HEALTH AND WELLBEING BOARD: 22 SEPTEMBER 2022

REPORT OF THE DIRECTOR OF ADULTS AND COMMUNITIES

LEICESTERSHIRE BETTER CARE FUND PLAN 2022/23

Purpose of report

1. The purpose of this report is to seek the Health and Wellbeing Board's approval of the final Leicestershire Better Care Fund (BCF) Plan for 2022/23.

Recommendation

2. It is recommended that the Health and Wellbeing Board approves the Leicestershire Better Care Fund (BCF) Plan 2022/23, including the Planning Template and Narrative which includes the proposed ambitions associated with the five BCF metrics, for submission to NHS England.

Policy Framework and Previous Decisions

3. The BCF policy framework was introduced by the Government in 2015, with the first year of BCF plan delivery being 2015/16. The Cabinet in February 2014 authorised the Health and Wellbeing Board to approve the BCF Plan and plans arising from its use.

4. The Board received a report concerning the 2021/22 Plan and work in progress to refresh the BCF Plan for 2022/23 at its meeting on 24 February 2022.

5. The report also confirmed the different funding elements for the BCF in 2022-23. The improved Better Care Fund grant (iBCF) continues, maintained at its current level. The Clinical Commissioning Group's (CCG) contribution was proposed to increase on average nationally between 5.66% and 7.4% in line with the NHS Long Term Plan settlement.

6. The Integration Executive, a subgroup of the Health and Wellbeing Board with responsibility for the day to day delivery of the BCF, considered the draft BCF Plan 2022/23 at its meeting on the 6 September 2022. The Executive supported its contents.

Timetable for Decisions

7. Subject to approval the BCF Plan for 2022/23 will be submitted to NHS England ahead of the 26 September 2022 deadline.

Background

8. The BCF programme supports local systems to successfully deliver the integration of health and social care in a way that supports person-centred care, sustainability

and better outcomes for people and carers. It represents a unique collaboration between:

- The Department of Health and Social Care
- Department for Levelling Up, Housing and Communities
- NHS England and Improvement
- The Local Government Association

9. The four partners work closely together to help local areas plan and implement integrated health and social care services across England, in line with the vision outlined in the NHS Long Term Plan. Locally, the programme spans both the NHS and local government to join up health and care services, so that people can manage their own health and wellbeing and live independently in their communities for as long as possible.

10. Launched in 2015, the programme established pooled budgets between the NHS and local authorities, aiming to reduce the barriers often created by separate funding streams. The pooled budget is a combination of contributions from the following areas:
    - minimum allocation from NHS clinical commissioning group(s) (CCGs)
    - disabled facilities grant – local authority grant
    - social care funding (improved BCF) – local authority grant
    - winter pressures grant funding £240 million – local authority grant

BCF Plan for 2022/23

11. The primary purpose of BCF reporting is to ensure a clear and accurate account of continued compliance of spending in line with the national conditions of the Fund. The secondary purpose is to inform policy making, the national support offer and local practice sharing by providing a fuller insight from narrative feedback on local progress, challenges and highlights on the implementation of BCF plans and progress on wider integration.

12. The BCF Plan consists of the expenditure plan, narrative, outcome metrics, demand and capacity modelling template and an expectation that areas will complete an assessment of their maturity against the High Impact Change Model.

13. An excel template is made available for areas to use to record and agree spending in local BCF plans, named the BCF Expenditure Plan. A copy is included as Appendix B. This is intended to support local planning and also reporting at year end. It includes targets and current data against the national metrics included in the requirements.

BCF National Conditions

14. The four national conditions set by the Government in the policy framework for 2021/22 are:

15. **A jointly agreed plan between local health and social care commissioners, signed off by the HWB**. National condition 1 requires that a plan for spending all funding elements is jointly agreed by the relevant local authority and ICB(s) and placed into a pooled fund, governed by an agreement under section 75 of the NHS Act 2006. Plans will need to confirm that individual elements of the mandatory funding have been used in accordance with their purpose as set out in the BCF Policy Framework, relevant grant conditions and these planning requirements.

16. **NHS contribution to adult social care to be maintained in line with the uplift to CCG minimum contribution.** National condition 2 requires that, in each HWB area, the contribution to social care spending from the NHS minimum contribution is maintained in line with the percentage uplift in the NHS minimum contribution to the BCF in that HWB area.

17. **Investment in NHS-commissioned out-of-hospital services.** National condition 3 states that a minimum of £1.28 billion of the NHS contribution to the BCF in 2022-23 is ringfenced to deliver investment in out-of-hospital services commissioned by ICBs, while supporting local integration aims. Each HWB area's share of this funding is set out in the BCF planning template and will need to be spent as set out in national condition 3. This condition will be assured through the planning template, based on spend allocated to primary, community, social care or mental health care, that is commissioned by ICBs from the NHS minimum contribution.

18. **Implementing the BCF policy objectives** National condition 4 requires that local partners should have an agreed approach to implementing the two policy objectives for the BCF, set out in the Policy Framework:
    - Enable people to stay well, safe and independent at home for longer
    - Provide the right care in the right place at the right time.

Strategic Narrative

19. The narrative section (attached as Appendix A) sets out Leicestershire's approach to the integration of health and social care under the following headings provided in the narrative template:
    a. Stakeholder engagement
    b. An executive summary
    c. Governance
    d. Overall approach to integration
    e. Implementing the BCF policy objectives
    f. Supporting unpaid carers
    g. Disabled Facilities Grant
    h. Equality and health inequalities

BCF Income

20. The BCF Plan for Leicestershire currently totals £65.3million. This includes Disabled Facilities Grant funding of £4.4million which has been has passported to District Councils. Contributions are summarised in the table below:

ICB minimum NHS contribution	£46,137,029
Improved BCF grant	£17,690,614
Disabled Facilities Grant	£4,447,227
Total	**£68,274,870**

BCF Metrics

21. In addition to the national conditions, the BCF Policy Framework sets national metrics that must be included in BCF plans in 2022-23. The local authority and Integrated Care Board are required to establish ambitions associated with each metric and set how they will be achieved.

22. The framework retains two Adult Social Care Outcomes Framework metrics from previous years:

    - Effectiveness of reablement (proportion of older people still at home 91 days after discharge from hospital into reablement or rehabilitation)
    - The number of older adults whose long-term care needs are met by admission to residential or nursing care per 100,000 population

23. In addition, local systems should also agree ambitions associated with two further metrics to improve outcomes across the Health and Wellbeing Board area for the following measures:

    - Improving the proportion of people discharged home using data on discharge to their usual place of residence.
    - Reducing unplanned admissions for chronic, ambulatory, care-sensitive conditions.

24. A summary of the metrics, ambitions for 2022/23 and additional current investment to support the meeting of targets is detailed in the executive summary section of the narrative document.

Demand and Capacity model

25. All systems must submit a high-level overview of expected demand for intermediate care and planned capacity to meet this demand alongside their BCF plans. The content of capacity and demand plans will not be assured in 2022-23 but their completion is a condition of BCF plan approval.

26. This is the first time that capacity and demand plans have been required through BCF. As far as possible, existing data and plans have been used to ensure alignment. For example, using Integrated Care System level projections for expected discharges per month and by discharge pathway. This data has been mapped to local authority footprints and agreed locally, making use of local management information data.

Background papers

Better Care Fund Planning Requirements 2022/23: https://www.england.nhs.uk/wp-content/uploads/2022/07/B1296-Better-Care-Fund-planning-requirements-2022-23.pdf

Better Care Fund Policy Framework 2022/23: https://www.gov.uk/government/publications/better-care-fund-policy-framework-2022-to-2023/2022-to-2023-better-care-fund-policy-framework

Circulation under the Local Issues Alert Procedure

27. None

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List of Appendices

Appendix A – BCF Plan – Strategic Narrative
Appendix B – BCF Expenditure Plan
Appendix C – BCF Demand and Capacity Model

Relevant Impact Assessments

Equality and Human Rights Implications

28. The BCF aims to improve outcomes and wellbeing for the people of Leicestershire, with effective protection of social care and integrated activity to reduce emergency and urgent health demand.

29. An equalities and human rights impact assessment has been undertaken when the BCF was established and is provided at http://www.leicestershire.gov.uk/sites/default/files/field/pdf/2017/1/11/better-care-fund-overview-ehria.pdf. This identified that the BCF will have a neutral impact on equalities and human rights.

30. A review of the assessment was undertaken in March 2017.

Partnership Working and associated issues

31. The delivery of the BCF plan and the governance of the associated pooled budget is managed in partnership through the collaboration of commissioners and providers in Leicestershire.

32. Day to day oversight of delivery is via the Integration Executive, a subgroup of the Health and Wellbeing Board.

Partnership Working and associated issues

33. The delivery of the Leicestershire BCF ensures that a number of key integrated services are in place and contributing to the system wide changes being implemented through the NHS Long-term plan.

Department of Health & Social Care | Department for Levelling Up, Housing & Communities | Local Government Association | NHS England

APPENDIX A

BCF narrative plan template

Cover

Health and Wellbeing Board(s)

Leicestershire

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils)

Leicestershire County Council
Leicester, Leicestershire and Rutland ICB
University Hospitals Leicester Trust
Leicestershire Partnership Trust
Blaby District Council
Charnwood Borough Council
Harborough District Council
Hinckley and Bosworth Borough Council
Melton Borough Council
Northwest Leicestershire District Council
Oadby and Wigston Borough Council
Rutland County Council
Healthwatch

Stakeholders have been involved via a well-established, place-based infrastructure (see governance section below). We have continuous strategic engagement with our partnership forums from the system including the Home First Collaborative, System-flow Partnership and strategic place-based partnerships including the Health and Wellbeing Boards and Integration Executive.

Operationally, the two sub-groups of the Integration Executive, the Integration Delivery Group and Joint Commissioning and Finance and Performance Group, meet monthly and bi-monthly (respectively) to discuss the delivery of BCF plans and any commissioning required to meet our objectives. The JCG is responsible for all co-commissioning activity for BCF spend from across the governance partnerships including, Children and Young People and the Staying Healthy Partnership. It also includes receiving and agreeing the section 75 agreement and agreement for the DFG amounts transported to each District Council within Leicestershire. This is passed on in its entirety with top slicing agreed by partners for wider housing related schemes.

