Theme	Scheme	High level description of what the spend will be invested in	2014/15 West Leics CCG £'000	2014/15 East Leics & Rutland CCG £'000	2014/15 Total £'000	2015/16 West Leics CCG £'000	2015/16 East Leics & Rutland CCG £'000	2015/16 Total £'000
Unified Prevention Offer	First Contact	Multi agency referral scheme for vulnerable adults. When a staff member from any of the agencies involved in the scheme, such as a volunteer, police officer / police community support officer, environmental health officer, victim support staff, council worker or fire fighter is in contact with a vulnerable adult by; a visit to their home, a telephone call or during their work with them, they can offer to complete one simple checklist to find out if that person has any other particular needs. http://www.leics.gov.uk/firstcontact	90.6	68.3	158.9	92.1	69.5	161.6
Unified Prevention Offer	Carers Services	Covers 3 areas: 1) Carers Support Fund - £85k. Payment to carers of up to £250 to support them in their caring roles. 2) GP Referral Service - £165k. Service to identify and support carers at GP Surgeries. Run as a pilot in North West Leics and Oadby & Wigston, looking to expand countywide in 2015/16 3) Carers respite £200k - currently limited to carers of people with dementia, this service is being remodelled to make it accessible to all carers http://www.leics.gov.uk/index/social_services/asc_support/asc_carer/social_care_short_breaks/asc_time_out_for_you.htm	210.9	159.1	370.0	256.5	193.5	450.0
Unified Prevention Offer	Time Banking	Timebanking is a means of exchange used to organise people and organisations around a purpose, where time is the principal currency. For every hour participants 'deposit' in a timebank, perhaps by giving practical help and support to others, they are able to 'withdraw' equivalent support in time when they themselves are in need. In each case the participant decides what they can offer. Everyone's time is equal, so one hour of my time is equal to one hour of your time, irrespective of whatever we choose to exchange. Because timebanks are just systems of exchange, they can be used in an almost endless variety of settings. http://www.timebanking.org/ http://www.leics.gov.uk/index/social_services/asc_support/asc_general_info/asc_partners/timebanking.htm	41.0	31.0	72.0			
Unified Prevention Offer	Advice & Information (c/f from 2013/14)	Staffing to support the writing of an information and advice strategy for Leicestershire. Costs run into 2013/14.	2.3	1.7	4.0			
Unified Prevention Offer	Carers Assessments (Care Bill Implications)	Part of the BCF includes money for certain aspects of the Care Bill, assessment of carers being one of them. The £275k should allow the County Council complete up to 2800 carers assessments and reviews required to meet the 'carers assessments: no. of people accessing services' proportion of 39.3% as suggested in the Care and Support Impact Assessment. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/275519/Care_and_Support_Legal_Reform.pdf				156.8	118.3	275.0
Unified Prevention Offer	Specialist Support to People with Dementia & Carers	Service commissioned from the voluntary sector (current provider Alzheimers Society) to provide continuity of support for people with dementia and their carers (on a 1:1 basis and through group activities) from diagnosis to end of life. This includes the delivery of advice and information and emotional support.	167.6	126.4	294.0	182.4	137.6	320.0
Unified Prevention Offer	Strengthening Autism Pathway	Temporarily funds 2 FTE Team Senior posts in the Mental Health Care Pathway Team until July 2015. A contract with NAS has also been commissioned where dedicated staff are employed to raise awareness of autism across the county. Part of the contract also includes the provision of a web based Information Hub, a source of resources and help for anybody affected directly, or indirectly by autism. http://www.laih.org.uk/home-page.aspx	92.8	70.0	162.8	54.1	40.8	94.9
Unified Prevention Offer	Assistive Technology	Providing telecare and standalone equipment to c3,600 service users to support them living at home in their community to avoid admission to permanent residential care, reduce the need for more costly services and reduce hospital admissions.	560.9	423.1	984.0	567.2	427.9	995.0
Unified Prevention Offer	Assistive Technology (replacement equipment)	Links to the existing service users in housing related support where the current contracts are currently under review which may result in the need to replace/renew existing equipment.	823.4	621.1	1,444.5			
Unified Prevention Offer	Local Area Co-ordination	Supporting vulnerable people more effectively in the community to reduce reliance on public services. Based on co-ordinators being a single point of contact who identifies and supports vulnerable people before they hit crisis. Recently, Derby City have started a scheme http://www.derby.gov.uk/health-and-social-care/help-for-adults/local-area-coordination/	136.8	103.2	240.0	342.0	258.0	600.0
Unified Prevention Offer	Disabled Facilities Grants	Grants provided by District Councils to adapt homes making them suitable for disabled people.				991.2	747.8	1,739.0
