BCF narrative plan template

This is a template for local areas to use to submit narrative plans for the Better Care Fund (BCF). All local areas are expected to submit narrative BCF plans. Although the template is optional, we ask that BCF planning leads ensure that narrative plans cover all headings and topics from this narrative template.

These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 25 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template. 2

Cover

Health and Wellbeing Board(s).

Bodies involved strategically and operationally 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
Royal Voluntary Service
Voluntary Action Leicester / Leicestershire

How have you gone about involving these stakeholders?

PR1: A jointly developed and agreed plan that all parties sign up to

Stakeholders are continuously involved in BCF planning and delivery via a well-established, place-based infrastructure (see governance section below).

For the 23-25 plan development, engagement has been received from partners via a series of forums. The first took place with system partners agreeing priorities for delivery across all three HWBB areas at a group discussion on the 24th April, 2023. This discussion looked at how the BCF can shape the desired system outcomes. For place-based development of the plan for Leicestershire, the Integration Delivery Group (IDG), listed below, established the priorities following on from the system session. The Joint Commissioning Group and Integrated Finance and Performance Group (JCG/IFPG) decided on the overall spend for Leicestershire.

Health and Wellbeing Board members were involved in the shaping of the plan at their meeting of the 25th May. An example of how this helped to shape the plan comes from a suggestion to ensure Mental Health support both for reducing delayed transfers of care and to support people to remain at home. This has shaped key investment into services for Mental health with additional investment in this area (detailed further below). With opportunities to comment on the schemes and spending allocations and assurance against the Key Lines of Enquiry. It also includes receiving and agreeing the section 75 agreement and agreement for the DFG amounts to be 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 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 BCF delivery is aligned to deliver against 'Living and Supported Well' and 'Dying Well' priorities. See governance section below. Planning activity for the 23-25 BCF has again been 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.

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. An example of how partners have helped to shape the plan comes from consultation on delivery of taken place with representatives from the Royal Voluntary Service specifically around supporting people to remain at home. This influenced the additional investment in helping to support people in the community who are discharged on pathway 0 and require some additional low-level support to remain at home. Funding has been aligned to support delivery of this priority using our community partners and is detailed further on in the narrative.

The 2023-25 BCF plan drafts have been agreed with executives within each stakeholder group, then to the Integration Executive on the 6th June before being formally approved by the Local Authority Chief Executive using delegated powers of authority agreed with the Health and Wellbeing Board. The plan will be formally approved by the Health and Wellbeing Board retrospectively at its September 2023 meeting. Full details on governance can be seen in the section below.

Governance

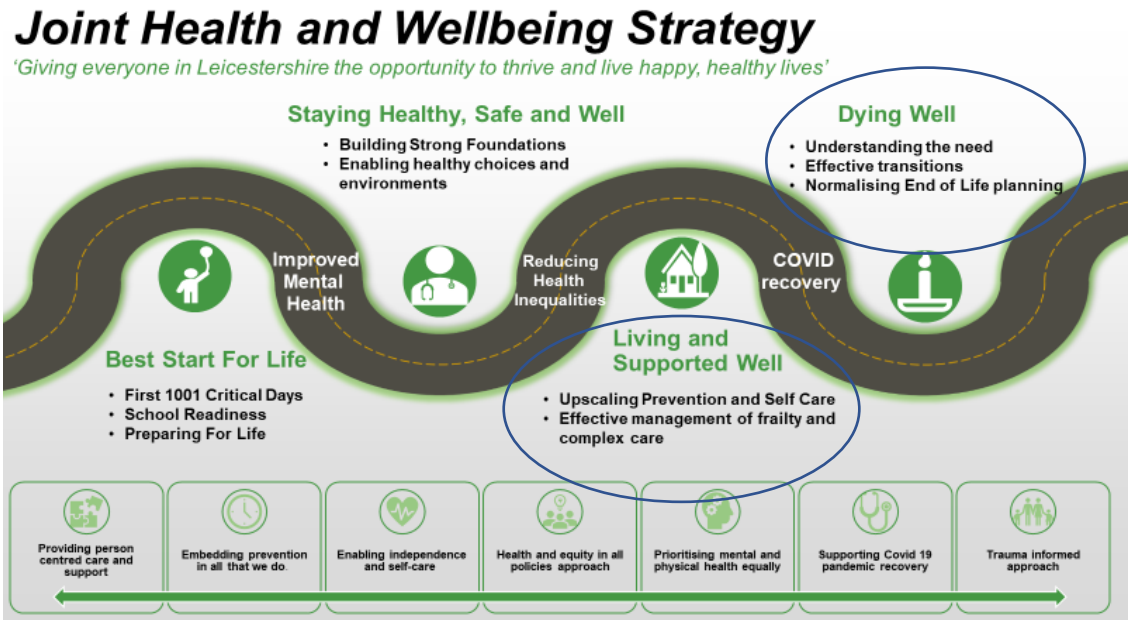
Please briefly outline the governance for the BCF plan and its implementation in your area.

PR1: A jointly developed and agreed plan that all parties sign up to

The Joint Commissioning and Integrated Finance and Performance Group (JCG/IFPG) and Integration Delivery Group (IDG) are sub-groups of the Integration Executive (IE). The JCG/IFPG 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/IFPG where new or re-commissioning is required.

Operationally, the two sub-groups of the Integration Executive, the Integration Delivery Group and Joint Commissioning and Finance and Performance Group (JCG/IFPG), meet monthly and bi-monthly (respectively) to discuss the delivery of BCF plans and any commissioning required to meet our objectives. The JCG/IPFG 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 agrees with District Councils the DFG amounts transported to of them within Leicestershire. This is passed on in its entirety with top slicing agreed by partners for wider housing related schemes. This has been agreed and transported for 23-24.

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.



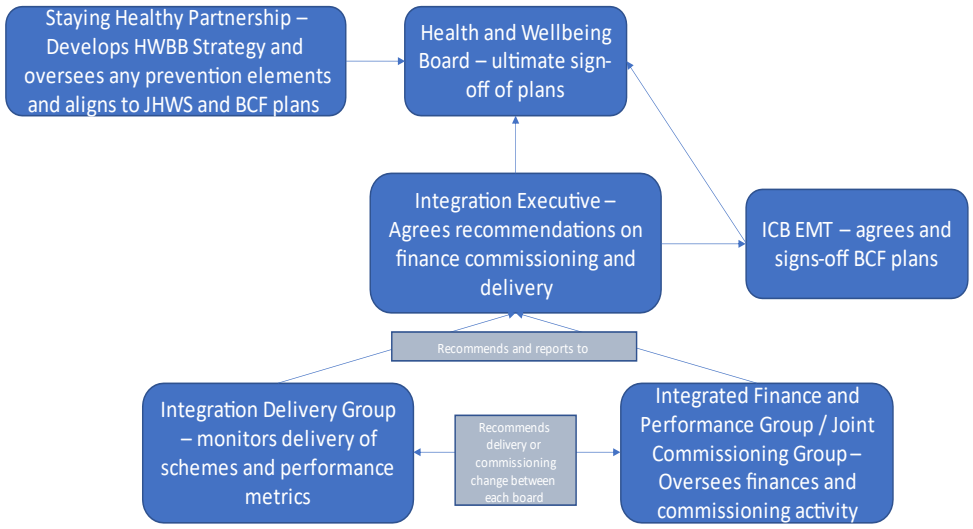
One of the cross-cutting themes is the reduction of health inequalities. Further information on this and the reduction of disparities including delivery against the Core20plus5 for LLR can be found in the health inequality and equality section below.

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, making any necessary recommendations for approval to the Health and Wellbeing Board. The IE regularly review delivery plans against the JHWS objectives set by the Health and Wellbeing Board (HWBB) in support of the delivery of JHWS priorities.

In addition, prevention schemes are reported to the Staying Healthy Partnership (also a sub-board of the HWBB). This is also a sub-board of the HWBB and welcomes representation from VCS organisations and district councils and is led by Public Health. It has overall responsibility for reporting to the Health and Wellbeing Board for JHWS delivery.

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 2023-25 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 plan will be formally signed off at the 28th September, however, to involve all members in the preparedness of the plans, a document outlining how the system aims to meet the BCF KLOES was presented for discussion and input.

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

Executive summary

This should include:

- Priorities for 2023-25
- Key changes since previous BCF plan.

PR 9: Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?

As in previous years, the BCF plan for Leicestershire for 23-25 reflects delivery against the established framework already in place for delivery of this across the Leicester, Leicestershire and Rutland (LLR) system.

Leicestershire County Council, NHS partners, District Councils and other key partners have collaborated through the established governance structure (see above) 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
- Developed 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 and duties relating to the Care Act
- 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).

As in previous years, BCF priorities have been aligned to the delivery of 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 above, including commissioning changes and improvements to the JCG/IFPG 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.

