Choose an item.

APPENDIX A

Integration and Better Care Fund

Better Care Fund 2025-26 HWB submission

Narrative plan template

	HWB area 1	HWB area 2
HWB	Please insert HWB name here	Please insert HWB name here
ICB	Please insert ICB name here	Please insert ICB name here
ICB	Please insert ICB name here (where appropriate)	Please insert ICB name here (where appropriate)
ICB	Please insert ICB name here (where appropriate)	Please insert ICB name here (where appropriate)

Introduction and guidance – **this can be deleted before submission**

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. Formatted text boxes have been included but these can be removed and a standard text used.

These plans should complement the agreed spending plans and goals for BCF national metrics in your area's Excel BCF Planning Template and intermediate care capacity and demand planning.

Although each Health and Wellbeing Board (HWB) will need to agree a separate Excel planning template and capacity and demand plan, 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 and capacity and demand plan.

Further guidance on completing HWB submission templates can be found on the Better Care Exchange.

Section 1: Overview of BCF Plan

This should include:

- Priorities for 2025-26
- Key changes since previous BCF plan
- A brief description of approach to development of plan and of joint system governance to support delivery of the plan and where required engage with BCF oversight and support process
- Specifically, alignment with plans for improving flow in urgent and emergency care services
- A brief description of the priorities for developing for intermediate care (and other short-term care).
- Where this plan is developed across more than one HWB please also confirm how this plan has been developed in collaboration across HWB areas and aligned ICBs and the governance processes completed to ensure sign off in line with national condition 1.

A brief description of approach to development of plan and of joint system governance to support delivery of the plan and where required engage with BCF oversight and support process

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
Homecare Alliance

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

For the 25-26 plan development, engagement has been received from partners via a series of forums. The first took place with system partners at the Integration Executive (IE) in early February, 2025 where a review of each line of spend within the BCF took place. This session also included members of the Integration Delivery and Commissioning Group (IDCG), the sub-group of the IE and members of the Health and Wellbeing Board (HWB). This was made to be as inclusive of partners as possible. The HWB, IE and IDCG membership includes local authorities (including district council representatives), Voluntary sector, NHS commissioners and providers, system clinical leads, Healthwatch and finance officers from Health and Social Care.

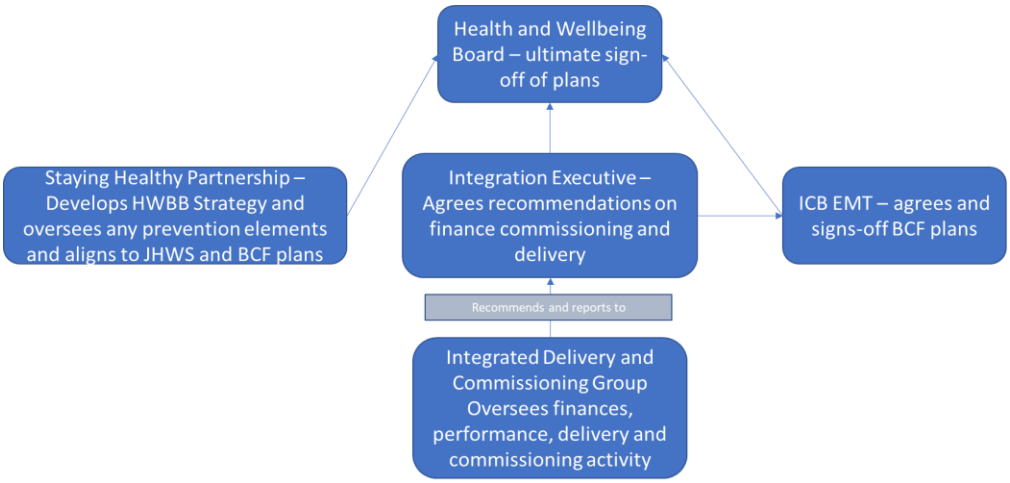
The review process is supported by a key line of enquiry document (KLOE) for each scheme. A copy of the KLOE template will be attached as an appendices to this document. The KLOE document details value for money, return on investment, outcomes for people, staffing, contracting information and business cases along with performance and demand and capacity information where applicable.

