revised financial governance will be put in place that will reflect

the governance associated with the Better Care Together programme.

There are a number of initiatives, in place and planned, that require the creation of a single entity to manage back office/shared services across the system. This programme will ensure that the management structures services defined within this document will align with these other planned services (e.g. Help To Live At Home programme).

We recommend that there is a stage-based approach to approval of spend for the implementation programme to ensure that funding matches the achievement of goals (both in terms of deliverables and benefits/savings).

For phases of delivery subsequent to the first Process Improvement phase we have estimated the costs and benefits based on the scope as currently set out. We would recommend that these figures are reviewed and refined in advance of the commencement of the Integration and Service Migration phases.

7.7.1. Benefits Tracking

This programme of works is dependent upon, and is a dependency for, a number of programmes of work across the system (e.g. Mobile Working within LPT Community Health). We would recommend that the programme structures put in place to manage the tracking and reconciliation of benefits and savings across the system for all works impacting the cost of delivery for the integrated service. This would ensure:

- That the interdependencies between programmes of work that ensure the delivery of the financial and non-financial benefits are monitored and reported upon
- That there is reduced risk of multiple business cases claiming the same benefits
- That the the full picture of the impact of the planned changes on the system are mapped, commonly understood and reported upon

8. Risks, Issues and Constraints

This section details the immediate risks, issues and constraints associated with the proposed integrated TOM and approach to implementation as well as mitigating actions.

8.1. Programme Risks

Table 10 - Initial Risk Register

Ref.	Risk	Probability	Impact	Mitigation Strategies
1	A delay in the final sign-off of the business case and a subsequent delay in the decision making process to proceed to implementation, may result in loss of momentum and key programme resources (who have participated in the business case process) *and* who have been assigned to the implementation programme may move on to other projects or programmes. This will leave a programme skills gap and result in a subsequent delay to programme mobilisation and ultimately an impact to benefits realisation	H	H	(1) Discuss and agree a robust decision making and business case sign-off process across partnering organisations. (2) Undertake a capacity planning exercise to assess skills available across organisations' PMO functions and develop a resourcing plan to fill capacity and skills gaps (3) Develop and agree a recruitment plan and mobilise
2	Subject Matter Experts (SMEs) and Change Champions assigned to the Transition and Transformation Programme from the points of access in-scope are not back filled therefore they will have conflicting priorities between Programme and BAU activities that may hinder progress	M	H	Agree which resources are required to participate in the programme as part of the implementation approach (Inc. costs) and agree approach to backfilling as part of the sign-off stage and pre-mobilisation of the implementation phase
3	The organisations involved may not be able to reach agreement on progressing through the implementation phases delaying progress and impacting benefits realisation	M	H	Ensuring that there is a commonly understood and agreed set of aims, objectives and Design Principles that are aligned to the LLR overall vision. This has created a framework to guide the programme though the design and implementation phases

Ref.	Risk	Probability	Impact	Mitigation Strategies
4	The overall benefits may be diluted as the timelines for benefit realisation become extended and the economies of scale of running a concertinaed implementation phase are reduced	L	M	Developing a set of reasonable assumptions that will allow the programme to move through each of the phases with known, unknown and managed risk
5	The Transition and Transformation programme is not resourced appropriately with a mix of internal and external staff with the required experience and the project will fail to meet the aims and objectives in the business case including benefits realisation	M	H	Undertake a skills gap analysis against programme governance resources to determine which internal resources may be assigned to the programme and those resources and skill sets that need to be procured
6	Health and Local Government cultures and ways of working, together with differing priorities may mean that there is a challenge getting stakeholders together and make timely decisions, which have an adverse impact on programme timescales	H	L	On-going stakeholder engagement and communication as per the proposed approach detailed in the implementation plan Use the Governance framework and controls to identify and mitigate risk as soon as possible
7	Cost of systems integration and interoperability may impede transition to optimum Operating Model	M	M	Complete a detailed business requirements mapping exercise as part of the design phase of the project to determine costs of integration between existing systems and the procurement of any additional systems and assess the impact to the TOM and agree alternative solutions
8	A lack of clearly thought through internal communications regarding the Transition and Transformation programme could result in inaccurate messages filtering through to staff impacting morale and delivery progress	L	M	(1) Communications strategy to be put in place early in programme mobilisation (2) Pre-emptive messages to be disseminated (3) Ensure the process is open and as documented as possible
9	As this level of integration has not been achieved before, the LLR system may not have confidence to move at the	M	M	(1) Developing a set of reasonable assumptions that will allow the programme to move through each of the

