Integration and Better Care Fund

Better Care Fund 2025-26 HWB submission

Narrative plan template

	HWB area 1
HWB	Leicestershire
ICB	Leicester, Leicestershire and Rutland ICB

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 Leicestershire

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

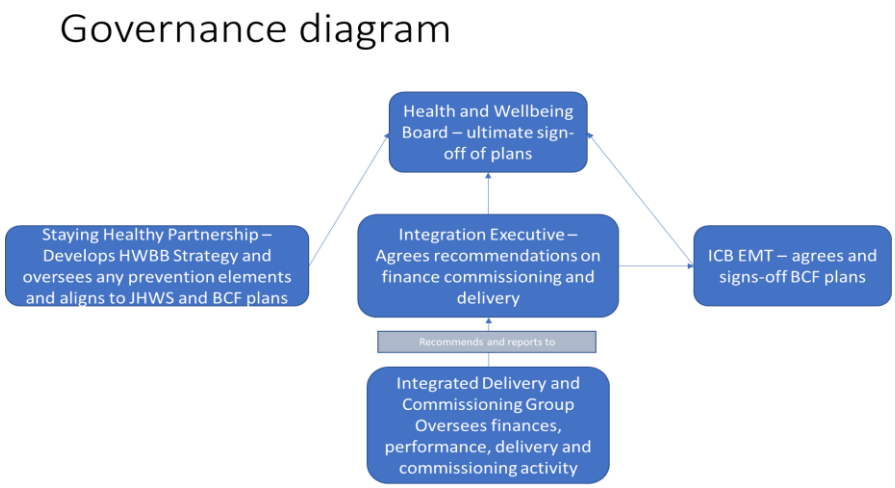
For the 25-26 plan development, engagement has been received from partners via a series of forums. The first took place with system partners on the 31st January, 2025 with a Joint Health and Wellbeing Development Session on the Living and Supported Well life-course of the Joint Health and Wellbeing Strategy. The second session on development was 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. An example KLOE for First Contact Plus is attached as appendix A 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. KLOE reviews occur annually to ensure that there is robust monitoring of all 89 schemes. Locally, we also review schemes in groups depending on workstreams. The workstreams are Community and Prevention, Intermediate Care and Acute Care. The division of schemes by these workstreams and associated spend can be seen in diagram 4 below.

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 Board meeting of the 29th May will sign-off the 25-26 BCF and accompanying templates, with the Chief Executive of Leicestershire County Council signing this off for submission on behalf of the Board using delegated powers. The governance structure for the board is shown in diagram 1, below:

Diagram 1



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. The HWB will further challenge current delivery and develop planning for future BCF years' in a workshop scheduled for Autumn 2025.

Priorities for 2025-26

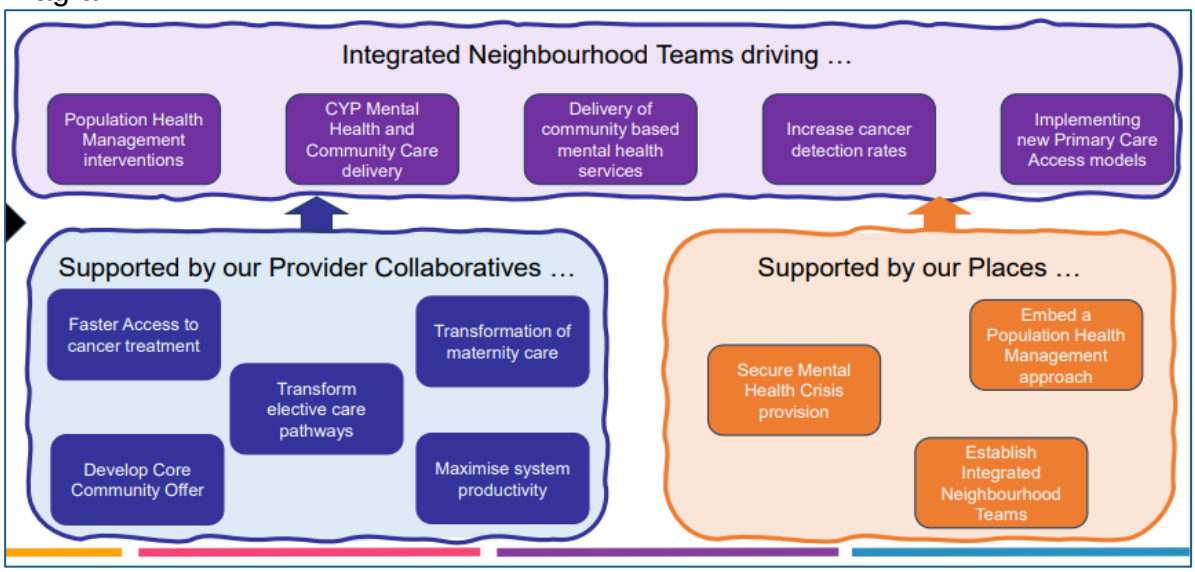
The below areas of work have been highlighted as areas of priority for 2025-26. Our main priority is developing a more preventative community offer. This is where the majority of BCF investment is focused for 2025-26.