The BCF plan is co-developed with stakeholders and forms part of the wider Joint Health and Wellbeing Strategy delivery. The production of which is the responsibility of the Staying Healthy Partnership which reports directly to the Health and Wellbeing Board. The planning and reporting process for this began in January of this year and is agreed via the governance structure set out below.

Healthwatch is part of the Integration Executive and its sub-groups and the Staying Healthy Partnership also includes District Council representatives (Leicestershire's Housing Partners) and VCS representation from Voluntary Action Leicestershire and others. Housing representatives also attend the Integration Delivery Group with a district council rep on the Integration Executive. In-year planning for BCF activity is aligned to the wider delivery of the Joint Health and Wellbeing Strategy priorities which is fully consulted on with activity agreed at wider group development sessions. The Integration Executive session was held on the 7th June 2022.

The BCF plan is agreed through drafts to executives within each stakeholder group, then to the Integration Executive before being formally agreed at the Health and Wellbeing Board (for 22/23 this was approved by the Local Authority Chief Executive using delegated powers of authority due to cancellation of the 22nd September Board). Full details on governance can be seen in the section below.

Executive summary

The BCF plan for Leicestershire for 2022/23 reflects the established framework already in place for delivery of this across the LLR system.

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 including
- Development of the Home First model
- 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 2022/23, joint priorities and projected spend were planned and approved by partners and stakeholders during the planning phase which began in January 2022. This included alignment to the Joint Health and Wellbeing Strategy (JHWS) priorities for Leicestershire. The strategy focuses on the life course approach, with specific integration focus on Living and Supported Well and Dying Well priorities.

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 Home First to work towards a pathway 1 intake model and a risk share for pathway 2 commissioned beds.

The BCF pooled budget will fund the following key areas of place-based services in 2022/23: Care Coordination, Integrated Hospital Discharge arrangements and Reablement Pathways, additional re-commissioning of Domiciliary Care contract (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).

In preparation for this submission, a review of schemes within the BCF took place from January 22. This was a joint initiative to examine and reflect on the KPI's being delivered within schemes. The review of BCF schemes provided information on the current activity being undertaken in relation to the scheme title and description.

A Key Lines of Enquiry (KLOE) Appendix 1) approach was developed, and information was collected on each of the programme areas. Each programme area was assessed against the following criteria:

- Lead officer/contract person
- Contract/Framework status
- Service description/outcomes
- Business case
- Performance measures
- Changes to scheme name/description

The review demonstrated that the current BCF schemes identified clear evidence that activity is taking place against the expenditure, either through externally contracted schemes or internal staffing arrangements

This has given us the scope to ensure that we are delivering against the shared objectives and has been used in the development of the BCF this year and in the development of renewed investment models and the production of delivery plans.

A further review based upon scheme values of circa £2m and above, has been recommended on two of the schemes to ensure clarity over what is required to be delivered against the BCF expenditure, including performance reporting and outcomes against those requirements.

Key changes within this years' plan 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.

The table below shows the metrics and associated targets and summarises the joint key priorities for 2022/23 alongside any additional investment that will work towards meeting the targets. Additional investment, both BCF and non-BCF totals in the region of 4.3 million to meet the priorities and desired outcomes outlined in the BCF plan for 2022/23.

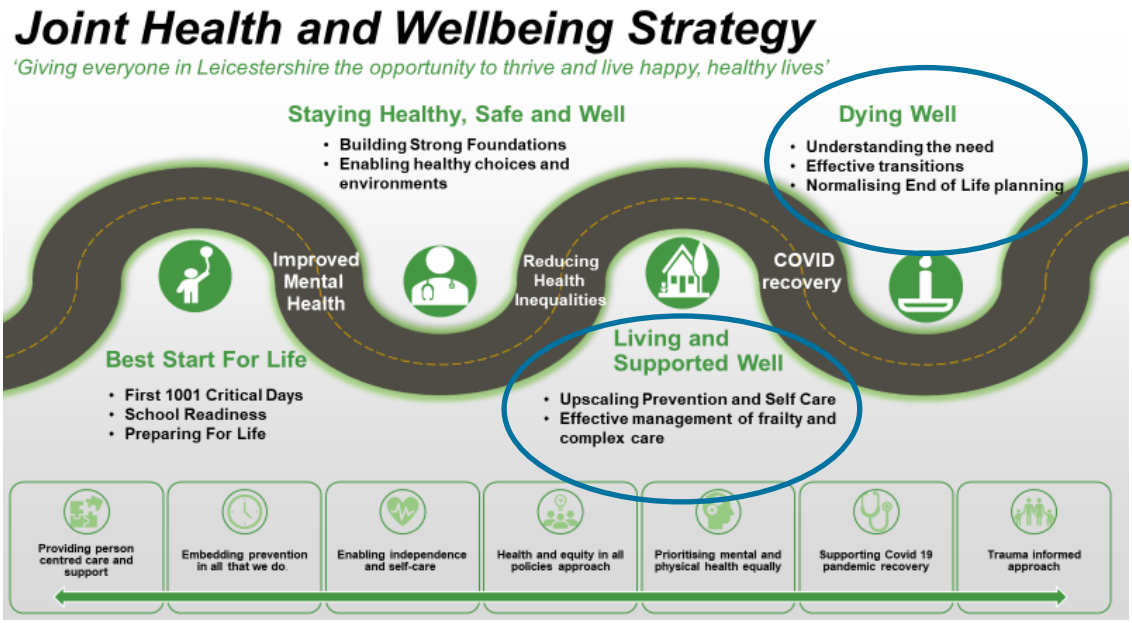
Metric	**Target**	**Schemes that contribute (2022/23 priority changes)**	**Additional investment from 2021/22**
Unplanned admissions for chronic ambulatory care-sensitive conditions.	10% reduction on 20121/22 actuals (723.7 to 650.6)	Pathway 1 intake development	2.3 million
Proportion of older people (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 case management Nursing and Therapy support to home first	260k 500k
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	92.9%. This represents an increase of 0.5% on 2021/22 data (92.04%)	Discharge Hub Disabled Facilities Grant top-slicing schemes	232k 1.27 million
Long-term support needs of older people (age 65 and over) met by admission to	Planned rate of 561.8 per 100k population based on an ONS		

residential and nursing care homes, per 100,000 population	population estimate of 153,090. This target is a 1% reduction on admissions in 2021/22	Winter incentive grants for providers / residential brokerage support	80k

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, LA's and ICB with targets and metrics agreed with all partners prior to formal governance sign-off. These have been added to the performance framework across LLR for joint delivery of outcomes related to activity to support timely discharge.

Governance

The Joint Commissioning and Integrated Finance and Performance Group (JCG and IFPG) and Integration Delivery Group (IDG) are sub-groups of the Integration Executive (IE). The first (JCG) is responsible for approving BCF expenditure throughout the year 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. The BCF plan and wider integration activity, forms part of the delivery plans for each of these groups. This includes overall responsibility for delivery of the Joint Health and Wellbeing Strategy (JHWS) priorities of Living and Supported Well and Dying Well. Below is a diagram showing the roadmap for the JHWS against the life courses along with the cross-cutting themes.



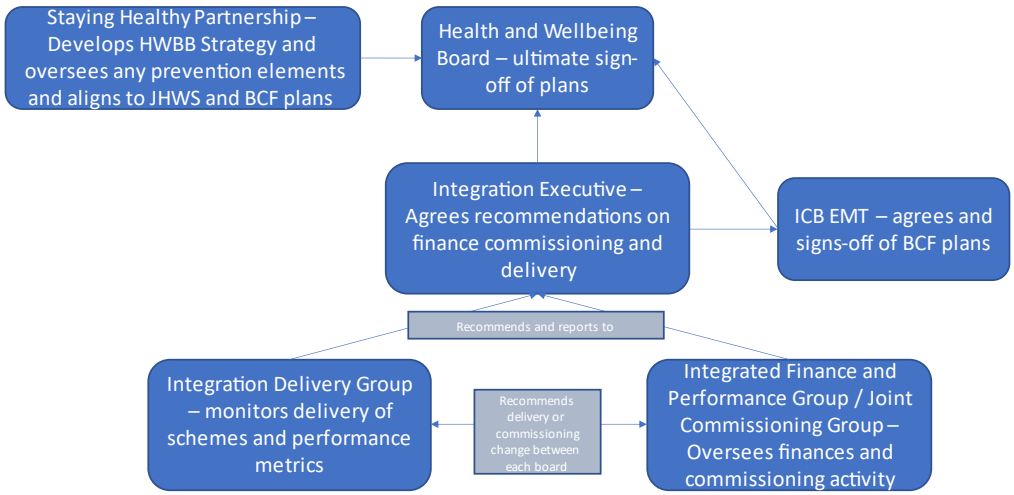
One of the cross-cutting themes is the reduction of health inequalities. Further information on this and the reduction of disparities including delivery against the Core20plus5 for LLR can be found in the health inequality and equality section below.

Recommendations are made from both the JCG / IFPG and the IDG to the Integration Executive which ultimately approves elements of the plan around income and expenditure. In addition to this, the IE conducted a development session in June 2022 to develop key activities that require further development by the Health and Wellbeing Board (HWBB) in support of the delivery of JHWS priorities.

The IE is a sub-board of the HWBB. In addition, prevention schemes are reported to the Staying Healthy Partnership (also a sub-board of the HWBB) which has recommenced monthly meetings as of April 2022. This is also a sub-board of the HWBB and welcomes representation from VCS organisations and district councils and is led by Public Health.

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.

BCF Governance diagram



The 2022/23 plan has been signed off by the local authority Chief Executive, using delegated powers of authority. This is signed post discussion and approval from the Local Authority Lead Member for Health and Chair of the Health and Wellbeing Board. The 22nd September, 2022 meeting of the Health and Wellbeing Board was cancelled, but all members of the board have been sighted on the BCF documents with the option to comment and make amendments where required. The documentation will be re-submitted to the board at it's meeting of the 1st December, 2022 for completeness.