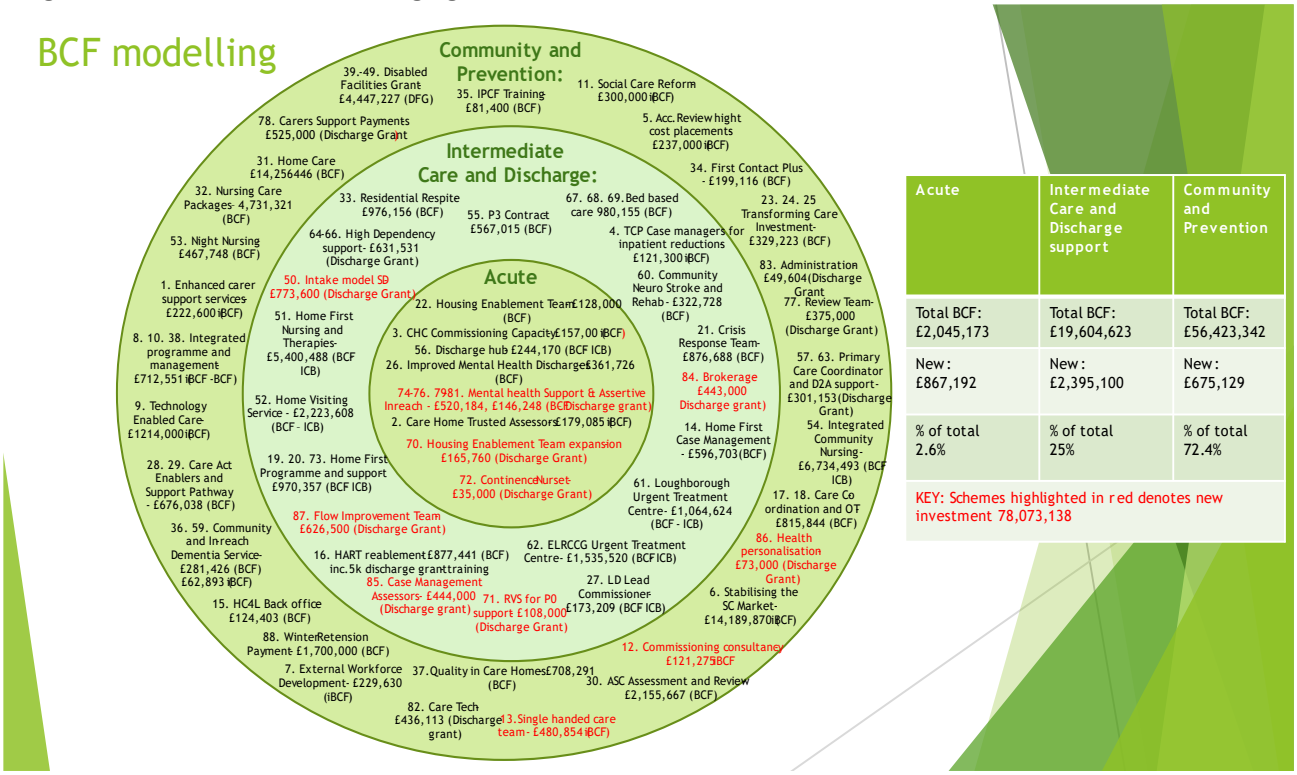
The BCF pooled budget will fund the following key areas of place-based services in 2023-25: Supporting the Domiciliary Homecare Market, Nursing and Therapy services, Intermediate Care Services to support discharges to home, Intermediate Bedded Care services that include nursing, Urgent Care Centres, high-dependency and Reablement and Rehabilitation, 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). Additional support to unpaid carers, further utilisation of the voluntary sector to

support discharges into the community and re-purposing of community hospital beds to support acute flow.

In preparation for this submission, a review of schemes within the BCF took place in March 2023 to ensure it was fully aligned to the delivery of the Intermediate Care Strategy currently in development. Timescales for completion of the strategy is July 23 with roll-out of schemes expected to begin in Dec 23. Outcomes from elements of the strategy such as the Intake Model are expected as early as December 2024. Further information on the strategy and the intake model can be found in the section relating to national condition 1. Full roll-out of the Intermediate care model is expected to be completed by April 2025. This is in line with the two-year BCF plan.

The model (diagram 1) below shows current BCF investment is primarily supporting community and prevention services with the greatest level of investment for the next two years, centred on delivery of Intermediate Care priorities.

Diagram 1: BCF financial modelling against levels of care



Acute	Intermediate Care and Discharge support	Community and Prevention
Total BCF: £2,045,173	Total BCF: £19,604,623	Total BCF: £56,423,342
New: £867,192	New: £2,395,100	New: £675,129
% of total 2.6%	% of total 25%	% of total 72.4%

KEY: Schemes highlighted in red denotes new investment 78,073,138

This has given us the assurance 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.

Key changes within this two-year plan include additional investment in the design and implementation of our Intermediate Care priorities including the Intake model. This model will revolutionise the way in which we support patients discharged home and give a basis for provision of Reablement, Recovery and Rehabilitation and inform a similar development for step-up community care.

Table 1 below shows the metrics and associated targets and summarises the rationale for target setting for 2023-24.

Table 1: Metric targets for 23/24 against 22/23 outturns

Metric	Target 23/24	22/23 outturn	Comments
Unplanned admissions for chronic ambulatory care-sensitive conditions.	651 8.5% reduction on 22/23 actuals	713	The target remains the same as last year. It wasn't met during that time so it has remained the same. However, performance against the metric did see improvement in this area
Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000.	1628.09 2.5% reduction on 22/23 estimated outturn	1669.8	This was previously included as a local metric for Leics BCF. The target has been set to align with City and Rutland Figures but still remains an improvement on previous years' actuals
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (excluding RIP)	93% 0.8% increase on 22/23 actual performance	92.2%	Leicestershire is already top quartile for this metric. The aim for next year is to improve to 93%.
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	525.2 (per 100,000 population) This would move us to the second quartile of national reporting	549 (per 100,000 population)	The aim for this target is to move into the second quartile when compared to similar authorities. Currently Leicestershire is in the third quartile.
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	90% 0.8% increase on 22/23 actual performance	89.2%	Again, Leicestershire is a top quartile performer in this metric nationally. The target represents an improvement on last years' performance

Metric targets have been jointly produced across LLR, with each area using the same methodology for target setting. 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. Where targets have remained the same or there has been a minimal increase, this is due to the rise in demand from an ageing population. Rising by 10% in Leicestershire from 2020 – 2025 (POPPI data) so services are working harder to keep current metric performance stable. Where there is a minimal increase in target, this represents a stretch target due to population increases and increases in demand for services.

National Condition 1: Overall BCF plan and approach to integration

Please outline your approach to embedding integrated, person-centred health, social care and housing services including:

- Joint priorities for 2023-25
- Approaches to joint/collaborative commissioning
- How BCF funded services are supporting your approach to continued integration of health and social care. Briefly describe any changes to the services you are commissioning through the BCF from 2023-25 and how they will support further improvement of outcomes for people with care and support needs.

PR2: A clear narrative for the integration of health, social care and housing
PR3: A strategic, joined up plan for Disabled Facilities Grant (DFG) spending

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.

The governance structure above has led on the following identification of priorities for 23-25 particularly around commissioning requirements to support improvements.

Our approach to joint commissioning for 23-25 has been to take a system-wide collaborative approach to defining priorities. These have been informed throughout the year by various workstreams to identify areas where improvement is required. Areas of improvement required begins with an analysis of data and service user feedback.

A key example is the work that commenced in 2022 to evaluate the systems integrated intermediate care offer. This began with a review by Dr Ian Sturgess to address challenges in the LLR system. Namely, high pressures in acute and ambulance trusts and high levels of failure demand (40%) for people attending A and E. Failure demand, in this context is defined as where patients could have or should have received support from elsewhere in the system instead of A and E.

The scope of the review was jointly agreed and focused on the following:

1. Define opportunities to increase the volume and speed of discharges within our system providers, including an assessment of whether we can increase P0 discharges
2. Define interventions to improve flow to home, community and social care provider
3. Define the key gaps or interventions required to improve flow, including a view on system capacity
4. Explore key feedback from the CQC and other colleagues to define improvements and solutions
5. Understanding the causes and interventions which can reduce medical length of stay
6. Assess flow into the organisation such as via the frailty pathway

Many of the discharge to assess findings of the review, centred around improved systems and processes. Many of which were simple improvements that have been made since the review e.g. simplified home first forms and discharge hub triage processes; both of which have improved timescales and communications between teams. However, several of the recommendations

required wholescale reviews of services and investment. The following are pertinent to the BCF plans and the development of the Intermediate Care Strategy development:

- Pathway 1 – sufficient capacity has not been commissioned effectively and jointly by the system.
- The 3 Local Authorities have set up effective in-house reablement Teams, however, capacity across Pathway 1 has not been optimised by the system and Care Agency delivery is unsatisfactory.
    - There are a significant proportion of patients in UHL and in LPT Community Hospital Beds and all the Patients in the Therapy led beds who could be discharged home earlier if there was sufficient Pathway 1 capacity.
    - There are also patients who have been transferred to Care Home beds in whom the preferred option was Pathway 1, their outcomes have potentially been compromised.
- The performance metrics for Pathway 1 of 85% within 24 hrs is not being achieved and is set too low, the aim should be 100% same day/next day.

Recommendations to improve the above findings, were as follows:

- Increase Pathway 1 capacity by at least 50%, and the System must ensure Pathway 1 is consistently Therapy led.
- As Pathway 1 capacity improves progressively close Pathway 2 beds outside of LPT Community Hospitals, whilst monitoring the queues.
- Develop a framework for Recovery, Reablement and Rehabilitation (RRR)
- Having 5 types of Pathway 2 is not an effective way to commission beds.
- The offer should be dynamic RRR. When Pathway 1 is right sized, the current 4 types of Care Home P2 could be decommissioned as 3 of them do not deliver quality RRR and no outcomes data.
- In the 3 LPT Community Hospitals visited approximately 25% of patients could have been supported by Pathway 1 and of the remaining 75% of in-patients approximately 1/3 could have been discharged earlier with a properly commissioned Pathway 1.
- There are un-opened Community Hospital beds whilst there are patients being transferred to inappropriate Pathway 2 settings.

This has led to the development of an intermediate care strategy to reduce over-utilisation of care, both bedded and non-bedded and to ensure that all patients being discharged from hospital received a period of recovery and rehabilitation. Currently, reablement is a selective model and this will be aligned to expand to all patients where it is practicable. This in turn has informed what we need to commission as an area and as a system in order to make the changes required. Further details are shown below as to what this means in terms of additional and re-aligned BCF investment.

Summarised below are the high-level priorities in the plan (highlighted in bold), 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 and includes any changes and additional investment to our Better Care Fund planning or spend.