Ref.	Risk	Probability	Impact	Mitigation Strategies
	pace required to deliver the benefits identified in the business case			phases with known, unknown and managed risk (2) A phased implementation approach to standardise and optimise the ways of working across all the organisations involved to drive out savings early in the programme to help build credibility and confidence
10	The timelines for the IT integration and the Vanguard projects may have a material impact on the progress on this project	M	M	Regular communication with IT and Vanguard stakeholders to asses progress, identify risks, issues and mitigating strategies and align change plans
11	The implementation phases cause business interruption	M	M	The planning of the implementation phases should be done in conjunction in the operational areas to minimise business interruption
12	The cost of the Transition and Transformation Programme is deemed too expensive and does not get the appropriate approval and therefore the programme is shelved	L	H	Present alternative costing options for review by the Sponsors and agree mitigating actions
13	Disagreement as to which body funds the service once it is in BAU as well as value of contribution which may adversely impact go-live and BAU	M	M	Explore the governance arrangements as part of the business case review and approach to securing funding from appropriate stakeholder groups
14	The proliferation of case management solutions and instances will prevent the transition to the optimum model and efficiencies may not be realised	L	M	(1) Complete a detailed business requirements mapping exercise as part of the design phase of the project to determine costs of integration between existing systems and the procurement of any additional systems and assess the impact to the TOM and agree alternative solutions (2) Align to the IM&T working group and strategy

Ref.	Risk	Probability	Impact	Mitigation Strategies
15	Senior management and operation staff do not know what is expected of them pre programme mobilisation and during during transition	L	M	(1) Agree governance of the programme early including roles, responsibilities and accountabilities (2) Ensure that a suitably skilled Change Manager is assigned to the programme to develop a Change strategy, communications and stakeholder engagement plan
16	As the phasing of the project is over a 30 month period the partners involved may drift away from the programme as their priorities change and this may have an impact on the overall benefits.	L	M	The partners are aligned to a strategic vision for the LLR system which should be reviewed and refreshed on a regular basis to ensure that this is still relevant to the system. In addition the project team must ensure that in the design and implementation phases that all organisations are actively engaged in the design and identification of benefits
17	There may be unforeseen policy or political changes that have an impact on both the benefits and the time line for the project	M	H	The project team should ensure that an impact assessment is completed on any changes that may impact the project. This impact assessment should allow the system leaders to make informed decisions about progress of the project.
18	Delay in the intervening period between the Business case Sign Off and the start of implementation, causing delay to benefits realisation and a loss of momentum and a potential lack of continuity of the personnel involved.	H	M	Activities are underway to start the process of finding a project manager to take the project forward. Retain, where possible the key personnel involved in the development of the Business case.

8.2. Constraints

Although there is a shared vision for the service and features of the operating model, there are a number of constraints associated with moving straight to the end solution for all services in scope, including:

- The maturity of each organisation's and the integrated system's change approach
- Different political priorities that may impair the ability to have an immediate unified service offering across Leicester City Council, Leicestershire County Council ASC and Rutland.
- The timescale for the Vanguard programme and its potential for overlap with this solution
- A phased approach may lead to organisations drifting away from the original vision as priorities move over time
- The costs associated with the integration of systems will be loaded against a single programme, when in reality progress is being made in this direction over a longer period of time
- Finding a location that could accommodate the service at its current size within the current estate
- The ability to realise cashable savings from vacating locations currently occupied by the existing points of access

9. Market Testing

In the original Request for Quotation (RFQ), the following was asked of the analysis team:

- Where available, explore what others have achieved in order to validate the integration options and identify any external best practice to consider as part of the integration programme
- Scope the requirement for a scheduling and capacity management system and identify and shortlist possible solutions

The primary focus for the capacity management system was for the planning and scheduling of work for staff in the field.

9.1. Approach

We undertook three methods of research to establish if and where, there had been integrations of Health and ASC services that were similar to the ambition in LLR. We specifically focused on finding exemplars that were at a certain level of depth and scale. These three methods were:

- Desktop research
- Engagement with Isle of Wight (IoW) Council
- Input from Health and ASC professionals

9.2. Conclusion

We were looking for the following characteristics so that we could use the research to support the development of this Roadmap:

i. The project was of the scale and ambition of the integrating LLR Points of Access project
ii. The project had similar aims and objectives to those of the LLR Points of Access project and those of the LLR Vanguard project
iii. The project had been fully implemented and its success measured so that the team to use the lessons learned from it

The team found that there was a myriad of Health and ASC integration initiatives under way across the country, however we were unable to identify an example where a comparable level of integration that is required in the LLR project had been achieved.

We were however, able to source the following material that has been summarised in the following narrative. This has been used to support the assumptions that underpin this business case and the recommended approach in this Roadmap.

9.3. Desktop Research

We reviewed a number of reports and publications on Integrated and the delivery of new models of care. We have selected and summarised those examples of integrated working that have helped in the production of this Roadmap. Many of the examples can be found in the Integrated Care and Support Pioneer Programme, released by NHS England. The full report can be found at the link below:

http://www.local.gov.uk/documents/10180/6927502/Integrated+Care+Pioneer+Programme+Annual+Report+2014/76d562c3-4f7d-4169-91bc-69f7a9be481c

9.4. Integrated Care and Support Pioneer Programme

A pioneer programme led by NHS England set out to test how integrated care could provide more support at home and earlier treatment in the community, how this could help people to be healthier for longer and how health and care services could work more closely. This process started in late 2013 when fourteen locations were chosen to develop innovative ways to coordinate people's care. The pioneering organisations include a broad range of health and care economies, ranging from large urban populations to rural counties across the country.