The main partners that sit on the key decision-making boards are listed below:

Integration Exec:

- Director of Adults and Communities, LCC
- Director of Public Health, LCC
- Director of Children and Families Services, LCC
- Associate Director for Integration (Adults and Communities), LCC
- Clinical Chairs (or their designates) LLR ICBs
- Executive Director of Nursing Quality and Performance and Deputy CEO, LLR ICB
- Executive Director, Finance, Contracting and Governance LLR ICB
- Executive Director of Integration & Transformation LLR ICB
- Deputy Director of Integration & Transformation LLR ICB
- Chief Executive LLR ICB
- Director representative from EMAS
- Director representative from UHL
- Director representative from LPT
- Representative of Local Healthwatch
- Officer representative from District Councils
- Director of Resources (or their designate) from LCC

Staying Healthy Partnership Board
LCC Representatives

- LCC Public Health

- LCC Adult and Communities
- LCC Children and Families
- LCC Chief Executives
- LCC Environment and Transport

Growth Service

- Air Quality Chair
- District Representatives
- District Health and Housing Lead Officer
- District Health Leads/Lightbulb Representative
- Chief Housing Officers Group Chair
- Communities Group Chair
- Strategic Planning Group Chair

Partner Representatives

- OPCC
- Violence Reduction Network Partnership
- LLEP
- Healthwatch
- Leicestershire Police
- Leicestershire Fire and Rescue Service
- Voluntary Action Leicestershire
- Active Together

NHS ICS

- NHS ICS Strategy and Planning
- NHS ICS Integration and Transformation
- NHS Provider: Primary Care Network
- NHS Provider: University Hospitals Leicestershire
- NHS Provider: Leicestershire Partnership Trust

Overall BCF plan and approach to integration

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 2022/23 has been to re-align the BCF into key sections of delivery against emerging 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, personalised care, Dementia Strategy, LD pooled budget arrangements and preablement. This has made it easier to determine overall commissioning activity within each key section. In January 2022, a review of all BCF schemes and how they are meeting KLOE's, began. This has helped to re-align BCF priorities for partners to new emerging models of care. For example, it is helping to shape the LPT contribution within the BCF to the proposed pathway 1 intake model.

Summarised below are the some of the new key schemes and developments that aim to meet the above priorities in addition to existing services described in previous years plans, including any changes and additional investment to our Better Care Fund planning or spend. The three examples show significant planned improvements to integrated community-based care and prevention, enhanced health care in the community and the shift to further increase the pathway 1 offer (both step-up and step-down). This acknowledges the requirement for our system to focus on community health and social care services in order to right-size pathways away from acute care. This in turn aims to reduce reliance on A and E and Ambulance 999 calls.

For each scheme described in brief below, the appendix attached details key features, desired, outcomes, overall impact, challenges and mitigations to these areas of work.

Overall BCF plan and approach appei

Pathway 1 intake model – initial health investment of circa 2.3 million recurrent funding – start implementation Sept 22 – ongoing until Sept 23

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 Adults and Communities went live at the beginning of April 22 and aligns to this model creating an integrated team of care provision that assesses and case manages patients at home. This will replace the separate functions that currently exist (HART reablement and Community Response Service) and expand on the previous ambitions of the Ageing Well strategy by further integrating community models of care, to maximise independence, support people to remain in their own homes and reduce inequality of ability to remain at home particularly those with protected characteristics within the Equality and Diversity strategy. This will further ensure that Leicestershire residents are receiving the right level of care in the right place at the right time,

supporting delivery of recommendations received in the system-wide review conducted by Dr Ian Sturgess, Urgent and Emergency Care Improvement Expert, during July and August, 2022. The recommendations relating to this piece of work are being fed into a programme plan (currently in development) which will include risks to delivery and a breakdown of individual task-related timescales.

Changes from 2021/22 -

- Further investment in recruitment (recurrent) of staff to support the model
- 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 community response services with reablement

Transform and build community service capacity through growing our virtual wards – 2.6 million initial investment – Start April 22 – completion Dec 23

Virtual wards aim to provide safe care in the patient's own home to avoid admission into the acute hospitals or facilitate earlier timely discharges for those patients where ongoing management can be provided with clinical and care support in their place of residence.

The approach is to create a model for "virtual out of hospital care" for patients presenting with urgent care (including higher acuity clinical needs) or emerging care needs so they can be supported, monitored and treated in their own homes. Patients will be virtually reviewed daily by Multidisciplinary teams (which can include medical, therapy and social care staff) and decisions will be made to manage the patient's condition and progress towards personalised goals for the individual.

Wider system involvement has been around the progression of the Frailty virtual wards as an integrated approach to delivery. Key risks (some of which are detailed in the challenges section attached, are discussed weekly at the delivery group). A key risk around geriatrician resource has impacted on delivery timescales for this particular cohort of beds, delaying decision making until January 2023.

Impacts on equality and access to asset-based community approaches will be detailed for each ward in the EHIRA attached below. Phase 2 stages for the EHIRA are in development and further work is underway to assess the ongoing requirements for this. E.g. whether impact assessments are required for each protected characteristic.

Paper D - Stage 1 EHIIRA questions MS '

Embed Integrated neighbourhood working and delivering anticipatory care – Additional circa £200k investment – this phase implementation until April 23

Integrated Neighbourhoods aim to provide proactive and integrated care to communities of 30,000-50,000. They aim to keep local people well and out of hospital and are built on the base of primary care networks. They bring all parts of the workforce together and put the people at the centre of the care they receive. The cornerstone of each Integrated Neighbourhood is a Primary Care Network.

Our model of care is shown in the diagram below:

Model-of-care-Leicestershire.pdf

Implementing the BCF Policy Objectives (national condition four)

Below are examples of investment in schemes to support enable people to stay well, safe and independent at home for longer and to provide the right care in the right place at the right time. All schemes are jointly agreed and approved with partners including Hospital Trusts and joint processes and resources are agreed in all cases. This is done both formally through the agreed governance structure and also through joint forums such as the Strategic Discharge Cell.

As in the previous section, for each scheme described in brief below, the appendix attached, details key features, desired, outcomes, overall impact, challenges and mitigations to these.

Implementing BCF Policy Objectives ap

Unscheduled Care Hub – pilot phase from April 22. Ongoing development until April 23
Our local health and care services will be taking responsibility for managing the needs of sub-acute patients who present to the Unscheduled Care Coordination Hub (UCCH). These are residents who are not seriously ill but are at immediate risk of attending hospital or having an ambulance response.

The UCCH will cumulate a multidisciplinary team made of representatives from DHU Health Care, East Midlands Ambulance Service (EMAS), Adult Social Care (ASC), Leicestershire Partnership Trust (LPT), Integrated Care Board (ICB) and the Emergency Care Improvement Support Team (ECIST).

The UCCH can continue to take referrals from the Emergency Operations Centre (EOC) for EMAS calls waiting, however there will be a dedicated CAT clinician on site for a complete overview of LLR EMAS calls waiting, along with UCCH reviewing the Clinical Navigation Hub (CNH) and Home Visiting Service (HVS) calls waiting. This will provide UCCH with oversight of a substantial proportion of LLR's unscheduled care demand providing the ability to safely navigate patients to the most appropriate care setting for their needs.

Referrals from community teams in LPT and ASC will also be able to phone the UCCH to discuss patients presenting with non-emergency clinical presentations. This will be to guide a decision on whether an ambulance should be requested, or if the patient can be supported in their home environment.

Referrals from EMAS crews on scene is advised where a patient is at risk of admission and there is a view that this could be prevented. This can be where there is no existing appropriate pathway, or the crew are not aware of an existing pathway. Where there is an existing pathway, this should be utilised.

All patients referred or reviewed will receive a multiple disciplinary team evaluation. This will support decisions being made within 15 minutes to ensure patients are placed into the most appropriate health or care setting. Further considerations will include proactive support
The UCCH will take ownership of patients moved from all patient lists and the UCCH team will inform patients of any alternative plan/pathway identified.

The multidisciplinary unscheduled care team will have real time visibility of EMAS, DHU and LPT caseloads and the ability to interact with Healthcare Professionals on scene to provide viable alternatives to hospital admission and enabling appropriate support within the home environment.

The unscheduled care coordination hub will be supported by health and care colleagues ensuring the right skill set, experience and knowledge is in place to support the diverse needs of the patients being referred in. There will be clinical oversight by DHU throughout the hubs operation to ensure risks are monitored and patient safety is adhered to.

Integrated Discharge Hub and Case Management for Discharge - £313k – Completion Oct 22
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. In 22/23 this will be further developed and enhanced.

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.

Multi-agency staff have access to all Systm1 health records and can update and track patient activity in real-time.

Re-Commissioning of step-down D2A beds to support the 3 R model of care – commissioning to start Oct 22 – completion for go live July 23
The introduction of the national discharge model to deal with COVID, and with it a more explicit onus on RRR as a core offer within the discharge process, is supporting a move to recovery and therapeutic interventions within a pathway 2 model. These Services give our local system an opportunity to embed strength-based, outcome focussed care for people 'stepping down' from an acute care episode and, ideally, as a way of avoiding admissions (step up).

Previously commissioned beds proved that 77% of patients returned to their usual place of residence with only a small percentage of people discharged into longer term residential care. The Care Co-ordination service has been enhanced to support this and offers links to ongoing community support and care. They work as part of the MDT alongside therapists to ensure that patients are effectively case managed and discharged with the appropriate levels of ongoing care, if any.

The clear importance of a dynamic and comprehensive rehabilitation, reablement and recovery (RRR) offer recognises that a shift from the provision of traditional care after discharge to one that is based on the principles of effective RRR, can maximise independence and wellbeing and potentially reduce the long-term costs of care. This supports the LLR vision for Home First.

These services ensure dedicated capacity is available for people who would benefit from a RRR intervention as part of our Home First approach. The Services will help facilitate timely and safe discharges and support Home First principles and approaches.