Developing the neighbourhood model of care – currently around 70% of our BCF investment is dedicated to community and prevention services (approximately 60 million pounds). Our priority for 2025-26 is to align applicable services to neighbourhood models of care in particular further development of Integrated Neighbourhood Teams (INT's) and associated Multi-Disciplinary Teams (MDT's). The initial design phase, incorporating the six core components, will look at our current service provision and how we can maximise delivery against these components by further integrating services across:

- Population health management
- Modern General Practice
- Community health services
- Neighbourhood multi-disciplinary teams
- Integrated intermediate care with a 'home first' approach
- Urgent neighbourhood services

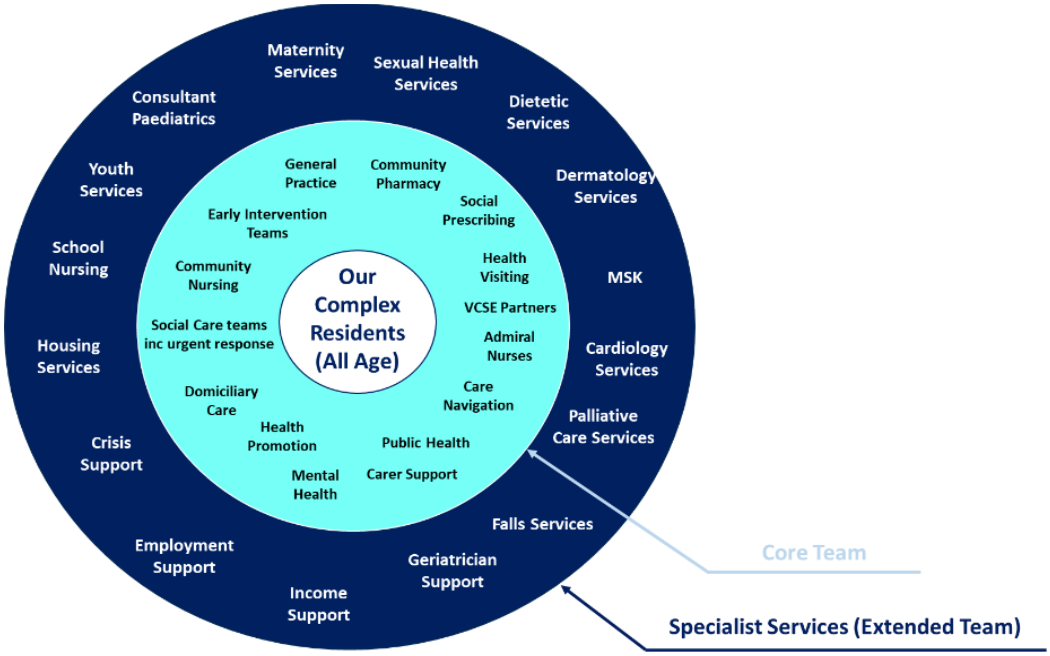
The initial design shown in diagram 2 below shows the overall services that will be incorporated into the model.

Diagram 2



The BCF programme will be supporting the place based elements in orange shown above as part of the Place based support. We have been working with other Local Authority and Health systems to look at best practice with early design examples presented to the HWB at their Living and Supported Well development session of the Joint Health and Wellbeing Strategy. One example is from Northwest London shown below (diagram 3) which represents where we would like to develop (or similar) during 2025-26:

Diagram 3



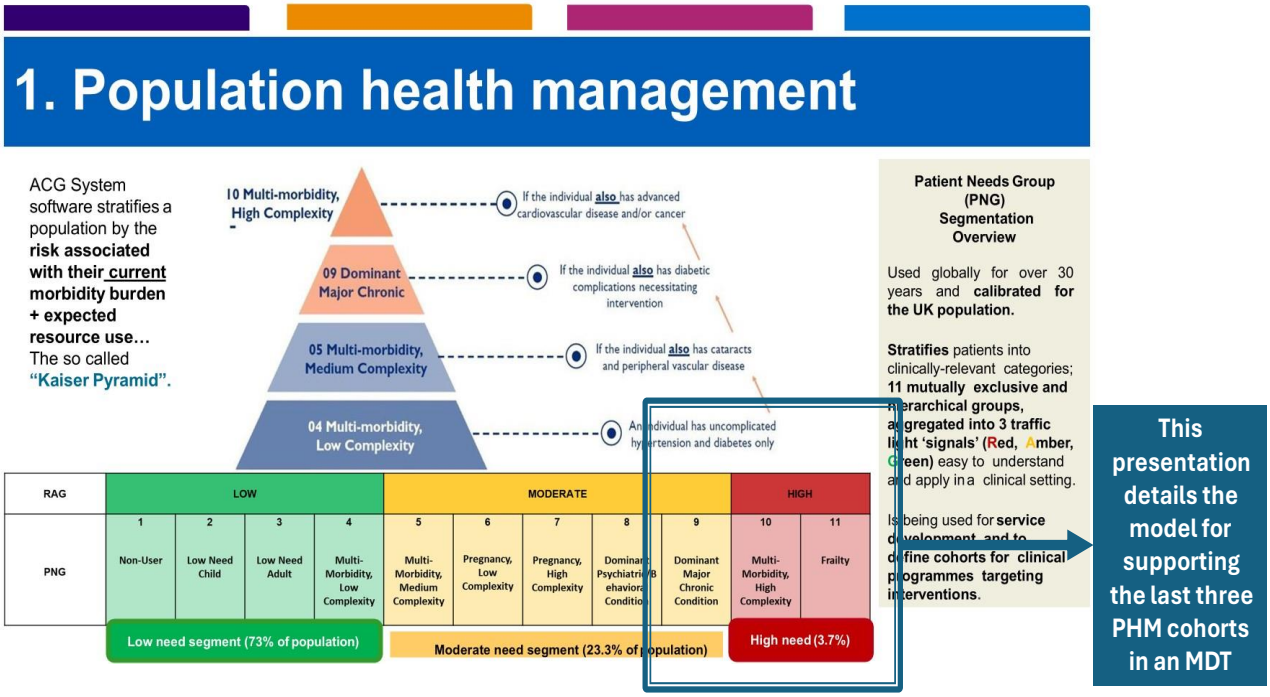
By 2026-27 as a system we are hoping to start to see outcomes from the re-design. This will include

- Improved outcomes for individuals including personalised models of care
- Improved care planning and sharing of this across all partners
- Better access to community services with fewer attendances and admissions to acute care (see below metrics section)
- Fewer admissions to long-term care (see below metrics section)
- Increased use of proactive care models utilising population health management data across services

Risk stratified population health management data will drive the demand of developing MDT's, which will focus on delivering support to cohorts 9, 10 and 11 on the below slide. Locally, this equates to 82,207 people in Leicestershire alone. MDT's will need to be made up of a combination of clinical and non-clinical staff from across the NHS and social care utilising data from the existing care co-ordination proactive care model as a proxy for demand and capacity modelling. Diagram 4 shows the population health management cohorts and how the MDT's align. INT's already focus on delivering support to people in the lower cohorts, however the aim is to streamline this more effectively in the next 12 months.

Diagram 4

How does this fit with the work so far?



Linked to delivery of the above emerging neighbourhood models, are a number of supporting priorities for 2025-26 which we will review in order to ensure our schemes are fit for purpose and offer value for money with the desired outcomes.

- **Review of prevention services** - the County Council is conducting a review of prevention services. The aim of this project is to review prevention activity across the council to ensure we are doing our best to identify and meet need early, reducing the need for specialist services wherever possible. Over the last 18 months, information has been collected from teams across the council to give a clear picture of the council's prevention offer and the cost of prevention services. This has involved mapping functions and activities, areas of spend and funding sources, statutory requirements and performance where available. We are now moving into the next phase of the review, with the support of an external partner, help us with this complex, cross-cutting review of prevention services. Between February and May 2025, they will be working directly with teams to understand more about our service areas: They will be building their assessment based on a review of key reports, financial and performance information, interviews, case reviews and workshops. Once an in-depth review has been completed, we will be co-designing next steps and testing ideas with teams during the summer.

- **Assistive and digital technology and equipment** – BCF investment in this area will be approximately 1.5 million in 2025-26. Currently, elements of AT and equipment are delivered across a range of organisations and to support a range of services often inconsistently available. During 2025-26 we aim to re-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. To support this, within ASC we are reviewing our AT service, Just Checking. This is an activity monitoring system that helps care professionals complete objective, evidence-based care needs assessments of adults with dementia, learning disabilities, autism, and other complex conditions. This supports a number of indicators and outcomes and helps to right-size care packages via a review and upgrading equipment. Within this we have also looked at early outcomes from areas of best practice (Manchester) where a 22% reduction in annual care costs for users of this technology were seen compared to the control group.

- **Home visiting service / night nursing service** – these are 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 prior to Winter 2025 with further re-procurement opportunities being sought in line with the end of the current contract. This will be measured by increased coverage and number of recipients supported.

- **Creating a Single Point of Access** (SPoA) – work has begun on this programme in the 4th quarter of 24-25 and will continue throughout 25-26. A maturity matrix against the NHSE framework has been completed for LLR. Our system aims to have a single point where community requests for support are triaged and correctly managed in the community across a range of co-ordinated services. The aim is to reduce 'ping-ponging' residents between services (including GP's, Urgent Treatment Centres, 111 and EMAS) and to better advise them of support available according to their needs via a single telephony service. This will build on the learning from the Unscheduled Care Coordination hub and involve all partners in delivery of community health and care resources.