The pioneer sites are:

- Barnsley
- Cheshire
- Cornwall and Isles of Scilly
- Greenwich
- Islington
- Kent
- Leeds
- North West London
- South Devon and Torbay
- Southend on Sea
- South Tyneside
- Stoke and North Staffordshire
- WELC (Waltham Forest, East London and the City) West Norfolk
- Worcestershire

9.5. Worcestershire

One example of the pioneer projects is being delivered in Worcestershire, which is a large county in West England with a population of 567,000. It has an urban centre and a scattered urban population, similar to the demographics of LLR. Their integration programme is called

Well Connected and is a collaboration between three Clinical Commissioning Groups (CCGs), an acute NHS trust, a health and community NHS trust, Worcestershire County Council, NHS England, Local Healthwatch and representation from the voluntary and community sector.

Their vision for improved and integrated care covers all people in Worcestershire with a focus on older people, adults and children with multiple long-term conditions or complex problems. At the beginning of the programme, all partners worked to identify what transformations in care the population needed through a series of multi-organisational meetings and visioning events. This process culminated in the development of a comprehensive five-year strategy defining the direction of changes in health and care in Worcestershire. The three main workstreams of the programme were defined as:

Future Lives: The major change programme for adult social care, including new models of care for integrated health and social care working.

Out of hospital care: This project is in an early stage and will be developing new models for primary care at scale and care closer to home, including enhanced services for prevention and early intervention.

Urgent Care: This encompasses fourteen projects to improve urgent care and manage increasing demand.

The Well Connected programme outlined three highlights in the first year of delivery:

- Developing and clarifying the health economy vision for health and care and incorporating the Well Connected vision into the Worcestershire five-year health and care strategic plan
- Profiling the health and care needs of half of Worcestershire's population to enable them to divide the population into segments with the aim of designing new models of care to meet their different needs, delivered by a collaboration of providers through the mechanism of a capitated budget
- Setting up an integrated commissioning unit to build on previous joint commissioning for mental health and learning disabilities, strengthening its governance and incorporating the necessary capacity for integrated commissioning for older people and to deliver our Better Care Fund proposals.

Key to the programme delivery has been system leadership and commitment to the enabling activity. The programme had buy in from all partners and a clear governance structure was installed from the outset. The strategy was developed with contribution from all stakeholders including service users and their families. Stakeholders are committed to the principle that the needs of service users are more important than the individual organisations.

One of the most challenging aspects of creating an integrated health and social care model

is laying the foundations of partnership working and maintaining this during challenging periods for each individual organisation. Information Governance has also been a struggle for the programme and has put a block on progressing certain areas of the project until a national agreement can be reached.

A lack of resources for the large-scale change made the implementation of the integration difficult, for example the extra investment needed in community services before the scaling down of effort from the acute sector. Workforce planning has also been a challenge and new ways of working can have unintended consequences, for example recruiting high-quality staff to the care home project has left workforce gaps elsewhere in the system.

Enablers and Barriers

Across the fourteen pioneer programmes, common themes were identified relating to the enablers and barriers for integration.

Enablers:

- Strong leadership and inter-organisation relationships
- Structured governance arrangements
- Public consultation and co-design of service
- Effective information sharing
- Capturing and sharing learning and evaluation

Barriers:

- Conflicting priorities across organisations
- Understanding the local workforce profile
- Information Governance
- Funding of Services

Impact of Integrated Care

In the first year, improvements in the pioneer population's health and experience of care started to show. This included reducing the number of times people were admitted to hospital (including admissions from care homes), increase in quality of life, greater independence in the home and, of course, financial savings. These programmes have shown how effective integrated care can be and why others should initiate work leading towards this model.

9.6. Isle of Wight Council – My Life a Full Life Programme

The Isle of Wight (IoW) Council are working together with the NHS Trust and CCG to create an integrated health and social care model. This programme is known as 'My Life a Full Life'.

The ambition is to link the established NHS Hub with the council's contact centre, which currently delivers contact facilities for all council services. The contact centre currently has a high rate of first contact resolution so a lot of training will be required to align the two services. The NHS Hub currently encompasses: 111, 999, Crisis team, Community Nursing, Social Workers, Hospital Transport, Pharmacy advice and Age UK. Mental health has so far been out of scope of the integrated programme.

The council and NHS Trust have formed a strategic partnership which has been signed off and they are now discussing the formal merging of the partnership. At present, all staff are still on their original contracts with no current plans to TUPE any staff. They aim to create a Single Access approach for the service users and residents of IoW. Training staff to be multi-skilled and work across functions has begun, however, slowly and only for those identified as having the appropriate level of knowledge and skill.