This strategy was also informed by work undertaken as described above using the demand and capacity methodology for identifying need (as per 22/23 BCF) and to reduce health inequalities and inequity of care provision. Key priorities for delivery incorporated in the 23-25 BCF plan include:

1. **Discharge Process Improvement** - Retain focus on reducing unwarranted variation in discharges across 7 days – additional £633k investment – Implementation July 23 including investment in the voluntary sector and support to unpaid carers

2. **Scoping use of P2 beds and right-sizing commissioning** - Aspire to have no more that 20% of patients placed in spot-purchased residential P2 placements by November 2023 - £1.8 million additional investment (3.7 million LLR wide). Implementation July 23
3. **Community Step-up and Step-down Pathway 1 model** - Utilise LLR demand and capacity modelling to right size P1 ensuring all patients discharged home are assessed for home-based intermediate care (intake model) - £774k – Implementation Dec 23. Once this model is in place, explore options for step-up - £375k – Implementation to begin March 24
4. **Repurposing Community Hospital Beds** - LPT Community Hospital beds become the predominent destination for P2 discharges / transfers – circa £9 million NHSE funding (will inform future BCF funding alignment) – Implementation by March 24
5. **Workforce Development** - Continue to work with strategic workforce colleagues to facilitate recruitment of sufficient reablement and rehabilitation capacity in community settings – 1 million (staff retention scheme?) Charnwood pilot – Implementation by March 24

This will aim to:

- Increase Pathway 1 capacity by 50%
- Patients waiting to be discharged into P1 wait no longer than 24 hours from complete referral time
- Urgent care response and surge capacity is required less than 15% of the time
- Pathway 2 D2A beds are de-commissioned outside of LPT community hospital bed usage
- Reach top quartile performance in 14 and 21 day LOS and 80-85% performance on ASCOF 2D – The outcome of short-term services and ASCOF 2B – Proportion of people still at home 91 days after discharge into reablement (already achieved in Leicestershire).

The development of each of the areas of work listed above has been further informed by work conducted by Newton Europe and the LGA on the extent to which care is incorrectly utilised based on a series of case reviews. Further details on this, can be found in the National Condition 3 section below.

The reduction of health inequalities will be assessed as part of each of the integration priorities above. The impact analysis for this is carried out at the beginning of each area of work. This is linked to the corresponding areas of delivery within the JHWS and any corresponding JSNA's. This includes the use of population health management data to identify areas of inequality in order to focus work particularly within the community. Examples: Care Co-ordination, Unpaid Carers support payments, Use of VCS for lower-level support needs, Transforming Care programme.

Our previous investment in housing related support continues to help us to deliver our priorities, however for 23-25, assessment of current schemes in place has shown us that we need increased support to meet demand particularly for supporting discharges from mental health settings. Demand modelling showed that there has been a long-standing inequality of access to support for mental health patients, particularly with regard to support to return and remain in the community. This has led to poor outcomes for people and lengthy delays in being discharged.

For 23-25 additional investment of circa £166k in the Housing Enablement Team has been set aside for expansion into mental health and community settings. Previously only telephony support has been available for Community Hospitals. This will begin in July 23.

In addition to this, investment into Mental Health support specifically includes an additional £563k of funding to support people both in acute and community settings and to remain at home.

National Condition 2

Use this section to describe how your area will meet BCF objective 1: **Enabling people to stay well, safe and independent at home for longer.**

Please describe the approach in your area to integrating care to support people to remain independent at home, including how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to help people to remain at home. This could include:

- steps to personalise care and deliver asset-based approaches
- implementing joined-up approaches to population health management, and proactive care, and how the schemes commissioned through the BCF will support these approaches
- multidisciplinary teams at place or neighbourhood level, taking into account the vision set out in the Fuller Stocktake
- how work to support unpaid carers and deliver housing adaptations will support this objective.

PR4: A demonstration of how the services the area commissions will support people to remain independent for longer, and where possible support them to remain in their own home

People tell us that access to most care, particularly same-day care, is challenging, complex and frustrating, with the easiest access point at times being the Emergency Department. Some of our primary and community teams tell us of their frustration of having to refer patients to a hospital because they do not have access to the right diagnostics or referral rights to a particular service, leading to a poor patient experience of care. Our emergency department teams say that it is, sometimes less time-consuming to admit a patient than to find the right community service for their patient, especially when these services are “full”. Our ward teams describe their difficulties in preparing patients for discharge and our social care teams regularly talk about their frustration in discharging patients onto a sub-optimal pathway, impacting on their experience of delivering care and the patient’s longer-term outcomes.

Better Care Fund investment in community and prevention services approximately half of the overall allocation for Leicestershire. The majority of this investment, approximately 38% is aligned to supporting people to stay at home. E.g. Commissioned domiciliary care 14 million BCF and 14 million iBCF, community nursing and therapies circa 15 million and 2.6 million on out of hospital urgent care centres preventing A and E admissions. However, we recognise that further investment and the re-aligning of investment is needed to improve quality of care and promote and enhance reablement. The Intake model described above aims to right-size domiciliary care spend, for example, by a reduction of 9% (Newton Europe case review data – see below). This would help us to realise savings within the fund of approx. 1.3 million which we aim to re-align away from traditional home care services to support reablement.

Table 2 below, shows the level of planned additional activity across LLR, with timescales and approximate Leicestershire BCF investment that supports these improvement areas. In some cases the BCF investment will be realigned to meet the deliverables:

Table 2: Planned additional activity to support National condition 2

Urgent and emergency care and Home first		
Streamline to a single point of access for same-day urgent care Implement an Urgent Care Coordination Hub Implement the LLR Integrated Discharge Hub Implement the Urgent Treatment Centre (UTC) model across LLR	23/24 & 24/25 23/24 to 25/26 23/24 24/25	2.6 million
Primary Care		
Increase primary care capacity to meet demand for services Streamline access processes including digital access Optimise triaging to appropriate services, including pathways wider than primary care Support PCN development, expansion and maturity, with a particular focus on PCNs that are experiencing difficulties Develop a transition pathway for PCNs to evolve into INTs (Fuller stocktake report) Undertake PCN estate reviews, leading to understanding of and proposed projects for estate development (Primary Care Estate Strategy)	23/24 & 24/25 23/24 & 24/25 23/24 & 24/25 23/24 & 24/25 23/24 & 24/25 23/24	1.2 million
Personalisation		
Develop a Personalisation Strategy Increase Social Prescribing Link Worker capacity and referrals Liberty Protection Safeguards service: a. Develop and deliver training in identifying need b. Implement Liberty Protection safeguards service Embed a working culture that embraces personalisation as the default approach to supporting people Implement processes to create All Age Continuing Care Model	23/24 23/24 23/24 24/25 to 25/26 From 23/24 From 23/24	1.5 million

In addition to the above, the High Impact Change model for reducing preventable admissions is available as an appendix to this document which shows projected improvements in these areas.

Where a person's needs cannot be met solely in the community, we have been piloting an unscheduled care hub during 22/23. This has comprised a multi-professional staff groups who are navigating people, who have originally called 999, to the right place at the right time. 85% of people have been safely navigated to the right care, freeing up ambulance teams and supporting patients in their own homes.

The above interventions will improve health equity by creating more capacity in the system for those with complex health needs (disproportionately older people, those from minority ethnic groups, or less affluent neighbourhoods), as those with minor illness/injury will be seen in the right place. Expanded access will better support those for whom standard healthcare offers are inaccessible. The focus on improving the resourcing and stability of healthcare provision in underserved areas will begin to address the "inverse care law" which sees those with the greatest need for healthcare often having the lowest provision.

We are applying a population health management approach, to better bring together service users, carers, families, health, social, community and independent partner organisations by investing in Care Co-ordinators that work directly with GP surgeries to identify those most likely to require a

hospital admission within the next 12 months using risk stratification. This is an early intervention service to create joined up care planning directly with people most in need of support.

To further promote personalised community care, LLR has undertaken a review of the LLR Health and Social Care Protocol (HSCP 2014) from 2019 in a context of growing demand, with increasing complexity of need, and reducing resources 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. In addition to this there has been an ongoing drive towards integration across Health and Social Care, including the development of Integrated Neighbourhood teams operating in relation to Primary Care Networks, recognising those local arrangements for this between localities.

The Leicester, Leicestershire, and Rutland (LLR) Framework for Integrated Personalised Care has subsequently been developed by LLR partners and comprises of two parts:

- Part A- Management Guidance - 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.
- Part B- Practice Guidance - 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 or organisation to another.

The fundamental principle of the Framework is that care commissioned and delivered to the patients and citizens of LLR is person-centred and tailored to meet their individual needs and a set of shared tasks have been identified for care providers to deliver across health and social care. The FIPC has been formally launched as a live Framework from 1st October 2022.

We are currently reviewing and re-designing the current FIPC training delivery model to better align with the new Framework for integrated Personalised Care (FIPC) to enable a more flexible and robust approach. This will enable better support for providers by eliminating any challenges and obstacles to access training and to ensure the best possible care for people within their place of residence.

National Condition 2 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support people in the community. This should include:

- learning from 2022-23 such as
    - where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. admissions avoidance and improved care in community settings, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
    - where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
    - how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

A significant amount of activity has taken place within 22/23 on demand modelling requirements both in the community and out of hospital. In 22/23 we determined the level to which demand outstrips capacity in the community for both an intake model and for rehabilitation associated with this. Demand modelling has taken into account seasonal variations based on the previous year's actual data in order to better align capacity.