In addition to the above priorities, members of the BCF governance structure have highlighted additional areas where review of integration opportunities will be investigated during 2025-26. This list was compiled using the KLOE documentation review which is completed annually as part of BCF planning:

- **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. The contract currently in place is up until Mar 26

so alignment planning will be completed along with and commissioning requirement timescales by this stage. For winter 25-26, support to P0 patients returning to their own home where this is a care home will be provided to support speed in decision making for returns.

- **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.

- **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. Current contracts are in place until end Mar 26.

- **Primary Care Co-ordinator** – 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 including the development of the Frailty SDEC which aims to further reduce emergency admissions. This work will aim to be complete within the first two quarters to be in place for winter 25-26.

- **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 HWB and BCF planning and agreement changed as Integration Executive sub-groups were reduced. 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 intermediate care delivery and 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 consolidation and re-design by the end of the 25-26 financial year. This year, FaME (the Falls Management Exercise

programme) has been included in the BCF. This is an evidence-based, strength and balance exercise programme that has been shown to reduce the rate of falls by up to 26%. It is a structured 24- week group-based programme (with additional home exercises) delivered in community venues and aimed at people over 65 who are at risk of falling (have fallen in the previous year or have a fear of falling). Class sizes are around 10-14 people and are delivered by specialist postural stability instructors. Steady Steps is the name of our LLR FaME programme. Public Health England have estimated that FaME has a social return on investment of £2.28 for every £1 invested, including savings for health and social care. The programme is managed by Active Together using local delivery partners across LLR and supports the BCF indicator to reduce emergency hospital admissions due to falls in people aged 65+. In 23/24 there were 43, 24-week courses run across Leicestershire and Rutland attended by 465 people at a cost of £331 per person (£13.80 per week). In 25/26 we hope to create efficiency by reducing this unit cost to £298 per person (£12.41 per week) by increasing the number of participants to 516 people. The scheme is cost effective as evidence shows that the rate of falls for every patient who has completed the programme could reduce by up to 26% in the subsequent 12 months.

- 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 and neighbourhood 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 production of a 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 and a shift towards step-up care. 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 0 support from the voluntary sector (RVS) will continue in 25-26 supporting approximately 700 people annually along with care co-ordinators working with approx. 2500 people leaving hospital each year on this pathway. UHL Urgent and Emergency Care discharge working group will be working on achieving a target of 66% P0

patients leaving on their discharge ready date. The targets in this plan align to the activity in the UEC Discharge Working Group in order to achieve ambitions.

- Pathway 1 – IC at home - We will endeavour to stabilise our P1 intake model already established by increasing and maintaining workforce to meet demand. This is supported with a further 883k of investment to ensure demand is met and people are able to return home whilst this expansion in service continues. During 24-25 demand for reablement services increased by 30%. Overall, our commitment to Home First will continue. During 24-25, 6% more people were supported into care at home than in the previous year (reducing demand for P2 bedded care). Our investment in reablement and review teams ensure this is right sized to meet need with the average cost of a package reducing to £343.42 from £356.57 at the start of the year. Furthermore, the average hours have reduced to 14.07 from 14.36 at the start of the year. Our priority will be to continue to support more people at home with the right-sized package to meet their needs with more people accessing reablement to increase the likelihood of independence. We will further align community step-up services to expand the IC model and meet the demand using continued service expansion and finance modelling ensuring the pathway is rightsized.

- 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 for discharge into a 3 R model bed for every person assessed as needing this level of support. Proposals were based on continuous demand and capacity modelling to establish the overall needs in relation to bedded D2A care. This included ensuring that the needs of this cohort could not be met at home. 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. Over 24-25 the use of short-term bedded care has reduced by 5% with discharge P2 usage reducing by 6% on the previous year. Our demand modelling has shown that we need a further 88 beds across LLR (50 for Leics) to support reablement, rehabilitation and recovery. Over the last 2 years Intermediate Care has worked to reduce P2 bed usage by over 35% so we are now confident that this is the cohort of numbers that remains requiring P2 support due to analyses for the P2 demand paper (attached as an appendix B). This shows analysis of demand at sub-pathway level to confirm requirements of this cohort. Delivery will be supported by investment in the P2 IC model of approx. 1.5 million with phased additional beds commissioned throughout 2025-26. By the end of 2026, it is projected that there will be a need for only 18 short-term spot-purchased beds required to meet demand for Leicestershire residents. Over winter, to reduce the risks associated with increased demand, plans to maintain the use of a further ward in Leicestershire Partnership Trust community hospitals (Grace Dieu) will alleviate

demand for this cohort as an interim solution. Increased solutions for step-up intermediate care are also being evaluated including increased therapy support at the front-door to support triage into step-up beds in the community where an acute bed is not appropriate. This will begin working with the frailty SDEC cohorts.

- 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. BCF investment of circa 15 million supports delivery of this. Within Leicestershire there are no waits for domiciliary care pick-up by providers for step-up or step-down provision.