The governance arrangements are in place for the strategic partnership, including an Integrated Care Programme Board and two Integrated Access Strategic Leads, one for each organisation. A weekly report is submitted to board members and weekly huddles are used to discuss issues or concerns. A formal engagement strategy was signed off by the Programme Board but this information was not being cascaded down through management. This became an issue as staff did not feel engaged and began to feel nervous about what the programme meant for them. Generic messaging was not always the best way to deliver information regarding the programme.

The case management systems are not integrated across functions but the underlying infrastructure is being brought together where possible. Once the new processes are fully aligned the requirements may drive the need for a new platform that supports both systems.

They are working on creating a summary care record so there is a single view of the patient across health and social care. Due to information governance issues, this will need to be kept at a high level and only the necessary information will be shared with other parties. The council already have a lot of transactions being completed online and will use this to make health and social care services easier to access. This will make it easier for users to see their information and take control of their care. The care pathways are being developed to load support at the front end to try and keep people out of the system as much as possible. Social workers are present to complete the assessment at the time of the call to ensure the appropriate care is given to the right people at the right time.

The programme is in its early stages so the decision is still being made on how to measure success and evaluate the outcomes. The emphasis will be on the effectiveness of the service and outcomes for service users. The aim is cost avoidance, stopping residents from getting

to an acute ward. The council contact centre and NHS Hub have already been through efficiency savings so the next stage is how to use the current resources more wisely.
The lessons learned from the programme so far include:

- Staff engagement, be honest and consistent, ensure information is cascaded effectively
- Conflicting priorities between organisations
- Budget constraints may impede project success
- Setting a clear vision for the service early on and documented the design principles
- Don't Underestimate the cost of investment in ICT which may impede transition to the optimum model
- Accessing patient information will be contentious and expectations will need to be set in terms of IG constraints

9.7. Capacity Management System Analysis

9.7.1. Approach

We completed the following three stage approach to identifying a potential capacity management system:

1. High-level user requirement assessment
2. Engagement with ICRS management to discuss functionality of their current scheduling and capacity management system
3. Desk top research

9.7.2. Conclusion

There are many systems available on the market that would satisfy the requirement for scheduling and capacity management. One particular product that is currently deployed by the ICRS service and receives good reviews by the management team is a product called Staff Plan from a company called Advanced Health Care.

Individual and team work schedules are input to the system by the support team in ICRS which then populates daily and weekly work schedules to the field staff's smart phones so that they know where they need to be and when. The information is refreshed frequently to account for any changes to the schedule of work, for example cancellations or in the event of a death.

A full analysis on this system together with research on alternative solutions (see appendix 6).

10. Appendices

Appendix 1 - Integrating LLR Points of Access - Design Principles

The following details the approved Design Principles used to determine the options for integration across Health and ASC Points of Access and proposed Target Operating Model (TOM):

1. The proposed operating model will provide a simplified and standardised method of access for a defined range of services and customer group
2. The proposed operating model will seek to shield customers from process complexity
3. The proposed operating model, (the technologies, locations and organisational structure) will be developed to ensure that additional services can be added over time at incremental cost
4. The model will utilise existing physical and technology assets, where appropriate, including Staff; Locations; Systems
5. The detailed delivery model will be co-designed with input from service users
6. The operating model will align with the NHS 111 service offering and Vanguard
7. Additional channels will be added to the proposed operating model where they deliver:
    - A safe more efficient and improved level of service
    - Improved access, awareness and connectivity to appropriate health and social care activities in LLR
    - Improved insight into the referral behaviours and activities in the LLR region
8. Where appropriate existing channels that are inefficient will be reviewed with a plan to remove them (e.g. Faxes, unstructured emails and white mail)
9. The processes associated with the operating model will be defined and prescriptive (in the form of Standard Operating Procedures) and will provide detailed performance analytics to provide the wider BCT functions with required Business Intelligence
10. Measures will be built into the operating model and will need to be developed further with operational teams, for example:
    - How people access the service
    - Numbers of people using the service
    - Quality of life impact
    - Quality Measures
        i. Citizens reporting a positive experience of care across all health and social care settings
        ii. Improved quality of life?

iii. Reduce inequalities
iv. Outcome framework measures

11. The Point of Access has visibility of progress of the service request wherever it is being delivered and regardless who it is being delivered by
12. Two way OLA's will be put in place between organisations and departments across the end to end service delivery
13. There will be a single number per service line for citizens to contact/access services
14. The Point of Access Operating Model will have a triage function in order to ensure the most appropriate use of resource
15. Care pathways which have a clinical aspect to them will be approved and quality assured

Appendix 2 – Why Programmes Fail

The NAO has frequently reported on difficult or failed implementations in the public sector. The following table summarises their reasons for failure and suggests mitigations. The business case's recommendations in the Implementation Approach in Section 5 align to these mitigations.