This has led to the development of the Intake Model of care which forms part of our overall Intermediate Care Strategy delivery, with initial delivery focused on patients being discharged to their own homes. Demand and capacity modelling has taken place for expansion to a step-up model if it is successful in improving outcomes. The demand for this has been calculated and would include an additional 20 staff to care for an additional 1009 people (currently those that do not receive a reablement offer prior to a package being put in place). This would offer a period of direct care whilst assessment for reablement, and rehabilitation took place. This will enable us as a system to 'right-size' care and maximise independence. To mitigate this unmet need for the short-medium term, additional investment is set out below to show how step-up community support will be provided.

In addition, a pilot has been taking place within the Charnwood locality to bridge this gap with and integrated MDT offer. Reablement and therapy staff work together to discuss care requirements for their cohorts of patients and look for ways to co-work cases. Data shows that around 20 new patients are discussed each day as part of this initiative with additional training on therapy equipment orders taking place to reduce duplication of visits using a trusted assessment methodology. This has reduced timescales for both workforces and HART reablement have reduced ongoing care costs by approx. 50% with therapists reducing timescales for referrals and a reduction in visit requirements. This has increased capacity to better cope with community demand. The pilot was also linked to the Integrated Neighbourhood Team in the area to provide further support to people at home by creating a process for MDT staff to include social prescribers, housing services and care co-ordinators in regular weekly meetings to onward refer to include lower-level support needs. This includes identifying and supporting unpaid carers with additional investment of approx. 500k in this years' BCF.

National Condition 2 (cont)

Describe how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25, and how these services will impact on the following metrics:

- unplanned admissions to hospital for chronic ambulatory care sensitive conditions
- emergency hospital admissions following a fall for people over the age of 65
- the number of people aged 65 and over whose long-term support needs were met by admission to residential and nursing care homes, per 100,000 population.

Table 3 below, sets out investment in the BCF for the next two-years informed by demand and capacity modelling detailed above. This indicates the metric improvements that the schemes will contribute to.

Table 3: Schemes for investment and metrics this will impact on

Scheme	Investment 2023-25	Metric Impact
Intake Model	£773,600 23/24 £700,000 24/25 (potential for step-up inclusion)	Reduction of admissions to care homes (up to 30% from discharges) Reduction in admissions due to falls
Review team	£375,000	Reduction in unplanned admissions and reduction in admissions due to falls (working step-up and step-down
Therapy-led assessment beds	£584,000	Reduction in permanent admissions to care homes (85% return home) Reduction in admissions due to falls
Care Home Quality Improvement Team	£658,000	Reduction in admissions due to falls
Care technology	£486,000	Reduction in unplanned admissions Reduction in admissions due to falls

Total additional investment in the intake model has largely been described above with the aim of reducing the levels of care home placements required, thus freeing up the market to meet more complex care needs. As per the LGA and Newton Europe analysis (see below) this has the potential to reduce care home admissions from discharge by 30%. Community step-up demand will be factored into any expansion of the intake model.

Currently, the re-alignment of jointly commissioned block-purchased bed capacity will focus on the 3 R model of care to enable as many people to return home as possible. The focus has been on providing environments suitable for rehabilitation and recovery with previous pilots showing an 85% rate of people returning home, reducing need for long term bedded care and reduced readmissions due to falls.

The Care Home Quality Team has worked to change focus onto care homes with high admission rates due to falls. This has re-aligned to work proactively to prevent falls and to better manage care in homes to avoid admissions.

Care technology has been expanded to include access for more people as part of the emerging step-up model of care. This will help people to remain at home with support to prevent falls, early indications of falls and reduce admissions.

Early identification of falls risk and early intervention can deliver benefits including improved quality of life for the person and savings across the health and social care systems. The LLR falls review (August 2020) identified that there is a current gap in identification of falls risk across LLR. A fall may currently be the first opportunity to provide intervention and assessment to reduce future falls risk.

To address this there are several ongoing projects to improve identification of falls risk prior to a fall and provision of information and advice to help individuals reduce risk factors. There is ongoing work to develop of unified Multifactorial Falls Risk Assessment Tool (MFRAT) that can be used across health and social care professionals to provide consistency and clarity in identifying risk. Use of an app to provide public self-assessment, signposting, information and advice.

In 2020 falls accounted for up to 40% of ambulance callouts for people aged 65+ in LLR. Following ambulance attendance approximately 40% of patients who have experienced falls are conveyed to ED. Older patients admitted to hospital are consistently reported to experience deconditioning and this is often due to the reduced mobilisation and independence experienced in a hospital setting rather than a presenting medical illness. Not all individuals who fall require ambulance attendance or conveyance to hospital (NHS England). A Review of interventions for reducing ambulance conveyance concluded that there is consistent evidence that rapid response models reduce avoidable conveyance to hospital (Knowles, Long & Turner 2020).

The Integrated Community Response Service (ICRS) provides a falls response for patients living in Leicester City who fall and are unable to get off the floor, either by themselves or with the assistance of a carer or friend/family member. There is no such service in Leicestershire or Rutland and as a consequence, care home and health care professionals are unable to refer patients on the floor to any service except the East Midlands Ambulance Service (EMAS). This creates a significant health inequality.

In order to eliminate a difference in service provision between Leicester city, Leicestershire and Rutland an Urgent Falls Response Pilot has been set up to operate in Leicestershire and Rutland. The pilot was started in October 2021 and aims to provide a service to patients living in Leicestershire and Rutland who have fallen and are unable to get off the floor, offering an alternative to an ambulance response. Two additional Home Visiting Cars based at Loughborough Urgent Treatment Centre and Oakham Urgent Care Centre are stocked with patient handling equipment and a Mangar Elk lifting cushion.

The service operates from 8am-6pm 7 days a week and aims to triage referrals within 15minutes and attend within 2 hours. This pilot is currently funded to continue until September 2023 with ongoing evaluation to inform development of a potential permanent model.

Housing services (Lightbulb and HET) support onward referrals from the above schemes in the community, particularly the intake and review teams. As part of the Charnwood pilot housing partners are included in the weekly MDT as part of the INT.

Total additional or realigned investment in the above areas exceeds £3.5 million for the next two financial years

National Condition 3

Use this section to describe how your area will meet BCF objective 2: **Provide the right care in the right place at the right time.**

Please describe the approach in your area to integrating care to support people to receive the right care in the right place at the right time, how collaborative commissioning will support this and how primary, intermediate, community and social care services are being delivered to support safe and timely discharge, including:

- ongoing arrangements to embed a home first approach and ensure that more people are discharged to their usual place of residence with appropriate support, in line with the Government's hospital discharge and community support guidance.
- How additional discharge funding is being used to deliver investment in social care and community capacity to support discharge and free up beds.
- Implementing the ministerial priority to tackle immediate pressures in delayed discharges and bring about sustained improvements in outcomes for people discharged from hospital and wider system flow.

PR5: An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.
PR 6: A demonstration of how the services the area commissions will support provision of the right care in the right place at the right time

Below are examples of investment in schemes to enable people to remain 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 and home First Collaborative.

Unscheduled Care Hub – roll-out phase – investment not within the BCF but outcomes impact on ability to realign BCF funding. People requiring same-day care that cannot be provided in primary or other community settings will be referred on to our LLR Urgent Care Coordination Hub. From here, services such as our 2-hour health and social care crisis response services, immediate mental health support, access to a virtual ward, physical ward or palliative care support will be arranged with the person and/or their carer/support. The Hub will access both system-wide services, such as virtual wards, as well as localised service provision within each place and neighbourhood. The hub will comprise of clinical and practitioner teams, covering physical and mental health, with a strong focus on ensuring the contact concludes with the person in the right care setting. To enable this, we will expand community services such as virtual wards, our 2-hour health and social care crisis response services, our step-up intermediate care offer and our urgent treatment centres to ensure capacity is available in these settings of care. Alongside this, we will expand our community diagnostic offer, based on local population needs, ensuring that access is equitable across LLR. People requiring acute care will also be referred through to the right acute care service, following a digitally enabled clinician-to-clinician conversation, accessed through the LLR Urgent Care Coordination Hub. This could be via an ambulance to same-day emergency care services or straight into an acute bedded service, as appropriate.

People who call 999 and do not present with an immediate, life-threatening need or require emergency care, will also be navigated to the right care through the Hub. If people access walk-in services, such as general practice, an urgent treatment centre or A&E, without being navigated to that service prior to arrival, we will apply the same clinical triage function through our primary care front door service. This way, people become clearer on the right service for them, and those who need to be seen in those services, are seen quicker. As exceptions to this approach arise, clinical advice will always be followed. By signposting people in this manner, we know we can manage demand across primary, community and acute care, make it as convenient as possible for people and their carers and make delivering care a better experience for our teams. This will enable us to deliver a service responsive to people's needs, delivering care in the right place and at the right time.

Integrated Discharge Hub and Case Management for Discharge - £831k – Completion Oct 23. We know that some people remain in hospital for longer than necessary. This is not good for their outcomes or their independence. To tackle this, we will ensure that everyone admitted to an inpatient service will have an estimated discharge date and that joined up discharge planning will support discharge in a timely manner.

In 2022/23 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 23/24 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 and investment has been included to expand this system to provide real-time discharge data for mental health settings. The discharge tracker data told us that the average wait for a discharge to a domiciliary care package was taking 3 days with only 13% leaving on the same day as referral and 53% people discharged after more than two days.

As an extension to the discharge hub, the employment of reablement team leaders to work alongside therapists on wards began in earnest in late 22/23 in order to improve this outcome for patients preparing for discharge. Eight members of social care staff work as part of an MDT to triage and maximise reablement and independence for those about to be discharged home. The pilot was trialled for 4 weeks within specialist medicine wards with HART Reablement Team Leaders (RTL's) to attend Board Rounds to integrate with ward teams and discuss their service provision.

