Appendix A

BCF narrative plan template

This is an optional template for local areas to use to submit narrative plans for the Better Care Fund (BCF). These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover the headings and topics in this narrative template.

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover
Health and Wellbeing Board(s)

Leicestershire

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, district councils)
How have you gone about involving these stakeholders?

Stakeholders have been involved via a well-established, place-based infrastructure (see governance section below which includes representation). We also have continuous strategic engagement with our partnership forums from across LLR including the Frailty Collaborative and PCCDG (Changing to Primary Care Transformation Group and Home First Programme Board). These groups are responsible for developing the Integrated Care System (ICS) which ensures co-ordination with BCF delivery plans.

The Leicestershire BCF plan for 2021/22 and pooled budget is developed jointly and approved formally as follows:

- By Leicester, Leicestershire and Rutland (LLR) Clinical Commissioning Groups (CCG's) governing bodies (8th – November 2021)
- By Leicestershire County Council (LCC) departmental consultation (adult social care and Public Health – 1st November 2021)
- By all partners via the Health and Wellbeing Board (HWBB) which comprises of:
    - Elected Members, LLR CCG's, Adult Social Care, Public Health, Children's Services, University Hospitals Leicester (UHL), Leicestershire Partnership Trust (LPT), District Council's, Police and Crime Commissioner and Healthwatch Leicester and Leicestershire (Commissioned to represent volunteers, VCS and the Public Voice).

BCF preparation reports are submitted for initial approval to the Chief Executive of the County Council and Lead Member for Health on 5th November 2021 pending formal approval at the 25th November 2021 board.

In addition, the Leicestershire HWBB is currently developing a new, 10-year Joint Health and Wellbeing Strategy (JHWS). The BCF plan has been aligned to the first draft of this strategy and will be jointly responsible for delivering against two life courses within the plan (Living and Supported Well and Dying Well). This has been agreed and developed with a sub-group of HWBB partners

including voluntary sector representation. It is due to go for wider public consultation after approval at the 25th November Health and Wellbeing Board alongside the BCF plan for 2021/22.

Oversight of BCF plan development is through the Integration Executive. This is a director level group, chaired by a clinical lead from the CCG (rotating approx. every 18 months) which currently meets bi-monthly. It has delegated duties from the Health and Wellbeing Board which includes the oversight of the preparation and day to day delivery of the BCF plan and pooled budget. It has representatives from the University Hospitals of Leicester, Public Health, Adult Social Care, LLR CCG's, Leicestershire Partnership Trust (MH and Community Health Services Provider), Derbyshire Health United, Health Watch, Voluntary Sector providers also attend to update on elements of BCF-funded provision. A sub-group drafted the initial 2021-22 BCF budget.

The Integration Executive is supported by two sub-groups as follows:

- Joint Commissioning and Integrated Finance and Performance Group (JCG) (Bi-monthly – commissioners only – oversight of the joint commissioning workplan and pooled budgets/s75 agreements including DFG allocation agreement. For 21/22 this was agreed as passported directly to districts at its meeting of 15th September along with agreement to top-slice DFG funds for additional housing schemes using Regulatory Reform Orders (RRO's) for discretionary use of DFG funding
- Integration Delivery Group (IDG) (Meets monthly – comprised of providers and commissioners, including PCN and primary care clinical reps, Children and Families Services, Public Health, District Councils - including housing representation and Healthwatch)

Executive Summary

This should include:

- **Priorities for 2021-22**
- **Key changes since previous BCF plan**

The BCF plan for Leicestershire for 2021/22 reflects the established framework already in place for 2021/22. Previous BCF planning submissions were developed earlier in the financial year. This will be the case for the 2022/23 plan which will include scheme reviews and further stretch targets to meet the indicators within next years plan. This work will begin in earnest in January 2022.

LCC, NHS, District Councils and other partners have collaborated through the established governance structure (see below) 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. It has:

- Brought health, social care and housing 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 and care coordination
- Delivered innovation, (falls pathways, data integration, technology enabled care and integrated housing support).

For 2021/22, joint priorities and projected spend were planned and approved by partners and stakeholders during the planning phase which began in January 2021. Each stage of the plan development has been through the governance structure shown below, including commissioning changes and improvements to the JCG and delivery plans to the IDG. In 2020 the approach to commissioning was revised to combine the Integrated Finance and Performance Group with the Joint Commissioning Group to ensure further join up of financial decision making alongside key commissioners of services from across our stakeholders. This year partners made the joint decision to increase investment in community schemes that support the Home First methodology and the discharge to assess guidance to work towards a community pull model providing both step-up and step-down requirements.

