# Appendix A – BCF Plan Strategic Narrative

## Summary

It has now been confirmed that areas will not be required to submit BCF plans in 2020-21. Areas must agree the use of the mandatory minimum funding streams locally and place these into a pooling arrangement governed by an agreement under section 75 of the NHS Act 2006.

The Strategic Narrative is therefore largely unchanged from that submitted in 2019/20.

## Section A – Integrating Care Around the Person

Leicestershire's vision for health and care integration is *to create a strong, sustainable, person-centred, and integrated health and care system, which improves outcomes for our citizens.* Our model of care is designed to:

- Deliver more care outside of hospital.
- Provide integrated, personalised, and holistic services.
- Help citizens, carers and professionals work hand in hand to maintain health, wellbeing and independence, for as long as possible.

The key features of our model are summarised in the table below. Please note the majority of these services/initiatives are currently in recovery, assessing the impact of Covid-19.

| BCF THEME | DESCRIPTION | IMPACT |
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| **Integrated Neighbourhood Teams** | Proactive, MDT teams delivering multiagency care planning in partnership with GP practice.<br><br>Care coordination targeted to segmented groups e.g. frailty, multiple long-term conditions, other complex high health and care needs, end of life, supporting simple hospital discharges at risk of readmission. | Minimising hospital admissions<br>Minimising readmissions<br>Improving the personalisation, quality and coordination of community care<br>Maximising the coordination and impact of local, multiagency resources on health and wellbeing outcomes<br>Maximising the impact of Leicestershire's prevention offer<br><br>Enabled by MDT working, risk stratification, population health management, Leicestershire's social prescribing and prevention offer. |
| **Home First** | Integrated teams for hospital discharge and reablement, involving nurses, therapists, social care and housing experts, operating on a "home first" philosophy<br><br>Supporting people to step down their care after a stay in hospital or step up their care at home, (e.g. when needs change and/or in a crisis). | Minimising hospital discharge delays<br>Minimising readmissions<br>Maximising opportunities for reablement<br>Maximising the number of people still in usual place of residence following reablement.<br><br>Enabled by the national high impact changes framework for DTOC, trusted assessment, |

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| | Joint planning, oversight and review of packages of care at home. | technology solutions, and co-location including new Locality Decisions Units (LDUs) to direct referrals and workflow. |
| **Adult Social Care Sustainability** | A new target operating model for sustaining adult social care involving large-scale process redesign and changes to cultural and operational practice - from the customer services centre, through assessment, to front line delivery.<br><br>Aligning adult social care resources to new health and care models e.g. neighbourhood working, crisis response, and integrated reablement. | Sustainability of social care<br>Releasing efficiencies and more time to front line care.<br>Minimising hospital discharge delays<br>Maximising opportunities for reablement<br>Maximising the number of people in usual place of residence following reablement<br>Reducing permanent admissions to residential care<br><br>Enabled by process improvements, technology, co-location, trusted assessment, the ASC Strategy, LLR Carers Strategy and the ASC accommodation strategy. |
| **Community Services Redesign** | A new specification and delivery model for NHS community services, including changes to bed-based services.<br><br>Aligning community nursing and therapy services to new care models e.g. neighbourhood working, crisis response, home first (integrated discharge and reablement) | Minimising hospital discharge delays<br>Reducing permanent admissions to residential care settings<br>Maximising reablement and independence at home<br><br>Enabled by process improvements, technology, co-location including LDUs, as noted above, trusted assessment and improved medical support in the community. |
| **Lightbulb: Leicestershire's Integrated Housing Service** | One stop shop for major/minor adaptations, home safety, affordable warmth, housing options/benefits, hoarding etc.<br><br>Delivered by innovation and "can do" housing coordinators based within hospital discharge teams and in the community. | Minimising hospital discharge delays<br>Reducing permanent admissions to residential care settings<br>Maximising reablement and independence at home<br><br>Enabled by embedding housing workers in hospital discharge teams, the housing MOT, streamlined DFG processes, continuous improvement, RRO, trusted assessment. |
| **Unified Prevention Offer** | A clear, coordinated multiagency prevention offer.<br>Targeted to population/ community needs<br>Supporting neighbourhood | Maximising the impact of local, multiagency resources on health and wellbeing outcomes<br>Maximising the uptake and impact of Leicestershire's prevention offer |