Alignment began with the following process changes:

- Therapists to call RTLs following assessment for patients appropriate for discharge with a HART package of care (POC) (if RTL is present on the ward when the assessment is being carried out, RTL can join)
- Therapist/RTL to complete Trusted Assessment referral form and email to Discharge Hub RTL +/- Therapist meets with patient to discuss HART provision, any urgent equipment needs for discharge (e.g. key safe/lifeline) and liaise with next of kin as appropriate.
- RTL to source POC +/- bridging and inform the ward of start date

After 4 weeks the average referral to discharge time was 0.8 days and 65% patients were discharged within the first day of referral. This is from approx. 3 days prior to start date. Discussions with patients and carers also resulted in improved outcomes for people and those asked about their experience felt that they were involved in decision making and that they felt their care was joined

up. This model is now being extended to additional wards and community hospitals. Discharge Grant investment totals £556k.

Step-down Intermediate Care – Intake Model - £774k discharge grant. We know that some people remain in hospital for longer than necessary. This is not good for their outcomes or their independence. We recognise that the current intermediate care offer needs to evolve to support this process. People will be provided with an integrated intermediate care offer, designed to help them move from hospital into the right care setting, for example, this could involve domiciliary services, therapy services or home-based reablement. This will be supported by growing our local social care workforce in each of our places and neighbourhoods.

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 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.

As mentioned above, the initial roll-out phase will be to support those patients being discharged into the community. Staffing will be in place to support people for an initial period of up to 7 days whilst assessment of ongoing care takes place in a person's own home. This involves direct care provision and case management, with projected utilisation calculated using demand and capacity modelling. Outputs and reductions in ongoing care needs will be monitored with a view to expanding this to a step-up model within 24-25.

Primary Care - £525k discharge grant. Some of our general practices have been trialling the use of cloud-based telephony, enabling call waiting times to be reduced significantly and patients navigated efficiently and effectively to the right service. Northwest Leicestershire Primary Care Network have been navigating patients calling their general practices to their Community Pharmacy Service, freeing up significant GP time for those with more serious needs.

People report a highly efficient service and practice staff appreciate the space this creates for other patient cohorts. The emergency department, working with our community and primary care providers, have been triaging people at the front door of the department. Those with non-emergency needs are offered a booked appointment at one of our community sites; this means people are treated quickly and safely in an alternative setting and frees up capacity within the emergency department for more serious interventions. This is enabling between 30 and 60 people per day to be seen outside of A&E.

Additional investment in primary care to support those discharged into temporary care home settings has been included in the discharge grant funding. This will enable primary care involvement to jointly commissioned block booked beds in helping to support people to return home after their period of recovery. Our aims for improvement to access to primary care services are set out below:

- People should report easier access to a range of primary care services with triaged and booked an appointment suitable to their needs in the right timeframe
- An increase in use of alternative channels

- An increase in localised, personalised care being delivered by a multi-agency, multi-professional team
- We should see a decrease in presentations to the emergency department and an overall decrease in GP contacts for this cohort of people
- There should be fewer people accessing or being referred to multiple access points before a definitive decision
- More equitable service across the 24-hour period; with local care being provided by local services based on local need, increasing equity of access and in a longer term, equity of outcomes
- People should see better longer-term outcomes from the care they receive, as they would be discharged in a safe and timely manner.

We will work at system, place and neighbourhood level to design and implement this model of care, tailored to each community. Deliverables against agreed baselines will also be agreed and monitored to ensure efficacy of service and of experience.

Realignment of Pathway 2 Bedded Capacity – Discharge Grant – 1.6 million plus circa 9 million (not BCF funded but will inform future investment). LLR's strategic aim is to fully utilise currently commissioned P2 capacity with the intention of supporting a reduction in delayed discharge, a reduction in length of hospital stay, improving system flow and patient experience. Reducing patient in delay will improve quality outcomes by reducing the risk of physical and mental health deterioration.

Patients with higher levels of care needs, are often not transferred out of hospital in a timely manner due to a combination of community capacity and criteria thresholds across existing services. To support patients all services that sit within the discharge pathways, must be agile and flexible enough to respond to patient and operational demand. It is expected that there will be greater joint working between all partners that allows a multi-disciplinary team approach to discharge planning (often referred to the integrated discharge team/ transfer of care team). The P2 bed offer should include a period of assessment that is meaningful and maximises the opportunity for rehabilitation and reablement.

Over the past year there have been significant improvements in the domiciliary market within Leicestershire. The positive impact of these improvements has meant that patients with larger packages, that often waited longer in hospital, can now have their needs met at home sooner.

This has led to a review of the current bed base, demand and capacity requirements. The aim is to reduce the use of block booked beds and to instead have a model based on utilisation of community hospitals to accept all D2A placements. Sufficient staffing modelling to wrap-around each patient will be in place alongside case management (already commissioned) to assess ongoing needs and to maintain flow. Current demand across LLR shows that there are around 50 patients per day waiting for beds due to varying levels of acuity. This would aim to reduce this delay entirely. For 23/24, jointly commissioned beds have been purchased in order for us to conduct thorough analysis of the cohort and to re-align staffing to meet needs.

A key risk to delivery, however, is providing the right level of staffing for the use of community hospital beds in order to de-commission block purchased beds. Mitigations against this will require increased recruitment and regular performance monitoring to ensure capacity is meeting demand.

National Condition 3 (cont)

Set out the rationale for your estimates of demand and capacity for intermediate care to support discharge from hospital. This should include:

- learning from 2022-23 such as where number of referrals did and did not meet expectations
    - unmet demand, i.e. where a person was offered support in a less appropriate service or pathway (estimates could be used where this data is not collected)
    - patterns of referrals and impact of work to reduce demand on bedded services – e.g. improved provision of support in a person's own home, plus evidence of underutilisation or over-prescription of existing intermediate care services);
- approach to estimating demand, assumptions made and gaps in provision identified
- planned changes to your BCF plan as a result of this work.
    - Where, if anywhere, have you estimated there will be gaps between the capacity and the expected demand?
    - how have estimates of capacity and demand (including gaps in capacity) been taken on board) and reflected in the wider BCF plans.

During 22/23, LLR took part in a support programme from the LGA, Newton Europe and the national Better Care Fund Team. This support work helped us to redefine the demand and capacity modelling that began in the 22-23 BCF submission. This expanded on the work already undertaken to identify demand for the Intake Model of Intermediate Care. Learning from 22-23 included identifying unmet need, the level to which people had been place in the incorrect setting of care and where over-commissioning of care had taken place.

The approach involved a series of workshops where representatives from all stakeholders conducted reviews of 192 cases from the previous winter period. Cases management systems were interrogated to inform the person-centred story of care from hospital into the community. Key findings, set out below, have helped to inform modelling in a variety of areas across all pathways:

- Just over 1/5th not achieving ideal outcomes ranging from 16% in pathway 1 to 25% in pathway 2.
- Over 1/3 (34%) of patients on pathway 2 were not on the ideal pathway and 25% did not achieve their ideal outcome
- Almost all people discharged with no formal care and those to nursing homes achieved their ideal outcome.
- 30% of patients discharged with homecare and 50% of patients discharged to residential care did not achieve their ideal outcome
- 16% of patients discharged with home care should receive a lower level of care accounting for 9% of home care hours over provided
- 41% of people discharged to a residential care home should have gone home
- Outcomes for patients discharged with home based reablement and home rehabilitation are almost identical to those discharged with traditional home care
- Outcomes for patients discharged to an interim placements (80%) were better than those discharged with bed based rehabilitation (76%) reablement (64%)

- 58 % could have left hospital sooner, reducing average length of stay (LOS) from 20 to 15.9 days. 35% of delays were driven by capacity 35% is driven by process delay in planning discharges, paperwork and communication issues between professionals
- 66% of patients on pathway 1 could have left hospital sooner and 56% of patients on pathway 2
- Cultural reasons play a part in why patients don't achieve ideal outcomes or are on a pathway that is not ideal, specifically
  - Risk adverse decision making
  - communication between services
  - Paperwork and process planning
- Patient and family wishes feature significantly in not achieving the ideal outcome and patients not being on the ideal pathway for discharges on all pathways
- Domiciliary care is over-commissioned by 9% on discharge

We have already used the above information to inform where there will be additional demand. For example, the unmet demand for reablement and rehabilitation services has been estimated at around 1086 discharges per year previously directly into the domiciliary care market but will now be part of the HART / CRS combined Intake Model which will be additional to current demand that was estimated for 22-23. This has informed the additional level of staffing needed to meet this demand and the additional investment required within the next two years. 28 additional staff will be required which includes, direct care staff, case management, programming and management.

In 2023-25 the plan will address:

- Recruitment into the new model
- Deliver a service that will meet the projected additional demand
- Realise savings against the projected outcome of 9% reduction in over-commissioned domiciliary care
- Create a culture of MDT working and joint decision making with clearer comms
- Joint decision making with the person and their family and carers

For demand and capacity modelling for social care data, tableau has been used to show current demand and has been projected to include additional demand created by the intake model. This has in turn been estimated to a locality hub level. For rehabilitation capacity, Leicestershire Partnership Trust data has been used and split between the 3 health and wellbeing board areas using the 22/23 Discharge Grant funding allocation methodology. This assumes that demand for Leicestershire is 58% of the overall demand for LLR.

In addition, the data informed us that 30% people discharged to residential care could have gone home had the right level of service been available in the community. This has been factored into potential additional pathway 1 capacity that may be required across the new intake model.

Community care providers have been informed of the potential changes through regular monthly forums to ensure market sustainability and confidence in future demand. The data for this has helped to inform a bed review of commissioned care across LLR. The potential for this reduction has been factored into commissioning requirements. Currently there are gaps in bedded capacity and demand and this is seen daily through data collated by the discharge hubs on the amount of people waiting for placements that are delayed in hospital settings. This has helped to inform the review of nursing and high dependency bedded capacity review.