The BCF pooled budget will fund the following key areas of place-based services in 2021/22:
Care Coordination, Home First Community Response Service including Integrated Hospital Discharge and Reablement Pathways, Re-commissioning of Domiciliary Care (Home Care for Leicestershire), First Contact Plus, Transforming Care and LD priorities, health and care data integration solutions, assistive technology developments, key services to support and 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).

Key changes include additional investment in Care Co-ordination, development of a new model for our Community Response Service, re-commissioning domiciliary care across Leicestershire and the

creation of an integrated discharge hub. District Councils have also developed plans around discretionary use of DFG funding through Regulatory Reform Orders to support a range of housing related services including a pilot support service for hoarders and early support to people diagnosed with dementia.

The table below shows the metrics and associated targets and summarises the joint key priorities for 2021/22 alongside any additional investment that will work towards meeting the targets. Additional investment, both BCF and non-BCF totals in the region of 3.6 million to meet the priorities and desired outcomes outlined in the BCF plan for 2021/22. The non-BCF funding has been agreed to support BCF schemes, however does not form part of the pooled budget arrangements so is therefore not included in the planning template as additional contributions:

Metric	**Target**	**Schemes that contribute (2021/22 priority changes)**	**Additional investment from 2020/21**
Unplanned admissions for chronic ambulatory care-sensitive conditions.	7% reduction on 2019/20 (831.5 to 775)	Home First (overall) Inc Brokerage, Review, Case Mgmt, Nursing and Therapy	1 million
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	85% an increase of 0.3% on 2020/21 data of 84.7%	Community Response Service	372k
		Care Co-ordination	142k
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (excluding RIP)	93.10%. This represents an increase of 1.5% on 2020/21 data and an increase of 1% on 19/20 data	Home Care 4 Leics	1.38 million
		Falls Crisis Response Service	510k (Ageing well)
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more	Weighted data = 14+ days = 10% 21+ days = 4.6% Maintaining current figures to meet national targets	Therapy-led D2A beds	300k to date (D2A funding)
		Discharge pathways case management	93k
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Planned rate of 519 = 3% reduction from 19/20 rate of 536		

Metric targets have been jointly produced with each area using the same methodology. This has been through a collaboration of representation from Mids and Lancs Commissioning Support Unit (M&LCSU), Local Authorities and CCG's with targets and metrics agreed with all partners including health trusts at the 28th October, Strategic Discharge Cell. These have been added to the performance framework across LLR for joint delivery of outcomes related to activity to support timely discharge.

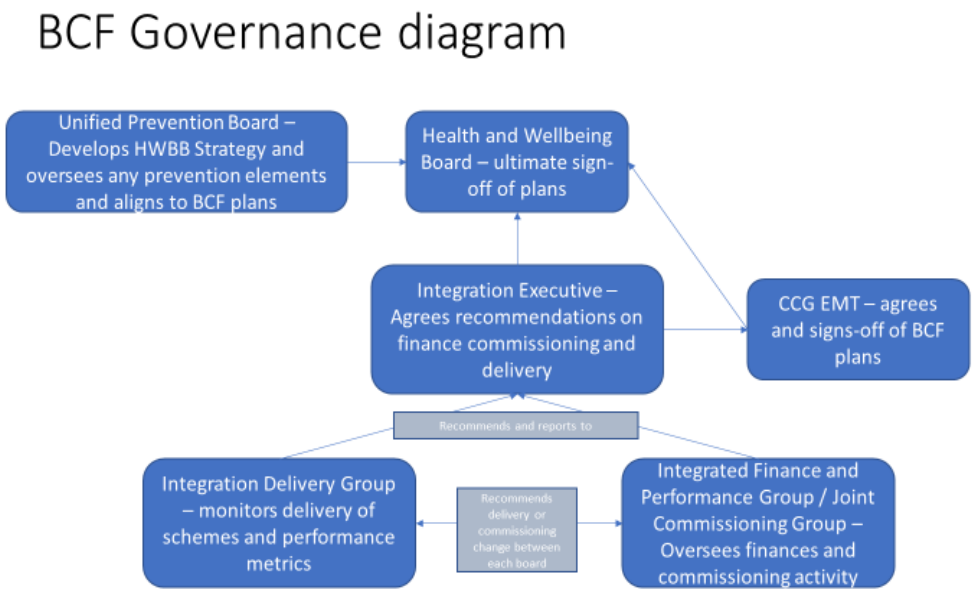
Governance
Please briefly outline the governance for the BCF plan and its implementation in your area.