Reason for failure	Questions to mitigate the risk of failure
Lack of clear links between the programme and the organisation's key strategic priorities, including agreed measures of success	Do we know how the priority of this programme compares and aligns with our other delivery and operational activities? Have we defined the critical success factors (CSFs) for the programme? Have the CSFs been agreed with the key stakeholders? Is the programme founded on realistic timescales taking into account any statutory lead times, and showing critical dependencies such that any delays can be handled? Are the lessons learnt from relevant programmes being applied? Has an analysis been undertaken of the effects of any slippage in time, cost, scope or quality? In the event of a problem/conflict at least one must be sacrificed Have the CSF's been agreed with the Service Provider? Do we have a clear programme plan that covers the full period of the planned delivery and all business change required, and indicates the means of benefits realisation?
Lack of clear Senior Management and Ministerial ownership and leadership	Does the Programme Management Team have a clear view of the inter-dependencies between programmes, the benefits, and the criteria against which success will be judged? If the programme traverses organisational boundaries are there clear governance arrangements to ensure sustainable alignment with the business objectives of all organisations involved? Are all proposed commitments and announcements first checked for delivery implications? Does the Senior Responsible Owner (SRO) have a suitable track record of deliver? Where necessary, is it being optimised through development and

Reason for failure	Questions to mitigate the risk of failure
	training? Are decisions taken early on, decisively and adhered to, in order to facilitate successful delivery? Does the programme have the necessary approval to proceed from its nominated Minister either directly or through delegated authority to a designated SRO? Does the SRO have the ability, responsibility and authority to ensure that the business change and business benefits are delivered?
Lack of effective engagement	Have we identified the right stakeholders? Have we, as intelligent customers, identified the rationale for doing so (for example, the why, the what, the who, the where, the when and the how)? Have we secured a common understanding and agreement of stakeholders' requirements? Does the business case take account of the views of stakeholders, including customers/users? Do we understand how we will manage stakeholders (for example, ensure buy-in, overcome resistance to change, allocate risk to the party best able to manage it)? Has sufficient account been taken of the subsisting organisation culture? Whilst ensuring that there is clear accountability, how can we resolve any conflicting priorities?

Reason for failure	Questions to mitigate the risk of failure
Lack of Skills and proven approach to Programme Management and risk Management	Is there a skilled and experienced programme team with clearly defined roles and responsibilities? If not, is there access to expertise, which can benefit those fulfilling the requisite roles? Are the major risks identified, weighted and treated by the SRO, the director, and programme manager and/or the programme team? Has sufficient resource, financial and otherwise, been allocated to the programme, including an allowance for risk? Do we have adequate approaches for estimating, monitoring and controlling the total amount of expenditure on programmes? Are the governance arrangements robust enough to ensure that 'bad news' is not filtered out of progress reports to senior managers? If external consultants are used, are they accountable and committed to help ensure the successful and timely delivery? Do we have effective systems for measuring and tracking the realisation of benefits in the business case?
Too little attention to breaking development and implementation into manageable steps	Has the approach been tested to ensure that it is not 'big bang' (for example, IT enabled programmes)? Has sufficient time been built in to allow for planning applications in property and construction programmes etc.? Have we done our best to keep deliver timescales short so that change during development is avoided? Have enough review points been built in so that the programme can be stopped if changing circumstances mean that the business benefits are no longer achievable or no longer represent value for money (VFM)? Is there a business continuity plan in the event of the programme delivering late or failing to deliver at all?
Evaluation of proposals driven by initial price rather than long-term value for money (especially securing delivery of	Is the evaluation based on whole-life VFM, taking account of capital, maintenance and service costs? Do we have a proposed evaluation approach that allows us to balance financial factors against quality and security of deliver? Does the evaluation approach take account of business criticality and

Reason for failure	Questions to mitigate the risk of failure
business benefits)	affordability? Is the evaluation approach business driven?
Lack of understanding of, and contact with the supply industry at senior levels in the organisation	Have we tested that the supply industry understands our approach and agrees that it is achievable? Have we checked that the programme will attract sufficient competitive interest? Are Senior Management sufficiently engaged with the industry to be able to assess supply side risks? Do we have a clear strategy for engaging with the industry or are we making sourcing decisions on a piecemeal basis? Are there processes in place to ensure that all parties have a clear understanding of their roles and responsibilities, and a shared understanding of desired outcomes, key terms and deadlines? Do we understand the dynamics of the industry to determine whether our acquisition requirements can be met, given potentially competing pressures in other sectors of the economy? Have we asked suppliers to state any assumptions that they are making against their proposals?
Lack of effective programme team integration between clients, the supplier team and the supply chain	Has a market evaluation been undertaken to test market responsiveness to the requirements being sought? Are the procurement routes that allow integration of the programme team being used? Is there early supplier involvement to help determine and validate what outputs and outcomes are being sought for the programme? Has a shared risk register been established? Have arrangements for sharing efficiency gains throughout the supply team been established?

Appendix 3 - Co-Design Workshop Output and Feedback

The Co-Design Workshop Output summary is provided separately in pdf format as the file is too large to embed in this section of the Business Case.