National Condition 3 (cont)

Set out how BCF funded activity will support delivery of this objective, with particular reference to changes or new schemes for 2023-25 and how these services will impact on the following metrics:

- Discharge to usual place of residence

PR 5: An agreement between ICBs and relevant Local Authorities on how the additional funding to support discharge will be allocated for ASC and community-based reablement capacity to reduce delayed discharges and improve outcomes.

Table 4 below sets out investment in the BCF for the next two-years informed by demand and capacity modelling detailed above. This indicates the schemes that will impact on discharges to usual place of residence:

Table 4: Investment informed by demand and capacity modelling

Scheme	Investment 2023-25
Intake Model	£773,600
Care technology	£486,000
Carers Support Payments	£525,000
Housing Enablement Team Expansion	£165,760
Continence nurse	£35,000
Mental Health	
Assertive In Reach MH	£146,248
Agency SW posts	£112,563
CSW in Hospital Team	£62,069
Mental Health Relationship Enabler officer	£35,000
Bridge Street Mental Health Support	£134,332

In Leicestershire, 92.2% of people already return to their usual place of residence on discharge. For 23-24 the target hopes to increase this to 93%. The above schemes will work to maintain and increase performance.

In 22-23 we further invested in the discharge hub to improve the use of discharge data to inform the system of performance. This is now a daily occurrence with a sitrep call and daily information sent to all system partners on current 1-3 pathways and numbers of patients waiting.

This system approach is hoped to be replicated in Mental Health to enable partners to track the status of patients leaving acute care. DTOCs in Mental health remain and ongoing issue that we want to address and reduce. Investment in this area has therefore been increased to enable people to return home, reduce DTOC's and improve flow which can also have knock on consequences in other areas of acute care.

The Housing Enablement Team is going to be further expanded to include community hospitals and other areas of mental health, including psychiatry wards. This is building on the success of the service since it began in 2015 as demand for housing support to enable discharge home has grown.

Another scheme that was tested in 22-23, was support to enable people to manage continence issues in community hospitals to enable them to be discharged home. The nurse has been training other staff on the wards in this area to prevent ongoing admissions to care home for night-time

continence needs. Additionally, Care Technology can also support this and a wider range of people including those with dementia who are prone to wandering.

There are several risks for delivery against the use of the discharge grant. The temporary nature of the funding carries risks around its use for recruitment on a permanent basis. This is in the current climate where recruitment is particularly difficult especially to fixed term or temporary positions. To mitigate against this, agreement has been reached that where savings in long-term budgets are not realised to cover recruitment, this will be underwritten by the ICB until such time as savings are realised. This is particularly important within the Intake model design, but it also extends to other areas of investment e.g. brokerage and reablement team leaders.

To mitigate and make new roles and functions as attractive as possible, roll-out in some areas, will progress to larger-scale investment over time. E.g. the Intake model will begin recruitment for discharge only. A smaller cohort of additional staff could then be absorbed with natural wastage over several years, thus reducing the risks associated with using non-recurrent funding.

Additional risks associated with 22/23 discharge grant schemes also apply to mobilisation of schemes at short notice. Learning has been taken from experiences in the previous years with pre-planning and improved comms. This was particularly relevant to ensuring as many unpaid carers were supported as possible with grants to support people on discharge.

National Condition 3 (cont)

Set out progress in implementing the High Impact Change Model for managing transfers of care, any areas for improvement identified and planned work to address these.

Progress against the High Impact Change model for managing transfers of care has been updated alongside current in year progress. Key changes and deliverables have been made within changes 2 and 3.

For change 2, the work highlighted above to review the current P2 commissioned beds will move the system to mature. Pathway one discharges have met the demand required with Leicestershire seeing a reduction of people waiting for discharges into domiciliary care and reablement. Pathway 2 re-design will enable the system to have a similar streamlined process for this.

MDT working has also improved in the last financial year with the re-introduction of specialist Adult Social Care staff onto wards to work with therapists to have joint conversations with patients and their carers. This requires further roll-out and will include staff training on Home First methodologies and services.

Areas of improvement are required in early discharge planning. Particularly with regards to MDT support in the community and primary care for elective discharge planning. This is going to be part of the improvements highlighted in primary care with additional investment to support INT's and PCN's to deliver MDT's to support this. The BCF currently funds Care Co-ordinators in all areas to support this model using population health management data.

Improvements have also been made within Change 7 – Engagement and Choice. In 22-23 we recognised that more could be done to include patient and families in decisions around their ongoing care. Part of the aim was to include voluntary sector support for lower level needs. This was commissioned through discharge grant investment and has been included in investment for 23-24. Similarly, support to unpaid carers for discharging back home has been vital in including them in discussions around their needs in order to help them support people. This has included reimbursement for unpaid leave. The voice of the person was also a key part of the work with the LGA and Newton Europe and has been fed into the work to develop cultural change in discharge planning to centre around person-centred care.

Improvements will also be made when discharging patients to care homes with specific investment to primary care to enable additional support to care homes in areas with jointly commissioned block booked bedded settings. Developments have been made from last year. Using discharge funding, the VCS sector has been commissioned to engage

A copy of the current HICM model is shown in table 5 below:

Table 5: High Impact Change Model for transfers of care – 2023-24

Impact change	Where are you now?	What do you need to do?	When will it be done by?	How will you know it has been successful?
Change 1: Early discharge planning	Established. Planned admissions go to pre-assessment clinics for discharge planning. Conversations started here with community health	Better planning with primary care for electives required particularly for social requirements e.g. housing. MDTs required which includes district nursing	March 24	**INTs are working across localities to put this in place as part of the locality plans developed with district councils**

Change 2: Monitoring and responding to system demand and capacity	Established / Mature We have data and it drives the commissioning requirements. For example P2 bed usage Focus needs to also be on patient 0's to reduce MOFD waiting to go	Increase the right amount of bedded capacity for P2 placements currently underutilized due to effective P1 model reducing need. Intake model will ensure even greater capacity for P1 discharges NE to work with UHL on lost discharges	1st July 23 for bedded commissioning March 24 for intake model Lost discharges – Mar 24	**Reduced MOFD in hospital waiting for a plan P2 beds** **All P1 and P2 discharges completed within 24 hours** **Lost discharges reduced to 10% from 50% per day**
Change 3: Multi-disciplinary working	Established / Mature Intro of RTLs working with therapists on daily MDT's has improved working practices	Roll this out to further UHL locations and Community hospitals Continue relationship building to roll out TA with health staff	July 23 Training elements built into Discharge Grant schemes	**Reduced delays and improved patient outcomes as has already been seen across the wider system** **Better TA of P2 referrals**
Change 4: Home first	Mature	Once CWD pilot and Intake model rolled out we will be exemplary for this Single points of access are in place within the discharge hub however this needs expansion to community access this is being streamlined with CSC developments	Mar 24 CSC – Oct 23	**Better referral times, less handoffs, assessment for ongoing need in people's homes, reduced dom care packages, better outcomes**
Change 5: Flexible working patterns	Mature / Established 70% P1 discharges within 24 hours but providers require more flexibility Service for HART and CRS in place 7 days	Work with providers to accept more packages and P2 referrals at weekends	Mar 24	**Reduced MOFD delays**
Change 6: Trusted assessment	Established Trusted assessors in place across UHL and LPT for specific community services (including a care home for reablement) TA for P1 in place	TA in place for P1 requires further roll-out and needs to include other wards and acute sites.	March 2024	**Quicker assessments resulting in quicker discharges**
Change 7: Engagement and choice	Established Intro of RTLs' has put this in place in some wards	P2 needs to include better, more inclusive decision making and P1 roll-out needs to be expanded to include RTL's working with specialist discharge sisters on P2 discharges	Mar 24	**Better outcomes and service to patients and carers and improved**
Change 8: Improved discharge to care homes	Established Care Home trusted assessors working well to help people return to bedded care settings	Bedded care review to inform demand required Attend local care home forums to establish what providers feel our challenges and working well on discharge process. Better/faster communication between wards and care homes Actively involve ambulance service when planning	March 2024	**Reduced conveyances from care homes who care for some of Leicestershire's most vulnerable people.** **Decreased waiting days once MOFD** **Use of TA's to reduce reliance on care home assessment requirements**

Change 9: Housing and related services	Mature Established service/roles (housing enablers) to allow for early planning before discharge, this is being expanded to further acute and mental health sites for 23/24	Use technology creatively within the home to enable safer discharges Communication campaign to allow all involved in discharge to know technology available and a clear pathway for referral Use an approved temporary housing whilst adaptations/changes are being made to people's homes	Jan 2024	**Increased use of technology within peoples homes allowing for quicker discharges.** **Less waiting time from referral to completion for adaptations to be made in a persons home** **Improved access and use of extra care facilities** **Use of DFG top-slicing for additional housing related initiatives**

National Condition 3 (cont)

Please describe how you have used BCF funding, including the iBCF and ASC Discharge Fund to ensure that duties under the Care Act are being delivered?

PR8 - 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?

The below table (table 6) details how some of the BFC funding is utilised to meet the necessary Care Act requirements. Each scheme has the level of investment shown and which of the key general care act duties it helps to deliver against:

Table 6: BCF funding utilised to meet Care Act requirements

Scheme	Investment	Duties
Provision for enhanced carer support services	£222,600 (iBCF)	Promoting individual wellbeing. Preventing needs for care and support. Providing information and advice.
Case managers for TCP to support inpatient reductions	£116,970 (iBCF)	Promoting diversity and quality in provision of services. Co-operating. Safeguarding adults at risk of abuse or neglect
Contribution to TCP Coordinator Role (ELRCCG)	£8,000 (iBCF)	Promoting diversity and quality in provision of services. Co-operating. Safeguarding adults at risk of abuse or neglect
Positive Behaviour Support Team	£104,940 (BCF)	Promoting diversity and quality in provision of services. Co-operating. Safeguarding adults at risk of abuse or neglect
Enhanced TCP Training Wraparound Service Offer	£65,296 (BCF)	Promoting diversity and quality in provision of services. Co-operating. Safeguarding adults at risk of abuse or neglect
Transforming Care Programme - Implementing Actions from the TCP Recovery Plan	£135,605 (BCF)	Promoting diversity and quality in provision of services. Co-operating. Safeguarding adults at risk of abuse or neglect
LD Short Breaks	£968,046 (BCF)	Promoting integration of care and support with health services.
Care Act Enablers	£88,537 (BCF)	Promoting individual wellbeing. Preventing needs for care and support. Promoting integration of care and support with health services. Providing information and advice. Promoting diversity and quality in provision of services. Co-operating. Safeguarding adults at risk of abuse or neglect
Care Act Support Pathway	£551,288 (BCF)	Promoting individual wellbeing. Preventing needs for care and support.

