Better Care Fund 2021-22 Template

1. Guidance

Overview

Note on entering information into this template

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

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

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

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

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

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

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

2. Cover (click to go to sheet)

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

4. Income (click to go to sheet)

1. This sheet should be used to specify all funding contributions to the Health and Wellbeing Board's (HWB) Better Care Fund (BCF) plan and pooled budget for 2021-22. It will be pre-populated with the minimum CCG contributions to the BCF, Disabled Facilities Grant (DFG) and improved Better Care Fund (iBCF). These cannot be edited.
2. Please select whether any additional contributions to the BCF pool are being made from local authorities or the CCGs and as applicable enter the amounts in the fields highlighted in 'yellow'. These will appear as funding sources when planning expenditure. The fields for Additional contributions can be used to include any relevant carry-overs from the previous year.
3. Please use the comment boxes alongside to add any specific detail around this additional contribution including any relevant carry-overs assigned from previous years. All allocations are rounded to the nearest pound.
4. For any questions regarding the BCF funding allocations, please contact england.bettercarefundteam@nhs.net

5. Expenditure (click to go to sheet)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting and to particularly demonstrate that National Conditions 2 and 3 are met.
The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and CCG minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:
1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.
2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.
3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned.
4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important to our understanding of how BCF funding is being used and levels of investment against different priorities.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.
5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "CCG minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.
6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns.
7. Provider:
- Please select the 'Provider' commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.
8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the CCG or Local authority
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2021-22:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)
10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

This is the only detailed information on BCF schemes being collected centrally for 2021-22 and will inform the understanding of planned spend for the iBCF grant and spend from BCF sources on discharge.

6. Metrics (click to go to sheet)

This sheet should be used to set out the HWB's performance plans for each of the BCF metrics in 2021-22. The BCF requires trajectories and plans agreed for the fund's metrics. Systems should review current performance and set realistic, but stretching ambitions for the last two quarters of 2021-22.
The previous measure of Non Elective Admissions is being replaced with a measure of Unplanned Admissions for Chronic Ambulatory Care Sensitive Conditions. Performance data on this indicator up to 2019-20, by local authority can be found at:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/february-2021/domain-2-enhancing-quality-of-life-for-people-with-long-term-conditions-nof/2.3.i-unplanned-hospitalisation-for-chronic-ambulatory-care-sensitive-conditions

A data pack showing breakdowns of data for new metrics (discharge and avoidable admissions) is available on the Better Care Exchange.

For each metric, systems should include a narrative that describes:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- how BCF funded schemes and integrated care will support performance against this metric, including any new or amended services.
1. Unplanned admissions for chronic ambulatory sensitive conditions:
- This section requires the area to input a planned rate for these admissions, per hundred thousand people for the year. This is the current NHS Outcomes Framework indicator 2.3i.
- The numerator is calculated based on the expected number of unplanned admissions for ambulatory sensitive conditions during the year.
- The denominator is the local population based on Census mid year population estimates for the HWB.
- Technical definitions for the guidance can be found here:
https://files.digital.nhs.uk/A0/76B7F6/NHSOF_Domain_2_S.pdf

2. Length of Stay.
- Areas should agree ambitions for minimising the proportion of patients in acute hospital who have been an inpatient for 14 days or more and the number that have been an inpatient for 21 days or more. This metric should be expressed as a percentage of overall patients.
- The ambition should be set for the HWB area. The data for this metric is obtained from the Secondary Uses Service (SUS) database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the average percentage of inpatient beds occupied by patients with a length of stay of 14 days and over and 21 days and over for Q3 2021-22 and for Q4 2021-22 for people resident in the HWB.

- Plans should be agreed between CCGs, Local Authorities and Hospital Trusts and areas should ensure that ambitions agreed for 21 days or more are consistent across Local Trusts and BCF plans.

- The narrative should set out the approach that has been taken to agreeing and aligning plans for this metric
3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay.