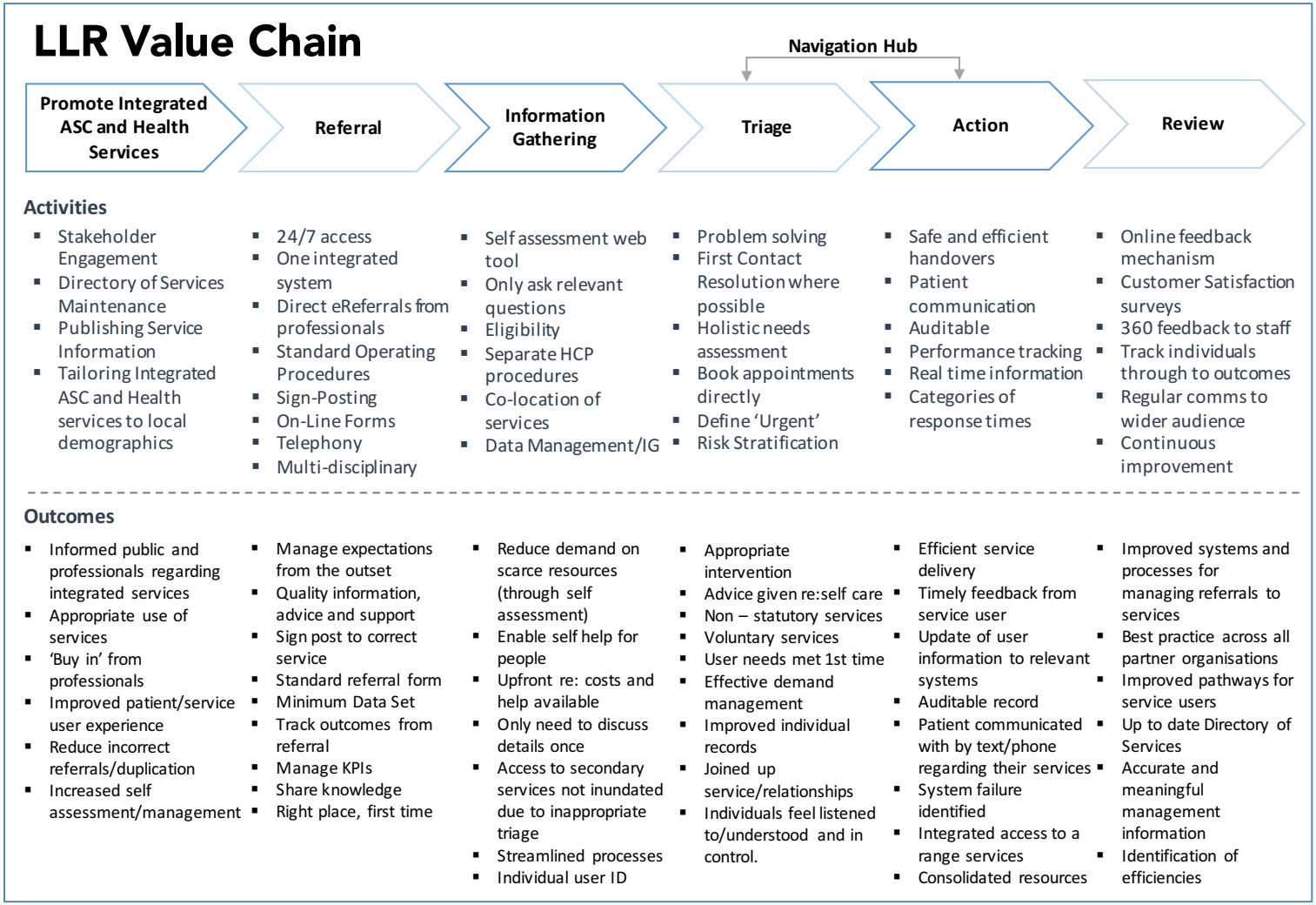
The pack provides a summary of the outputs from the two co-design workshops that were facilitated by LLR-Integrating Points of Access programme resources, as part of the information gathering stage of the programme

Contents

The pack provides the following:

- The purpose of each workshop
- A Summary of attendees/representatives present in each session
- An updated Value Chain - workshop 1
- Common Themes – workshop 1
- 'Sound bites' - workshop 2
- Common Themes – workshop 2
- Potential barriers and constraints to implementing an integrated health and social care delivery model