		Promoting integration of care and support with health services. Providing information and advice. Promoting diversity and quality in provision of services. Co-operating. Safeguarding adults at risk of abuse or neglect
Post Diagnostic Community & In-Reach Service for people affected by Dementia	£360,247 (BCF)	Promoting diversity and quality in provision of services. Safeguarding adults at risk of abuse or neglect Promoting individual wellbeing.
Residential Respite Service (ASC protected)	£923,865 (BCF)	Preventing needs for care and support. Promoting integration of care and support with health services
First Contact Plus	£184,974 (BCF)	Providing information and advice.
LLR Community Integrated Neurology & Stroke Rehabilitation Service (CINSS)	£322,728 (BCF)	Promoting diversity and quality in provision of services. Safeguarding adults at risk of abuse or neglect Promoting individual wellbeing.
Improving Quality in Care Homes	£657,986 (BCF)	Co-operating. Safeguarding adults at risk of abuse or neglect
Support for Social Care Reform	£500,000 (iBCF)	Promoting individual wellbeing. Preventing needs for care and support. Promoting integration of care and support with health services. Providing information and advice. Promoting diversity and quality in provision of services. Co-operating. Safeguarding adults at risk of abuse or neglect
HET Expansion	£165,760.00 (Discharge Grant)	Promoting individual wellbeing. Preventing needs for care and support. Promoting integration of care and support with health services. Providing information and advice. Promoting diversity and quality in provision of services.
RVS Discharge Support	£108,000.00 (Discharge Grant)	Promoting individual wellbeing. Preventing needs for care and support. Promoting integration of care and support with health services. Providing information and advice.
Carers support payments	£525,000 (Discharge Grant)	Promoting individual wellbeing. Preventing needs for care and support Providing information and advice.

Supporting unpaid carers

Please describe how BCF plans and BCF funded services are supporting unpaid carers, including how funding for carers breaks and implementation of Care Act duties in the NHS minimum contribution is being used to improve outcomes for unpaid carers.

PR8 - 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?

The Joint Carers Strategy Refresh 2022-2025 was finalised in early 2023. The strategy centres around Recognising, Valuing and Supporting Carers in Leicester, Leicestershire and Rutland (LLR) and has been approved by Leicester City Council, Leicestershire County Council and Rutland County Council.

This is a joint strategy which has been developed by Leicestershire County Council, Leicester City Council, Rutland Council and the Integrated Care Board (ICB) across the LLR area. It commits all three councils to a shared vision and priorities for recognising, valuing, and supporting carers across Leicester, Leicestershire, and Rutland. The aim is to help carers to continue in their caring role and maintain their own health and wellbeing.

As part of the strategy refresh, new commitments have been made to introduce a Young Carer's passport across the region, and to work more effectively with health services to improve carer identification and the consideration of carer needs on admission to and discharge from hospital.

Other priorities include:

- Identifying and recognising carers quickly, partners and community organisations will encourage people to self-identify as carers
- Valuing carers and young carers' experience and ensuring they are involved in what happens to the person that they care for
- Making sure carers can access the information they need in the formats they require
- Encouraging communities to support carers through community groups, and helping carers access local groups to enhance opportunities for carers breaks
- Recognising that carers have their own lives to lead alongside their caring role, and leading by example as carer-friendly employers, encouraging more local businesses to do the same
- Ensuring that carers know about new technology that could support them in their caring roles, and supporting them to be confident using new technology or gadgets
- Working with partners to raise the profile of schemes like the Carers Passport, which helps organisations to easily recognise and acknowledge carers

Developing a range of support for young carers including improved awareness in schools and colleges of young carers, the roll out of a Young Carers passport scheme, and improved support for young carers dealing with the health system locally.

Details of the BCF finances used to support carers is detailed in the above table and also 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 - £968k
- Residential Respite Service - £924k
- Care Act Enablers - £89k
- Care Act Support Pathway - £551k

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 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.

The Hospital Discharge Grant for Carers (HDGfC)
This began as a short-term scheme which ran from 25 January to 31 March 2023. The HDGfC was one of a number of projects funded through the £2 million of government money given to Leicestershire County Council (LCC) in November 2022 from the Adult Social Care Discharge Grant.

The aim of the project was to provide support for carers to facilitate the discharge from hospital back home. It was recognised that during the first few days of discharge, carers would benefit from additional support to help the cared for so they are supported and kept safe. As a result of this, the HDGfC short term scheme was initiated.

Carers who have supported someone living in Leicestershire who has recently been discharged from hospital could be eligible for the HDGfC, if the cared for person:

- lived in Leicestershire
- was discharged from hospital during the last four weeks
- needed the carer for help and support to keep them safe

- incurred additional costs for the carer since the hospital discharge - including a loss of income due to taking time off work

The HDGfC short term scheme was administered and led by Voluntary Action South Leicestershire (VASL) - Support for Carers on behalf of LCC and was a successful short-term scheme which resulted in 138 applications processed and a total of £39,793.80 was given out in under 10 weeks during January to March 2023. This equated to an average carer receiving £288.36. From the success of the HDGfC, 94 (68%) new carers were identified as a result of the HDGfC scheme. The HDGfC has supported us with achieving one of our key priorities set in LLR Carers Strategy Joint Refresh 2022-2025 - identifying early and recognising our carers. Details of the overall analysis of the 138 applications processed and breakdown of the analysis by district can be found in Appendix 3.

The carer feedback obtained, showed not all carers knew about the HDGfC scheme and they were contacted by the LLC reablement team leader or VASL Officers about the scheme and supported the carers with their HDGfC application. This shows the additional resources we identified to support the HDGfC worked well to support the process of contacting eligible carers to apply for the grant.

As a result of additional resources to support the HDGfC and efficient application and payment process in place, it meant eligible carers were able to benefit from the scheme and able to provide the support the cared for, following their discharge from hospital.

Further analysis showed, 63% (87 out of 138) received the HDGfC payments within 4 weeks of discharge. This shows the efficiency of the HDGfC systems in place to process the payments without delay, which allowed the carers to be supported with the additional incurred costs. Almost a third - 31% (43 out of 138) where known to HART when their HDGfC payments were processed and demonstrates the extra resources to support the HDGfC worked well to help identify carers who were eligible for the HDGfC.

Carers advised the application process was straight-forward to complete and the decision-making process and processing of HDGfC applications for payments were highly commended by the carers. There have been no reports of carers chasing up their payments, which allowed carers to utilise the grant awarded to them without any delay. Here are some of the positive feedback from carers who have received HDGfC and evidences the impact the short term scheme has made to them:

“It was brilliant to be able to get help with the additional costs and lost in income I have incurred as a result of moving up from London to look after my parents. VASL were amazingly helpful in assisting me to apply and the with their help the process was very easy and the payment came through really quickly. Thank you. "

"It was an unexpected surprise and much appreciated to help with all the additional expense incurred in caring. The additional needs are never ending and every little helps Thank you.”

“I am truly grateful for this support both financially and emotionally after my Aunt was unexpectedly taken into hospital and discharged without the proper care package she needed. It has helped to ensure I can travel to help her a lot more as well as paying for extra aids around the home that are not covered by the council. I also received supportive communication and information from Support for Carers which was extremely helpful and made me feel less alone.”

Due to its success, this scheme will have continued Discharge Grant funding allocated to it for 23-24 totalling an investment of £525k.

Disabled Facilities Grant (DFG) and wider services

What is your strategic approach to using housing support, including DFG funding, that supports independence at home?

PR3: A strategic, joined up plan for Disabled Facilities Grant (DFG) spending

Leicestershire transformed the delivery of Disabled Facilities Grants in 2017 following a comprehensive review. An integrated partnership was set up between Social Care, Health, Public Health and Local Authorities. Resulting in customers across Leicestershire now having 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.

Diagram 2 –Unified prevention offer for Leicestershire

The new delivery model sits alongside a range of other initiatives as part of Leicestershire's Unified Prevention Offer, ensuring a co-ordinated approach to preventative services both across the county and different stakeholder organisations. This comprehensive preventative offer:-

- brings together resources available to Local Councils and NHS partners
- ensure every opportunity is taken to improve health and wellbeing, support vulnerable people, maintain peoples independence, manage demand and address the wider determinants of health
- helps to meet the BCF objectives of independence, unnecessary hospital admission, support discharge, reduce admissions to residential placements.
- The model supports ambitions to expand the offer further supporting the home first model.

From Oct 2017 to date, 11,350 residents have been supported by the Trusted Assessors and have carried out over 10,000 MOT's across Leicestershire. This has resulted in over 24,200 interventions.