Other areas of short-term care will form part of the neighbourhood model of care. 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. However, recently announced changes to NHSE and ICB's (in an already lean system) could severely impact not only the support required but also on delivery of some of the key elements of this plan.

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 but overall this will only have an impact of 0.5% on discharge timescales overall. Regardless, 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 and will provide equitable access to a recovery, reablement and rehabilitation offer to all. 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 (in addition to approx. 200 pathway 0 patient support per month). These are identified from risk-stratified population health management data extracted directly from GP systems.

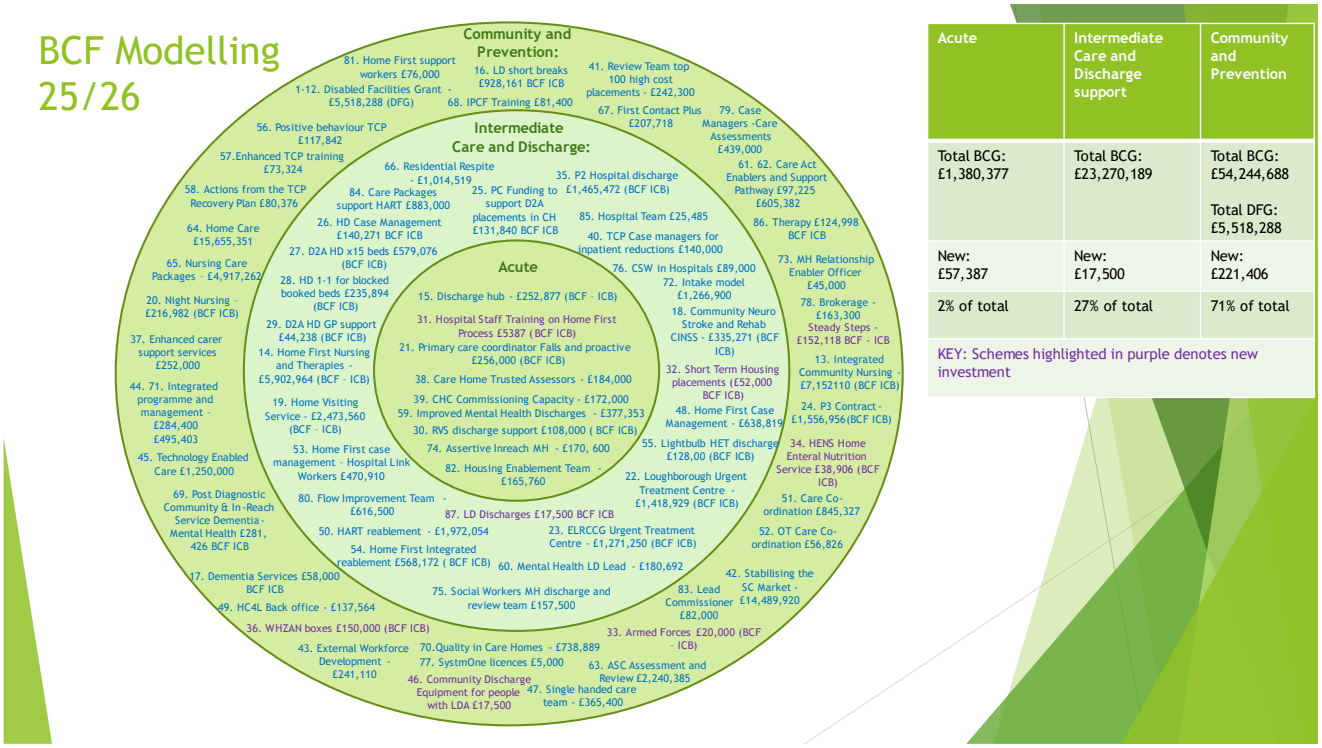
Plans for 25-26 include learning from the models in place and aligning other community support teams to provide similar services including social prescribers and Local Area Co-ordinators. This will be supported by reablement, therapy and nursing teams which already deliver services on the same locality 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 as our step-up community bed offer as part of our 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 5, shows the level of investment aligned to community and prevention activity in Leicestershire. For 25-26 this is 71% of the overall fund with 27% aligned to Intermediate Care and 2% aligned to acute care.