The priorities for delivery below include areas where partners have used the KLOE's to determine where improvements and areas of opportunity are to be made.

Health and Wellbeing Board members were involved in the shaping of the plan at their meeting of the 27th February. This meeting gave members the opportunity to comment on the schemes and spending allocations and assurance against the KLOE's. In addition the draft plan was agreed including priorities for delivery during the next 12 months. The governance structure for the board is shown in diagram 1, below.

Diagram 1

Governance diagram



The board also receives and agrees 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 BCF delivery is aligned to deliver against 'Living and Supported Well' and 'Dying Well' life courses within the strategy. Planning activity for the 25-26 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 group development sessions.

As in previous years there will be continuous improvement and engagement with partners and members of the governance structure to complete quarterly returns, review KLOE documentation and to ensure financial planning. The administration of this process is conducted by the local authorities Integration team who are supported by finance colleagues and commissioning support colleagues. This resource is financed through the BCF fund. This includes working with other local authority areas on their plans to ensure that this aligns to the ICB and wider system plans for integrated services across LLR.

Priorities for 2025-26

The below areas of work have been highlighted as areas of priority for 2025-26.

- Assistive and digital technology – design and progress delivery of this across health, housing and LA's to provide more effective and efficient services. This will begin as soon as the plan is approved and is expected to take the full financial year. This will increase availability for residents to digital and technology services and increase capacity for delivery.

- Review of the role of trusted assessors for care homes – currently there are two models of delivery in LLR – we will aim to look at whether there is merit in re-designing these services. This will be completed by winter 2025. Currently acute trusts still face delays with care homes assessment timescales. This will reduce the LOS past expected discharge dates.

- Quality in care homes – looking at opportunities to work closer with ICB quality teams. This will begin at plan approval stage and is expected to take 6 months for the initial phase of development.

- Home visiting service / night nursing service – both contracted services so will be reviewed as part of contractual arrangements to maximise benefits to residents with any improvements to services to take effect in Winter 2025. This will be measured by increased coverage and number of recipients supported.

- Integrated stroke services – this needs to be reviewed with a view to reducing waits across LLR for community based services and hope to increase capacity. Currently LPT and UHL led contracts. This has begun in very early stages of development and is expected to take the full financial year.

- One Primary Care Co-ordinator remains working in the hospitals – this needs to be reviewed with regards to other ED services and wider work on points of access and step-up work. This will be aligned to UEC models of delivery which are currently in draft form. Timescales will be dependent on wider work to improve non-admission services

- Care Co-ordination to be included in producing neighbourhood models of care which would include other community based workforce. Early presentations of the model have been shared with members of the Health and Wellbeing Board as part of the Joint Health and Wellbeing Strategy development sessions. This will continue to be developed as an integrated model throughout 25-26 aligning to the Neighbourhood Health Guidance.

- ICB will be reviewing the CHC framework practices and any associated contracts – this could include wider development of working relationships in practice between health and social care. This began in quarter 4 of 24-25 and with some elements of the review due for completion in April 2025 with other elements dues to complete by June 2025

Key changes from the previous plan

There are several key changes to the previous BCF plan. These are listed below:

- In 24-25 the governance process for HWBB and BCF planning and agreement. Integration Executive sub-groups was simplified. This has reduced from two sub-

groups to one in order to ensure join up of commissioning and delivery intentions for integrated schemes

- Increased focus on step-up, transforming neighbourhood services, which is linked to delivery of urgent and emergency care diversion to reduce demand
- Review of falls services in order to support more people across Leicestershire and reduce admissions from peoples own homes. This began in 24-25 with a view to completing any commissioning to support the re-design by the end of the 25-26 financial year.
- Discharge to Assess bedded models to be commissioned to reduce need for temporary care placements. The first cohort of beds is due to come online to meet a proportion of the demand in July 2025 with additional capacity increasing through the rest of the financial year.
- Increased focus on equality and diversity considerations in specific service redesign. This has been focused on P1 intermediate care during 24-25 and will be expanded to other schemes during 25-26
- Focus on proactive care models and further utilising population health management data and risk stratification to focus care on the greatest need. This will increase responsiveness and avoiding acute care needs. This is linked to urgent and emergency care focuses on frailty support and single point of access.