- The ambition should be set for the healthand wellbeing board area. The data for this metric is obtained from the Secondary Uses Service database and is collected at hospital trust. A breakdown of data from SUS by local authority of residence has been made available on the Better Care Exchange to assist areas to set ambitions. Ambitions should be set as the percentage of all discharges where the destination of discharge is the person's usual place of residence.

4. Residential Admissions (RES) planning:
- This section requires inputting the information for the numerator of the measure.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) for the Residential Admissions numerator measure.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.
5. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health & Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2021-22 for further details.
The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.
The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

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

Better Care Fund 2021-22 Template

2. Cover

HM Government

NHS

Version 1.0

Please Note:
- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.
- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".
- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2021-22.
- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

		Checklist: Complete:
Health and Wellbeing Board:	Leicester	Yes
Completed by:	Mark Pierce	Yes
E-mail:		No
Contact number:		No

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

Job Title:	Chair of Leicester City Health & Wellbeing Board	Yes
Name:	Councillor Vi Dempster	Yes
Has this plan been signed off by the HWB at the time of submission?	Yes	Yes
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:		Yes

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:	
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair		Vi	Dempster		No
	Clinical Commissioning Group Accountable Officer (Lead)		Andy	Williams		No
	Additional Clinical Commissioning Group(s) Accountable Officers		Rachna	Vyas		No
	Local Authority Chief Executive		Alison	Greenhill		No
	Local Authority Director of Adult Social Services (or equivalent)		Ruth	Lake		No
	Better Care Fund Lead Official		Ruth	Lake		No
	LA Section 151 Officer		Colin	Sharpe		No
Please add further area contacts that you would wish to be included in official correspondence -->						Yes
						Yes
						Yes

**Only those identified will be addressed in official correspondence (such as approval letters). Please ensure all individuals are satisfied with the information entered above as this is exactly how they will appear in correspondence.*

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

Please see the Checklist below for further details on incomplete fields

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

<< Link to the Guidance sheet

Better Care Fund 2021-22 Template

3. Summary

Selected Health and Wellbeing Board: Leicester

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,714,004	£2,714,004	£0
Minimum CCG Contribution	£26,627,780	£26,627,780	£0
iBCF	£17,040,259	£17,040,259	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£46,382,043**	**£46,382,043**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£7,566,860
Planned spend	£7,567,313

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£17,144,028
Planned spend	£17,229,099

Scheme Types

Assistive Technologies and Equipment	£300,963	(0.6%)
Care Act Implementation Related Duties	£0	(0.0%)
Carers Services	£723,098	(1.6%)
Community Based Schemes	£2,878,889	(6.2%)

DFG Related Schemes	£2,714,004	(5.9%)
Enablers for Integration	£127,189	(0.3%)
High Impact Change Model for Managing Transfer of C	£3,551,165	(7.7%)
Home Care or Domiciliary Care	£30,107,069	(64.9%)
Housing Related Schemes	£222,574	(0.5%)
Integrated Care Planning and Navigation	£1,064,380	(2.3%)
Bed based intermediate Care Services	£0	(0.0%)
Reablement in a persons own home	£4,183,666	(9.0%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£115,000	(0.2%)
Prevention / Early Intervention	£358,227	(0.8%)
Residential Placements	£0	(0.0%)
Other	£35,819	(0.1%)
Total	**£46,382,043**	

Metrics >>

Avoidable admissions

	20-21 Actual	21-22 Plan
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	875.6	1,197.7

Length of Stay

21-22 Q3 Plan	21-22 Q4 Plan

Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients	LOS 14+	27.3%	32.7%
	LOS 21+	20.3%	23.9%

Discharge to normal place of residence

	0	21-22 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence	0.0%	94.4%

Residential Admissions

		20-21 Actual	21-22 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	411	557

Reablement

		21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	92.1%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	PR1	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	PR4	Yes
NC3: NHS commissioned Out of Hospital Services	PR5	Yes
NC4: Plan for improving outcomes for people being discharged from hospital	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
Metrics	PR8	Yes