The Joint Commissioning and Integrated Finance and Performance Group and Integration Delivery Group are sub-boards of the Integration Executive. The first (JCG) is responsible for approving BCF expenditure throughout the year including the direct passporting of DFG funds to District Councils and making commissioning recommendations and leading on the delivery of commissioning activity within the BCF. The IDG is responsible for the ongoing implementation and delivery of schemes within the BCF and also makes recommendations to the JCG where new or re-commissioning is required. Voluntary Sector providers and other commissioned services providers attend to update on elements of BCF-funded provision.

Recommendations are then made from both the JCG / IFPG and the IDG to the Integration Executive (a sub-board of the HWBB) which ultimately approves elements of the plan around income and expenditure.

Prevention schemes are reported to the Unified Prevention Board which has recommenced monthly meetings as of April 2021. This is also a sub-board of the HWBB and is co-chaired by the Director of Public Health and a District Council Chief Executive. It comprises senior managers from all health and care partners as well as the voluntary sector, fire, ambulance service and police. The group has been tasked with re-designing the model for a unified prevention offer into a Staying Healthy Board. This will include delivery of the staying healthy elements of the newly developed Joint Health and Wellbeing Strategy, this includes health inequalities, wider determinants workplan and overall health improvement agenda. Additional prevention priorities in the BCF plan are developed and delivered through this board with wider funding primarily through the Public Health budget. This group reports directly to Leicestershire's Health and Wellbeing Board given the importance of this work in relation to both Leicestershire's Joint Health and Wellbeing Strategy

The BCF plan is approved and signed off by the Health and Wellbeing Board for Leicestershire County Council. Below is a diagram that shows the BCF sign-off processes and governance, including where boards oversee commissioning or delivery activity.



The 2021/22 plan will be signed off at 25th November meeting of the Health and Wellbeing Board. For the submission deadline, the plan will be approved by the Chief Executive for Leicestershire County Council and the lead elected member for Health.

Overall approach to integration
Brief outline of approach to embedding integrated, person centred health, social care and housing services including

- **Joint priorities for 2021-22**
- **Approaches to joint/collaborative commissioning**
- **Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.**
- **How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21**

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 jointly agreed priorities for delivering models of care are to:

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

Our approach to joint commissioning for 2021/22 has been to re-align the BCF into key sections of delivery against these priorities in order to make it clear how BCF investment aligns to person-centred care and maintaining independence wherever possible. These are: Home First, Discharge to Assess, Transforming Care, Mental Health and Health and Social Care protected services. Within these sections, schemes are funded to deliver outcomes around proactive care, place-based models of care development, Falls and AT, personalised care, Dementia Strategy, LD pooled budget arrangements and preablement. This has made it easier to determine overall commissioning activity within each key section.

Summarised below are the key features and developments that aim to meet the above priorities, including any changes to our Better Care Fund planning or spend:

Home First - circa £8.6 million with additional investment of circa £1 million from 2020/21.
One of the major ambitions in our approach to integrated care has been the development of an overarching health and social care service that aims to 'pull' people into the community from hospital and to provide a step-up crisis model of care.

The current restructure in ASC aligns to this model creating an integrated team of care provision that assesses and case manages patients at home. This replaced the separate functions that previously existed and expanded on the previous ambitions of the Ageing Well strategy by further integrating community models of care, including reablement services, to maximise independence, support people to remain in their own homes and reduce inequality of ability to remain at home based on age and disability.

The key features are outlined below with additional information on links to this service in the supporting discharge section:

- Integrated teams for hospital discharge and reablement, involving nurses, therapists, social care and housing experts, operating on a "home first" philosophy that provides immediate support in the community and assesses ongoing need
- Supporting people to step down care after a stay in hospital or step up care at home, (when needs change and/or in a crisis).