Aligning the plan to improving flow in Urgent and Emergency Care

Within LLR, Urgent and Emergency Care (UEC) governance is under review and transformation. This includes system-wide agreed priorities. These are currently in draft form, however, early work to align lace-based BCF plans has taken place to ensure it supports out of hospital services to reduce demands on acute care and to improve discharge. Initial priorities have been subject to further work across system partners through a variety of workshops. These have been listed below in their current format with BCF scheme activity to support each one, however the priorities are subject to change prior to the commencement of the next financial year:

UEC plan priority	**Leics BCF schemes that support**
Prevention and proactive personalised care (including LTC management) is embedded across the system	ASC review of prevention services / Care Co-ordination model works on proactive care and utilises risk stratified GP data to identify people who may need support when likely to be an acute admission in the next 12 months
When people need same day or urgent care, they can easily and rapidly access the right care at the right place at the right time	Aligning single point of access models. HART Urgents service (previously Crisis Response) into an LLR model with health and other community partners

Effective and efficient emergency care pathways that are appropriate, safe, and integrated	Reablement services working on non-admission wards alongside therapy teams / Review of falls admission avoidance cars / Urgent Treatment Centre review
Effective and efficient emergency care pathways for children and young people, mental health crisis response, frailty and end-of-life care	Housing Enablement Team working across Mental Health wards / Re-investing in the Mental Health Relationship Officer / Review of End of Life care strategy due for completion in 25-26.
Partners work together to ensure joined up and coordinated care, including improved flow and early supported and safe step-down from services	Intermediate Care P2 offer to be commissioned and to begin in 25-26 to cover the gap in the D2A offer for P2 group of patients / Continuation of the scheme to provide temporary support to capacity rejections from the reablement service and investment to increase the capacity to meet demand.
Be data and intelligence led; fully understand and predict our population needs in order to support those at greatest risk, tackle health inequalities and deliver tailored population-based approaches	Utilise population health management data to shape a range of neighbourhood models of care schemes / Utilise new equalities framework when developing schemes

A brief description of the priorities for developing intermediate care (and other short-term care).

LLR has had a plan to improve and deliver integrated Intermediate Care Services since 2023. In 25-26, Intermediate Care (IC) will prioritise recruitment to ensure we meet the increased demand for Pathway 1 Intake Model. Renewed investment within the plan supports this from NHS minimum contributions and the Better Care Grant. Ongoing risks to recruitment and retention pose as a challenge, however, we will seek to regularly review our recruitment processes and look at streamlining teams and activity across Leicestershire for better effective service delivery. The plan is split into three parts with an accompanying programme plan. The three parts and developments for 25-26 are listed below alongside additional workstream on equality and equity of access:

- Pathway 1 – IC at home - We will endeavour to stabilise our P1 intake model already established by increasing and maintaining workforce to meet demand. Our next priority will be to align community step-up to expand the service and meet the demand using continued service expansion and finance modelling ensuring the pathway is rightsized. This is for both P1 and P2 activity.

- Pathway 2 - Within our pathway 2 work stream we will continue to prioritise our demand work for modelling step up and implementing an agreed option from our long term P2 proposal paper to meet the current bed gap. Proposals were based on continuous demand and capacity modelling to establish the overall needs in relation to bedded D2A care. In addition, we will look to transform our High Dependency, Bariatric and Nursing cohorts and ensure patients receive the right care, at the right time in the right place, again using demand and capacity modelling and effectively

reviewing and reporting on impacts of lengths of stay. Several risks are posed around funding for each cohort and inequality due to bed deficit that will regularly review and monitor within a multi partner steering group.

- Decision making - Aligned to the above, a Voice of the Person survey will be evaluated and used to inform patient outcomes and how we can improve our services by providing crucial insights to what is working well and what isn't. This will allow us to deliver better tailored services and develop our personalised models of care.

- Equality and equity - An overall priority for 25/26 will be to review the quality and equity of access for all LLR residents for Intermediate Care and to implement any recommendations through our Equality Delivery System Task Force with leads across the system. This has begun within P1 services and will expand during 25-26. They will gather comprehensive and diverse feedback to ensure any gaps are captured and resolutions are embedded to eliminate risks or inequalities to those from protected characteristics. They will develop a Framework to provide service overview to enable us to remove any risks or barriers service users may face in accessing services, which will also support frequent evaluations and determine any risks/gaps that can be rectified as soon as possible. Reporting findings will be developed from engagement events alongside The Intermediate Care Steering Group and EDI improvement plans.