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| | teams to apply prevention interventions to their caseload | Enabled by<br>• First Contact (front door for the prevention offer)<br>• Staff "making every contact count"<br>• Local Area Coordinators –an asset-based approach in communities.<br>• GP practice-based social prescribers**.** |
| **Easy to access urgent care** | Providing clear alternatives to A&E e.g. via urgent care centres, the acute home visiting service, and extended GP services. | Reducing hospital admissions<br><br>Reducing attendances at A&E and the overall burden on the ambulance service |
| **Technology enabled care** | Digital solutions for care delivery, professionals and their customers. | Maximising staff efficiency through technology and via e-care transfers between organisations.<br>Reducing permanent admissions to residential care settings<br>Maximising reablement and independence at home<br><br>Enabled by:<br>• PHM tools<br>• Summary Care Record,<br>• E-referrals/transfers<br>• Assistive/smart tech at home<br>• Residential/nursing home connectivity<br>• Improved digital channels for prevention & self-care |

<u>Person Centred Approaches: Promoting Choice, Maximising Independence</u>

Leicestershire's integrated reablement and crisis response service has a joint holistic person-centred assessment which directs joint care planning and delivery across community nursing and adult social care.

The UHL Integrated Discharge Team has Trusted Assessment (TA) in place, delivered by a small team of UHL admission avoidance nurses, on the Acute medical unit, in-reaching into ED, across the emergency floor. TA competency workshops have taken place to help facilitate this, and Community Hospitals can now accept discharges direct from the Integrated Discharge Team.

The Integrated Needs Assessment Tool (INAT - single assessment tool) has been developed and approved by all partners. This is used to identify the individual's needs in the acute sector and supports matching patients to suitable onward placements or care pathways. This is now operating as the accepted tool for TA between all organisations.

A Trusted Assessor role has been recruited to deliver care homes' assessments across City and County, to ensure that potential clients for Care Homes are assessed within 24 hours,and can be received without query/delay into care homes, improving DTOC.

In Leicestershire's integrated housing service (Lightbulb) the Housing Support Coordinators are also now trusted assessors for major and minor adaptations, was achieved through service and process redesign, with appropriate training from the OT service.

Leicestershire's jointly commissioned domiciliary care service (Help to Live at Home) has integrated, person centred approaches built into the process of assessment, placing and review of care packages delivered in the home. As we prepare for recommissioning the service from November 2020 these will be reviewed/improved further in conjunction with the new reablement pathway.

The operating model of integrated teams is focused on improving MDT working, care coordination and person-centred care planning/delivery, for patients who are frail, multi morbid or who have high health care costs, with their named GP retaining overall accountability. Investing further in care coordinators for this cohort of patients across each area of Leicestershire.

Care Coordinators will be supported by the introduction of designated social prescribing roles for each PCN per the NHS long term plan, which in the case of Leicestershire will build on our existing prevention offer and social prescribing infrastructure. Care Coordinators in Neighbourhood Teams have tested commissioning a small threshold of social care support as part of the integrated teams pilot in Leicestershire, which can inform the model further.

Promoting Personalisation, Choice and Independence

Leicestershire's model of integrated health and care is designed to offer more choice and personalised care planning via:

- The delivery of improved person-centred care planning in neighbourhood teams, supported by a strong platform of social prescribing, including face to face support from local area coordinators
- The home first philosophy, promoting maximum reablement opportunity at home
- The LLR Carers Strategy
- The holistic and asset-based assessment/offer from adult social care's customer services team
- The holistic housing MOT from the Lightbulb Housing Service
- Supporting those with learning disabilities to achieve maximum independence in the community through the LLR Transforming Care programme and the council's accommodation strategy, whereby a large capital investment for additional supported living and extra care units across the county has recently been approved by Cabinet.

Personal Budgets

NHS and LA partners continue to prioritise and scope further opportunities for joint working.

This work is being led from the Leicestershire BCF but is being conducted on an LLR-wide basis. The joint areas of focus will likely include technical and process developments to create joint commissioning infrastructure, cultural change, identifying cohorts of service users to test integrated personal budgets, and joint approaches to market development.

**Narrative Section B (i)**

**Approach to Integrating Services at HWB Board Level (Place) – (and neighbourhood level where applicable)**

***To include reference to joint commissioning arrangements, alignment with PCNs and primary care, approach to partnership with the VCS, services to be commissioned via the BCF, noting any major changes to the approaches/BCF schemes.***

LCC, NHS, District Councils and other partners collaborate to ensure the BCF plan and pooled budget is used in accordance with national conditions and funding rules, and to maximum impact, so that the model of health and care integration is implemented, can be sustained, and that Leicestershire delivers good performance against the BCF metrics.