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: Leicester

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Leicester	£2,714,004
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£2,714,004**

iBCF Contribution	Contribution
Leicester	£17,040,259
Total iBCF Contribution	**£17,040,259**

Are any additional LA Contributions being made in 2021-22? If yes, please detail below	No

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

Checklist

Complete:

Yes

Yes

CCG Minimum Contribution	Contribution
NHS Leicester City CCG	£26,627,780
Total Minimum CCG Contribution	**£26,627,780**

Are any additional CCG Contributions being made in 2021-22? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional CCG Contribution	**£0**	
Total CCG Contribution	**£26,627,780**	

	2021-22
Total BCF Pooled Budget	**£46,382,043**

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

Yes

Yes

Better Care Fund 2021-22 Template

5. Expenditure

Selected Health and Wellbeing Board: Leicester

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£2,714,004	£2,714,004	£0
Minimum CCG Contribution	£26,627,780	£26,627,780	£0
iBCF	£17,040,259	£17,040,259	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	**£46,382,043**	**£46,382,043**	**£0**

Required Spend

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

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£7,566,860	£7,567,313	£0
Adult Social Care services spend from the minimum CCG allocations	£17,144,028	£17,229,099	£0

Checklist

Column complete:

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

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Existing ASC Transfer	Resource for ASC provision	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Local Authority	Minimum CCG Contribution	£13,066,810	Existing
3	Carers Funding	Statutory Support for carers	Carers Services	Respite services		Social Care		LA			Local Authority	Minimum CCG Contribution	£723,098	Existing
4	Reablement funds - LA	In House ASC reablement service	Reablement in a persons own home	Reablement to support discharge - step down		Social Care		LA			Local Authority	Minimum CCG Contribution	£917,778	Existing
5	Lifestyle Hub	Culturally competent primary & secondary prevention of LTCs & Health promotion.	Prevention / Early Intervention	Other	Exercise/weight Mx/Smoking support	Community Health		CCG			Local Authority	Minimum CCG Contribution	£113,237	Existing
6	Assistive technologies	Assistive technology to support independence & reduce social isolation	Assistive Technologies and Equipment	Telecare		Social Care		LA			Local Authority	Minimum CCG Contribution	£300,963	Existing

7	Strengthening ICRS - LA	ASC 2 hr response 24/7 step up/down	Reablement in a persons own home	Rapid/Crisis Response - step up (2 hr response)		Social Care		LA			Local Authority	Minimum CCG Contribution	£1,254,390	Existing
8	Health Transfers Team - in hospital social workers	on-site social work team to facilitate timely Acute hospital discharge	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		Social Care		LA			Local Authority	Minimum CCG Contribution	£207,579	Existing
9	MH Discharge Team - Health Transfers Team - individual based in	on-site social work team to facilitate timely MH in-patient discharge	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		Social Care		LA			Local Authority	Minimum CCG Contribution	£70,965	Existing
10	IT System Integration	RA card support/ Help Desk support for ICRS/Care Navigators to	Enablers for Integration	Data Integration		Social Care		LA			NHS Community Provider	Minimum CCG Contribution	£28,606	Existing
11	Services for Complex Patients (Care Navigators)	6x Care Navigators to case-manage prevention interventions for frail & older people	Integrated Care Planning and Navigation	Care navigation and planning		Primary Care		CCG			Local Authority	Minimum CCG Contribution	£334,380	Existing
12	Discharge Home to Assess staff costs	ASC Case Managers to facilitate hospital discharge home	High Impact Change Model for Managing Transfer	Home First/Discharge to Assess - process		Social Care		LA			Local Authority	Minimum CCG Contribution	£337,753	Existing
13	H&SC Protocols - training	Training for ASC and dom care providers to undertake delegated health tasks safely	Enablers for Integration	Workforce development		Social Care		LA			NHS Community Provider	Minimum CCG Contribution	£72,996	Existing
16	Social worker for alcohol dependent people/hoarders	Specialist dedicated case management, support and service coordination for those with a hoarding disorder	Housing Related Schemes			Social Care		LA			Local Authority	Minimum CCG Contribution	£53,574	Existing
17	6m funding for change manager to support JICB	Joint funding of admin support for range of integration activities	Enablers for Integration	Joint commissioning infrastructure		Social Care		CCG			Local Authority	Minimum CCG Contribution	£25,587	New
18	The Centre Project	Day Centre and outreach support for vulnerable adults	Prevention / Early Intervention	Social Prescribing		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£23,200	Existing
19	Training for Falls Prevention	CIC provider of community strength & balance programmes for those at risk of falls	Prevention / Early Intervention	Social Prescribing		Community Health		CCG			Private Sector	Minimum CCG Contribution	£101,790	Existing