The current domiciliary care contract will be re-tendered during 26-27 this will further maximise delivery of support for care at home. This will be right-sized and developed with the Homecare Alliance in order to include providers in the shaping of future services. This will be in the planning stage during 25-26.

Other areas of short-term care will form part of the neighbourhood model of care of. This includes use of the voluntary sector alongside formal care provision in order to maintain independence at home. Examples include, the Royal Voluntary Service discharge support, support to carers, dementia service contract led by AgeUK and Local Area Co-ordination and First contact plus which connects people with support in their local community. This connectivity builds on the integrated reablement and therapy services in localities where once a week their MDT meeting links to other locality support services.

Brief challenges, risks, mitigations and timescales

There are challenges that have been identified in delivery of the BCF plan for 25-26. This includes ensuring capacity is in the right place to support needs. For example, the focus for delivery has been on improving discharge timescales and this has been at the detriment to reducing flow into acute care services which has seen an 11% increase during the past 12 months. This shift is a system approach to improving community services to support reduced reliance on emergency care which will take time to embed. This may be beyond the timescales for the next 12 months and may have difficulty in seeing reduced demand within this time period. However, schemes will have a focus on community and step-up care built

into them to ensure that they link to the left-shift required. This will be supported by robust demand and capacity modelling and monitoring to show impact.

As a system we recognise that we haven't quite got personalised care right for individuals including conversations around care provision with partners and carers and family members. To mitigate we are ensuring that we work more closely with co-production groups and care providers to develop services and to renew work within intermediate care programme on the voice of the person.

We are keen to work with NHSE and the BCF national team on support for key priorities. Initial support may be needed to help with joined up conversations around the national CHC framework and how this can better improve relationships. Support from other systems on provision of step-up bedded care would also be useful to include in the next phase of the delivery of our intermediate care model along with supporting any national recruitment drives.

Timescales for delivery of schemes and impact vary depending on maturity of the plans. Impact on metrics will be expected within 25-26 on the Intermediate Care P2 D2A offer. This will have immediate impact on reducing timescales for discharging patients (over and above the current capacity) into residential care settings. Overall this financial year should see capacity increased in P2 D2A by 88 beds. For this cohort, delays in discharges should improve by reducing delayed bed days by approximately 700 per month. This has been reflected in the revised demand and capacity modelling.

Section 2: National Condition 2: Implementing the objectives of the BCF

Please set out how your plan will implement the objectives of the BCF: to support the shift from sickness and prevention; and to support people living independently and the shift from hospital to home. This should include:

- A joint system approach for meeting BCF objectives which reflects local learning and national best practice and delivers value for money
- Goals for performance against the three national metrics which align with NHS operational plans and local authority social care plans, including intermediate care demand and capacity plans
- Demonstrating a "home first" approach that seeks to help people remain independent for longer and reduce time spent in hospital and in long-term residential or nursing home care
- Following the consolidation of the Discharge Fund, explain why any changes to shift planned expenditure away from discharge and step down care to admissions avoidance or other services are expected to enhance UEC flow and improve outcomes.

A joint system approach for meeting BCF objectives which reflects local learning and national best practice and delivers value for money

The LLR system is currently aligning schemes to deliver proactive care models into a Neighbourhood Model of Care. This will support the shift from sickness to prevention and will add to the models already in place to ensure there is an integrated offer for residents. For example, our current care co-ordination teams which are based in each locality hub, proactively identify and manage caseloads in excess of 200 per month across 16 FTE staffing. These are identified from risk-stratified population health management data extracted directly from GP systems.

Plans for 25-26 include learning from the models in place and aligning other community support teams to provide similar services including social prescribers and Local Area Co-ordinators. This will be supported by reablement, therapy and nursing teams which are already deliver services on the same locality footprints. Levels of case management resources will be modelled on demand for current services and using population health management data to increase preventative caseloads to enable the shift from sickness to prevention.