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 properties secure
- Relocation Grant – if a property can't be adapted help with relocation costs
- DFG for those with Mental Health and LD – support for the less common adaptations
- Equipment for perm long term substantial diagnosed condition i.e. ceiling track hoists

- Extended warranty cover for stairlifts – ensure equipment lasts
- Modular ramping grant for temporary access – helps with viewings and hospital discharges
- 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 – allows support for grants over the DFG 30K limit
- Temporary Adaptation Grant – a set amount for speedy discharge during the pandemic

An example of how beneficial the grants are is demonstrated here. Following a vehicle collision a young mother sustained life changing injuries. Unable to access living facilities multiple grants were utilised in conjunction to adapt a garage to suitable accommodation with necessary equipment including a hoist. To ensure long term sustainability other grants were used to ensure the extension was insulated which will help with energy efficiency and bills. The carer also had extra support by way of assistive tech interventions and a family space for the young children.

Following the pandemic to further develop the Housing Offer to Health a review of the service will take place, aiming to complete by March 2024 to look at gaps in provision and realignment to new pathways.

- Development of the Trusted assessors offer to support the new community adults and children's occupational therapist's model
- Full evaluation of the pilots commissioned as part of the housing offer to health
    - Assistive technology pilot –Home Gadgets provides smart technology to introduce people to assistive technology earlier and support the carers
    - 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. Further opportunities have arisen to develop a self-neglect arm of the service
    - 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.
    - A green grant to support other initiatives in making adapted properties more energy efficient and lower costs for people
    - A respiratory illness pilot to link in and explore more opportunities to support the work started on health inequalities within local plans.

Housing Enablement Team – part of the Housing Offer to Health

The Hospital Housing Enablement Team (HET) 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. There is a gap the service provides support for included in the list below:-

- Supporting patients with a responsive service outside of statutory duty for Local Authorities
- Fulling statutory duty of referral of homeless patients to the Local Authority.
- Support to 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 necessary to secure safe, effective discharges for patients.
- Housing support for patients identified by public health for example the patients using TB centre for the East Midlands which is located in the Leicester hospitals.

- Support to patients with No Recourse to Public Funds but who are otherwise unable to be discharged from hospital safely.
- Providing measures such as creating a downstairs-existences where possible
- Cleans and clearances to make properties safe and accessible for discharges for patients and carers. Avoiding use of hospital / residential beds and other high-cost interventions.
- Support of referrals to a bespoke 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. preventing readmissions because of unsafe discharges.

In 2022/23 a review of the service was undertaken and restructure is to be implemented in 2023 /24 following the expansion of the service to support wider services and flow in the Mental Health Rehabilitation units and in all Community, Hospitals including MHSOP units. These changes will further support local priorities within local plans as well as the BCF objectives.

For 2023/23 DFG income is £4,447,228. Amounts have been agreed with all 7 districts via the Integrated Finance and Performance Group and passported in their entirety as per the below splits:

- Blaby - £623,445
- Charnwood - £836,247
- Harborough - £472,005
- Hinckley and Bosworth - £538,575
- Melton - £304,350
- North West Leicestershire - £720,214
- Oadby and Wigston - £419,872

The amounts are expected to be the same for the 24/25 plan. Discretionary use of the funding is detailed below.

Additional information (not assured)

Have you made use of the Regulatory Reform (Housing Assistance) (England and Wales) Order 2002 (RRO) to use a portion of DFG funding for discretionary services? (Y/N)

YES

If so, what is the amount that is allocated for these discretionary uses and how many districts use this funding?

Current forecasted spend on discretionary use of DFG funding is projected to be £385,520. This will be for 3 projects:

- Support to Hoarders - £115,500
- Extending Housing Occupational Therapy - £20,020
- Integrated Green Grant planning - £250,000

All projects can be utilised by all 7 districts on a needs basis.

Equality and health inequalities

How will the plan contribute to reducing health inequalities and disparities for the local population, taking account of people with protected characteristics? This should include

- Changes from previous BCF plan
- How equality impacts of the local BCF plan have been considered
- How these inequalities are being addressed through the BCF plan and BCF funded services
- Changes to local priorities related to health inequality and equality and how activities in the document will address these
- Any actions moving forward that can contribute to reducing these differences in outcomes
- How priorities and Operational Guidelines regarding health inequalities, as well as local authorities' priorities under the Equality Act and NHS actions in line with Core20PLUS5.

Reducing health inequalities is a core priority for the LLR Integrated Care System (ICS). The BCF investments across LLR continue to address inequalities through their strategic alignment to various programmes across LLR – primarily the Core20PLUS5 programmes (adults and children), Health inequality projects by collaboratives and the Fuller Stocktake priorities. Place-based BCF plans will continue to focus on proportionate investments to make universal services more accessible and effective for those with the greatest barriers to good health and care. The established health and care partnerships will use local data to drive population health approaches to improve health outcomes. This will enable us to more equitably manage need and not just manage demand. In doing so, we will be able to continue to improve our implementation across all the components of the High Impact Framework in 2023-4 and beyond.

Examples of BCF investments to reduce health inequalities in the County in 2023-24 include:

- Care Co-ordinators – Strengths-based support to a predominantly older group of people and those with multiple long-term conditions and disabilities to access care and support – including community assets.
- Specialist support for those with Hoarding Disorder – DFG top-slicing
- Housing Enablement Team (HET) – provides expert housing support to facilitate hospital discharge (including in the range of MH facilities) for a cohort of people with hard-to-resolve housing issues – homelessness, insecurely housed, No Recourse to Public Funds, in dispute with landlord etc.
- Carers support payments – to help identify and support unpaid carers
- Dementia specific support
- Transforming care partnership for support to those with Learning disabilities and autism
- Additional £500k of support for Mental Health patients in the community

Previously, the development of the LLR Learning Disability and Autism (LDA) Collaborative in 22/23 co-ordinated the transformation of Learning Disability and Autism health services, as well as oversaw the quality, performance, and outcomes of wider LDA services across the system, including ensuring the local implementation of the national Mental Health and LDA Quality Transformation Programme. The Collaborative works closely with the LLR local authorities and other stakeholders and oversees delivery of our LDA Operational Plan. Performance in this area has significantly

improved from worst quartile to second quartile as a result. In order to support the delivery of this in 23/24, BCF investment has increased to £431k.

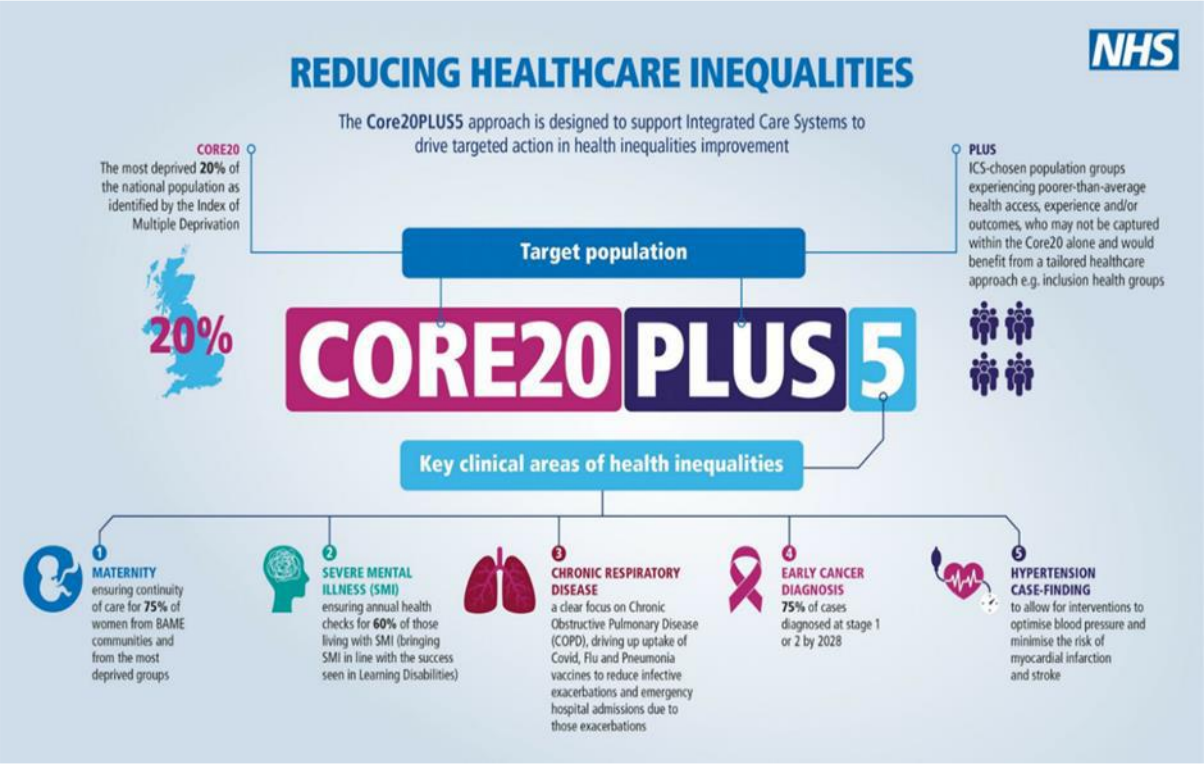
These services strive to develop stronger local communities to support local residents to lead more active, socially engaged lives by addressing the wider, nonmedical needs of individuals with the provision of asset-based community programmes

It is also recognised that more can be done. Our focus in 2023-4 will be on working with BCF partners to improve access to care and experience of care for in the CORE20 and PLUS groups – linking to opportunities created through the primary care enhanced services and the developments outlined in the Fuller Stock Take - particularly in primary and secondary prevention.

Core20Plus5 is the national approach to improving health equity and focuses on:

- The people in LLR who live in the 20% most deprived parts of England (whom we know have disproportionately poor access and outcomes)
- LLR seldom heard and underserved groups with additional barriers to good outcomes, such as those with learning disabilities, ethnic minority groups, carers and older people; and
- Five key clinical areas which are known to have the greatest adverse impact on life expectancy and healthy life expectancy.

More information about this approach, as well as on the CORE20Plus5 approach for children and young people can be found in Better Care for All, our Health Inequalities Framework.



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