LEICESTER CITY
HEALTH AND WELLBEING BOARD

Date: THURSDAY, 28 NOVEMBER 2019

Time: 11:00 am

Location:
MEETING ROOM G.01, GROUND FLOOR, CITY HALL,
115 CHARLES STREET, LEICESTER, LE1 1FZ

Members of the Board are summoned to attend the above meeting to consider the items of business listed overleaf.

Members of the public and the press are welcome to attend.

G. J. Carey
For Monitoring Officer

NOTE:

This meeting will be webcast live at the following link:-

http://www.leicester.public-i.tv

An archive copy of the webcast will normally be available on the Council's website within 48 hours of the meeting taking place at the following link:-

http://www.leicester.public-i.tv/core/portal/webcasts

MEMBERS OF THE BOARD

Councillors:

Councillor Vi Dempster, Assistant City Mayor, Health (Chair)

Councillor Piara Singh Clair, Deputy City Mayor, Culture, Leisure and Sport

Councillor Sarah Russell, Deputy City Mayor, Social Care and Anti-Poverty

Councillor Elly Cutkelvin, Assistant City Mayor, Education and Housing

Councillor Danny Myers, Assistant City Mayor, Policy Delivery and Communications

City Council Officers:

Steven Forbes, Strategic Director of Social Care and Education

Ivan Browne, Director Public Health

2 Vacancies

NHS Representatives:

John Adler, Chief Executive, University Hospitals of Leicester NHS Trust

Professor Azhar Farooqi, Co-Chair, Leicester City Clinical Commissioning Group

Angela Hillery, Chief Executive, Leicestershire Partnership NHS Trust

Sue Lock, Managing Director, Leicester City Clinical Commissioning Group

Dr Avi Prasad, Co-Chair, Leicester City Clinical Commissioning Group

Frances Shattock, Director of Strategic Transformation, NHS England and NHS Improvement

Healthwatch / Other Representatives:

Harsha Kotecha, Chair, Healthwatch Advisory Board, Leicester and Leicestershire

Lord Willy Bach, Leicester, Leicestershire and Rutland Police and Crime Commissioner

Chief Superintendent, Adam Streets, Head of Local Policing Directorate, Leicestershire Police

Andrew Brodie, Assistant Chief Fire Officer, Leicestershire Fire and Rescue Service

Kevan Liles, Chief Executive, Voluntary Action Leicester

Kevin Routledge, Strategic Sports Alliance Group

Mandip Rai, Director, Leicester, Leicestershire Enterprise Partnership

STANDING INVITEES: (Non-Voting Board Members)

Richard Lyne, General Manager, Leicestershire, East Midlands Ambulance Service NHS Trust

Professor Bertha Ochieng – Integrated Health and Social Care, DeMontfort University

Professor Andrew Fry – College Director of Research, Leicester University

Information for members of the public

Attending meetings and access to information

You have the right to attend formal meetings such as full Council, committee meetings, City Mayor & Executive Public Briefing and Scrutiny Commissions and see copies of agendas and minutes. On occasion however, meetings may, for reasons set out in law, need to consider some items in private.

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Braille/audio tape/translation - If you require this please contact the Democratic Support Officer (production times will depend upon equipment/facility availability).

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If you intend to film or make an audio recording of a meeting you are asked to notify the relevant Democratic Support Officer in advance of the meeting to ensure that participants can be notified in advance and consideration given to practicalities such as allocating appropriate space in the public gallery etc.

The aim of the Regulations and of the Council's policy is to encourage public interest and engagement so in recording or reporting on proceedings members of the public are asked:

- ✓ to respect the right of others to view and hear debates without interruption;
- ✓ to ensure that the sound on any device is fully muted and intrusive lighting avoided;
- ✓ where filming, to only focus on those people actively participating in the meeting;
- ✓ where filming, to (via the Chair of the meeting) ensure that those present are aware that they may be filmed and respect any requests to not be filmed.

Further information

If you have any queries about any of the above or the business to be discussed, please contact Graham Carey**, Democratic Support on (0116) 454 6356 or email graham.carey@leicester.gov.uk** or call in at City Hall, 115 Charles Street, Leicester, LE1 1FZ.

For Press Enquiries - please phone the **Communications Unit on 454 4151**

PUBLIC SESSION

AGENDA

FIRE/EMERGENCY EVACUATION

If the emergency alarm sounds, you must evacuate the building immediately by the nearest available fire exit and proceed to area outside the Ramada Encore Hotel on Charles Street as directed by Democratic Services staff. Further instructions will then be given.

1. APOLOGIES FOR ABSENCE

2. DECLARATIONS OF INTEREST

Members are asked to declare any interests they may have in the business to be discussed at the meeting.

3. MINUTES OF THE PREVIOUS MEETING **Appendix A (Pages 1 - 4)**

The Minutes of the previous meeting of the Board held on 19 September 2019 are attached and the Board is asked to confirm them as a correct record.

4. HEALTHY AGEING **Appendix B (Pages 5 - 10)**

To note that the theme of the meeting is Healthy Ageing, one of the five themes within the Joint Health and Wellbeing Strategy.

The objectives of the theme are to:-

1. Support older people to have good wellbeing and feel safe in their own homes.
2. Support informal carers to continue to care and improve their health and wellbeing.
3. Support older people to utilise and engage with their local communities.
4. Support older people to manage and protect their health and wellbeing.

The Director of Public Health will give a presentation to introduce the theme.

5. THE CHALLENGES POSED BY MULTI-MORBIDITY AND THE IMPACT OF SOCIAL ISOLATION **Appendix C (Pages 11 - 26)**

Mark Pierce, Senior Strategy and Implementation Manager, Leicester City Clinical Commissioning Group and Jeremey Bennett, Strategy and Implementation Manager, Leicester City Clinical Commissioning Group to give a presentation on an overview of multi-morbidity in Leicester.

6. LONELINESS PRESCRIPTION SERVICE

Appendix D (Pages 27 - 36)

Troy Young, Assistant Director, Age UK Leicester Shire and Rutland to give a presentation on the Loneliness Prescription Service.