Nationally, LLR has taken part in a series of peer reviews with other regions and NHSE. This has enabled us to connect with other systems for learning on discharge pathways and intermediate care models both to share our good practice and to learn from other areas. We plan to work alongside areas such on our step-up community bed offer as part of out Intermediate Care Programme.

Our BCF plans have been aligned to this model when taking decisions around funding and value for money in delivery of community care services. Areas for more integrated work is detailed above and investment has been aligned to follow this. The below diagram shows the level of investment aligned to community and prevention activity in Leicestershire. For 25-26 this is (72.4%*)

(*Draft for 23-25 this will be updated with new financial figures when the revised template has been completed. The final version attached as Appendix B was published on the 18th February 2025.)

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		

Goals for performance against the three national metrics which align with NHS operational plans and local authority social care plans, including intermediate care demand and capacity plans

Below is a table that shows the metrics for 25-26 and associated targets with explanatory notes on the ambitions: (Ambitions / Targets for the metrics have yet to be set and agreed).

Metric	Ambition	Comments
Emergency admissions to hospital for people aged over 65 per 100,000 population		Developments in the step-up models of care aim to reduce the demand activity increase seen in 24-25.
Average length of discharge delay for all acute adult patients, derived from a combination of: • proportion of adult patients discharged from acute hospitals on their discharge ready date (DRD) • for those adult patients not discharged on their DRD, average number of days from the DRD to discharge		National data on this will be published in due course to enable systems to work on this indicator. As yet there is no data to base a target on. However, the below will impact from a system perspective: P2 D2A bed offer for 88 cohort, increase in HART capacity, maintaining current investment in HART capacity rejection care packages. This demand is derived from demand and capacity planning.
Long-term admissions to residential care homes and nursing homes for people aged 65 and over per 100,000 population		Looking at a possible target of 23-24 as this was the last full year of data linked to latest population estimations. Reduction in long-term bedded care across Leics has been seen in prev years

Demonstrating a "home first" approach that seeks to help people remain independent for longer and reduce time spent in hospital and in long-term residential or nursing home care

Leicestershire has been improving against targets for 'home first' as part of the wider Adult Social Care strategy for service delivery. This has resulted in a reduction in demand and usage for bedded care of approximately 35%. During the focus on care at home, reablement demand has also increased by approx. 100% with capacity increasing by 50%. This has

reduced the amount of long-term bedded care need also along with a successfully commissioned and healthy domiciliary care market. Which supports unmet demand in reablement services and also increases flow through hospitals by providing timely discharges and exit from reablement services.

In addition to the above the plan for 25-26 will build on the integrated therapy and HART reablement offer in localities which has reduced waiting times for elements of the service such as equipment ordering and delivery, increasing capacity and building better relationships between services. This will be expanded to include additional tasks around skin degradation and work with stroke services to reduce wait times. This will be part of the intermediate care model and also build on the emerging neighbourhood model of care.

The following schemes and areas of work for 25-26 to support this are listed below:

- Falls commissioned service review – to provide support to fallers at home to avoid conveyance and ensure people are supported to remain at home where relevant
- Increased capacity in review services to ensure that care is right-sized to meet needs
- Review of front-door services to avoid admissions and to provide a same-day service
- Development of neighbourhood models of care shifting focus to prevention

Following the consolidation of the Discharge Fund, explain why any changes to shift planned expenditure away from discharge and step down care to admissions avoidance or other services are expected to enhance UEC flow and improve outcomes.

The consolidated local authority discharge fund will continue to support with the same activity as last year for discharge. In addition, the fund will support the following schemes:

- Increase usage and ordering of care technology
- Increased support to the intake model to enable step-up pathway one offer
- Additional home first team support workers
- Home Care Packages due to HART no capacity
- Lead Commissioner Post
- HET Expansion – this includes the service renting 3 units to support people with short-term needs whilst finding permanent accommodation

Across Mental Health a range of support services are included in the usage of the grant for 25-26 investment:

- Assertive In Reach M

- Agency Social Workers (MH teams)
- Community Support Workers in Hospital Team (MH)
- MH relationship Enabler

Please describe how figures for intermediate care (and other short-term care) capacity and demand for 2025-26 have been derived, including:

- how 2024-25 capacity and demand actuals have been taken into account in setting 2025-26 figures (if there was a capacity shortfall in 2024-25 what mitigations are in place to address that shortfall in 2025-26)
- how capacity plans take into account therapy capacity for rehabilitation and reablement interventions

How 2024-25 capacity and demand actuals have been taken into account in setting 2025-26 figures (if there was a capacity shortfall in 2024-25 what mitigations are in place to address that shortfall in 2025-26)

Analysis of 24-25 data on HART reablement demand shows a projected increase over the course of the 12 months by approximately 30%. There is a projected stable amount of demand from hospitals (this is expected due to a finite number of beds). This increase has been projected into the demand modelling. The service has increased capacity over the past 12 months by approximately 10%, however this is not keeping up with increases in demand. Further investment has been apportioned to ensure continuous recruitment into the service. This has been ongoing throughout 24-25.

To mitigate, we will meet the unmet demand with domiciliary care packages as an interim, with a daily review of capacity. This ensures that there are no delays to discharges and residents can access the service as and when capacity becomes available in the community. In cases where this does not occur, our two-week review team support the person to right-size their care at this point. This investment into additional care packages will continue in 25-26 to support hospital discharges, paid for from the Better Care Grant. It is hoped that as recruitment continues to increase the need for temporary packages will decrease as more reablement capacity becomes available.

During 24-25, led by Leicestershire County Council, the Intermediate Care Steering Group employed specific resource to conduct an options paper on the requirements for pathway 2 discharge to assess bedded care requirements. This is intended to form the basis of the long-term commissioning plan for future requirements and is being used to inform demand and capacity requirements for future years. The piece of work identified an 88 bed gap for the LLR system which new models of care will attempt to fill during 25-26. Currently this cohort is supported by temporary residential care placements but do not have comprehensive access to therapy and reablement services.

Three options from the paper will be worked on in more detail. This includes purchasing system run beds for D2A patients, increasing community capacity for low-level medical step-down requirements and increased utilisation of community hospital capacity (which has already been met in part during 24-25).

To mitigate further the needs of the cohort, additional beds have been utilised through periods of surge including winter with 20 beds in a further community hospital ward flexed to increase capacity. In addition, investment from the discharge grant has enabled the system to support people for the first 4 weeks of their bedded stay to receive onwards assessment and support. This enables an equitable financial provision for all in the first 4 weeks post discharge. Investment will continue in this way but has been scaled down in-line with proposed additional capacity beginning.

How capacity plans take into account therapy capacity for rehabilitation and reablement interventions

For therapy capacity, this has been aligned to all models of intermediate care within LLR. Commissioned therapy teams support the High Dependency cohort and bariatric cohorts within specifically commissioned bedded contracts. In addition, therapy capacity supports intermediate bedded care on specific wards in community hospitals. In total this equates to 36 beds. Therapy will be aligned to the additional 88 bed gap detailed above.

Within localities, therapy and HART teams have become integrated to ensure maximum coverage to care needs across Leicestershire. This has enabled HART to increase capacity in part through trusted assessment across teams and daily MDT's between reablement staff and therapy staff in order to co-ordinate care needs for individuals.

Section 3: Local priorities and duties

Local public bodies will also need to ensure that in developing and delivering their plans they comply with their wider legal duties. These include duties:

- to have due regard to promoting equality and reducing inequalities, in accordance with the Equality Act 2010 public sector equality duty.
- to engage or consult with people affected by the proposals. For ICBs, trusts and foundation trusts this includes their involvement duties under the NHS Act 2006.
- for ICBs, to have regard to the need to reduce inequalities in access to NHS services and the outcomes achieved by NHS services.
- for ICBs, to have regard to the duty to support and involve unpaid carers in line with the Health and Care Act 2022

Please provide a short narrative commentary on how you have fulfilled these duties

Our focus in 2024-25 was to work 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.

During 24-25 specific local authority, ICB and provider resource was aligned to reviewing integrated care against national and equality diversity frameworks. An initial strategy for this was developed and work began on evaluating equality within Intermediate Care provision.