- Joint planning, oversight and review of packages of care at home.
- Incorporating Crisis response duty team working at the Hospital front-door
- Development of the case management function into a bespoke team including review staff
- Additional brokerage function to improve flow into longer term domiciliary care

Desired outcomes –

- Assessment of people in their own homes to gain better insight into their requirements – both maximising reablement potential and reducing the likelihood of over commissioning
- Helping people to remain in their own home
- Partnership led service that can adapt to meet increased needs in the community
- Singular case management function improving links to VCS and community services to provide additional / ongoing support
- Development and delivery of the Integrated Personalised Care framework

Overall Impact -

- Reduce the number of unplanned admissions for chronic ambulatory care-sensitive conditions.
- Maximising opportunities for reablement and aims to increase the number of people at home 91 days after discharge into reablement services
- Maximising the number of people discharged to their usual place of residence
- Reducing length of stay
- Preventing admissions to long-term residential care

Changes from 2020/21 -

- Further investment in recruitment (recurrent) of review staff, brokerage, Home Care Assistants and Case Management
- Aligning the locality model of delivery to LPT hubs to incorporate community nursing and therapy
- Re-assessment (post-pandemic) of demand and capacity modelling
- Incorporating Crisis response services
- Incorporating previously externally commissioned bridging services including staff TUPE

Challenges -

- Recruitment – established a temporary recruitment team to focus on increasing capacity in direct support roles. Additional 50k funding from ageing well is contributing to this for 2021/22 and a joint LLR workforce strategy has been produced with health and LA partners for long-term recruitment, retention and workforce development.
- Capacity in the domiciliary care market and recent fluctuations has meant ongoing capacity modelling to ensure staffing requirements for CRS is met. For example, the original demand modelling for this service showed that approx. 20 HCA's would be required to care for the approx. 120 discharges per week to a persons' own home as at April 2020. This has now increased to 40 HCA's due to increased wait times for care packages to start from 3 days to 7 days and the increase in acuity from requiring on average 2 calls per day to 2.5 calls per day. Currently an additional 17 staff have been recruited to this service so far this year.

Care Co-ordination – circa £663k – with additional funding of £142k from System Development Funds (recurrent)

Care co-ordination has been funded through the BCF since 2015, however this was commissioned and delivered differently across East and West Leicestershire. In 2021 the process for establishing one service, commissioned and funded singularly across Leicestershire, began. A jointly agreed and funded model to support discharges, D2A assessment beds and PCN's in their proactive care requirements has been developed including integrated joint funding arrangements, with additional investment through recurrent health funding, secured to further expand the service.

Care co-ordinators will work in three ways:

- Proactively working with GP surgeries and Primary Care Networks. With 18 co-ordinators (ensuring one for each PCN) using risk stratification data to identify those at highest risk of emergency admission within the next 12 months
- Reactively working with patient 0's that are over 65 with LTC's as they settle back home after being discharged from hospital
- 8 of the 18 case manage the exit of patients from D2A therapy-led beds and D2A social care beds, to successfully move patients back home and reduce ongoing bedded care

Desired outcomes -

- To develop a model of proactive care working within neighbourhood teams and PCN's to reduce admissions
- Create care plans with patients in the community to help maintain people at home and reduce admissions to care homes.
- To reduce long-term admissions to care homes
- To work with patient 0 cohorts over 65, to help them engage with community support to improve health outcomes and reduce the risk of readmission.

Overall impact -

- Minimising hospital admissions for care sensitive ambulatory conditions contributing to the 7% reduction by working with approx. caseload of proactive patients of 10 cases per Care Co-ordinators identified per week
- Minimising readmissions within the patient 0 cohort to ensure sufficient community support.
- Preventing admission to long-term care from D2A beds. 6 FTE case managing currently allocated 3 cases per week each.
- Reducing admission to residential care in the community
- 4-5 GP referrals per PCN referred to their allocated care co-ordinator per week

Changes from 2020/21 -

- One service across all of Leicestershire working in the same way
- Increased investment and recruitment
- Improved rostering to provide a duty service for patient 0's

Home Care for Leicestershire – 16.7 million plus 14.3 million IBCF for stabilising the care market – with additional funding 1.38 million for 2021/22

The current Help to Live at Home (HTLAH) service contract ends on 31st October 2021 and the new Leicestershire integrated health and social care service Home Care for Leicestershire, starts on 1st November 2021. The Home Care for Leicestershire service is jointly commissioned by Leicestershire County Council and the County Clinical Commissioning Groups (CCGs) and will provide on-going care, following reablement by HART, or where people are assessed as having eligible needs and will help people to live as independently as possible.