7. HEALTHY AGEING

Appendix E (Pages 37 - 48)

Kate Galoppi, Head of Commissioning, Social Care and Education, Leicester City Council and Ruth Rigby, Programme Lead, Leicester Ageing Together to give a presentation on a 12-month pilot that is taking place in 2 parts of the City using a community connector model, and utilising Social Value to connect isolated or lonely adults to activities and support within their communities.

8. STEADY STEPS

Appendix F (Pages 49 - 62)

Lucy Baginskis (Leicester-Shire & Rutland Sport) to give a presentation on the Steady Steps Programme (Falls Management Exercise) which aims to provide an opportunity for older people at risk of falling to increase their strength and balance and thus reduce their falls risk.

9. BETTER CARE FUND PLAN 2019-20

Appendix G (Pages 63 - 96)

Mark Pierce, Senior Strategy and Implementation Manager, Leicester City Clinical Commission Group and Ruth Lake, Director, Adult Social Care and Safeguarding, Leicester City Council to submit a report on the Better Care Fund Plan 2019-20.

The Plan was required to be submitted between scheduled meetings of the Board, with the approval of the Chair of the Board. A narrative report giving details of the plan which is currently awaiting final government approval is attached.

Please note that pages 82-90 have no detail of expenditure in them, but these pages could not be removed as the original document is password protected.

The Board is requested to note the submission of the Plan.

10. QUESTIONS FROM MEMBERS OF THE PUBLIC

The Chair to invite questions from members of the public.

11. DATES OF FUTURE MEETINGS

To note that future meetings of the Board will be held on the following dates:-

Thursday 27 February 2020 – 11.00 am
Thursday 30 April 2020 – 11.00 am

Meetings of the Board are scheduled to be held in Meeting Rooms G01 and 2 at City Hall unless stated otherwise on the agenda for the meeting.

12. ANY OTHER URGENT BUSINESS

Leicester
City Council

Minutes of the Meeting of the
HEALTH AND WELLBEING BOARD

Held: THURSDAY, 19 SEPTEMBER 2019 at 11:00 am

Present:

Councillor Dempster (Chair)	–	Assistant City Mayor, Health, Leicester City Council.
Lord Willy Bach	–	Leicestershire and Rutland Police and Crime Commissioner.
Rebecca Brown	–	Chief Operating Officer, University Hospitals of Leicester NHS Trust.
Ivan Browne	–	Director of Public Health, Leicester City Council.
Harsha Kotecha	–	Chair, Healthwatch Advisory Board, Leicester and Leicestershire
Councillor Piara Singh Clair	–	Deputy City Mayor, Culture, Leisure and Sport, Leicester City Council.
Inspector Jim Smallman	–	Local Policing Directorate, Leicestershire Police.

In Attendance

Graham Carey	–	Democratic Services, Leicester City Council.

* * * * * * * *

15. APOLOGIES FOR ABSENCE

Apologies for absence were received from:-

John Adler	Chief Executive, University Hospitals of Leicester NHS Trust
Andrew Brodie	Assistant Chief Fire Officer, Leicestershire Fire and Rescue Service

Councillor Elly Cutkelvin	Assistant City Mayor Education and Housing
Professor Azhar Farooqi	Co-Chair, Leicester City Clinical Commissioning Group
Steven Forbes	Strategic Director of Social Care and Education, Leicester City Council
Dr Avi Prasad	Co-Chair, Leicester City Clinical Commissioning Group
Councillor Sarah Russell	Deputy City Mayor Social Care and anti-Poverty
Chief Supt Adam Street	Head of Local Policing Directorate, Leicestershire Police

16. DECLARATIONS OF INTEREST

Members were asked to declare any interests they may have in the business to be discussed at the meeting. No such declarations were received.

17. MINUTES OF THE PREVIOUS MEETING

RESOLVED:

The Minutes of the previous meeting of the Board held on 27 June 2019 be confirmed as a correct record.

18. HEALTHY AGEING

The Chair thanked Board members present and those officers who had attended the meeting to make presentations to the Board on a number of aspects in relation to ageing. She commented that whilst the Board was quorate, there was no representation from the Leicester City CCG, Leicester Partnership Trust or GPs and she felt that they had important roles to play in addressing healthy ageing.

The Chair further commented that the Board was not simply an opportunity to share information, but it had an important strategic role to consider what all providers of health services were doing to address issues affecting aspects of health and what else should be done to improve outcomes for citizens relating to the issues considered.

As a number of key stakeholders on the Board were not represented at the meeting, the Chair felt that it would not be worthwhile for those present to

receive the presentations as they would only need to be repeated to those not present in order for all key partners to discuss the issues raised.

The Chair asked officers to re-arrange the meeting as a matter of urgency and before the next scheduled meeting of the Board in November to enable the presentations to made all key stakeholders on the Board.

RESOLVED:

That consideration of the presentations intended for this meeting be deferred until a re-arranged meeting as suggested by the Chair above.

19. QUESTIONS FROM MEMBERS OF THE PUBLIC

There were no questions from members of the public present at the meeting.

20. DATES OF FUTURE MEETINGS

The Board noted that future meetings of the Board would be held on the following dates:-

Thursday 28 November 2019 – 11.00 am
Thursday 27 February 2020 – 11.00am
Thursday 30 April 2020 – 11.00 am

Meetings of the Board were scheduled to be held in Meeting Rooms G01 and 2 at City Hall unless stated otherwise on the agenda for the meeting.

21. CLOSE OF MEETING

The Chair declared the meeting closed at 11.12 am.