			2,126.2	1,604.0	3,730.2	2,642.2	1,993.3	4,635.5
	Protection of Services:							
Unified Prevention Offer	NHS - LD Short Breaks	Services commissioned by WLCCG & ELRCCG				588.0	256.0	844.0
TOTAL PREVENTION			**2,126.2**	**1,604.0**	**3,730.2**	**3,230.2**	**2,249.3**	**5,479.5**
Long Term Conditions	Proactive Care (West Leics)	Supporting people with long term conditions and frail older people by enabling more alternatives to hospital stays delivered closer to home. Proactive care provides structured interventions those people at highest risk of adverse outcomes (admissions or crisis)	540.0		540.0	540.0		540.0
Long Term Conditions	Long Term Conditions (East)	Similar service to proactive care in West CCG as described above.		460.0	460.0		460.0	460.0
Long Term Conditions	Pathway to Housing	Project set up to support staff and service users when accessing supported living services. The team (2FTE) provide information and advice, identify housing options, ensuring packages of care are outcome based, person centred and cost effective.	41.2	31.0	72.2			
Long Term Conditions	Memory Plus Service Evaluation	Memory Plus supports professional providers of dementia care in the development and delivery of activities using museum objects, reminiscence and multi-sensory approaches. In 2013/14 funds were allocated to develop new resources and provide training, funds this year will be used to evaluate the programme to inform the future delivery of this service. http://www.leics.gov.uk/memory_plus	5.7	4.3	10.0			
Long Term Conditions	Improving Quality in Care Homes	Integrated Support Team – An integrated social care and health team to improve quality in residential care homes, responding quickly and proactively to any breaches and reducing the number of safeguarding incidents. Improving quality will enable homes to support individuals better and avoid unnecessary primary care and hospital involvement.	277.2	209.1	486.3	285.7	215.6	501.3
Long Term Conditions	IT Enablers - Data sharing, care plans, t/health & t/care	One of the conditions for the BCF is to improve data sharing between heath and social care. This allocation is to support that condition, although needs further scoping.				370.5	279.5	650.0
			864.0	704.5	1,568.5	1,196.2	955.1	2,151.3
	Protection of Services:							
Long Term Conditions	Social Care - Nursing care packages	Ongoing provision of c300 nursing care placements enabling these services users to stay outside of the acute sector.	1,707.3	1,287.9	2,995.2	1,915.5	1,445.1	3,360.6
Long Term Conditions	Social Care - Sustainable community services	To support service users' increased dependency for home care and other community based services enabling more people to remain in , or return to their homes.	835.6	630.4	1,466.0	1,069.3	806.7	1,876.0
Long Term Conditions	Social Care - Increasing demographic pressures	Provision of care packages resulting from increased demographic pressures, in particular 18-64 year old service users with increasingly complex needs and dementia in older people. This is in addition to the £21m being funded by the local authority.	992.4	748.6	1,741.0	2,612.9	1,971.1	4,584.0
Long Term Conditions	Social Care - Protection of community care packages	To maintain support levels for existing service users. This will avoid a 20% reduction in all long term support packages.				2,195.6	1,656.4	3,852.0
TOTAL LONG TERM CONDITIONS			**4,399.3**	**3,371.4**	**7,770.7**	**8,989.6**	**6,834.3**	**15,823.9**
Urgent Response	Integrated Crisis Response Service (Health & Social Care)	The long term aim of the Integrated Crisis Response Service is to provide effective short-term support at a point of crisis that will help to maintain someone in their own home, preventing admission to hospital or long-term residential care. The service will provide specialist domiciliary support coordinated with other home based support as appropriate, such as Assistive technology, I-care (meals) and Health Intermediate Care. The service will operate over 7 days, from 7.00am to 10.00pm and provides a short-term intervention for a maximum of 72 hours following referral.	592.1	446.6	1,038.7	1,140.0	860.0	2,000.0
Urgent Response	Health & Social Care Older People's Frail Service	New - consolidating a number of existing services into a rapid assessment and treatment service for frail/complex older people with the potential to offer outpatient and short stay options (e.g. up to 72 hours) which are not readily available in current models of care.	570.0	430.0	1,000.0	1,140.0	860.0	2,000.0
Urgent Response	Ambulance Falls Prevention	Joint health and social care service to prevent unnecessary conveyance to hospital for people who suffer from a fall at home	28.5	21.5	50.0	57.0	43.0	100.0
Urgent Response	Expanded Role of Primary Medical Care	New. Further work needed to develop this but initial thoughts include 7 day working (BCF condition), workforce development and proactive care gp leads.	171.0	129.0	300.0	427.5	322.5	750.0
TOTAL URGENT RESPONSE			**1,361.6**	**1,027.1**	**2,388.7**	**2,764.5**	**2,085.5**	**4,850.0**