Desired Outcomes from the new contract -

- Increase resilience and maximise independence.
- People are supported in the right place, whether at home, in the community or in a specialist setting according to need
- With enough support to keep people safe and prevent, reduce or delay the need for long term help, delivered by the right people with the right skills and technology
- Reduce the length of time it takes for care packages to start and reducing length of stay in hospitals

Overall Impact -

- The proposed new service will incentivise providers to pick up packages of care in a timelier way across the County - including in the more rural and remote areas.
- There will be four pricing levels in the new service aligned to providers' costs to ensure a good rural supply and responses to all requests for care
- Reducing care waits to as short a time as possible, helping to meet the joint targets around discharge to assess within 24 hours and improve flow through the CRS and HART reablement services (pick up within 3 days of D2A home)
- Contribute to the reduction in the amount of long-term admissions to care homes from a rate of 536 to 519.
- Reduce the use of interim beds currently used for discharges where all other support services cannot bridge until a package of care can start

Changes -

- Reablement support is not included in HC4L; all reablement will be provided by HART.
- HC4L Zones replace the HTLAH Lots. Zones are based on analysis of local operating areas including population centres and transport links.
- The HC4L framework includes nearly 50 small, medium and large providers with no limits on the number of providers that can operate in each of the new HC4L zones.
- Four Price bands have been introduced (Urban, Fringe, Rural and Isolated) to reflect the costs of delivering care to different areas of the county.

Challenges -

- Recruitment and retention in the care sector – 213k of iBCF is utilised to develop the external workforce annually – for 2021/22 there is an increase of 7k on this investment.
- Commissioning a new contract has meant that it has led to some instability within the care market. Additional care requirements have been picked up through HART capacity and working with ICRS colleagues in the City and the use of interim beds where necessary.

Supporting Discharge (national condition four)

What is the approach in your area to improving outcomes for people being discharged from hospital?

How is BCF funded activity supporting safe, timely and effective discharge?
Below are examples of investment in schemes to support discharge and discharge planning. All schemes are jointly agreed and approved with partners including University Hospitals Leicester and Leicestershire Partnership Trust both represented on boards and delivery groups as part of the agreed governance structure and through joint forums such as the Strategic Discharge Cell. The discharge cell, created during the pandemic agreed that University Hospitals Leicester would host the discharge hub and during 2020 it was agreed out of area trusts (George Eliot Hospital NHS Trust, University Hospitals of Derby and Burton NHS Foundation Trust, Kettering General Hospital NHS Foundation Trust) would liaise with the hub to record all Leicestershire patient discharge plans in a singular place. This ensures equity for Leicestershire residents in the joint discharge offer, regardless of their nearest trust.

Community Response Service (CRS) and increased HART reablement capacity – circa £1.7 million with 372k additional funds
Within our Home First Service the CRS community pull model aims to support approximately 120 discharged patients per week with increased HART capacity to have 87 patients start reablement per week. This represents an increase in overall capacity to HART of 15% and is part of the ASC Target Operating Model. The forecast is to see significant improvement in capacity fully during 2022/23 when investment from this year has taken full effect (including recruitment of additional staffing to support the model). During 2021/22 the forecast is to make a slight increase in the number of people at home following reablement which reflects the delayed impact of benefits of in-year investment. Targets will increase in following years.

The aim for the CRS, is to apply the D2A guidance and successfully discharge people into care provision at home within 24 hours of becoming medically optimised with wrap-around health and social care alongside timely case management. As described above, the BCF is supporting the recruitment of 20 additional HCA's and the ASC restructure is supporting the development of a team of circa 20 dedicated case managers to support the function and visit patients within the first 3 days to establish ongoing care needs.

Desired outcomes -

- Timely discharges reducing delays attributable to care capacity
- Discharging patients within 24 hours of medical optimisation
- Supporting more people at home and reducing use of temporary and long-term bedded care solutions
- Providing social care tasks and lower level health tasks together
- Providing assessment of ongoing care at the right time and in the right place to make better judgements on ability and maximise the opportunities for reablement

Overall impact -

- To meet the national D2A guidance metrics of 45% discharges on pathway 1
- Maximising the number of people discharged to their usual place of residence
- Preventing admissions to long-term residential care
- To meet the 2-day CSDS target for reablement linked to Ageing Well funding outcomes

Changes from 2020/21 -

- Combined service incorporating step-up and step-down support

- Dedicated case management team to ensure flow
- Bridging services brought in-house to provide a holistic, cost-effective solution