‘Healthy Ageing ’
The Joint Health and Wellbeing Strategy 2019- 2024

Appendix B

Presentation to Leicester City
Health and Wellbeing Board
28th November 2019

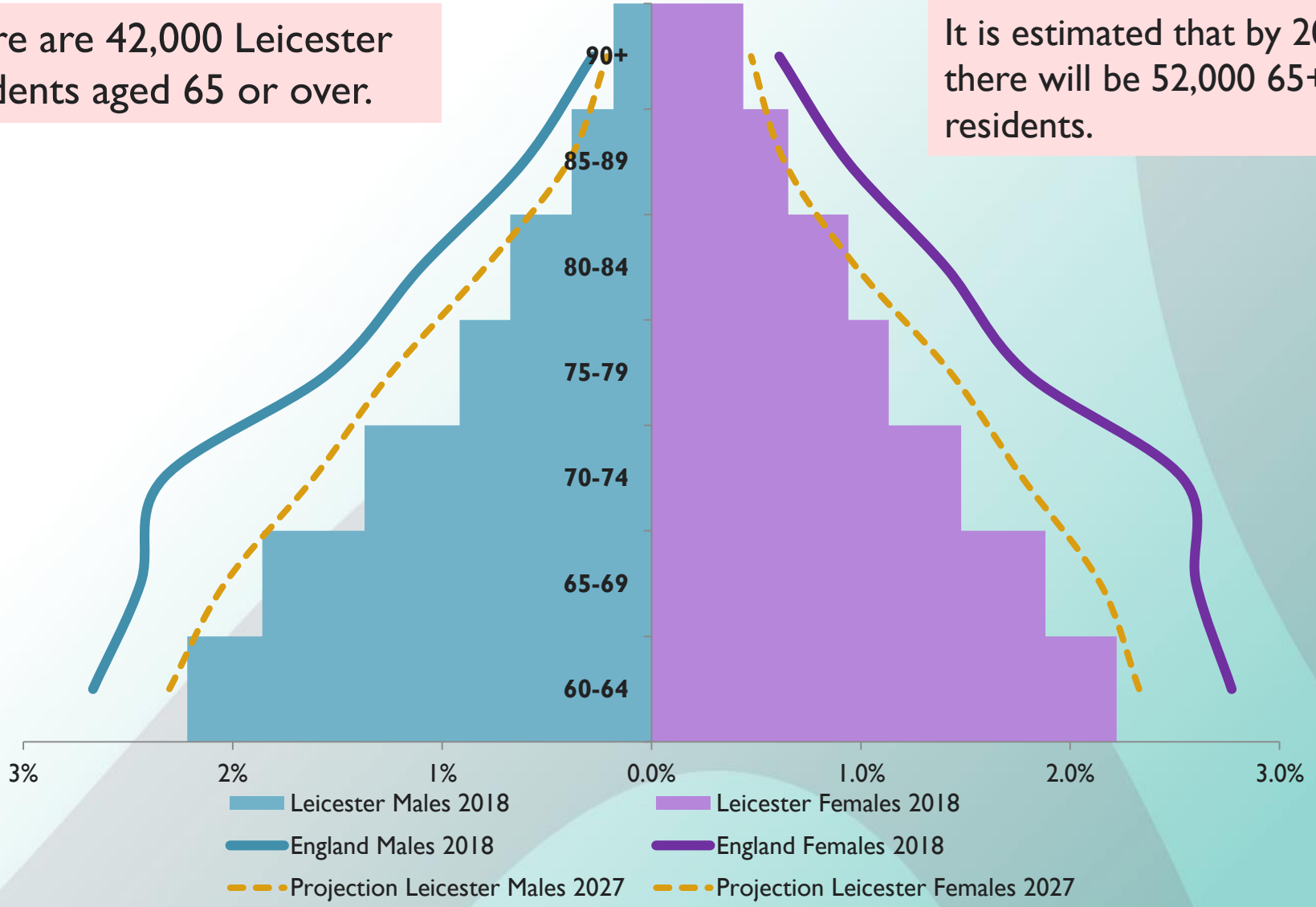
Ivan Browne – Director of Public Health

Leicester City Council

Healthy Ageing in Leicester

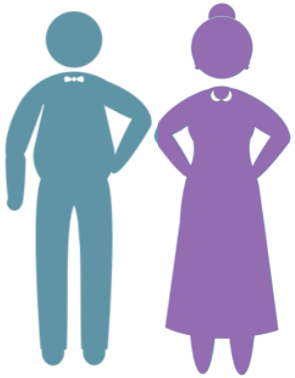
There are 42,000 Leicester residents aged 65 or over.

It is estimated that by 2027 there will be 52,000 65+ residents.



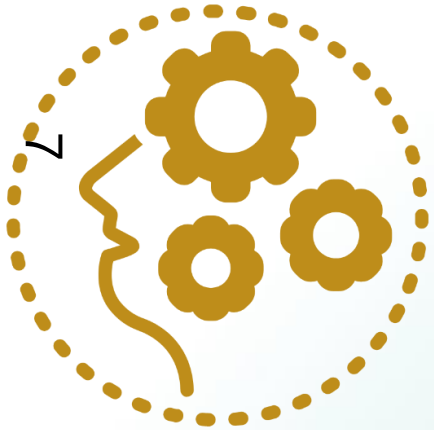
Source: ONS mid year estimates 2018

Healthy Ageing: An overview



Leicester **men** are expected to live 17 years in poor health, compared to 16 for the average man in England.

Leicester **women** are expected to live 23 years in poor health, compared to 19 for the average woman in England.



It is estimated that **12.7%** of Leicester residents aged 65+ have a **common mental health disorder** such as depression.

About 2,500 or 5.5% of 65+ Leicester residents are recorded with dementia.

Local surveys show that **12%** of those aged 65+ **currently smoke** compared to 20% for Leicester overall.

About half of those aged 65 and over are not completing the recommended amount of exercise.

Healthy Ageing: Key Issues

Physical Health (lifestyle factors)	Social Health (environmental factors)	Mental Health
The onset or progress of some health related conditions can be influenced by lifestyle factors, with those aged 65+ being less likely to undertake the recommended amount of exercise, and more likely to be overweight or obese and drink above recommendations.	For some older people living in Leicester it is more difficult to travel independently and/or access facilities. This leaves them at risk of social isolation and loneliness.	An increasing number of people aged 65+ feel socially isolated and lonely. However those aged 65+ generally report a higher state of mental wellbeing than people under 65. The risk of developing dementia is also higher for people in this age group.