Diagram 5



Acute	Intermediate Care and Discharge support	Community and Prevention
Total BCG: £1,380,377	Total BCG: £23,270,189	Total BCG: £54,244,688 Total DFG: £5,518,288
New: £57,387	New: £17,500	New: £221,406
2% of total	27% of total	71% of total
KEY: Schemes highlighted in purple denotes new investment		

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:

Metric	Ambition	Comments
Emergency admissions to hospital for people aged over 65 per 100,000 population	2550 admissions per month	The ambition for 25/26 is for projected monthly targets to be lower than 24/25 actuals with a target to improve on 23-24 rates of admissions. This represents a reduction of 2% on 24-25 admissions and a reduction of a further 0.8% on 23-24 rates. This equates to a reduction of approx. 70 admittances per month. Our frailty SDEC which began in Jan 2025 has initially seen a 76% admission avoidance rate – this will contribute to 31 of the 70 required avoidable admissions for Leics (based on 71% of demand) and plans to extend this function aim to lead to a potential further 30

		avoidable admissions per month. Reduced admissions due to falls will contribute to the remainder of the target. This has reduced by 6% in 24-25 and the aim is to reduce this again by a further 6% which equates to 9 emergency admissions per month. The remainder is supported by increases in activity in Virtual Wards. This will equate to approx. 14 more people supported for step-up virtual care in Leics.
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	89%	Current data shows performance at approx. 85%. The target of 89% is in line with the Criteria to reside target for 25-26 across acute care partners. Achievement of this will be graduated from the current levels to reach 89% by Mar 26. Our current system activity in support of this is listed below. This is in line with UHL planning: •Develop/refine nervecentre collection of 'Criteria to Reside' to aid data accuracy •Produce a SOP on Criteria to reside/ EDD/ Planned date of Discharge. •Undertake staff education / training •Continue to develop Criteria Led Discharge Pathways. •Continue to work with CMG's to reduce internal reasons for incomplete discharges •Staff education and training / communications on Estimated Discharge Setting Two voluntary organisations provide support to P0 discharges will receive investment to work towards meeting this target during 25-26 P2 D2A bed offer for which for Leics will see a reduction in days of 190 bed days per month across 32 patients. The numbers of people is a reduction in 5% from the current data of 628. The number of bed days represents a reduction in 8.5% of lost bed days. Other activity in support of this includes, increase in HART capacity, maintaining current investment in HART capacity rejection care packages. This demand is derived from demand and capacity planning. Will maintain P1 discharges at approx. 2 days for County.
Long-term admissions to residential care homes and nursing homes for people aged 65 and over per 100,000 population	867	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. Our target is to get back to the 23/24 level (867). Divide by four quarters is 216/217 per quarter or on average 72 admissions per month. The current figures for admissions per month is approx. 75 based on full year 24-25 projections.

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. 75% with capacity increasing by 38%. 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. It is projected that this will increase to include an additional 28 people per month for Leicestershire by quarter 3, 2025.
- Increased capacity in review services to ensure that care is right-sized to meet needs. This will continue the reductions in domiciliary care packages in hours and costs seen in 25-26 (see data in IC Pathway 1 section above)
- Review of front-door services to avoid admissions and to provide a same-day service in a SPoA – detailed above
- Development of neighbourhood models of care shifting focus to prevention (also detailed above)

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 – this has shown to improve the amount of people remaining at home post-acute spell in hospital. Outcomes should see an improvement in the number of people accessing long-term care homes.
- Increased support to the intake model to enable step-up pathway one offer – see information in IC section above
- Additional home first team support workers – see outcomes and timeframes associated with increased P1 care at home above.
- Home Care Packages due to HART no capacity – see IC section on meeting demand for reablement services through use of care packages and increased review teams to support 2 weeks post discharge
- Lead Commissioner Post
- HET Expansion – In 24-25 expansion of the overall HET service was funded through the discharge grant. Planning and evaluation report of this expansion is attached as appendix C. This will continue in 25-26 and includes an increase in funding to allow the service to rent 5 serviced units to support people with short-term needs whilst finding permanent accommodation. This will be subject to a PDSA review within the first 6 months of 25-26.

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

- Agency Social Workers (MH teams)
- Community Support Workers in Hospital Team (MH)
- Mental Health Discharge Unit has been built with Leicestershire Partnership trust for Local Authority Mental Health staff to be able to access patient information to build on Integration between Health and Social Care. We are currently onboarding staff members to have access to this custom built discharge unit and we aim to have this completed by June 2025. This will allow sharing of appropriate information which will facilitate quicker and safer discharges. In addition some of the benefits will also include:
    - AMHP assessments contributing to analysing risk and current services/circles of support
    - Reduce duplication of information gathering from patients between social care and ward staff
    - Staff will be informed on the person they are visiting before they enter the ward.
    - Quicker preparation for tribunals

- Timely social care assessments and interventions
- Reducing the risk of breeching legal time frames for tribunals
- Help put provisions in place before visit i.e. housing, adaptations, support reducing risk of re admission and reducing the length of stay
- Reduces miss communication from different ward staff and social care staff