Challenges -

- Increased acuity of patients has meant that in some cases assessment isn't appropriate until after a period of recovery. This increases the time spent within the service before handing on to longer-term solutions which can cause blockages and increase the use of interim and D2A beds. Further demand modelling on the CRS service has shown that the 'bridging' element has increased from 2 calls in November 2019 to almost 3 calls per day in April 2021. Partners have mitigated to provide additional temporary bedded capacity and City's ICRS service has contributed to bridging capacity in agreed locality areas.
- Demand for care has grown by 30% during the pandemic. Managing the increased demand for domiciliary care market has meant that the CRS service cannot flow patients into ongoing care for up to 7 days in some areas of the county. To mitigate, further investment in brokerage functions and review functions to increase care capacity has taken place as part of the expansion of the Home First service. The Home Care for Leicestershire re-contracting will also help to improve available capacity – see section above.

Integrated Discharge Hub and Case Management for Discharge - £135k
In 2020/21 Leicester, Leicestershire, and Rutland established an Integrated Discharge Hub with Hospital Trusts to streamline, coordinate and facilitate discharges for patients requiring ongoing support post discharge on pathways 1-3.

- We have developed an electronic LLR Discharge Tracker that serves to provide system-wide assurance, across our single bed-base, of acute and community hospital inpatient beds, on key quality and performance metrics aligned to the national discharge guidance.
- LLR have recently established a System Flow Partnership and is developing a dashboard of quality and performance indicators.
- Multi-agency staff have access to all Systm1 health records and can update and track patient activity in real-time
- Adult social care staff are supported to return to triaging patients alongside clinical and ward staff to establish appropriate level of care needs with approx 10 staff members available on a daily basis to support ward rounds at 3 UHL sites

Desired outcomes -

- Timely discharge for all patients to their usual place of residence
- Correct level of care on discharge, reducing over-prescription
- Increasing flow through hospitals
- One data set to enable real-time information
- Increase description of care needs not prescription

Overall Impact -

- To meet the 2-hour CSDS targets linked to Ageing Well funding outcomes
- To meet the national D2A guidance for discharging patients within 24 hours of medical optimisation and meet the local target of 75%
- To increase the number of residents discharged to their usual place of residence
- Reduce length of stay

Changes -

- The development of the discharge hub replaces the Integrated Discharge Team

- Adult Social Care staff are a physical presence on wards after the covid pandemic restrictions were lifted
- Enables early discharge planning (HICM)
- One system for real-time patient information means reduced time spent at daily sitrep calls

Challenges -

- Increased overall admissions has been observed nationally due to many people not seeking healthcare support during the covid pandemic. In some cases this has led to greater healthcare needs overall and has created higher demand for services both within health and social care.
- LLR is currently challenged with high numbers of inpatients who are medically optimised for discharge, and the percentage of inpatients over the age of 65 being discharged into residential settings is higher than the national ambition.
- Workforce recruitment and retention remains the greatest area of challenge across LLR. The Better Care Fund has been, and continues to be, instrumental in supporting the development of roles and services, across health, social care, VCSE and Housing sectors to support discharge in line with our Home First ambitions.

Additional discharge support schemes

Housing Enablement Team (HET) - £107k
The Hospital Housing Team work in a pragmatic way to remove barriers and have strong links with local authority and voluntary services, which has proved key in reducing readmission and reducing length of stay in hospitals. As part of the Housing Offer to Health developed in 2018 the HET service demonstrated a reduction in the burden on acute care, reduced delays in discharge and length of stay in care settings and shows a return on investment by reducing costs associated with delays to discharging patients and reduced A&E attendance through this integrated team.

During the pandemic to support flow, the team of housing specialists supported patients in mental health rehab units to unblock barriers and allow flow through the system to reduce inequality of access to mental health and housing services during the pandemic. This is being looked at as a long-term change to the HET service provision. The UHL HET team have also been supporting therapists and D2A patients and their families to create downstairs existences for longer-term care requirements in their own homes.

Commissioning of step-down Therapy-led D2A beds - £300k (D2A funding to date)
With a growing need for therapy input to help reable patients after an acute spell in hospital, a set of 28 beds across 4 care homes has jointly been commissioned to provide a community therapy pull model. This enables patients to access therapy services when their acute phase has finished but when they aren't well enough to return home. It allows therapy resources to reach a greater number of county patients if concentrated in specific locations.