ACTIONS

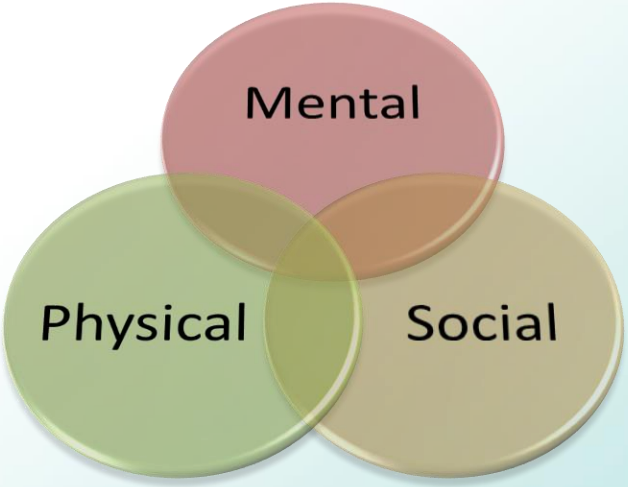
Managing dementia in the community – we are creating 'dementia friendly' public spaces

Working towards managing the health of multi-morbid older people- working with partners to signpost and refer people to relevant lifestyle services and supporting the NHS to deliver the frailty pathway

Empowering older people to live independent lives for longer – we are encouraging older people to practice self-care and independence

The Joint Health and Wellbeing Strategy and Action Plan

Ambition: *'To enable Leicester's residents to age comfortably and confidently'*



Aims:

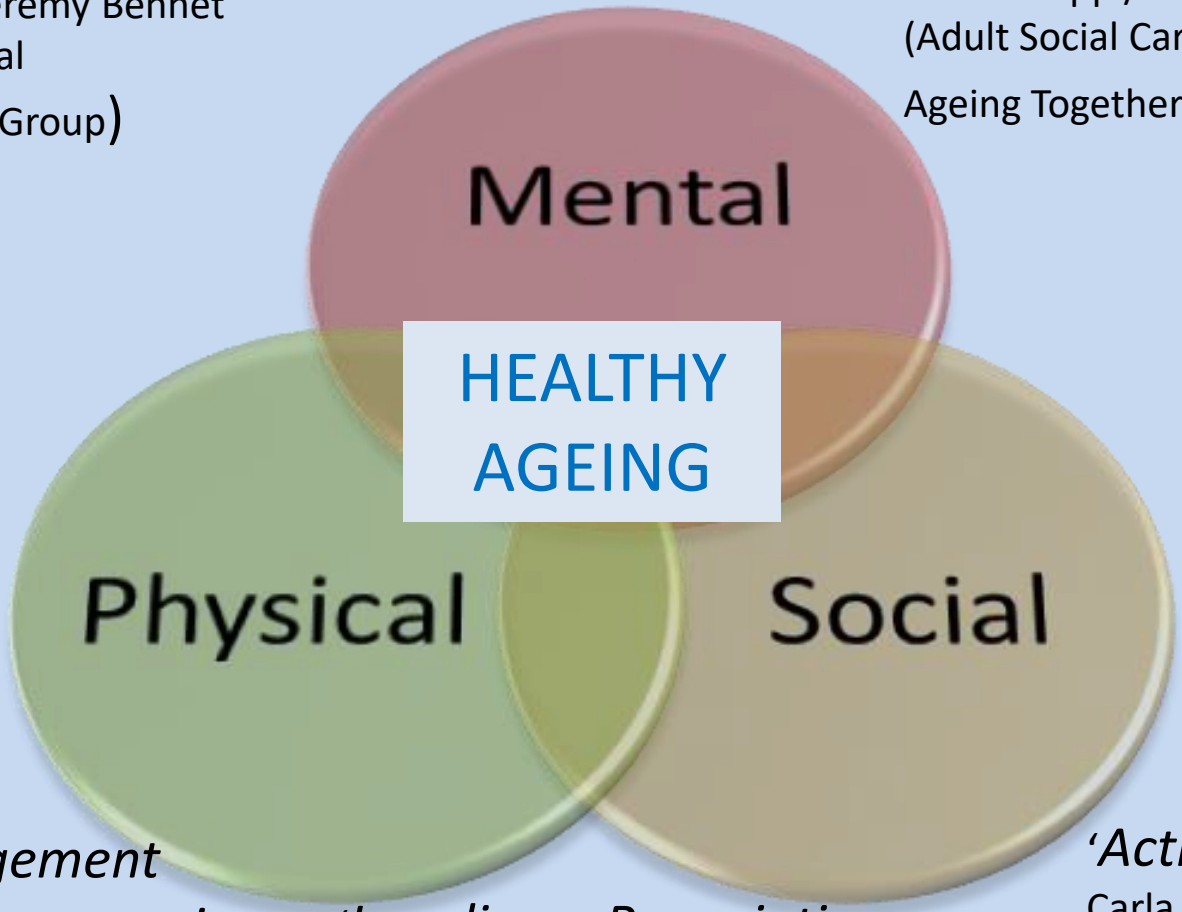
1. Support older people to have good wellbeing and feel safe in their own homes
2. Support informal carers to continue to care and improve their health and wellbeing
3. Support older people to utilise and engage with their local communities
4. Support older people to manage and protect their health and wellbeing

Leicester City Council

Todays meeting topics …

'Multi-morbidity social isolation and loneliness'
Mark Pierce / Jeremy Bennet (Leicester Clinical Commissioning Group)

'Social Value Project'
Kate Galoppi/ Ruth Rigby (Adult Social Care/ Leicester Ageing Together)



'Falls Management Exercise Programme'
TBC

'Loneliness Prescription Service'
Troy Young (Age UK)

'Active Lifestyles'
Carla Broadbent/ Harpreet Sohal
Leicester City Council

Appendix C

LEICESTER CITY HEALTH AND WELLBEING BOARD

Theme of Meeting	Healthy Aging
Title:	The challenges posed by multi-morbidity and the impact of social isolation
Presented to the Health and Wellbeing Board by:	Mark Pierce Senior Strategy and Implementation Manager Leicester City Clinical Commissioning Group Jeremey Bennett Strategy and Implementation Manager Leicester City Clinical Commissioning Group
Date:	**28th November 2019**

EXECUTIVE SUMMARY:

Multi-morbidity is commonly defined as the presence of two or more chronic medical conditions in an individual and it can present several challenges in care particularly with higher numbers of coexisting conditions and related polypharmacy. Nationally and locally initiatives are being delivered to begin addressing these challenges.