Since 2015, the Leicestershire BCF plan and pooled budget has been deployed to transform and enable new models of care closer to home. It has:

- Brought health and social care partners into more effective joint working/teams,
- Redesigned pathways of care more effectively around the individual
- Delivered a unified prevention offer, and developed the approach to social prescribing
- Provided major improvements to hospital discharge and reablement
- Sustained adult social care financially, supporting delivery of the adult social care strategy
- Supported the development of new urgent care services, in the community and at home
- Supported the development of neighbourhood teams, testing new approaches to risk stratification, MDT working, care coordination and prevention
- Delivered innovation, (falls pathways, data integration, technology enabled care and integrated housing support).

The BCF pooled budget continues to fund the following key areas of place-based services in 2020/21: First Contact, Care Coordination, Urgent Care at Home/in the Community, Integrated Hospital Discharge and Reablement Pathways, Domiciliary Care, Transforming Care and LD priorities, health and care data integration solutions, assistive technology developments, key services and support to sustain adult social care, (e.g. Care Act requirements, residential respite, assessment and review teams, quality assurance team for care and nursing homes, mitigation of demographic growth and winter pressures).

Alignment with Primary Care/PCNs

Leicestershire's neighbourhood teams, previously aligned to GP localities, are now being aligned to PCNs. They are comprised of designated social care staff and community nursing staff, supported by Local Area Coordinators, Lightbulb Housing Services, and the wider multiagency prevention offer. There are good working relationships with district councils in each neighbourhood, and via county wide arrangements, (e.g. Health and Wellbeing Board, Unified Prevention Board, Lightbulb Management Board).

How Leicestershire's Prevention Offer and approach to Social Prescribing supports the work of Neighbourhood Teams

Leicestershire's multiagency Unified Prevention Board (health, social care, police, fire, district councils and VCS) has designed and implemented the county wide prevention offer and approach to social prescribing over the last two years, ensuring recurrent investment in the model by partners. The BCF plan continues to contribute to the First Contact prevention

hub, a one stop shop featuring web based/telephone self-referrals and GP e-referrals, via PRISM.

To support the development of community-based assets and provide a face to face element of the prevention offer for citizens, Local Area Coordinators, funded by public health, operate in Leicestershire, with a dual role of community capacity building, and supporting individual citizens to access local support to maintain their health, wellbeing and independence.

The prevention offer has been specifically designed around the model of neighbourhood teams, which have very productive working relationships with First Contact, LACs and local district councils, maximising their engagement with, and the uptake of, the prevention offer.

The introduction of social prescribing roles within PCNs provides an additional resource into Leicestershire's prevention offer. Local partners are in the process of co-designing how these new roles will operate. A support offer from Local Area Coordinators is part of this approach.

Joint Commissioning

Joint commissioning arrangements for domiciliary care services have been in place since 2016. This service was due to be recommissioned from November 2020 onwards but plans were placed on hold following the outbreak of Covid-19. The procurement process is due to restart in the spring of 2021 and planning and Covid-19 impact assessment work has already begun in readiness for this.

A new joint commissioning work plan was developed in 2019, for the emerging place-based ICS arrangements. The workplan includes updating the LD s75 pooled budget, developing an approach to integrated personal budgets, improving CHC systems/processes for jointly funded cases, commissioning plans for the NHS community services redesign programme, and the future of the health and social care protocol. Again, much of this work is currently being recovered post Covid-19 suspension.

Partners continue to consider future opportunities for reviewing VCS commissioning at place level.

Enablers and Governance for Joint Commissioning

A new Leicestershire joint commissioning forum was established 2019/20 to lead delivery of the workplan at place. The implementation of population health management across LLR, our refreshed JSNA and a joint commissioning outcomes framework, provides improved insights for partners, with the ability to measure impact both on individual and population outcomes more effectively at place level. It is anticipated the current reconfiguration of the CCGs will lead to further opportunities to develop joint commissioning infrastructure once completed.

**B(ii) Approach to integration of Disabled Facilities Grants and wider housing services, to support the needs of people with disabilities or care needs, include any arrangements for the use of adaptions and technologies to support independent living in line with Regulatory Reform Order 2002.**

Strategic Growth Plan for Leicestershire

Leicestershire's LA's strategic growth plan to 2050 indicates the level of housing expansion and infrastructure developments expected over this period. The HWBB is already actively

engaged, ensuring design elements for healthy places/spaces and planning the impact of population and housing growth on health and care.

Lightbulb

The Lightbulb Service **is** a collaboration of seven districts councils, LCC, Public Health, three CCG's and UHL. The service delivers an integrated housing offer which promotes health, wellbeing and independence, which has both a community-based component and a hospital discharge component.

The service is well evidenced in terms of reducing delays to hospital discharge, maximising independence at home, and revolutionising the DFG process.

The service went live across Leicestershire in October 2017. It is configured in a hub and spoke model, hosted by Blaby District Council. The hub provides general management support, there is a community-based service with "spokes" into each District Council, with staffing allocated according to demand.