Appendix 4 - Value Chain Analysis



Appendix 5 – High Level Options Appraisal

Options	Description	Features	Benefits Areas	Advantages	Disadvantages
Option 1 Full Integration – three locations	Health and Social Care SPAs are fully integrated and operated from three geographical locations • Rutland • Leicester City • Leicestershire County	• Three discreet integrated ASC and Health SPAs servicing local populations • Multiskilled and professionalised workforce • Integrated ICT where possible • Case management system configured consistently across the three locations • On-line 'self serve' capability • Standardised and pathway driven business processes • Professional support available on-site to support first contact resolution and sign-posting • Up-to-date and maintained DOS to support effective sign-posting	**Cashable Benefit Areas** • Reduction in Management Structure • Estates rationalisation • Productivity and efficiency savings **BCT Benefit Enablers** • To optimise both the opportunities for integration and the use of physical assets across the health and social care economy • Ensure that services are easily accessible through appropriate access channels to as many people as possible within the community • To improve the utilisation of the in scope workforce and develop new capacity and capabilities where appropriate, in our people and the technology we use • To support the delivery of high quality, citizen centred, integrated care pathways, delivered in the appropriate place and at the appropriate time by the appropriate person, supported by staff/citizens	• Retains localised knowledge around user groups and pathways • Financial Savings • Allows the testing of integrated working on a reduced scale and allow for the review of effectiveness • Financial savings could be delivered earlier than Option 2, albeit at reduced quantum • Can be used to spearhead efficient, effective and standard service delivery model across sites • Aligns to the BCT programme aims and objectives • Approach aligns to the Vanguard model	• Potentially more expensive to implement than Option 2 (maybe multiple transformation teams and locations across multiple sites) • Potentially longer timescale to implement (decision making by 100 cuts) • Fewer financial savings due to the above • Complex transition, merging existing operational activities with the new • Could create confusion with the user group • Potential confusion over accountabilities and responsibilities across partners • The opportunity to address underlying issues through pooled capability will be reduced resulting in an inability to deliver BCT objectives • The efficiencies of scale will not be realised and a larger level of management control will need to be maintained • More effort will be required to maintain and develop standard operating procedures across three sites

Options	Description	Features	Benefits Areas	Advantages	Disadvantages
Option 2 Full Integration Co-Located Services in One location	All Health and Social Care SPAs are fully integrated and operated from one location, operating to consistent operating procedures and with data integration to existing systems	• Co-located ASC and Health services • Multiskilled and professionalised workforce • Integrated ICT • On-line 'self serve' capability • Standardised and pathway driven business processes • Consistent service Delivery model for ASC and Health services • Demand management and scheduling capability • Managed under one management structure and/or one organisation's governance • Professional support available on-site to support first contact resolution and sign-posting • Up-to-date and maintained DOS to support effective sign-posting	**Cashable Benefit Areas** • Reduction in Management Structure • Estates rationalisation • Productivity and efficiency savings • Potential ICT support and maintenance costs **BCT Benefit Enablers** • To optimise both the opportunities for integration and the use of physical assets across the health and social care economy • Ensure that services are easily accessible through appropriate access channels to as many people as possible within the community • To improve the utilisation of the in scope workforce and develop new capacity and capabilities where appropriate, in our people and the technology we use • To support the delivery of high quality, citizen centred, integrated care pathways, delivered in the appropriate place and at the appropriate time by the appropriate person, supported by staff/citizens	• Financial Savings including Estates, Management Resource and Operational delivery and Support Costs • Opportunity to achieve optimal integration across services and across ICT platforms • Opportunity to deliver an efficient and effective service delivery model staffed by an easier to flex professional and multi-skilled workforce • Easier to manage performance and drive standardised working practices under one management structure • Easier to drive change initiatives under one management structure • Allows the development of multi-disciplinary teams to develop interventions to reduce service demand • May help obviate some IG constraints • Step change will reduce the disruption caused by many and disparate programmes across the impacted organisation • The full benefits effect is realised on implementation • Aligns to and supports the delivery of the BCT programme aims and objectives • Approach does align to the Vanguard model [though more detailed co-design is required	• May create additional complexity of governance across statutory bodies and incur legal costs • Longer time frame for design and implementation • Potentially more expensive to implement (major programme resource injection will be needed) • Increased complexity in decision making throughout the design and implementation phases • Increased complexity leading to increased risk • Will require complex ICT infrastructure support the business process (increasing costs) • New ways of integrated working are only partially tested before they are changed for good • Early commitment to the model will be required from organisations who may have changing or uncertain futures • Loss of localised knowledge • Loss of well trained and productive staff

Options	Description	Features	Benefits Areas	Advantages	Disadvantages
Option 3 Part Integration of Health and ASC services (Reduced Scope)	Part integration of 'best fit' Health and ASC services: • ASC County • ASC City • LPT Community • First Contact Plus Specialist/smaller services continue to operate from discreet locations retaining individual governance but with revised and standardised operating procedures: • Bed Bureau • ASC Rutland • Adult Mental Health	• As Above in Option 2	• As Above in Option 2	• As Above with a nominal reduction in cashable benefits	• Less integration between mental and physical health excluding the mental health

Options	Description	Features	Benefits Areas	Advantages	Disadvantages
Option 4 Standardised Operating Model	All SPAs across Health and Social Care operate 'As Is' from discreet locations with a service improvement plan in place to address service delivery and operational issues	• Disparate services managed under one Governance • Shared MI and service improvement teams to manage change consistently across services • Information sharing across services	• **Potential process efficiencies**	• A level of consistent service delivery is achieved through the implementation of standard operating procedures • Improved quality and efficiency • Complex cases can be managed more efficiently • Improved customer experience	• Inefficient service delivery • No economies of scale • Service users access more expensive care (ED) • Increase in health and social care costs • Increased pressure on all health and social care resources • Cultural barriers to change • Political impact to services delivered

Appendix 6 - Capacity Management System – Research Findings

A number of staff rostering systems exist for use in the care industry. In this section we have outlined three that are specifically designed and in use in health and social care settings.