Social Isolation is similarly a growing concern, and it does not immediately appear as an issue that is in the NHS gift to address. However it it's increasingly being seen that addressing it, there is a positive impact on a person's ability to keep well. Age UK, in partnership with the CCG and Public Health; have developed a service to tackle loneliness that has already seen significant levels of referrals from City GP Practices.

Contributing to the objectives of the Joint Health and Wellbeing Strategy:

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to: Note the paper

Background Information:

Introduction

Multi-morbidity refers to people having more than one illness at the same time. We know that seventeen million people in the UK have a chronic illness and that many of these people have at least two illnesses.

The size of the challenge:

Recent analysis by the Health Foundation highlights the scale of the challenge, revealing that one-in-four adults in England are now living with two or more health conditions, which are around 14.2 million people in total[1]. Half of all primary and secondary care consultations and admissions are for multi-morbid patients.

The number of people living with multiple health conditions is expected to rise significantly over the time frame of the long term plan, with both projected hospital activity and costs up by 14% and £4bn over the next five years respectively.

However, multi-morbidity is not just a problem of ageing.

Nearly a third (30%) of people with 4+ conditions are under 65, and this is higher in deprived areas. For patients, the impact of living with multi-morbidity can be profound. People with multiple health conditions have poorer quality of life, difficulties with everyday activities and a greater risk of premature death.

The nature of the challenge[2]:

1. Increasing multi-morbidity is associated with higher costs and use of the healthcare system
2. Multi-morbidity is often associated with disability and the progressive need for support with activities of daily living.
3. Multi-morbidity is the norm.
4. Multi-morbidity, more than age, drives emergency admission costs.
5. Multi-morbidity is distributed throughout the population and does not just occur in the elderly.

[1] https://www.health.org.uk/publications/understanding-the-health-care-needs-of-people-with-multiple-health-conditions

[2] These points will be expanded using the attached slides

6. Not All Patients with a Particular Long Term Condition (LTC) are the Same

Addressing multi-morbidity:

There are a number of changes being made locally to begin addressing some of the issues presented by multi-morbidity, examples include:

- *Being more person centred* :

The NHS Long term plan recommended making personalised care available to more patients, widening access to social prescribing, and improving coordination of care and links with social care. Leicester City CCG, along with partners in the social care sector is working to develop a more integrated system of care.

- *Planning and data sharing*

A well thought out collaborative planning process is crucial for people with multi-morbidity. This identifies what's most important to people. It is equally important to share (where appropriate) and keep readily available and regularly updated documentation of the outcomes of discussions and decisions made. The enhanced summary care (eSCR) record can help coordinate across care settings (including Secondary care and Ambulance crews) by enabling the sharing of key information, subject to patients' explicit consent.[3]

- *Addressing Frailty* :

Frailty can predate crisis by a decade or more[4] and many people with frailty also have multi-morbidity. The electronic Frailty Index (or eFI),uses existing coded data from the electronic primary care record to identify frailty in people aged 65 years or over.

- *Planning for Integrated care (PIC) in General Practice*

The PIC GP scheme in Leicester aims of this scheme is to improve the quality of care, the quality of patient and carer experience as well as improve the clinical outcomes for patients with frailty and/or multi-morbidity and/or predicted high cost and/or those with none of the above but whom are in need to extra input to help them manage their long term condition.

[3] https://digital.nhs.uk/services/summary-care-records-scr/summary-care-records-scr-information-for-patients
[4] https://www.england.nhs.uk/blog/martin-vernon-2/

Tackling Loneliness.

In the last few years loneliness has been identified as a significant public health challenge.

Three quarters of GPs surveyed say they see 1 to 5 people a day who are suffering from loneliness has been linked to conditions such as heart disease, strokes and Alzheimer's. 200,000 older people haven't had a conversation with a friend or relative in the past month.

The number of over 50s suffering from loneliness is set to reach 2 million by 2025/6. This amounts to a 49% increase in 10 years[5]

In Leicester's Health and Well-being survey (2018) it was reported that around one in ten residents feel lonely or isolated often or all of the time. In addition, it was found that 7% of over 65s feel this way and 30% of our sick and disabled residents feel lonely.

In October 2018 the government launched its policy paper, "A Connected Society: A Strategy for Tackling Loneliness"[6]. In this paper, it was recommended that the NHS tackle loneliness by developing Social prescribing schemes. Social prescribing is also a part of the NHS Long term plan and the Primary Care Network model.

NHS England estimates that 60% of Clinical Commissioning Groups have already commissioned some form of social prescribing scheme and is currently compiling evidence and developing a common outcome framework for use by CCGs.

Leicester City CCG is in discussion with Public Health, local VSCE and PCNs about how to develop a city wide Social Prescribing model that builds on existing services.

An example of an existing service is the Loneliness prescription service delivered by Age UK [7]

The Loneliness prescription service

Leicester Aging Together[8] (LAT) is part of Ageing Better, a programme set up by The National Lottery Community Fund. The programme is focused in 5 city wards: Belgrave, Evington, Thurncourt, Spinney Hills and Wycliffe. These were selected because of the prevalence of risk factors associated with social isolation which have been identified by older people

[5] https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/loneliness/loneliness-report.pdf
[6] https://www.gov.uk/government/publications/a-connected-society-a-strategy-for-tackling-loneliness
[7] https://www.ageuk.org.uk/bp-assets/globalassets/leicester-shire--rutland/original-blocks/our-services/our-leaflets-and-guides/aulsr-guides/2019/loneliness-prescription-service---jan-19.pdf
[8] https://www.leicesterageingtogether.org.uk/

One of the partner agencies in LAT, Age UK, developed a Loneliness Prescription service. This proved to be successful with GPs in the selected areas, consequently Age UK have expanded their offer to cover the entire city.