In the longer-term, improved joint-commissioning models are being discussed along with increasing therapy resources to support residents at home with CRS and domiciliary care to increase further the number of patients discharged on pathway one.

Focus on LOS
Within UHL, data examined during October 2021 on patients with a long LOS showed that for those patients with a LOS 21 days+, approx. one third were not medically fit, one third were delayed discharges and one third had other reasons for delay (e.g. transfer to specialist brain injury units etc). In October 2021, the discharge cell agreed a regular focus on the third of patients who are

delayed for reasons due to discharge arrangements who have been medically fit for over 10 days to ensure a reduction in patients staying for both 14 days+ and 21 days+. Reports are pulled each Monday (starting mid-Oct 2021) for partners on that days sitrep call work on discharging this cohort of patients in particular. This is showing an immediate effect in reducing long LOS patients. Within the first week numbers reduced from 51 patients to 31 the following week. This activity aims to reduce the one third of patients that have been analysed as 21days+ LOS that are medically optimised for discharge.

Disabled Facilities Grant (DFG) and wider services
What is your approach to bringing together health, care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

Leicestershire transformed the delivery of Disabled Facilities Grants in 2017, with a partnership set up between Social care, Health, Public Health and Local Authorities. Customers across Leicestershire now have access to a more efficient service including reduced handoffs. A Trusted Assessor model was adopted to provide a housing MOT to ensure customers' homes are dealt with in a holistic way. All housing related schemes apart from the Housing Enablement Team (direct BCF funding with LLR partners) are funded through DFG grants including discretionary use of DFG funding via Regulatory Reform Orders (RRO's).

From Oct 2017 to date, 8122 residents have been supported by the Trusted Assessors and have carried out over 7000 MOT's across Leicestershire.

The Lightbulb model has also introduced further tools to help residents by introducing the following grants via an RRO, housing assistance policy:

- Minor home safety improvements (Home Support Grants) – help with home safety items and keeping the structure secure
- Relocation Grant – if a property can't be adapted help with relocation costs
- DFG for those with Mental Health and LD
- Equipment for perm long term substantial diagnosed condition i.e ceiling track hoist
- Extended warranty cover for stairlifts
- Modular ramping grant for temporary access
- Hospital Discharge Grants – currently being trialled with UHL therapy teams to support accessing properties for return home as well as easy access for appointments
- Discretionary funding Grant
- Temporary Adaptation Grant – a set amount for speedy discharge during the pandemic

As the DFG is subject to strict statutory governance these new grants also have eligibility criteria but open the door to new areas that the DFG has not traditionally been used for.

During the pandemic, due to the knowledge of the HSC's they were able to support Care Coordinators with follow up calls to recently discharged patients. Although Lightbulb has its own Governance structure which is maintained by Blaby District Council on behalf of all Districts and Boroughs in Leicestershire and Adult Social Care, there are links with local Health Boards and the Place based HWBB which can receive requests for support and can allow services to step up when required.

Currently plans are being realised for the development of several further projects to help support discharge and flow

- Assistive technology pilot – to reassess the current offer and develop the early prevention offer to residents
- Early Dementia support – provide dementia related support for adaptations earlier in diagnosis and introduce to assistive tech solutions as soon as possible
- Hoarding pilot – to introduce a standard pathway and joint approach to support long-term and short-term cases

- Ramp / Access from hospital discharge – a trial is underway to improve access for patients that are involved with therapy services and D2A pathways

The Hospital Housing Enablement Team (HET) who provide a bedside service to residents and support flow through acute and mental health hospitals continue to support the integrated discharge hub.

Most of the work involves cases that are outside of statutory duty for local authority housing teams but fulfil the hospitals requirement to have a legal route for referral of homeless patients to the local authority.

The additional support provided includes housing support for TB patients that access the TB centre for the east midlands located in the Leicester hospitals, as well as extending support to mental health rehab services. Most recently Lightbulb services and HET have been supporting therapy service patients with housing related issues by providing measures such as creating a downstairs existence where possible.

Equality and health inequalities.

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

Changes from previous BCF plan.

How these inequalities are being addressed through the BCF plan and services funded through this.

Inequality of outcomes related to the BCF national metrics.

The Leicestershire BCF plan is an enabler to all statutory organisations in our integration partnership in discharging their duties with respect to tackling and reducing inequalities. Reduction in health inequalities is informed by socio-economic data and woven into the design and prioritisation of interventions.