This began with a partnership review of Pathway 1 intermediate care against the NHS Equality Delivery System (EDS) Domain 1. EDS is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010 and domain 1 covers commissioned or provided services. The LLR team conducted a series of workshops with service users and workforce in order to grade ourselves on equality and diversity characteristics when delivering core services. A copy of the report will be attached as an appendices once completed.

During 25-26 a timetable for conducting similar equality and diversity analysis against our key priority areas for delivery will be developed aligned to highlighted areas for progress listed above.

We continue to invest in services that aim to specifically reduce health inequalities particularly using population health management data in the following invested schemes:

- 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 relationship and staffing support for Mental Health patients in the community

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.

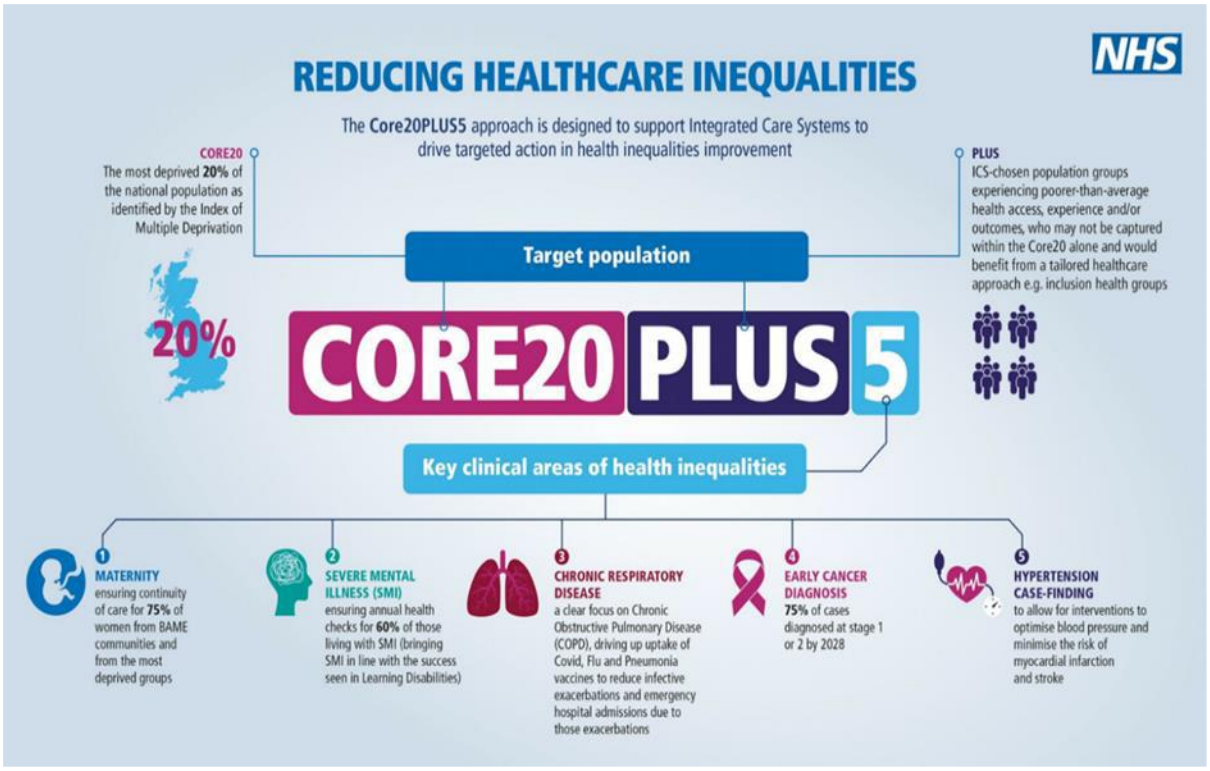
One of the main ways the Integrated Care Board (ICB) ensures meeting the Public Sector Equality Duty (PSED) is by undertaking an Equality Impact Assessment (EIA).

These help us to demonstrate we have considered the impact of policies, services and practices have on our patient population and our workforce, particularly those people with protected characteristics or those from inclusion health and vulnerable groups.

More information about this approach, as well as on the CORE20Plus5 approach for children and young people can be found at:
https://leicesterleicestershireandrutland.icb.nhs.uk/equality-statement/

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.



Department of Health & Social Care

Ministry of Housing, Communities & Local Government

NHS England