20	Hospital Housing Enablement Team	Specialist housing support to enable timely hospital discharge and NRPF cases	Housing Related Schemes			Social Care		LA			Local Authority	Minimum CCG Contribution	£169,000	Existing
21	Risk stratification	Licensing and data processing fees for risk strat programme. Sessional fees for clinical lead	Prevention / Early Intervention	Risk Stratification		Other	Licence cost for risk strat product. Additional data processing costs to CSU. GP technical lead time	CCG			Private Sector	Minimum CCG Contribution	£70,000	Existing
22	Services for Complex Patients (GP PIC/Training)	Enhanced programme of primary, community/VCS support to high-risk LTC patients	Integrated Care Planning and Navigation	Care navigation and planning		Primary Care		CCG			Private Sector	Minimum CCG Contribution	£730,000	Existing
23	Action on Deafness – Audiology and	Specialist support for those with hearing loss and Deafness	Personalised Care at Home	Mental health /wellbeing		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£35,000	Existing
24	Eye Clinic Liaison Service	Specialist support for those with sight loss & blindness	Personalised Care at Home	Physical health/wellbeing		Other	Specialist Vol Sector Support to those w/ sight loss (includes registration)	CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£50,000	Existing
25	Royal Voluntary Service	Post-discharge offer of 6 weeks of support to regain skills and confidence	Personalised Care at Home	Mental health /wellbeing		Other	Reducing readmissions through Vol Sector support to recently discharged patients	CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£30,000	Existing
26	Leicester Mammas	Voluntary sector support for breast feeding, budget management and cooking skills	Prevention / Early Intervention	Social Prescribing		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£35,000	New
27	Home Visiting Service	Skill mixed home visiting service to assess frail & older people at home	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			Private Sector	Minimum CCG Contribution	£1,352,996	Existing
28	Unscheduled Care Team	Home First	Reablement in a persons own home	Rapid/Crisis Response - step up (2 hr response)		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£555,710	Existing
29	MH Planned Care Team	Dedicated specialist MH assessment and treatment for those whose LTC management is complicated by functional MH issues	Community Based Schemes	Integrated neighbourhood services		Mental Health		CCG			NHS Mental Health Provider	Minimum CCG Contribution	£415,063	Existing
30	Care Home Therapies Team	Proactive in-reach to care homes residents to reduce risk of falls	Reablement in a persons own home	Preventing admissions to acute setting		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£155,008	Existing