The hub is now approximately half-way through the three year extension agreed in January 2019.

The community-based service is accessed via several routes, (ASC customer service centre, First Contact, Neighbourhood Teams, District Councils). Wherever the entry point happens, the referral will immediately come into the one-stop shop, Lightbulb and staff continue to be embedded within integrated discharge teams and are established as an essential part of the discharge and flow, offering a follow up service in the community for complex cases.

Along with providing a holistic housing MOT which considers all the potential housing issues for the person (such as affordable warmth/damp homes, home safety and falls prevention, major and minor adaptations, advice on housing options and benefits), Lightbulb has developed innovative solutions to address those housing issued which previously took many weeks to resolve, (and in hospitals impacted on valuable clinical time).

Governance

The governance for Lightbulb continues to be comprised of a Management Board of senior officers of all District Councils, LCC and NHS representation. The purpose of this Board is to oversee the delivery and performance of the Lightbulb service, and its medium-term strategy. The Board is supported by a Lightbulb Delivery Group comprised of operational managers leading continuous improvement in housing services across the county.

**Narrative Section C – System Alignment**

**How the BCF plan and other plans align to the wider integration landscape, such as STP, ICS. A brief description of the joint governance arrangements for the BCF plan *(visuals/diagrams can be added to supplementary information sheet)***

The transformation and integration of health and care continues to be tackled at system (across LLR), at place (across Leicestershire) and at neighbourhood (within local teams and communities). Further information on the approach to the delivery of models of integrated health, care, prevention and housing, (at both place and neighbourhood levels), is given in sections B(i) and B(ii)

The Leicestershire BCF plan and pooled budget is just one element of many components of activity and sources of funds that can be prioritised and deployed by all partners to drive and deliver transformational change at these three tiers. It is also a comparatively small investment (£62.4m) when compared to the over £1.4bn spent on health and care in LLR annually.

Since 2014 partners across LLR have been collaborating on the transformation of health and care via the "Better Care Together" programme, now known as the LLR Better Care Together Sustainability and Transformation Partnership (STP). The LLR STP has several clinical and enabling workstreams. (see diagram and list on the supplementary sheet).

Many of the activities, services and deliverables funded via the Leicestershire BCF feed into the delivery plans of LLR-wide STP workstreams.(

<u>Maintaining Strategic and Financial Alignment</u>

Funding allocations through the BCF and iBCF plans continue to be carefully managed, both in terms of meeting the conditions of use, such as in support of DTOC including the HET (housing discharge team), but also by ensuring financially the application of non-recurrent funding within ASC is used to implement transformational change that generates medium term benefits or by applying time limited project support, infrastructure and quality improvements for work with specific short term milestones.

The Leicestershire BCF plan and pooled budget is fully refreshed and aligned annually in Q3/Q4 so that it maintains alignment with the medium-term financial plan of LCC, departmental budget setting for ASC, and the operational plan and financial plans of both CCGs including QIPP assumptions. Planning for 2021/22 has already commenced.

<u>System, Place and Neighbourhood</u>

The delivery of integrated models of health and care with Local Authorities relies on a clear vision and direction at place, and strong coordination and relationship management with a range of other agencies outside of the STP partnership, such as District Councils, the Police and enterprise partnerships. In particular, those commissioning and delivering solutions targeted to the wider determinants of health and wellbeing, including economic growth, housing, transport, community safety and other socio-economic factors.

For Leicestershire, there are a number of key areas of wider place-based partnership working which have implications for the commissioning and provision of integrated health, care, housing and prevention services. These include:

- Leicestershire's 2050 Strategic Growth Plan
- The priorities of the Housing Services Partnership

- The target operating model for adult social care
- The priorities of the Children's Partnership Plan
- The adult social care Accommodation Strategy (extra care/supported living)
- The priorities of the LLEP, and its associated Industrial and Workforce Strategies
- The Leicestershire Communities Strategy (asset-based communities)
- The overall role and work of Public Health
- The overall role and work of Leicestershire and Rutland Sport

Place level working also necessitates effective arrangements and infrastructure for joint commissioning including the implementation and oversight of pooled budgets between the NHS and Local Government, (see further detail about Leicestershire's arrangements at section Bi).

Previous plans and timetables for change are currently being impact assessed as a result of Covid-19. As a result, Leicestershire's placed-based governance arrangements continue to be updated and reviewed.

Joint Governance Arrangements for the BCF Plan

As a result of Covid-19; Leicestershire's place-based governance arrangements are currently being revisited to ensure that they are still appropriate to support services moving forwards. Any changes will be reflected in the BCF plan for 2021/22.

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