These Services have at their core, the principles and values of personalisation and community-based support, this is central to improving outcomes for people transferring from hospital into these settings. This specification borrows from Think Local Act Personal's Making it Real framework which is a set of 'I' and 'We' statements that describes what good care and support looks like from a person's perspective.

Integrated Personalised Care Framework - £81k for training packages – go live Nov 22
A review of the LLR Health and Social Care Protocol (2014) began in 2019 in a context of growing demand, with increasing complexity of need across all health and social care partners and against a backdrop of ongoing budgetary pressures and significant challenge in relation to capacity across all parts of the system.

The protocol listed and enabled partners to have a mandate for health and care providers to deliver a set of shared tasks on behalf of each other linked to the personalisation of deliveries of care models. The Integrated Personalised Care Framework aims to:

- Identifies the Principles, Statutory duties and National guidance that underpin and inform decision making around the delegation of support tasks between Health and Social Care.
- Identifies the elements required to support appropriate delegation and aims to help registered practitioners and commissioning workers understand the decision-making process involved in safe and effective delegation of a task from one provider /organisation to another.

In addition to this, there has been an ongoing drive towards integration across Health and Social Care, including the development of Primary Care Networks, Integrated Neighbourhood Teams, Home First and the effective utilisation of the voluntary sector and wider community assets.

Training and launch events are scheduled for September to roll out the new framework to the health and care workforce within Leicestershire.

High Impact Change Model – self-assessment

Leicestershire has undertaken a self-assessment against the high impact change model of care for 22/23. Attached is the summary of the assessment conducted and the work to progress through the levels of maturity.

High impact Change model Aug

Supporting unpaid carers.

Leicestershire has a comprehensive offer that supports carers within our community. There are various schemes and services for unpaid carers and ways for them to access funds and short-breaks.

Details of the BCF finances used to support carers is detailed below. The last two bullets show the investment by the NHS in the delivery of the care act duties in relation to supporting unpaid carers:

- Provision for enhanced carer support services - £223k
- LD Short Breaks - £929k
- Residential Respite Service - £874k
- Care Act Enablers - £84k
- Care Act Support Pathway - £522k

Help is available through the customer service centre in Adult Social Care, with the BCF funding two carer champions to help carers access support initiatives shown below. In addition, Leicestershire has worked with the community and voluntary sector to commission VASL to support carers in the following ways:

- a dedicated telephone advice line Monday to Friday
- a telephone befriending service specifically for carers
- local carers groups and events
- support to complete Leicestershire County Council's online carer's assessment form

Carers support grants of £250 and personal budgets for carers are accessed through a carer assessment. This looks at existing support networks for example, family or friends. It considers the things a carer wants or need to achieve outside of your caring role and the impact this has on their ability to carry out those activities and affects their wellbeing.

Support to young carers is also included in the support offer and includes:

- help with school and college work
- training to get a job
- help to get a job
- activities
- spending time away from your caring responsibilities

In 2020 we signed up to become a partner organisation to Carefree which offers al breaks away listed on Carefree's Breaks Hub. Unpaid carers can browse available options and submit a request for a specific hotel on specific dates.

Respite at home (sitting service / time with)
Carers can find providers by using our online information and support directory and the Leicester, Leicestershire and Rutland Care Directory. The website also informs carers on NICE guidance on what to expect from a good service.

Short term care
This is available for carers to take a short break or holiday, this can be arranged by contacting any residential home and asking for availability and pricing for respite care.

Disabled Facilities Grant (DFG) and wider services

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.

From Oct 2017 to date, 8122 residents have been supported by the Trusted Assessors and have carried out over 9000 MOT's across Leicestershire.

The Lightbulb model has also introduced further tools to help residents by introducing the following grants via a regulatory reform order, 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 there are pilots in place which we are already seeing the benefits of in supporting discharge and flow. These are funded schemes through system agreed top-slicing of the DFG funds:

- Assistive technology pilot –Home Gadgets provides electric blinds on timers, smart bulbs and plugs along with many other items to enhance the offer of people remaining independent at home and not being intimidated by technology
- Early Dementia support – providing small grants to support with things like lighting and paint as well as access to a range of home gadgets
- Hoarding pilot – Safe Spaces is already proving to be hugely successful in providing an early enhanced support service to help people to manage their belongings and live safely. The team were inundated with referrals and have hired more staff to support
- Ramp / Access from hospital discharge – a successful trial is underway to improve access for patients that are involved with therapy services and D2A pathways. Feedback from staff and patients has been extremely positive and we will be looking at developing this offer
- A green grant to support other initiatives in making adapted properties more energy efficient and lower costs for people

- Working with RCOT and Foundations to develop virtual assessments and telephone assessment to support the traditional face to face assessments for efficiency and to reach a wider audience

Housing Enablement Team
The Hospital Housing Enablement Team (HET) who provide a bedside service to patients and support flow through the UHL hospitals and the Bradgate Mental Health Unit continue to support the Integrated Discharge Hub.

A high volume of the work involves cases that fall outside of statutory duty for Local Authority Housing Options teams but fulfil the hospitals requirement to have a legal route for referral of homeless patients to the Local Authority. In addition, HET also supports patients with preventing evictions, accessing refuges, moving into new tenancies, provision of essential furniture items/white goods, support with adequate heating of homes, housing applications and benefit applications as just some of the work undertaken by HET that is outside the remit of statutory services but is otherwise necessary to secure safe, effective discharges for patients.

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 patients with No Recourse to Public Funds but who are otherwise unable to be discharged from hospital safely. Most recently Lightbulb services and HET have been supporting therapy service patients with housing related issues by providing measures such as creating a downstairs-existences where possible and by undertaking small-scale cleans and clearances to make properties safe and accessible for discharges for patients and carers. In this way, patients are more likely to be able to return home in the first instance, rather than require interim placements or other high-cost interventions. Within mental health services, HET continues to work alongside Action Homeless to manage the Community Transitions Project, a step-down facility where patients who are ready to leave hospital can stay whilst they await long-term accommodation but who would otherwise be unsuitable for other temporary accommodation. This partnership allows vulnerable patients to be discharged safely from acute mental health beds, whilst still preventing readmissions as a result of unsafe discharges.

The team has expanded in a number of pilots to support the wider services and flow in the Mental Health Rehabilitation units and in all Community Hospitals. This is currently on a temporary basis to monitor demand. A similar pilot in MHSOP is also in discussion.
In 2021/22 the HET service undertook:

- 698 referrals from the UHL hospitals
- 173 referrals from the Bradgate Mental Health Unit
- 30 referrals from the MH Rehab units
- Managed 5 long-term TB cases in the community
- Achieved average resolutions times of just 2.61 days for UHL cases and 15.21 days for BMHU cases

Equality and health inequalities

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, once again, 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 supported the development of the Joint Health and Wellbeing Strategy. 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.

Reducing health inequalities is a core priority for the LLR Integrated Care System (ICS) and its programme of work to reduce health inequalities will be guided by the 12 principles within the LLR Health Inequalities Framework (see Appendix) with a focus on addressing the five priorities in the 21/22 & 22/23 NHS Operational Planning Guidance and the Core20Plus5 approach. Attached is a report that was presented to the HWBB of 26 May, 2022, for Leicestershire and includes further details on the LLR approach to delivery of the core principles of the Core20Plus5.

Reducing Health Inequalities - Core20F

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.

Partners are working on consistent plans to update EHRIA's this across all levels at place with consistent timescales for delivery. A plan for improving this area of work will be completed alongside dedicated resources for Mar 23. The HWBB will be responsible for ensuring that this is delivered at a place level in its entirety.

All schemes when newly commissioned are subject to EHIRA's which form part of the overall development of business cases and presented throughout the corresponding governance structure. Work is underway to ensure that timescales for the development of EHIRA's is consistent within the development of schemes.

Current 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 Strategy. Specifically, a proposal for the establishment of an LLR health inequality resource will be presented to the system executive during the 2022/23 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 2022. 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.

BCF Planning Template 2022-23

1. Guidance

Overview

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a blue background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

For a more optimal view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level between 90% - 100%. Most drop downs are also available to view as lists within the relevant sheet or in the guidance sheet for readability if required.

The details of each sheet within the template are outlined below.

Checklist (click to go to Checklist, included in the Cover sheet)

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'

3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template be sent to the Better Care Fund Team: england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2022-23. It will be pre-populated with the minimum NHS contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.

2. Please select whether any additional contributions to the BCF pool are being made from local authorities or ICBs and enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources in sheet 5a when you planning expenditure.

3. Please use the comment boxes alongside to add any specific detail around this additional contribution.

4. If you are pooling any funding carried over from 2021-22 (**i.e. underspends from BCF mandatory contributions**) you should show these on a separate line to the other additional contributions and use the comments field to identify that these are underspends that have been rolled forward. All allocations are rounded to the nearest pound.

5. Allocations of the NHS minimum contribution (formerly CCG minimum) are shown as allocations from ICB to the HWB area in question. Mapping of the allocations from former CCGs to HWBs can be found in the BCF allocation spreadsheet on the BCF section of the NHS England Website.
6. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net (please also copy in your Better Care Manager).

5. Expenditure (click to go to sheet)

This sheet should be used to set out the detail of schemes that are funded via the BCF plan for the HWB, including amounts, type of activity and funding source. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting.

The information in the sheet is also used to calculate total contributions under National Conditions 2 and 3 and is used by assurers to ensure that these are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and NHS minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:
1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.
2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.
3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned. The information in this field assists assurers in understanding how funding in the local BCF plan is supporting the objectives of the fund nationally and aims in your local plan.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important in assurance and to our understanding of how BCF funding is being used nationally.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "NHS minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3. Any spend that is from the funding source 'NHS minimum contribution', is commissioned by the ICB, and where the spend area is not 'acute care', will contribute to the total spend under National Condition 3. This will include expenditure that is ICB commissioned and classed as 'social care'.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and NHS and enter the respective percentages on the two columns.

7. Provider:
- Please select the type of provider commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.
8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the ICB or Local authority
- If a scheme is funded from multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2022-23:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2022-23 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's ambitions (i.e. numerical trajectories) and performance plans for each of the BCF metrics in 2022-23. The BCF policy requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for 2022-23.