31	Intensive Community Support Beds	Home First	High Impact Change Model for Managing Transfer	Home First/Discharge to Assess - process		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£1,019,910	Existing
32	Reablement	Home First	Reablement in a persons own home	Reablement to support discharge - step down		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£1,300,780	Existing
33	Additonal Community therapy	Home First	Community Based Schemes	Integrated neighbourhood services		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£1,110,830	Existing
34	IBCF	Meeting ASC needs/Reducing NHS pressures/Supporting local ASC market	Home Care or Domiciliary Care	Domiciliary care packages		Social Care		LA			Local Authority	iBCF	£17,040,259	Existing
35	Disabled Facilities Grant	Adaptations to support independence for those who meet eligibility criteria	DFG Related Schemes	Discretionary use of DFG - including small adaptations		Social Care		LA			Local Authority	DFG	£2,714,004	Existing
36	UHL fund	Hospital discharge specialist team	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£1,856,955	Existing
37	Fund Care Package costs relating to hospital discharge activity	Additional discharge coordinator in Health Transfers team	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning		Community Health		CCG			Local Authority	Minimum CCG Contribution	£58,003	New
38	Stop Smoking app developed by Public Health	Mobile phone app to support stop smoking efforts	Other		Digital support for stop smoking attempts	Community Health		CCG			Local Authority	Minimum CCG Contribution	£15,819	New
39	Dear Albert	Lived experience worker to support inclusion population	Prevention / Early Intervention	Social Prescribing		Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£15,000	New
40	Leicester Counselling Centre	Provision of counselling services including bereavement	Other		Responding to increased MH needs related to pandemic, lock down and their consequences	Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£20,000	New

2021-22 Revised Scheme types

Number	Scheme type/ services	Sub type	Description
1	Assistive Technologies and Equipment	1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
2	Care Act Implementation Related Duties	1. Carer advice and support 2. Independent Mental Health Advocacy 3. Other	Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the CCG minimum contribution to the BCF.
3	Carers Services	1. Respite services 2. Other	Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
4	Community Based Schemes	1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other	Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services shoukld be recorded under the specific scheme type 'Reablement in a person's own home'
5	DFG Related Schemes	1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other	The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate
6	Enablers for Integration	1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other	Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.

7	High Impact Change Model for Managing Transfer of Care	1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other	The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
8	Home Care or Domiciliary Care	1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other	A range of services that aim to help people live in their own homes through the provision of domiciliary care including personal care, domestic tasks, shopping, home maintenance and social activities. Home care can link with other services in the community, such as supported housing, community health services and voluntary sector services.
9	Housing Related Schemes		This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.
10	Integrated Care Planning and Navigation	1. Care navigation and planning 2. Assessment teams/joint assessment 3. Support for implementation of anticipatory care 4. Other	Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
11	Bed based intermediate Care Services	1. Step down (discharge to assess pathway-2) 2. Step up 3. Rapid/Crisis Response 4. Other	Short-term intervention to preserve the independence of people who might otherwise face unnecessarily prolonged hospital stays or avoidable admission to hospital or residential care. The care is person-centred and often delivered by a combination of professional groups. Four service models of intermediate care are: bed-based intermediate care, crisis or rapid response (including falls), home-based intermediate care, and reablement or rehabilitation. Home-based intermediate care is covered in Scheme-A and the other three models are available on the sub-types.

12	Reablement in a persons own home	1. Preventing admissions to acute setting 2. Reablement to support discharge -step down (Discharge to Assess pathway 1) 3. Rapid/Crisis Response - step up (2 hr response) 4. Reablement service accepting community and discharge referrals 5. Other	Provides support in your own home to improve your confidence and ability to live as independently as possible
13	Personalised Budgeting and Commissioning		Various person centred approaches to commissioning and budgeting, including direct payments.
14	Personalised Care at Home	1. Mental health /wellbeing 2. Physical health/wellbeing 3. Other	Schemes specifically designed to ensure that a person can continue to live at home, through the provision of health related support at home often complemented with support for home care needs or mental health needs. This could include promoting self-management/expert patient, establishment of 'home ward' for intensive period or to deliver support over the longer term to maintain independence or offer end of life care for people. Intermediate care services provide shorter term support and care interventions as opposed to the ongoing support provided in this scheme type.
15	Prevention / Early Intervention	1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other	Services or schemes where the population or identified high-risk groups are empowered and activated to live well in the holistic sense thereby helping prevent people from entering the care system in the first place. These are essentially upstream prevention initiatives to promote independence and well being.
16	Residential Placements	1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other	Residential placements provide accommodation for people with learning or physical disabilities, mental health difficulties or with sight or hearing loss, who need more intensive or specialised support than can be provided at home.
17	Other		Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Leicester