Discharge & Reablement	HART Reablement	HART is the Council's Home Care Assessment and Reablement Team. Provides intensive support for up to 6 weeks to help service users maintain their independence in the community. Evidence shows that this type of service can reduce and/or delay the need for longer term, more costly services. http://www.leics.gov.uk/index/social_services/adults/adults_srv/support_home/rehabilitation	246.2	185.8	432.0	246.2	185.8	432.0
Discharge & Reablement	Intermediate Care	LPT's intermediate care team co-works with the County Council's HART service to support hospital discharges, prevent avoidable readmissions and reduce the risk of falls.	313.0	267.0	580.0	313.0	267.0	580.0
Discharge & Reablement	Integrated Residential Reablement	Step down service to support the discharge to assess pathway. Patients are discharged from hospital to a short tem residential care placement for up to 6 weeks where their longer term support needs are assessed. Interventions from HART and other therapies support the service users to go back to their home. The service aims to avoid unnecessary admissions to long term residential care and reduces excess bed days in the acute service. An integrated health and social care service is currently being designed.	316.9	239.1	556.0	316.9	239.1	556.0
Discharge & Reablement	Hospital to Home	A reablement service provided by the RVS for patients who leave hospital with no family/local support. Volunteers work with patients for up to 6 weeks with a range of tasks to rebuild confidence and prevent social isolation, including preparing the patient's home for return from hospital, supporting them to access community activities and befriending.	41.0	31.0	72.0	41.0	31.0	72.0
Discharge & Reablement	HART Scheduling System	A new system to plan/schedule the visits made by HART Care Assistants to make the service more effective and efficient. The costs charged to the BCF are for the initial purchase and set up of the system. Ongoing costs are funded from the savings generated.	54.2	40.9	95.0	74.1	55.9	130.0
Discharge & Reablement	Patient Transfer Minimum Data Set	During 2013/14 clinical, therapeutic and social care partners worked together to agree a minimum data set to enable the safe transfer of patients between care settings. Across LLR agreement has been reached to implement the tool currently being used electronically by South Warwickshire Foundation Trust this has delivered a three day reduction in processing time for discharging older adults, and has smoothed transitions generally across health and social care boundaries. Plans are in place to use the tool across UHL in 2014/15.	51.3	38.7	90.0			
Discharge & Reablement	Bridging Service	Service to reduce delayed transfers of care where a patient no longer has a need for acute inpatient services, but is still too ill to return home, or the support at home cannot be arranged and be in place immediately. New service that still needs to be worked up in detail.	285.0	215.0	500.0	427.5	322.5	750.0
Discharge & Reablement	Strengthening Mental Health Discharge Provision	Approved Mental Health Professionals to carry out assessments and meet increasing demands. Predominantly based in hospital and crisis teams. 6FTE	145.2	109.6	254.8	148.6	112.1	260.7
			1,452.9	1,126.9	2,579.8	1,567.4	1,213.3	2,780.7
	Protection of Services:							
Discharge & Reablement	NHS - Step Down	Services commissioned by WLCCG & ELRCCG				300.0	229.0	529.0
Discharge & Reablement	NHS - Intensive Community Service	Services commissioned by WLCCG & ELRCCG				951.0	870.0	1,821.0
Discharge & Reablement	NHS - Assertive InReach	Services commissioned by WLCCG & ELRCCG	324.3	244.7	569.0	342.0	227.0	569.0
Discharge & Reablement	NHS - Reablement	Services commissioned by WLCCG & ELRCCG				2,419.0	1,713.0	4,132.0
Discharge & Reablement	Social Care - Residential Respite	Ongoing provision of residential respite to service users to prevent carer breakdown and the need for more costly services.	423.3	319.3	742.6	423.3	319.3	742.6
Discharge & Reablement	Social Care - cost pressures linked to new models of working	Maintaining capacity in the social care pathway to support integrated methods of working. This equates to c41 FTE social care staff in hospital and locality teams.	125.4	94.6	220.0	934.8	705.2	1,640.0
TOTAL DISCHARGE & REABLEMENT			**2,325.9**	**1,785.5**	**4,111.4**	**6,937.5**	**5,276.8**	**12,214.3**
Enablers	Better Care Fund Programme Leads	Project leads for Carers, Early intervention & Prevention and Learning Disabilities	93.5	70.6	164.1	14.8	11.2	26.0
Enablers	Better Care Fund - Programme Support	Specific staff support to the overall BCF Programme	48.7	36.8	85.5	49.5	37.3	86.8
TOTAL ENABLERS			**142.3**	**107.3**	**249.6**	**64.3**	**48.5**	**112.8**
		TOTAL BETTER CARE FUND EXPENDITURE	**10,355.2**	**7,895.4**	**18,250.6**	**21,986.1**	**16,495.4**	**38,480.5**
		NOTIFIED BETTER CARE FUND ALLOCATION			**13,643.0**			**38,343.0**
		ADDITIONAL EXPENDITURE FUNDED FROM RESERVES			**4,607.6**			**137.5**

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