A data pack showing more up to date breakdowns of data for the discharge to usual place of residence and unplanned admissions for ambulatory care sensitive conditions is available on the Better Care Exchange.

For each metric, areas should include narratives that describe:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- the local plan for improving performance on this metric and meeting the ambitions through the year. This should include changes to commissioned services, joint working and how BCF funded services will support this.

1. Unplanned admissions for chronic ambulatory care sensitive conditions:
- This section requires the area to input indirectly standardised rate (ISR) of admissions per 100,000 population by quarter in 2022-23. This will be based on NHS Outcomes Framework indicator 2.3i but using latest available population data.
- The indicator value is calculated using the indirectly standardised rate of admission per 100,000, standardised by age and gender to the national figures in reference year 2011. This is calculated by working out the SAR (observed admission/expected admissions*100) and multiplying by the crude rate for the reference year. The expected value is the observed rate during the reference year multiplied by the population of the breakdown of the year in question.
- The population data used is the latest available at the time of writing (2020)
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.
- Exact script used to pull pre-populated data can be found on the BCX along with the methodology used to produce the indicator value: https://future.nhs.uk/bettercareexchange/viewdocument?docid=142269317&done=DOCCreated1&fid=21058704
- Technical definitions for the guidance can be found here: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-2---enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

2. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay. In 2021-22, areas were asked to set a planned percentage of discharge to the person's usual place of residence for the year as a whole. In 2022-23 areas should agree a rate for each quarter.
- The ambition should be set for the health and wellbeing board area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions.
- Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.
- Actual performance for each quarter of 2021-22 are pre-populated in the template and will display once the local authority has been selected in the drop down box on the Cover sheet.

3. Residential Admissions (RES) planning:
- This section requires inputting the expected numerator of the measure only.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care)
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

4. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the expected number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- Column H asks for an estimated actual performance against this metric in 2021-22. Data for this metric is not published until October, but local authorities will collect and submit this data as part of their salt returns in July. You should use this data to populate the estimated data in column H.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health and Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2022-23 for further details.

The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.

The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

1. For each Planning Requirement please select 'Yes' or 'No' to confirm whether the requirement is met for the BCF Plan.
2. Where the confirmation selected is 'No', please use the comments boxes to include the actions in place towards meeting the requirement and the target timeframes.

Better Care Fund 2022-23 Template

2. Cover

HM Government

NHS

Version 1.0.0

Please Note:

- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.

- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".

- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2022-23.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

- Where BCF plans are signed off under a delegated authority it must be reflected in the HWB's governance arrangements.

		Checklist
		Complete:
Health and Wellbeing Board:	Leicestershire	Yes
Completed by:	Lisa Carter	Yes
E-mail:	Lisa.Carter@leics.gov.uk	Yes
Contact number:	0116 3050786	Yes
Has this plan been signed off by the HWB (or delegated authority) at the time of submission?	Yes	Yes
If no please indicate when the HWB is expected to sign off the plan:		Yes
If using a delegated authority, please state who is signing off the BCF plan:	John Sinnott Chief Executive, Leicestershire County Council	

Please indicate who is signing off the plan for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Chief Executive, Leicestershire County Council	Yes
Name:	John Sinnott	Yes

	Role:	Professional Title (e.g. Dr, Cllr, Prof)	First-name:	Surname:	E-mail:	
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Cllr	Louise	Richardson	Louise.richardson@leics.gov.uk	Yes
	Integrated Care Board Chief Executive or person to whom they have delegated sign-off		Andy	Williams	andy.williams12@nhs.net	Yes
	Additional ICB(s) contacts if relevant		Rachna	Vyas	rachna.vyas@nhs.net	Yes
	Local Authority Chief Executive		John	Sinnott	John.Sinnott@leics.gov.uk	Yes
	Local Authority Director of Adult Social Services (or equivalent)		Jon	Wilson	Jon.Wilson@leics.gov.uk	Yes
	Better Care Fund Lead Official		Lisa	Carter	Lisa.Carter@leics.gov.uk	Yes
	LA Section 151 Officer		Chris	Tambini	Chris.Tambini@leics.gov.uk	Yes
*Please add further area contacts that you would wish to be included in official correspondence e.g. housing or trusts that have been part of the process -->						Yes
						Yes
						Yes

Question Completion - When all questions have been answered and the validation boxes below have turned green, please send the template to the Better Care Fund Team england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'. Please also copy in your Better Care Manager.

Please see the Checklist below for further details on incomplete fields

	Complete:
2. Cover	Yes
4. Income	Yes
5a. Expenditure	Yes
6. Metrics	No
7. Planning Requirements	Yes

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2022-23 Template

3. Summary

Selected Health and Wellbeing Board: Leicestershire

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£4,447,227	£4,447,227	£0
Minimum NHS Contribution	£46,137,029	£46,137,029	£0
iBCF	£17,690,614	£17,690,614	£0
Additional LA Contribution	£0	£0	£0
Additional ICB Contribution	£0	£0	£0
Total	**£68,274,870**	**£68,274,870**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum ICB allocation

Minimum required spend	£13,107,300
Planned spend	£18,519,199

Adult Social Care services spend from the minimum ICB allocations

Minimum required spend	£27,565,566
Planned spend	£28,124,346

Scheme Types

Assistive Technologies and Equipment	£714,000	(1.0%)
Care Act Implementation Related Duties	£858,150	(1.3%)
Carers Services	£1,803,388	(2.6%)
Community Based Schemes	£7,794,197	(11.4%)
DFG Related Schemes	£4,447,227	(6.5%)
Enablers for Integration	£1,133,699	(1.7%)
High Impact Change Model for Managing Transfer of (	£3,570,389	(5.2%)
Home Care or Domiciliary Care	£28,185,741	(41.3%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£3,372,319	(4.9%)
Bed based intermediate Care Services	£859,158	(1.3%)
Reablement in a persons own home	£1,296,604	(1.9%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£9,204,193	(13.5%)
Prevention / Early Intervention	£175,065	(0.3%)
Residential Placements	£4,860,741	(7.1%)
Other	£0	(0.0%)
Total	**£68,274,871**	

Metrics >>

Avoidable admissions

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (Rate per 100,000 population)	0.0	0.0	0.0	0.0

Discharge to normal place of residence

	2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	92.2%	92.7%	92.7%	93.9%

Residential Admissions

		2020-21 Actual	2022-23 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	309	562

Reablement

		2022-23 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	87.1%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	Yes
NC4: Implementing the BCF policy objectives	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
Metrics	PR8	Yes

Better Care Fund 2022-23 Template

4. Income

Selected Health and Wellbeing Board: Leicestershire

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Leicestershire	£4,447,227
DFG breakdown for two-tier areas only (where applicable)	
Blaby	£663,804
Charnwood	£1,126,607
Harborough	£512,365
Hinckley and Bosworth	£578,935
Melton	£344,710
North West Leicestershire	£760,574
Oadby and Wigston	£460,232
Total Minimum LA Contribution (exc iBCF)	**£4,447,227**

iBCF Contribution	Contribution
Leicestershire	£17,690,614
Total iBCF Contribution	**£17,690,614**

Are any additional LA Contributions being made in 2022-23? If yes, please detail below	No

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional Local Authority Contribution	**£0**	

NHS Minimum Contribution	Contribution
NHS Leicester, Leicestershire and Rutland ICB	£46,137,029
Total NHS Minimum Contribution	**£46,137,029**

Are any additional ICB Contributions being made in 2022-23? If yes, please detail below	No

Additional ICB Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional NHS Contribution	**£0**	
Total NHS Contribution	**£46,137,029**	

	2021-22
Total BCF Pooled Budget	**£68,274,870**

Funding Contributions Comments Optional for any useful detail e.g. Carry over

Checklist
Complete:

Yes

Yes

Yes

Yes

See next sheet for Scheme Type (and Sub Type) descriptions

Better Care Fund 2022-23 Template

5. Expenditure

Selected Health and Wellbeing Board: Leicestershire

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£4,447,227	£4,447,227	£0
Minimum NHS Contribution	£46,137,029	£46,137,029	£0
iBCF	£17,690,614	£17,690,614	£0
Additional LA Contribution	£0	£0	£0
Additional NHS Contribution	£0	£0	£0
Total	**£68,274,870**	**£68,274,870**	**£0**

Required Spend

This is in relation to National Conditions 2 and 3 only. It does NOT make up the total Minimum CCG Contribution (on row 31 above).

>> Link to further guidance

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum ICB allocation	£13,107,300	£18,519,199	£0
Adult Social Care services spend from the minimum ICB allocations	£27,565,566	£28,124,346	£0

Checklist

Column complete:

Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	Yes	Yes

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Provision for enhanced carer support services	Home First	Care Act Implementation Related Duties	Carer advice and support		Social Care		LA			Local Authority	iBCF	£222,600	Existing
2	Link Workers (to support community & out	Home First	High Impact Change Model for Managing	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	iBCF	£78,750	Existing
3	Home First Case Management	Home First	Integrated Care Planning and Navigation	Assessment teams/joint assessment		Social Care		LA			Local Authority	Minimum NHS Contribution	£556,107	Existing
4	HC4L Back Office Support	Home First	Enablers for Integration	Joint commissioning infrastructure		Social Care		LA			Local Authority	Minimum NHS Contribution	£115,940	Existing
5	HART Reablement	Home First	Reablement in a persons own home	Reablement to support discharge step down		Social Care		LA			Local Authority	Minimum NHS Contribution	£817,746	Existing
6	Care Coordination	Integrated Care Planning	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	Minimum NHS Contribution	£712,445	Existing
7	Care Coordination - OT	Integrated Care Planning	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	Minimum NHS Contribution	£47,893	Existing
8	Home First, Nursing & Therapies	Home First	Community Based Schemes	Multidisciplinary teams that are supporting		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£5,095,607	Existing
9	Home Visiting Service	Home First	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			Private Sector	Minimum NHS Contribution	£2,109,685	Existing
10	Night Nursing Service	Home First	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			Private Sector	Minimum NHS Contribution	£443,783	Existing
11	Integrated Community Nursing	Integrated Planning	Personalised Care at Home	Physical health/wellbeing		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£6,361,267	Existing
12	Care Homes Support / Trusted Assessor	Discharge to Asses	High Impact Change Model for Managing	Trusted Assessment		Social Care		LA			Local Authority	iBCF	£138,000	Existing
13	CHC Commissioning Capacity	Discharge to Asses	High Impact Change Model for Managing	Improved discharge to Care Homes		Social Care		LA			Local Authority	iBCF	£172,725	Existing
14	Community Response Service	Discharge to Asses	High Impact Change Model for Managing	Home First/Discharge to Assess - process		Social Care		LA			Local Authority	iBCF	£361,200	Existing
15	Home First Case Management (Hosp Link	Discharge to Asses	high Impact Change Model for Managing	Multi-Disciplinary/Multi-Agency Discharge		Social Care		LA			Local Authority	Minimum NHS Contribution	£392,092	Existing
16	Home First Integrated Reablement	Discharge to Asses	Reablement in a persons own home	Reablement to support discharge step down		Social Care		LA			Local Authority	Minimum NHS Contribution	£478,858	Existing
17	Community Response Service - including	Discharge to Asses	High Impact Change Model for Managing	Home First/Discharge to Assess - process		Social Care		LA			Local Authority	Minimum NHS Contribution	£843,850	Existing
18	Lightbulb - Housing (Discharge)	Discharge to Asses	High Impact Change Model for Managing	Housing and related services		Social Care		LA			Local Authority	Minimum NHS Contribution	£114,000	Existing
19	Discharge Pathway 3 Contract	Discharge to Asses	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			Private Sector	Minimum NHS Contribution	£537,965	Existing
20	Primary Care Coordinator	Discharge to Asses	High Impact Change Model for Managing	Early Discharge Planning		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£37,097	Existing
21	Case managers for TCP to support inpatient	Transforming Care Programme	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	iBCF	£116,970	Existing
22	Contribution to TCP Coordinator Role (ELRCCG)	Transforming Care Programme	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			CCG	iBCF	£8,000	Existing
23	Positive Behaviour Support Team	Transforming Care Programme	Personalised Care at Home	Mental health /wellbeing		Social Care		LA			Local Authority	Minimum NHS Contribution	£99,318	Existing
24	Enhanced TCP Training Wraparound	Transforming Care Programme	Personalised Care at Home	Mental health /wellbeing		Social Care		LA			Local Authority	Minimum NHS Contribution	£61,798	Existing
25	Transforming Care Programme - Implementing	Transforming Care Programme	Personalised Care at Home	Mental health /wellbeing		Social Care		LA			Local Authority	Minimum NHS Contribution	£128,341	Existing
26	Improving Mental Health Discharge	Mental Health	High Impact Change Model for Managing	Early Discharge Planning		Social Care		LA			Local Authority	Minimum NHS Contribution	£318,034	Existing
27	LD Lead Commissioning Arrangements	Mental Health	Enablers for Integration	Integrated models of provision		Social Care		LA			Local Authority	Minimum NHS Contribution	£152,288	Existing
28	LD Short Breaks	Mental Health	Carers Services	Respite services		Social Care		CCG			NHS Community Provider	Minimum NHS Contribution	£929,012	Existing
29	Multi-disciplinary review team for top 100 high cost	Integrated Care Planning	High Impact Change Model for Managing	Monitoring and responding to system demand		Social Care		LA			Local Authority	iBCF	£223,545	Existing
30	Stabilising the social care provider market	Care providers Market stabalisation	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	iBCF	£14,463,350	Existing
31	Development of External Workforce	Promotion of Care Work	Home Care or Domiciliary Care	Domiciliary care workforce development		Social Care		LA			Local Authority	iBCF	£229,635	Existing
32	Care Act Enablers	Care Act Services	Care Act Implementation Related Duties	Carer advice and support		Social Care		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£83,794	Existing
33	Care Act Support Pathway	Care Act Services	Care Act Implementation Related Duties	Carer advice and support		Social Care		LA			Local Authority	Minimum NHS Contribution	£521,756	Existing
34	Post Diagnostic Community & In-Reach Service for	In Reach Services	High Impact Change Model for Managing	Improved discharge to Care Homes		Mental Health		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£59,670	Existing
35	Assessment and Review (ASC protected)	Integrated Care Planning	Integrated Care Planning and Navigation	Care navigation and planning		Social Care		LA			Local Authority	Minimum NHS Contribution	£1,930,903	Existing
36	Home Care Service (ASC protected)	Care Services	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Private Sector	Minimum NHS Contribution	£13,492,756	Existing
37	Nursing Care Packages (ASC protected)	Care Services	Residential Placements	Nursing home		Social Care		LA			Private Sector	Minimum NHS Contribution	£4,238,002	Existing
38	Residential Respite Service (ASC protected)	Care Services	Carers Services	Respite services		Social Care		LA			Private Sector	Minimum NHS Contribution	£874,376	Existing
39	First Contact Plus	Early Intervention	Prevention / Early Intervention	Social Prescribing		Social Care		LA			Local Authority	Minimum NHS Contribution	£175,065	Existing
40	LLR Community Integrated Neurology &	Care Services	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)	Reablement/Rehabilitation Services	Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£306,193	Existing
41	Loughborough Urgent Treatment Centre	Urgent Care	Community Based Schemes	Low level support for simple hospital discharges	Urgent Care	Community Health		CCG			Private Sector	Minimum NHS Contribution	£1,010,080	Existing
42	Urgent Care Centres	Urgent Care	Community Based Schemes	Low level support for simple hospital discharges	Urgent Care	Community Health		CCG			Private Sector	Minimum NHS Contribution	£1,456,850	Existing
43	Home First Programme Team	Integration Planning	Enablers for Integration	Integrated models of provision		Social Care		LA			Local Authority	iBCF	£279,939	Existing
44	Adult Mental Health Step Down Beds	Mental Health	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Social Care		LA			Local Authority	iBCF	£15,000	Existing
45	Technology Enabled Care	Technology Services	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	iBCF	£714,000	Existing
46	Support for Social Care Reform	Integration Planning	High Impact Change Model for Managing	Monitoring and responding to system demand		Social Care		LA			Local Authority	iBCF	£500,000	New
47	Specialist Residential Brokerage	Residential Brokerage	High Impact Change Model for Managing	Home First/Discharge to Assess - process		Social Care		LA			Local Authority	iBCF	£50,000	Existing
48	Winter Incentive Packs	Winter Care Packs	Care Act Implementation Related Duties	Other	Winter Care Packs	Social Care		LA			Local Authority	iBCF	£30,000	Existing
49	Integrated Personal Care Framework	Training	Enablers for Integration	Integrated models of provision		Community Health		LA			Local Authority	Minimum NHS Contribution	£81,400	Existing
50	Post Diagnostic Community & In-Reach Service for	In Reach Services	high Impact Change Model for Managing	Home First/Discharge to Assess - process		Mental Health		LA			Charity / Voluntary Sector	Minimum NHS Contribution	£281,426	Existing
51	Improving Quality in Care Homes	Integrated Improving Planning	Residential Placements	Care home		Social Care		LA			Local Authority	Minimum NHS Contribution	£622,739	Existing
52	Integration Programme Management	Implementation and change management capacity.	Enablers for Integration	Integrated models of provision		Social Care		LA			Local Authority	Minimum NHS Contribution	£417,232	Existing
53	Blaby DC	Integrated Blaby Planning	DFG Related Schemes	Adaptations, including statutory DFG		Social Care		LA			Local Authority	DFG	£450,661	Existing
54	Charnwood BC	Integrated Charnwood Planning	DFG Related Schemes	Adaptations, including statutory DFG		Social Care		LA			Local Authority	DFG	£1,063,464	Existing
55	Harborough BC	Integrated Harborough Planning	DFG Related Schemes	Adaptations, including statutory DFG		Social Care		LA			Local Authority	DFG	£374,222	Existing
56	Hinckley and Bosworth BC	Integrated Hinckley Planning	DFG Related Schemes	Adaptations, including statutory DFG		Social Care		LA			Local Authority	DFG	£365,792	Existing
57	Melton BC	Integrated Melton Planning	DFG Related Schemes	Adaptations, including statutory DFG		Social Care		LA			Local Authority	DFG	£131,567	Existing
58	North West Leicestershire BC	Integrated North Planning	DFG Related Schemes	Adaptations, including statutory DFG		Social Care		LA			Local Authority	DFG	£547,431	Existing
59	Oadby and Wigston BC	Integrated Oadby Planning	DFG Related Schemes	Adaptations, including statutory DFG		Social Care		LA			Local Authority	DFG	£247,089	Existing
60	Hoarding Project	Integrated Hoarding Planning	DFG Related Schemes	Discretionary use of DFG - including small adaptations		Social Care		LA			Local Authority	DFG	£315,000	Existing
61	EHOT	Integrated EHOT Planning	DFG Related Schemes	Discretionary use of DFG - including small adaptations		Social Care		LA			Local Authority	DFG	£70,000	Existing
62	OT	Integrated OT Planning	DFG Related Schemes	Discretionary use of DFG - including small adaptations		Social Care		LA			Local Authority	DFG	£57,000	Existing
63	Green Grant	Integrated Green Planning	DFG Related Schemes	Discretionary use of DFG - including small adaptations		Social Care		LA			Local Authority	DFG	£825,000	New
64	Integration Programme Management	Implementation and change management capacity.	Enablers for Integration	Integrated models of provision		Social Care		LA			Local Authority	iBCF	£57,500	Existing
65	HC4L Back Office Support	Home First	Enablers for Integration	Joint commissioning infrastructure		Social Care		LA			Local Authority	iBCF	£29,400	Existing
66	Discharge Hub	Discharge to Assess	Community Based Schemes	Low level support for simple hospital discharges		Community Health		CCG			NHS Community Provider	Minimum NHS Contribution	£231,660	Existing