In this year's BCF we have further developed our approach to population health management particularly in light of inequalities highlighted during the covid pandemic. Partners have been provided with integrated sets of data to examine these issues which is in turn currently informing a refresh of the Health and Wellbeing Strategy which is being developed in 2021/22. One of the main aims of the strategy is to pinpoint health inequalities in order to design effective services to reduce these. This will be fed into current and future BCF planning. Examples of investment already in place include Care Co-ordination proactive care model which targets services in areas of greatest deprivation, Care home interventions delivering enhancements in care for people living with severe LD alongside a strongly personalised and enabling approach in care in the community and partners assessing national guidance on digital inclusion to ensure due regard to this when we introduce new technologies for service users.

BCF schemes, when newly commissioned have updated Equality Impact Assessments completed at the start of the commissioning process to better identify and inform any new commissioning requirements and how this may impact on inequalities.

Strategic actions to reduce health inequalities at the Integrated Care System level and local level:

Action 1
Places will be expected to apply the principles, outlined in this framework, to their specific populations in the most appropriate way that meets their local needs. This is likely to embrace the various factors that can affect people's health.

Action 2
The ICS will make investment decisions for people across LLR that reflect the various needs of different communities. In this way, actions can be universal, but adjusted and made proportionate to the level of disadvantage. The aim of reducing health inequalities will be a high priority. Specifically, we will develop a new strategic long-term model of primary care (GP practice) funding, distribution and investment. This will 'level up' funding based on population need rather than historical allocation. Delivery of actions to reduce health inequalities locally, will be the responsibility of the Unified Prevention Board being re-designed as a Staying Healthy Board.

Action 3
We will establish a defined resource to review health inequalities at this strategic level. This will be a virtual partnership between the NHS, local authorities and local universities. An enhanced ability to process and analyse data will support a better understanding of inequity across the area. We will

gather and share best practice in effective interventions and provide teaching and training to all levels of staff in undertaking health equity audits. We will facilitate local research. Public health teams will deliver, with partners, the health inequalities support function at a place and neighbourhood level as part of the delivery of the Health and Wellbeing Stratgy. Specifically, a proposal for the establishment of an LLR health inequality resource will be presented to the system executive during the 2021/22 financial year.

Action 4
All decision makers within the ICS will have expertise, skills, insight and understanding of health inequity and how to reduce it. Specifically, health inequity and inequality training will be mandatory for all executive decision makers in each organisation by the end of November 2021. We will work with local and regional partners to develop appropriate and robust training packages relevant to roles.

Action 5
Partner organisations will work together to understand the impact of Covid-19 on health inequalities across LLR, to allow effective and equitable recovery after the pandemic. We will be looking to:

- Identify groups and communities, across all ages and across protected characteristics, which have been most affected by the pandemic as a result of pre-existing vulnerabilities and disadvantages
- Undertake proportionate additional work to ensure vaccine uptake is equitable
- Include consideration of the role of the wider determinants of health, such as education, employment, housing and poverty
- Promote equal support for mental and physical health to those groups worst affected by the pandemic and the consequences of lockdown.

Action 6
All partners will work to improve the completeness and consistency of their data to enable a better understanding of health inequity. This mainly relates to data collection on people with 'protected characteristics' under the Equality Act. Specifically, partner organisations will develop an action plan for having ethnicity, accessibility and communication needs of their population appropriately coded in records. In addition, we will make better use of our data sets in order to identify vulnerable groups and individuals to offer proactive, holistic care through Integrated Neighbourhood Teams. The BCF funded Care Co-ordination model is an example of how this will be addressed.

Action 7
At the ICS level, we will obtain and use data to help us better understand where we can do more work to reduce health inequity. Specifically, each organisation will adopt a standard health equity audit tool and put training plans in place to use this tool, so that each 'place' area can compare their performance against other areas.

Action 8
We will undertake health equity audits to identify health inequalities between different population groups. These will be carried out at the planning stage when we commission, redesign or evaluate services. Action to reduce health inequity will be taken based on audit findings (at a minimum considering the protected characteristics of the Equality Act 2010).

Action 9
The NHS and public sector partner organisations within the ICS will seek to reduce health inequalities in respect of work opportunities, use of buildings and purchasing. The aim of doing this collaboratively, will increase purchasing power and commercial viability.

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