8.1 Avoidable admissions

	19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative		Checklist Complete:
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only	875.6	1,197.7	Our planned figure for 21-22 represents a 9% reduction from 19/20. Key schemes that are expected to impact as follows: •Step up Home First and ICRS response (Mostly BCF-Funded). Current demand and capacity figures show that the ICRS service could respond to an estimated 550	**Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**	Yes

>> link to NHS Digital webpage

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments		
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	27.3%	32.7%	Q3 and Q4 figures are based on previous averages with the trend on current data for Q1 and Q2 being taken into consideration. Overall we aim to reduce our overall annual figure from 19/20 by 0.41% for 14+ days (29.29%) and 0.88% reduction on our overall annual figure for 21+ days (21.58%) Key schemes that are expected to impact as follows: BCF-funded ICRS and Reablement teams supporting patients discharge home (Inc. bridging care for ASC)	**Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**	Yes
	Proportion of inpatients resident for 21 days or more	20.3%	23.9%			Yes

8.3 Discharge to normal place of residence

	21-22 Plan	Comments		
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	94.4%	This ambition has been reached via analysis of actual in year performance, projected performance and known service developments which should impact positively on the outcomes for people. The primary strategic approach is our Home First offer across social care and community services, supported via	**Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**	Yes

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	586	696	411	557	Leicester continues to focus on activity that supports people to remain in their own homes. This includes: Responsive crisis services Effective reablement services Increasing use of risk stratification and data to support targeted interventions within primary / community
	Numerator	254	300	179	250	
	Denominator	43,358	43,121	43,602	44,865	

Please set out the overall plan in the HWB area for reducing rates of admission to residential and nursing homes for people over the age of 65, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Yes

Yes

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

8.5 Reablement

		19-20 Plan	19-20 Actual	21-22 Plan	Comments
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	93.0%	90.0%	92.1%	The plan for this metric is based on a range of factors including in year activity to date, forecast activity, covid recovery plans and the development of other, supporting services. We anticipate a small improvement in the number of people still at home, due to increased capacity to accept referrals, enhanced support via
	Numerator	214	207	198	
	Denominator	230	230	215	

Please set out the overall plan in the HWB area for increasing the proportion of older people who are still at home 91 days after discharge from hospital into reablement/rehabilitation, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Yes

Yes

Yes

Please note that due to the splitting of Northamptonshire, information from previous years will not reflect the present geographies. As such, all pre-populated figures above for Northamptonshire have been combined.

For North Northamptonshire HWB and West Northamptonshire HWB, please comment on individual HWBs rather than Northamptonshire as a whole.

Better Care Fund 2021-22 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Leicester

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it	Checklist Complete:
NC1: Jointly agreed plan	PR1	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted? Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes				Yes
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes:** • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally. • The approach to collaborative commissioning • The overarching approach to support people to remain independent at home, and how BCF funding will be used to support this. • How the plan will contribute to reducing health inequalities and inequalities for people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered, - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the BCF plan will address these	Narrative plan assurance	Yes				Yes
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes				Yes

NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes				Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes				Yes
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	**Is there an agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach?**	• Does the BCF plan demonstrate an agreed approach to commissioning services to support discharge and home first including: - support for safe and timely discharge, and - implementation of home first? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? • Is there confirmation that plans for discharge have been developed and agreed with Hospital Trusts?	Narrative plan assurance Expenditure tab Narrative plan	Yes				Yes
Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 32 – 43 of Planning Requirements) (tick-box) • Has funding for the following from the CCG contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plans and confirmation sheet	Yes				Yes
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching metrics been agreed locally for all BCF metrics? • Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric, including how BCF expenditure will support performance against each metric? • Are ambitions across hospital trusts and HWBs for reducing the proportion of inpatients that have been in hospital for 21 days aligned, and is this set out in the rationale? • Have hospital trusts and HWBs developed and agreed plans jointly for reducing the proportion of inpatients that have been in hospital for 14 days or more and 21 days or more?	Metrics tab	Yes				Yes