- Mental Health Relationship Enabler - significant delays were identified in the discharge of homeless mental health patients from hospitals, who had previously come from a county setting prior to discharge. County settings involve multiple district councils, creating complexities that disadvantage patients requiring discharge. These administrative and procedural differences often result in extended hospital stays and an increased risk of readmission due to inadequate post-discharge support. To address these challenges, a pilot scheme was introduced to streamline the discharge process, enhance inter-agency collaboration, and provide structured post-discharge support to reduce the likelihood of readmission. The initiative involved creating a dedicated role within the Housing Enablement Team (HET) to specifically assist district councils in managing complex mental health discharge cases, ensuring smoother transitions into appropriate accommodation and long-term stability. The Mental Health Relationship Enabler role was established to bridge the gap between mental health services and housing, working closely with district councils and the Bradgate Mental Health Unit (BMHU) to facilitate the timely and effective transition of homeless patients into suitable housing arrangements. The core objectives of this role include:
  - Reducing Delayed Transfers of Care (DTOC) for mental health patients with housing needs.
  - Providing intensive post-discharge support to reduce readmissions.
  - Facilitating better coordination between hospital discharge teams, local authorities, and housing providers.
  - Addressing barriers in the housing allocation process to ensure vulnerable patients receive appropriate accommodation.
  - Impact and Future Plans (2025/2026)

  The pilot has demonstrated a reduction in county-based delayed cases due to the targeted intervention model. The inclusion of structured post-discharge support has proven essential in reinforcing confidence among partner agencies and improving patient outcomes during the critical transition period. The officer supports approximately 70 people annually. The scheme has led to:

- A reduction in hospital readmissions for patients with housing-related discharge barriers.
- More efficient hospital discharge processes, alleviating bed pressures and improving patient flow.
- Stronger inter-agency collaboration, fostering better relationships between NHS services, local authorities, and housing providers

- Improving Mental Health Discharge supports a variety of staffing roles to contribute to improving discharge for Metal Health:
  - Hospital Discharge team. This team supports people who need commissioned
  - support out of hospital that is based at the Bradgate unit (Care act and S117.)
  - Community based service - Duty of assessing people who need compulsory admission to hospital. This is a working age adults service.
  - Forensic team- discharge through forensic route (more secure setting). This is also a working age adults service.

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 factored 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 reablement 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. Therapy capacity has increased by 15% during 24-25 and this has been reflected in the demand and capacity plans for 25-26.

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

Under Section 14Z45 of the Health and Social Care Act 2022 and as set out in the NHS Constitution we have a duty to involve the public in our commissioning plans and decisions that we make as a commissioning organisation. LLR ICB has a clear vision for engagement and patient experience. We want our patients, carers public and stakeholders to be among the most involved, informed and empowered when it comes to local healthcare. We recognise the fundamental importance and benefit of ensuring that our decisions are shaped through effective communication and engagement with the local population.

Principles for working with people and communities
The principles that underpin our work with people and communities align with 10 national principles for how ICSs should collaborate with people and communities, are shown below:

- Build on the engagement capability and capacity in our workforce and empower our 21,000 members of staff as the NHS or social care family, service users/patients, community members and carers, to make connections to social change.
- Embed business intelligence and insights from people and communities into the heart of the ICS, ensuring that at all levels of decision making and implementation they are a valued asset, used to improve experiences and enhance the health and wellbeing of our population.
- Harness the power of Equality Impact Assessments to support the eradication of health inequalities. To help embed equality considerations (including health inequalities) within decision-making, we will use the six steps approach of the LLR Inclusive Decision - Making Framework.
- Build relationships with children, young people, families and groups that represent them

- Build stronger relationships with unpaid family carers and groups that represent them ensuring that they can share their experiences of care and drive improvements across health and care.

Our work with the public and communities discharges our public involvement duty, as set out in the NHS constitution. It also takes account of the range of legislation, including the NHS Act 2006, that relates to involvement and decision making.

We have placed the voice and experience of people and communities in LLR at the heart of the work of the ICB and partners and as a golden thread through the governance structure (see structure below). This is supporting the system and all partners to understand what people need, what is working, what can be improved and how we can work together to deliver what matters to the people we serve. Evidenced based insights and business intelligence, based on the experiences of people into the delivery of safe, high quality and compassionate care is reported into the ICB board through the Quality and Safety Committee, which assures that the data is being acted upon.

The Public Sector Specific duties also require the ICB to publish equality information annually that sufficiently demonstrates how we are thinking about equality across the services we provide and/or commission and our employment of staff. Our EDI Annual Report demonstrates how we meet these duties see link:

https://leicesterleicestershireandrutland.icb.nhs.uk/equality-statement/

The report includes the requirement to produce specific and measurable equality objectives and publish our Gender Pay Gap (this is also found separately on the website).We also demonstrate due regard to advancing equality and reducing inequalities through our Equality Impact Assessments which are listed in the Annual Report and some good practice assessments are found on the on the website. We are presently taking the EDI Annual Report for 2024/25 through our governance procedures. This includes more information on the Armed Forces Act 2021 (AFC).

More specifically, in response to in NHS England's Statement on Information on Health Inequalities (duty under section 13SA of the National Health Service Act 2006), the ICB has developed its first annual report on health inequalities. This is the first time the ICB has compiled this level of health inequalities for the system – covering 10 clinical domains with a range of indicators segmented by deprivation and ethnicity. The data gives the system a comprehensive baseline assessment of inequalities in access to services that are driving inequalities in patient outcomes and patient experience.