Staffplan Roster

The first of these is the product is Staffplan Roster by Advanced Health and Care which is currently being used successfully in the ICRS Point of Access. We have outlined the key features of this product and these can be used as a base upon which detailed requirements can be drawn at the later stages of the programme.

Staffplan Roster is a fully integrated software solution designed specifically for the homecare sector and is used by more than 1,000 homecare providers in the UK. It allows providers of all sizes to increase operational efficiency, improve care delivery and compliance.

Additionally, it serves all functions of a modern community care service from support worker recruitment and service user referrals, through to scheduling, training, timesheets, customisable invoicing, gross payroll, expenses and management reporting.

The features of Staffplan Roster are as follows:

- Service user record
- Care worker record
- Team management
- Allocation assistance
- Planning tools
- Communications
- Financial control modules
- Notes and journals
- Reporting and management information
- Design Your own reports

Service user record

- A comprehensive case file for each service user is stored in a compact and easy to navigate notebook tab format
- A full history of the referral and care plan is maintained, along with a complete record of all care planned and delivered

Care worker record

- A detailed personnel record is held for each care worker
- Contains extensive information relating to the care worker and their employment

history, training and qualifications, preferences, employment details, employment history and shift patterns

- Caters for management of care worker holiday
    - Automates care worker holiday management, whether care workers are on permanent, zero-hour or multiple contracts, making it easy to calculate care worker entitlement and their pay

Team management

- Care workers and service users can be allocated to teams which work both as rostering and reporting aid
- Care Managers can be set up to control a team or team group
- Only care workers and service users allocated to those teams will appear on their screen

Allocation assistance

- System includes a search feature that suggests care workers for a booking, taking into account such things as compatibility with service user, number of previous visits, skills, qualifications, languages, location and contracted hours

Planning tools

- Highly flexible toolset helps managers effectively plan care worker rosters, work patterns and visit cycles
- Planning tool takes into account cancelled, aborted, clashed and valid bookings
- A centralised management tool is available to help ensure care workers are kept fully informed of relevant changes made in their roster
- Wallcharts allow for easy visualisation and can be viewed from either a service user or care worker perspective

Communications

- System includes an integrated text message broadcasting feature, enabling efficient delivery of information to care workers without tying up office staff
- Messages can be sent to individuals, selected groups or even the entire workforce

Financial control modules

- All call charges and pay rates are automatically and accurately calculated as bookings are entered or updated
- A complete history of all invoices is maintained and every visit cross-referenced to its invoice, establishing a robust audit trail for query management
- All gross payroll calculations are automatically performed, saving time and ensuring accuracy

- Travel or any other type of expense can be entered against appropriate booking and automatically included in invoice and/or payroll runs

Notes and journals

- QuickNotes feature stores incoming messages against relevant service user / care worker and automatically bringing message to the attention of the coordinator
- A full log of all communications with both service users and care workers can be stored in 'Journal'
- Notes system allows targeted announcements and message passing within the organisation and provides an audit trail of activities

Reporting and management information

- All reports can be viewed on screen, printed or exported to a variety of standard formats
- Reports can accept user defined selection criteria, offering reporting flexibility

Design Your own reports

- System uses Microsoft SQL Server database and ODBC connectivity which allows users to design their own reports
- System also includes a built in banded report generator, ReportBuilder Enterprise.
- Following on from the features of Staffplan Roster, the associated benefits are:
- Intuitive and easy to learn
- Offers data security
- Offers flexibility to meet evolving demands of the care market
- Enables users to respond quickly and easily to ever-changing circumstances
- Enables users to make informed decisions quickly

QuikPlan Home Care Software

As previously mentioned there are a number of staff rostering systems for use in the care industry. Another example is QuikPlan Home Care Software. It is a cloud based staff rostering, care management and finance system that automates time consuming domiciliary care processes whilst reinforcing CQC compliance. This software has very similar features to Staffplan Roster, including:

- Care Staff Rostering
- Staff GPS Track and Trace
- ECM Visit Confirmation
- QuikPlan Mobile NFC App
- QuikCheck Care Monitoring

- Home Care Invoicing
- Domiciliary Staff Payroll
- Care Staff Details
- Service User Details
- Timesheets and Web Portals
- Mileage, Maps and Travel

Tagtronics

In addition to the above, Tagtronics also offers a home care management system. This system takes care of all carers training, application and recruitment process, supervision reviews, appraisals, DBS expiries and holidays and sickness. It therefore ensures the best match carer attends the home visit.

The benefits of Tagtronics' system are:

- Invoicing option allows user to produce invoices for both private clients and local authority with no limit to the number of invoice rates
- Payroll option calculates all pay rates by number of hours worked to produce gross wage totals of all staff
- Easy to use Windows based software
- Seamless integration with electronic monitoring system