Further guidance for completing Expenditure sheet

National Conditions 2 & 3

Schemes tagged with the following will count towards the planned **Adult Social Care services spend** from the NHS min:
- **Area of spend** selected as 'Social Care'
- **Source of funding** selected as 'Minimum NHS Contribution'

Schemes tagged with the below will count towards the planned **Out of Hospital spend** from the NHS min:
- **Area of spend** selected with anything except 'Acute'
- **Commissioner** selected as 'ICB' (if 'Joint' is selected, only the NHS % will contribute)
- **Source of funding** selected as 'Minimum NHS Contribution'

2022-23 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Carer advice and support 2. Independent Mental Health Advocacy 3. Safeguarding 4. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the NHS minimum contribution to the BCF.
3	Carers Services	1. Respite Services 2. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services should be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services	1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.
12	Reablement in a persons own home	1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
14	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
15	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
16	Residential Placements	1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
18	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2022-23 Template

6. Metrics

Selected Health and Wellbeing Board: Leicestershire

8.1 Avoidable admissions

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition	Checklist: Complete:
Indirectly standardised rate (ISR) of admissions per 100,000 population (See Guidance)	Indicator value	188.1	184.3	184.5	166.8	166.8Our Planned figures for 22/23 are based on a 10% reduction on last years' actual of 650.6. Our 21/22 plan was exceeded by 6.7% against target More people are now starting to access acute care therefore a 10% reduction on last years' actuals is more realistic with plans that are being put in place.	1) Piloting an unscheduled care hub triaging calls from the EMASS Stack enabling referrals to be diverted into the community. 2) Crisis Response Service receives on average 460 referrals per month which includes step up activity contributing to avoidable admissions 3) CRS and HART Services alignment intake model (including step-up) circa 2 million initial recurrent investment. 4) Care Coordination now fully aligned and increasing pro-active case management based on the top 5% of people in	
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan			
	Indicator value	165	164	162	160			Yes
	Denominator	713,100	713,100	713,100	713,100			Yes

[>> link to NHS Digital webpage (for more detailed guidance)]

8.3 Discharge to usual place of residence

		2021-22 Q1 Actual	2021-22 Q2 Actual	2021-22 Q3 Actual	2021-22 Q4 Actual	Rationale for how ambition was set	Local plan to meet ambition	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	Quarter (%)	92.2%	92.6%	92.0%	92.9%	We aim to stay in line with historical figures. Our ambition is for a further 0.5% increase in the total annual percentage of people discharged from acute hospital to their normal place of residence.	1) Re-Opening of the Domiciliary Care framework. To build on previous improved performance in await care times. This will go live October 2022. £145k 2) Developing a 3R intake model with partners to increase the availability of Recovery, Rehabilitation and Reablement within a persons normal place of residence. Initial 2 million investment.	Yes
	Numerator	13,746	13,749	13,375	13,293			
	Denominator	14,915	14,852	14,543	14,306			
		2022-23 Q1 Plan	2022-23 Q2 Plan	2022-23 Q3 Plan	2022-23 Q4 Plan			
	Quarter (%)	92.2%	92.7%	92.7%	93.9%			
	Numerator	13,530	13,540	13,550	13,490			Yes
	Denominator	14,675	14,613	14,613	14,374			Yes

8.4 Residential Admissions

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	308.8	518.8	598.6	561.8	The current forecast for 22/23 is very low, possibly due to a lag in recording so not an accurate reflection of overall performance. Last year had 870 admissions so based on this, the target for this year (22/23) would be 860 or 561.8 per 100k population based	1) Increased brokerage function for quicker POC starts eliminating the use of interim beds. Circa 3367k 2) Increased presence of ASC staff on wards contributing to effective triaging for suitable care support. Circa £400k	Yes
	Numerator	453	780	900	860			Yes
	Denominator	146,675	150,361	150,361	153,087			

Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population (aged 65+) population projections are based on a calendar year using the 2018 based Sub-National Population Projections for Local Authorities in England:
https://www.ons.gov.uk/releases/subnationalpopulationprojectionsforengland2018based

8.5 Reablement

		2020-21 Actual	2021-22 Plan	2021-22 estimated	2022-23 Plan	Rationale for how ambition was set	Local plan to meet ambition	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	84.7%	85.1%	89.4%	87.1%	Performance last year and this has been consistent at 89%. However, performance is calculated on just three months of discharges so performance can be changeable. A target of 87% would remain some way ahead of the latest national	1) Scoping of a 3R intake model improving peoples independence for longer. Including the HART reablement offer. £646k in the BCF 4.5million overall. 2) Implementation of New enhanced Care Technology Service in conjunction with	Yes
	Numerator	431	410	395	392			Yes
	Denominator	509	482	442	450			Yes

Please note that due to the demerging of Northamptonshire, information from previous years will not reflect the present geographies.

As such, the following adjustments have been made for the pre-populated figures above:
- 2020-21 actuals (for **Residential Admissions** and **Reablement**) for North Northamptonshire and West Northamptonshire are using the Northamptonshire combined figure;
- 2021-22 and 2022-23 population projections (i.e. the denominator for **Residential Admissions**) have been calculated from a ratio based on the 2020-21 estimates.

Better Care Fund 2022-23 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Leicestershire

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it	Checklist Complete:
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between ICB(s) and LA; been submitted? Has the HWB approved the plan/delegated approval? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes	Cover sheet Cover sheet HWBB 22/09/22 Narrative page 2 Metric target methodology agreed across LLR Narrative doc page 4			Yes
	PR2	**A clear narrative for the integration of health and social care**	Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes: • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally • The approach to collaborative commissioning • How the plan will contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the document will address these. The area will need to also take into account Priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.	Narrative plan	Yes	Narrative pages 9-10 Narrative page 9 Narrative pages 10, 17-19			Yes
	PR3	**A strategic, joined up plan for Disabled Facilities Grant (DFG) spending**	Is there confirmation that use of DFG has been agreed with housing authorities? • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory DFG? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes	Narrative page 2 Narrative pages 15-16 Narrative page 2			Yes
NC2: Social Care Maintenance	PR4	**A demonstration of how the area will maintain the level of spending on social care services from the NHS minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the NHS minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes				Yes
NC3: NHS commissioned Out of Hospital Services	PR5	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the NHS minimum BCF contribution?**	Does the total spend from the NHS minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes				Yes
NC4: Implementing the BCF policy objectives	PR6	**Is there an agreed approach to implementing the BCF policy objectives, including a capacity and demand plan for intermediate care services?**	Does the plan include an agreed approach for meeting the two BCF policy objectives: - Enable people to stay well, safe and independent at home for longer and - Provide the right care in the right place at the right time? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? •Has the area submitted a Capacity and Demand Plan alongside their BCF plan, using the template provided? • Does the narrative plan confirm that the area has conducted a self-assessment of the area's implementation of the High Impact Change Model for managing transfers of care? • Does the plan include actions going forward to improve performance against the HICM?	Narrative plan Expenditure tab C&D template and narrative Narrative plan Narrative template	Yes	Narrative pages 11-13 Yes Narrative page 13			Yes
Agreed expenditure plan for all elements of the BCF	PR7	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 31 – 43 of Planning Requirements) (tick-box) • Has the area included a description of how BCF funding is being used to support unpaid carers? • Has funding for the following from the NHS contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plan Narrative plans, expenditure tab and confirmation sheet	Yes	Yes Yes Narrative page 14			Yes
Metrics	PR8	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching ambitions been agreed locally for all BCF metrics? • Is there a clear narrative for each metric setting out: - the rationale for the ambition set, and - the local plan to meet this ambition?	Metrics tab	Yes	Yes Narrative page 4-5			Yes

Better Care Fund 2022-23 Capacity & Demand Template

1.0 Guidance

Overview

The Better Care Fund (BCF) requirements for capacity and demand plans are set out in the BCF Planning Requirements document for 2022-23, which supports the aims of the BCF Policy Framework and the BCF programme. The programme is jointly led and developed by the national partners Department of Health (DHSC), Department for Levelling Up, Housing and Communities, NHS England (NHSE), Local Government Association (LGA), working with the Association of Directors of Adult Social Services (ADASS).

Appendix 4 of the Planning Requirements sets out guidance on how to develop Capacity and Demand Plans, useful

This template has been designed to collect information on expected capacity and demand for intermediate care. These plans should be agreed between Local Authority and Integrated Care Board partners and signed off by the HWB as part

The template is split into three main sections.

Demand - used to enter the expected demand for short term, intermediate care services in the local authority (HWB) area from all referral sources from October 2022-March 2023. There are two worksheets to record demand

- Sheet 3.1 Hospital discharge - expected numbers of discharge requiring support, by Trust.
- Sheet 3.2 Community referrals (e.g. from Single points of Access, social work teams etc)

Intermediate care capacity - this is also split into two sheets (4.1 Capacity - Discharge and 4.2 Capacity - community). You should enter expected monthly capacity available for intermediate care services to support discharge and referrals from community sources. This is recorded based on service type.
23 (October to March)

Spend data - this worksheet collects estimated spend across the local authority area on intermediate care for the whole year ie 2022-23. This should include all expenditure (NHS and LA funded) on intermediate care services as defined in

Note on entering information into this template

Throughout the template, cells which are open for input have a yellow background and those that are pre-populated have a grey background, as below:

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

To view each of the sheets and in particular the drop down lists clearly on screen, please change the zoom level to between 90% - 100%. Most drop downs are also available to view as lists in the relevant sheet or in the guidance tab for

The details of each sheet in the template are outlined below.

2. Cover

1. The cover sheet provides essential information on the area for which the template is being completed, contacts and sign-off.
2. Question completion tracks the number of questions that have been completed; when all the questions in each section of the template have been completed the cell will turn green. Only when all cells are green should the template

england.bettercarefundteam@nhs.net

(please also each copy in your respective Better Care Manager)
If you have any queries on the template then please direct these to the above email inbox or reach out via your BCM.
3. Please note that in line with fair processing of personal data we request email addresses for individuals completing the reporting template in order to communicate with and resolve any issues arising during the reporting cycle. We remove these addresses from the supplied templates when they are collated and delete them when they are no longer

3. Demand

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway (as set out in the Hospital Discharge Guidance avalable on Gov.uk)

Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template uses the pathways set out in the Hospital Discharge and community support https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-co

We suggest that you enter data for individual trusts where they represent 10% or more of expected discharges in the area. Where a Trust represents only a small number of discharges (less than 10%), we recommend that you amalgamate the demand from these sources under the '**Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.

Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2022-23
- Data from the NHSE Discharge Pathways Model.

3.2 Demand - Community

This worksheet collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care (non-discharge) each month, split

Further detail on definitions is provided in Appendix 4 of the Planning Requirements. This includes the NICE Guidance definition of 'intermediate care' as used for the purposes of this exercise.

4.1 Capacity - discharge

This sheet collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or reabilitation in a person's own home
- Bed-based intermediate care (step up or step down)
- Residential care that is expected to be long-term (collected for discharge only)

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest level of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services at a given time.

4.2 Capacity - community

This sheet collects expected capacity for intermediate care services where a person has been referred from a community source. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 5 types of service:

- VCS services to support someone to remain at home
- Urgent Community Response (2 hr response)
- Reablement or rehabilitation in a person's own home
- Bed-based intermediate care (step up)

5.0 Spend

This sheet collects top line spend figures on intermediate care which includes:

- Overall spend on intermediate care services - using the definitions in the planning requirements (BCF and non-BCF) for
- Spend on intermediate care services in the BCF (including additional contributions).

These figures can be estimates, and should cover spend across the Health and Wellbeing Board (HWB). The figures do not need to be broken down in this template beyond these two categories.

HM Government

NHS

Better Care Fund 2022-23 Capacity & Demand Template

2.0 Cover

Version 1.0

Health and Wellbeing Board:	Leicestershire
Completed by:	Lisa Carter
E-mail:	lisa.carter@leics.gov.uk
Contact number:	O1163050786
Has this report been signed off by (or on behalf of) the HWB at the time of submission?	Yes
If no, please indicate when the report is expected to be signed off:	

Please indicate who is signing off the report for submission on behalf of the HWB (delegated authority is also accepted):

Job Title:	Chief Executive, Leicestershire County Council
Name:	John Sinnott

How could this template be improved?	The demand data is not comparable to the capacity data. We have had to accumulate out of county figures with a large community provider as they were not available on the drop down menu. In general, figures are requested at HWBB level but this does not

Question Completion - Once all information has been entered please send the template to england.bettercarefundteam@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

[<< Link to the Guidance sheet]

[^^ Link back to top]

Better Care Fund 2022-23 Capacity & Demand Template

3.1 Demand - Hospital Discharge

Selected Health and Wellbeing Board: Leicestershire

3. Demand

This section requires the Health & Wellbeing Board to record expected monthly demand for supported discharge by discharge pathway.

Data can be entered for individual hospital trusts that care for inpatients from the area. Multiple Trusts can be selected from the drop down list in column F. You will then be able to enter the number of expected discharges from each trust by Pathway for each month. The template uses the pathways set out in the Hospital Discharge and community support guidance - https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance

If there are any 'fringe' trusts taking less than say 10% of patient flow then please consider using the '**Other**' Trust option.

The table at the top of the screen will display total expected demand for the area by discharge pathway and by month.

Estimated levels of discharge should draw on:

- Estimated numbers of discharges by pathway at ICB level from NHS plans for 2022-23
- Data from the NHSE Discharge Pathways Model.

Totals Summary (autopopulated)	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
0: Low level support for simple hospital discharges - e.g. Voluntary or Community Sector support - (D2A Pathway 0)	5712	5712	5712	5712	5712	5712
1: Reablement in a persons own home to support discharge (D2A Pathway 1)	274	274	274	274	274	274
2: Step down beds (D2A pathway 2)	231	231	231	231	231	231
3: Discharge from hospital (with reablement) to long term residential care (Discharge to assess pathway 3)	2	2	2	2	2	2

Any assumptions made:	The demand data is not comparable to the capacity data. For pathway 0, Leics data is assumed to be two thirds of the total of UHL data as it is not broken down by LA area. Average per month has been calculated by applying 10% winter pressures to Jun-Sept 22 actuals. For UHL pathway 1, actual discharge numbers from Jun-Sept 22 has been averaged with

!!Click on the filter box below to select Trust first!!

Trust Referral Source (Select as many as you need)	Demand - Discharge Pathway	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	0: Low level support for simple hospital discharges - e.g. Voluntary or Community Sector support - (D2A Pathway 0)	5665	5665	5665	5665	5665	5665
OTHER		47	47	47	47	47	47
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	1: Reablement in a persons own home to support discharge (D2A Pathway 1)	232	232	232	232	232	232
OTHER		42	42	42	42	42	42
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	2: Step down beds (D2A pathway 2)	227	227	227	227	227	227
OTHER		4	4	4	4	4	4
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	3: Discharge from hospital (with reablement) to long term residential care (Discharge to assess pathway 3)	1	1	1	1	1	1
OTHER		1	1	1	1	1	1

Better Care Fund 2022-23 Capacity & Demand Template

3.0 Demand - Community

Selected Health and Wellbeing Board: Leicestershire

3.2 Demand - Community

This worksheet collects expected demand for intermediate care services from community sources, such as multi-disciplinary teams, single points of access or 111. The template does not collect referrals by source, and you should input an overall estimate each month for the number of people requiring intermediate care (non-discharge) each month, split by different type of intermediate care.

Further detail on definitions is provided in Appendix 4 of the Planning Requirements. This includes the NICE Guidance definition of 'intermediate care' as used for the purposes of this exercise.

Any assumptions made:	The demand data is not comparable to the capacity data. Vol and community = Care co-ordination GP referrals average per month and Community response service step-up average per month and added together to form overall projected monthly demand. For Urgent community response, averaged per month data from Dec 21 - Jun 22 and applied

Demand - Intermediate Care						
Service Type	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Voluntary or Community Sector Services	389	389	389	389	389	389
Urgent community response	4	4	4	4	4	4
Reablement/support someone to remain at home	73	87	86	75	92	98
Bed based intermediate care (Step up)	0	0	0	0	0	0

Better Care Fund 2022-23 Capacity & Demand Template

4.0 Capacity - Discharge

Selected Health and Wellbeing Board: Leicestershire

4.1 Capacity - discharge

This sheet collects expected capacity for services to support people being discharged from acute hospital. You should input the expected available capacity to support discharge across these different service types:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or reabilitation in a person's own home
- Bed-based intermediate care (step down)
- Residential care that is expected to be long-term (collected for discharge only)

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

Any assumptions made:	The demand data is not comparable to the capacity data. Pathway 0 discharge support goes through our Care Co-ordination service which then link to VCS services within the community. All figures include an average per month for capacity based. Pathway 2 beds is combined LPT community hospital bed numbers plus 26 beds commissioned for therapy and

Capacity - Hospital Discharge							
Service Area	Metric	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
VCS services to support discharge	Monthly capacity. Number of new clients.	0	0	0	0	0	0
Urgent Community Response (pathway 0)	Monthly capacity. Number of new clients.	250	250	250	250	250	250
Reablement or reabilitation in a person's own home (pathway 1)	Monthly capacity. Number of new clients.	210	210	210	210	210	210
Bed-based intermediate care (step down) (pathway 2)	Monthly capacity. Number of new clients.	330	330	330	330	330	330
Residential care that is expected to be long-term (discharge only)	Monthly capacity. Number of new clients.	8	8	8	8	8	8

Better Care Fund 2022-23 Capacity & Demand Template

4.2 Capacity - Community

Selected Health and Wellbeing Board: Leicestershire

4.2 Capacity - community

This sheet collects expected capacity for community services. You should input the expected available capacity across the different service types.

You should include expected available capacity across these service types for eligible referrals from community sources. This should cover all service intermediate care services to support recovery, including Urgent Community Response and VCS support. The template is split into 5 types of service:

- Voluntary or Community Sector (VCS) services
- Urgent Community Response
- Reablement or rehabilitation in a person's own home
- Bed-based intermediate care (step up)

Please consider the below factors in determining the capacity calculation. Typically this will be (Caseload*days in month*max occupancy percentage)/average duration of service or length of stay

Caseload (No. of people who can be looked after at any given time)

Average stay (days) - The average length of time that a service is provided to people, or average length of stay in a bedded facility

Please consider using median or mode for LoS where there are significant outliers

Peak Occupancy (percentage) - What was the highest levels of occupany expressed as a percentage? This will usually apply to residential units, rather than care in a person's own home. For services in a person's own home then this would need to take into account how many people, on average, that can be provided with services.

Any assumptions made:	The demand data is not comparable to the capacity data. Step-up community response service and GP referrals into care co-ordination. Step-up referrals for 2 hour community response Currently don't utilise beds for intermediate care.

Capacity - Community							
Service Area	Metric	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Voluntary or Community Sector Services	Monthly capacity. Number of new clients.	389	389	389	389	389	389
Urgent Community Response	Monthly capacity. Number of new clients.	4	4	4	4	4	4
Reablement or rehabilitation in a person's own home	Monthly capacity. Number of new clients.	90	90	90	90	90	90
Bed based intermediate care (step up)	Monthly capacity. Number of new clients.	0	0	0	0	0	0

Better Care Fund 2022-23 Capacity & Demand Template

5.0 Spend

Selected Health and Wellbeing Board: Leicestershire

5.0 Spend

This sheet collects top line spend figures on intermediate care which includes:

- Overall spend on intermediate care services (BCF and non-BCF) for the whole of 2022-23
- Spend on intermediate care services in the BCF (including additional contributions).

These figures can be estimates, and should cover spend across the Health and Wellbeing Board (HWB). The figures do not need to be broken down in this template beyond these two categories.

Spend on Intermediate Care

	2022-23
Overall Spend (BCF & Non BCF)	£8,943,238
BCF related spend	£2,831,178

Comments if applicable	The spend includes: County Reablement and Crisis Response Teams, Care co-ordination, ICB spend on a contract for Therapy Beds across the County and one County employee based full time at the Therapy Unit.