- Core population demographics for LLR with a focus on the drivers of health inequalities
- Health inequalities in LLR
- A review of how LLR is addressing health inequalities strategically
- A review of the work that LLR, LPT and UHL are doing to address health inequalities

- LLRs statement on information on health inequalities across 10 domains, setting out a summary of the key metrics, local actions that are in place to target and address health inequalities and case studies of key actions that the system is taking.

This report has been developed in collaboration with LPT and UHL and features a wide range of case studies from across the system illustrating the breadth and depth of initiatives that are targeted towards reducing health inequalities and improving health equity.

This is the first time that this breadth and depth of health inequalities data has been made available to clinical and system leaders to support and drive change. It is essential that the system acts on this evidence to address health inequalities and improve outcomes for the most disadvantaged populations in the LLR system.

This report provides the system with a baseline for health outcomes and for access to services from a health inequalities lens. There is ongoing work, through the delivery partnership and clinical executive to raise awareness of this report and the key metrics that are included with the aim that these groups endorse the health inequalities dataset as the single, unified dataset to drive transformative improvements across all workstreams, ensuring a consistent and evidence-based approach to addressing disparities. It is important to note that the report does not include all the programmes of work the ICB is involved in with respect to health equity but provides examples of ongoing work.

The report has been approved and will be published on the website in accessible format in due course.

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 Leicestershire County Council, 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. The latest copy of the draft report is attached as appendix D. The outcome of this work will be an improvement plan which is drafted and set for approval in April 2025.

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.

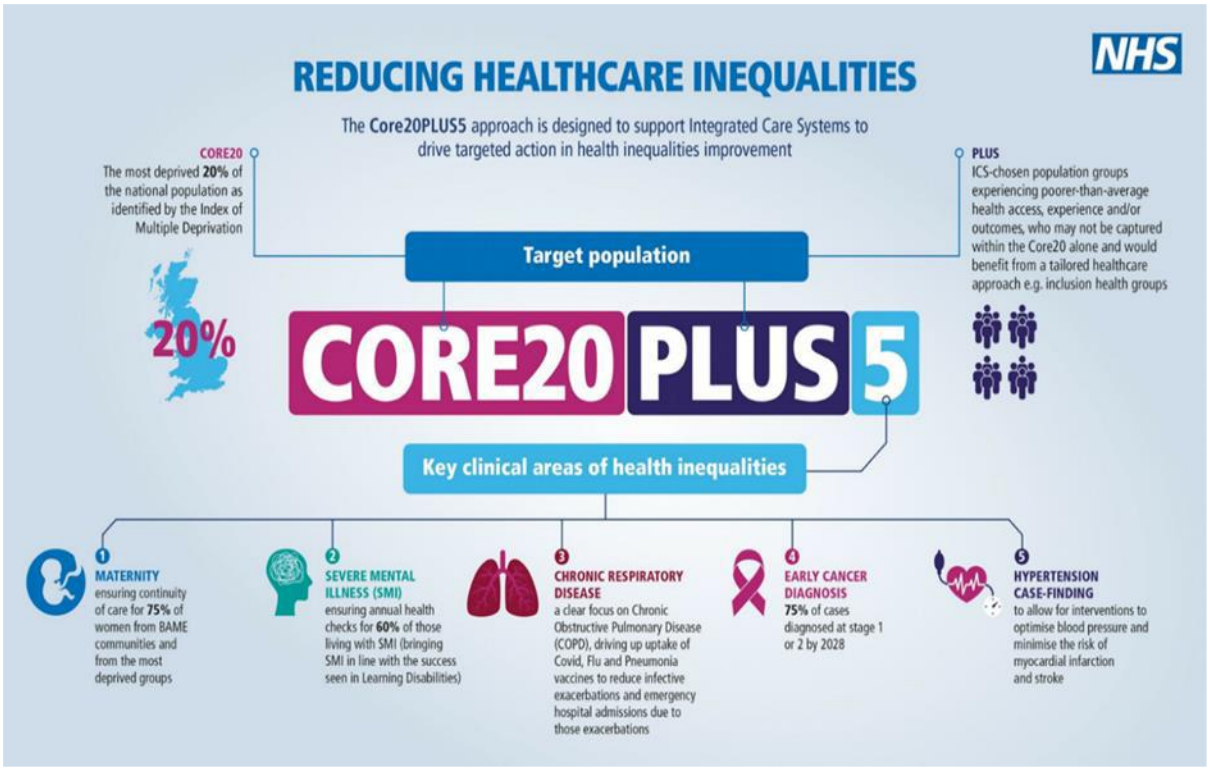
One of the main ways the Integrated Care Board (ICB) ensures meeting the Public Sector Equality Duty (PSED) is by undertaking an Equality Impact Assessment (EIA).

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.



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