City CCG and Public Health have worked with Age UK to refine the service, to ensure that it engages well with current services and that referrals reflect need as closely a possible . To date, the service has delivered some interesting results.

Activity for quarter one of this service is detailed below:

Referrals From	Number	Percentage
Care Navigators	71	80.68%
GP or Pharmacy	14	15.91%
Other Health Source	3	3.41%
	88	100.00%

Fig1: age UK Loneliness prescription service - referral activity Q1 2019/20

Self-reported condition	Number
Physical disability	48
Mental health condition	4
Dementia	3
Learning disability	0
None / not yet asked	33

Fig2: age UK Loneliness prescription service - referred patients self-reported conditions Q1 2019/20

Referrals To:	Number
Caring for Carers	15
Telephone Befriending	14
Mentoring	9
I & A	8
Leicester Charity Link	7
LCC (Adult Social Care) / (OT)	7
Lunch Clubs	4
Social Groups	3
Vista	2
MacMillan	1
Digital Champions	1
Call-in-Time	1
Dial-a-ride	1
Total	73

Fig1: age UK Loneliness prescription service - onward referrals from Age UK Loneliness prescription service Q1 2019/20

Indicative of the level of need is that fact the age UK have already exceeded their GP referral target of 160 for 2019/20. However, there are a number of reasons to find this an encouraging development;

1. GP practices are acknowledging that there is a problem, and
2. that they are comfortable in referring to this service as a part of addressing that.
3. Because the referrals are predominantly via the Care Navigators, this increased the chances of the individual getting an holistic assessment and being linked up with other statuary and non-statutory services, this maximises support and can further reduce isolation

Coverage is not universal yet and not all CCG practices are referring, but the CCG is working with practices to encourage them to refer into the service and the CCG and Public Health will continue to support the service and monitor activity.

The implications of the activity and type of onward referrals made by Age UK will be used to inform future strategy.

Multi-morbidity in Leicester an overview

Jeremy Bennet/ Mark Pierce

Leicester Clinical Commissioning Group

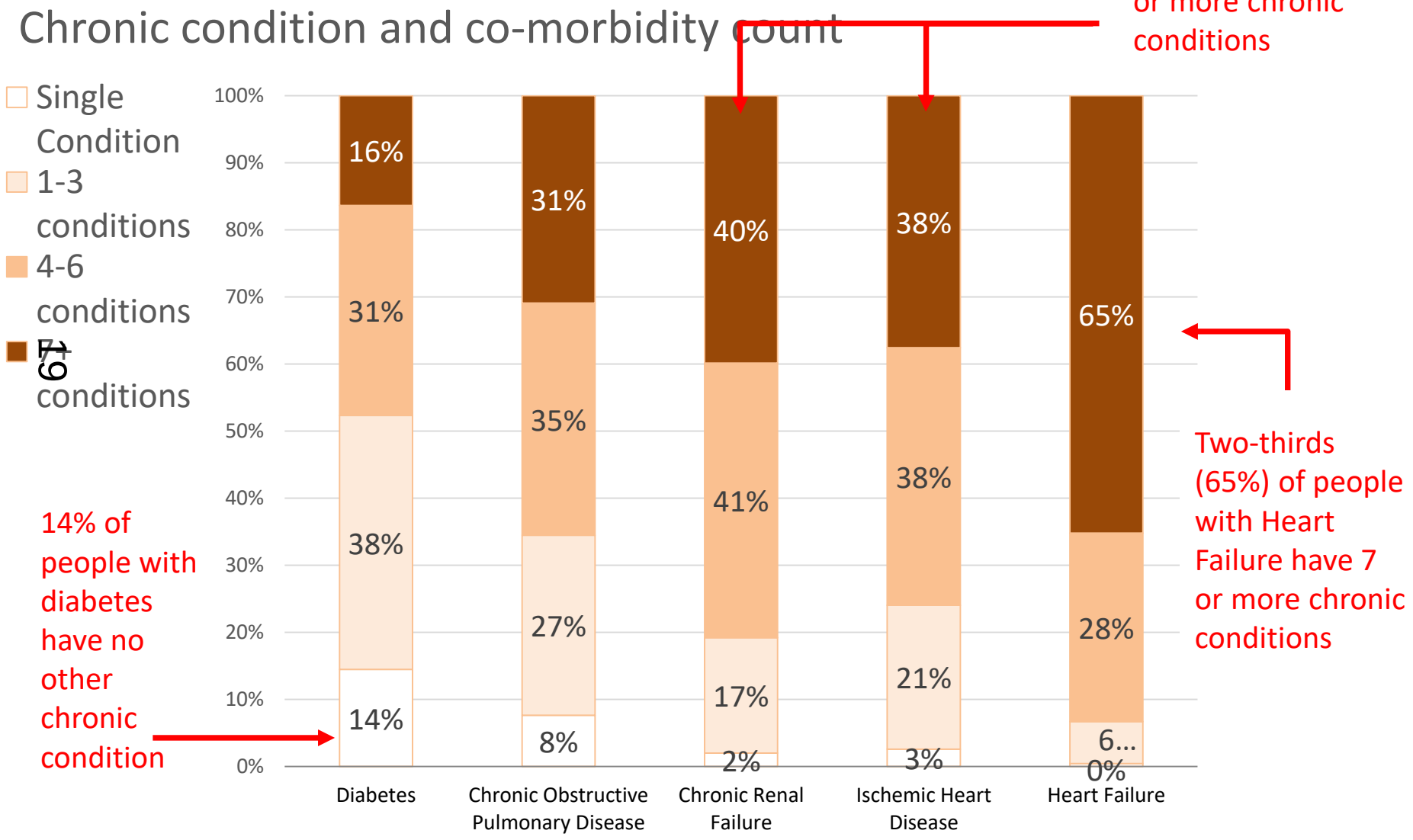
28th November 2019

Multimorbidity Drives Cost

Increasing multimorbidity is associated with higher costs and resource use:

			Average (mean)								
LTC Count	Number of patients	% of patients	Emergency admissions	Elective Admissions	A&E attendances	Outpatient attendances	Total APC cost	Emergency admission cost	Unique Prescription types	Risk of Emergency Admission	Risk of Persistent High Cost
0	250,269	61.7%	0.0	0.0	0.3	0.4	£ 50.55	£ 34.56	1.0	6%	1%
1	69,065	17.0%	0.1	0.1	0.4	1.1	£ 169.42	£ 90.81	2.8	12%	3%
2	32,849	8.1%	0.1	0.2	0.4	1.8	£ 301.89	£ 138.95	4.8	17%	7%
3	19,067	4.7%	0.2	0.3	0.5	2.4	£ 490.95	£ 214.77	6.7	22%	13%
4	12,041	3.0%	0.2	0.4	0.5	3.0	£ 664.20	£ 310.83	8.3	27%	20%
5	7,739	1.9%	0.4	0.5	0.7	3.8	£ 995.25	£ 483.40	9.9	33%	29%
6	4,893	1.2%	0.5	0.7	0.7	4.5	£ 1,318.20	£ 702.84	11.3	39%	37%
7	3,289	0.8%	0.7	0.8	0.9	5.3	£ 1,867.63	£ 1,108.36	12.5	46%	45%
8+	6,452	1.6%	1.4	1.0	1.6	6.9	£ 3,795.74	£ 2,716.70	15.1	61%	61%
Total	405,664	100%	0.1	0.1	0.3	1.1	£ 237.66	£ 137.25	2.7	11%	5%

Multimorbidity is the norm…
…and varies by condition type



Two-fifths (c.40%) of people with CRF or with IHD have 7 or more chronic conditions

Two-thirds (65%) of people with Heart Failure have 7 or more chronic conditions

14% of people with diabetes have no other chronic condition

Multimorbidity Drives Cost – adults

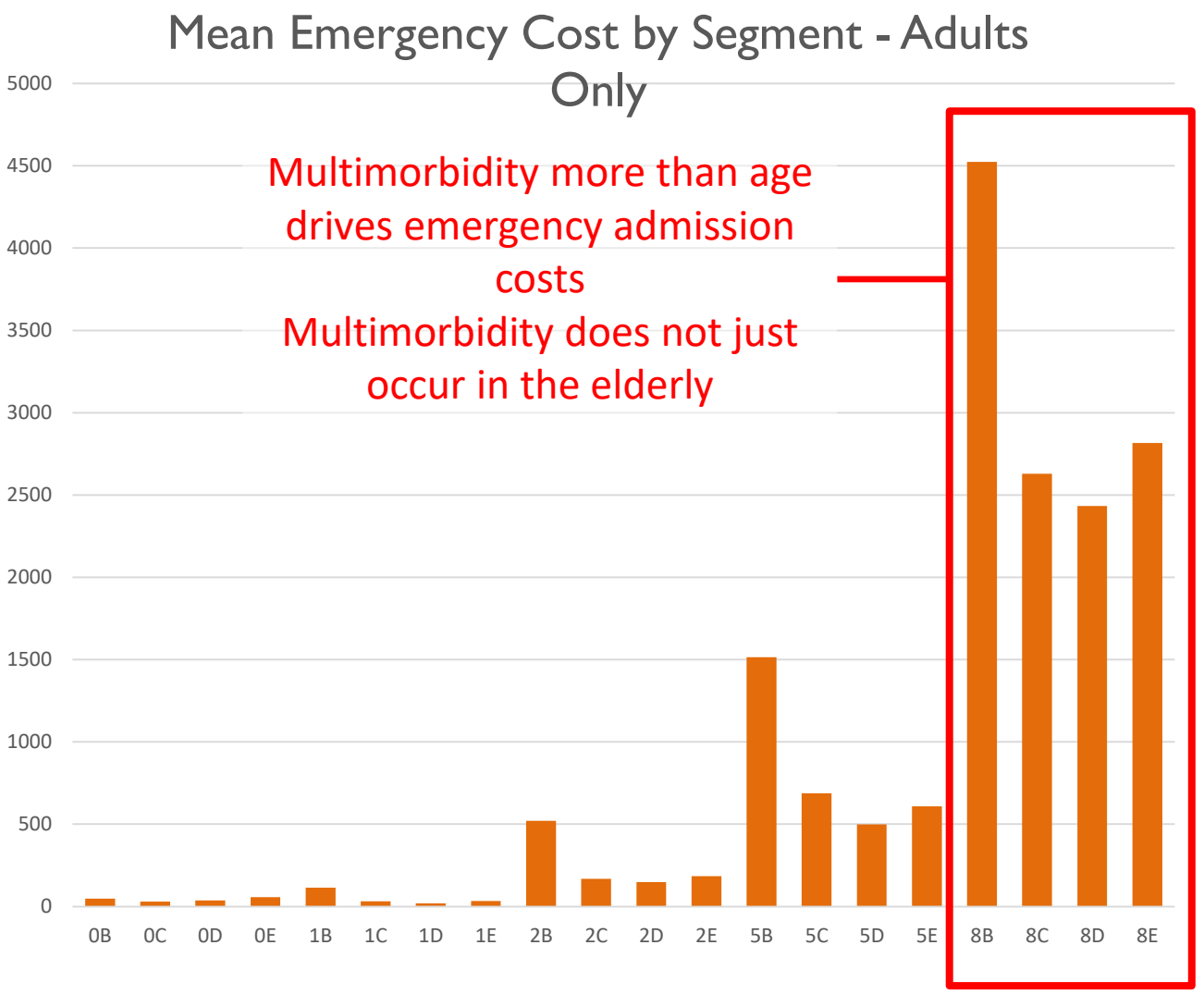
Segments created by combining age of patient and the number of chronic conditions they have:

Number denotes number of chronic conditions:

- 0 = 0
- 1 = 1
- 2 = 2 to 4
- 5 = 5 to 7
- 8 = 8 or more

Letter denotes age band:

- A = 0-17
- B = 18-44
- C = 45-64
- D = 65-79
- E = 80+



Not All Patients with a Particular LTC are the Same

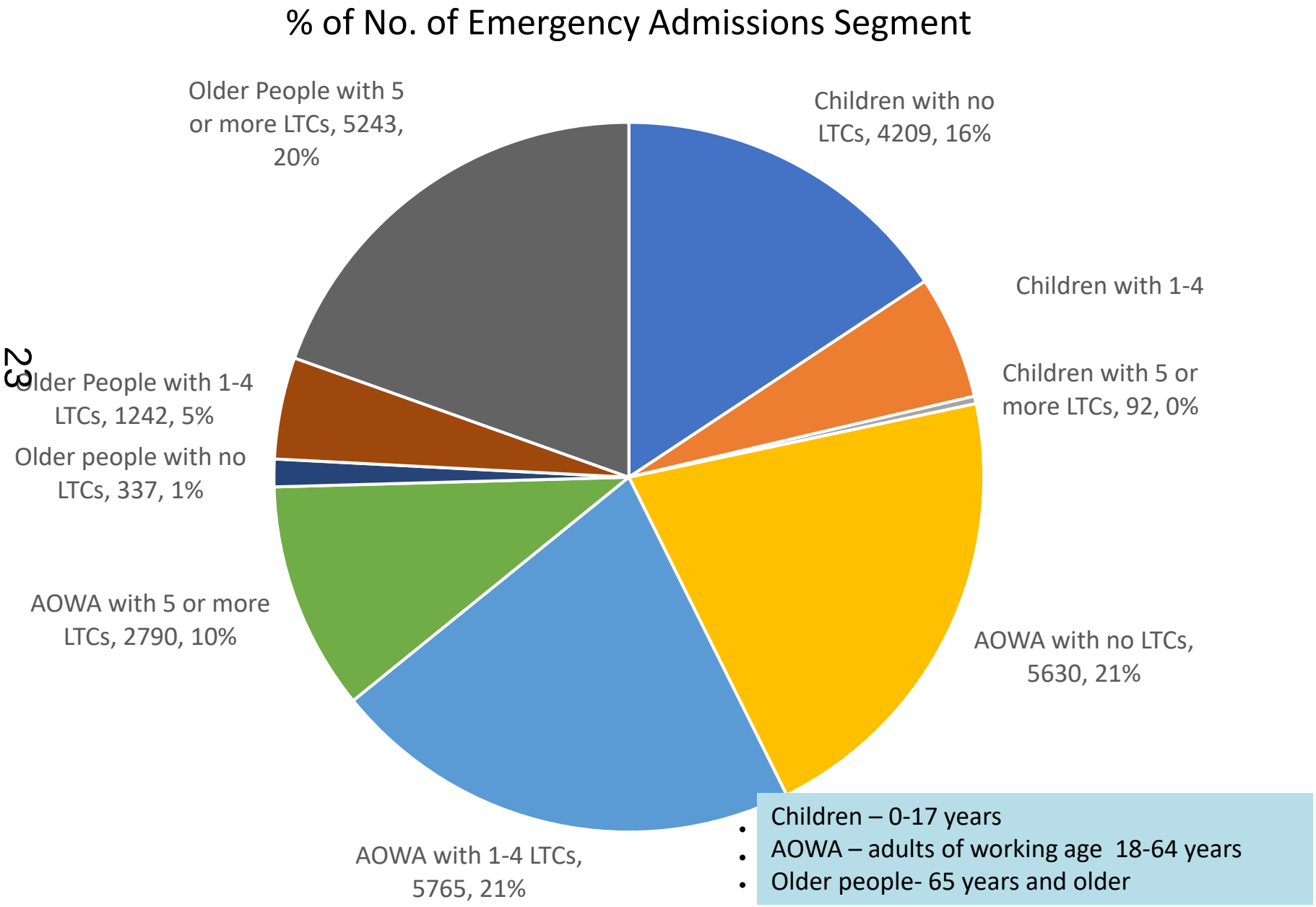
Diabetes & multimorbidity:

			Average (mean values)								
	Number of patients	% of patients	A&E attendances	Outpatient attendances	Elective Admissions	Emergency admissions	Total APC cost	Emergency admission cost	Unique Prescription types	Risk of Persistent High Cost	Risk of Emergency Admission
Diabetes only	4,391	14.5%	0.3	1.3	0.0	0.0	£ 66	£ 40	4.2	5%	13%
Diabetes + 1 other LTC	6,021	19.8%	0.2	1.4	0.1	0.0	£ 103	£ 45	6.0	8%	15%
Diabetes + 2 other LTC	5,462	18.0%	0.3	1.9	0.2	0.1	£ 215	£ 94	7.8	13%	19%
Diabetes + 3 other LTC	4,198	13.8%	0.4	2.6	0.2	0.1	£ 355	£ 157	9.6	21%	24%
Diabetes + 4 other LTC	3,184	10.5%	0.5	3.3	0.4	0.2	£ 602	£ 270	10.8	29%	30%
Diabetes + 5 other LTC	2,116	7.0%	0.5	4.2	0.5	0.3	£ 893	£ 421	12.2	37%	36%
Diabetes + 6 other LTC	1,535	5.1%	0.8	5.0	0.6	0.5	£ 1,384	£ 859	13.7	46%	44%
Diabetes + 7 other LTC	1,085	3.6%	0.9	5.6	0.8	0.7	£ 2,104	£ 1,211	14.4	54%	50%
Diabetes + 8 or more LTC	2,344	7.7%	1.7	7.6	1.0	1.6	£ 4,133	£ 3,085	17.1	70%	65%
Total	30,337	100%	0.5	2.9	0.3	0.3	£ 708	£ 436	9.0	23%	26%

Long Term Condition Count by Age Band

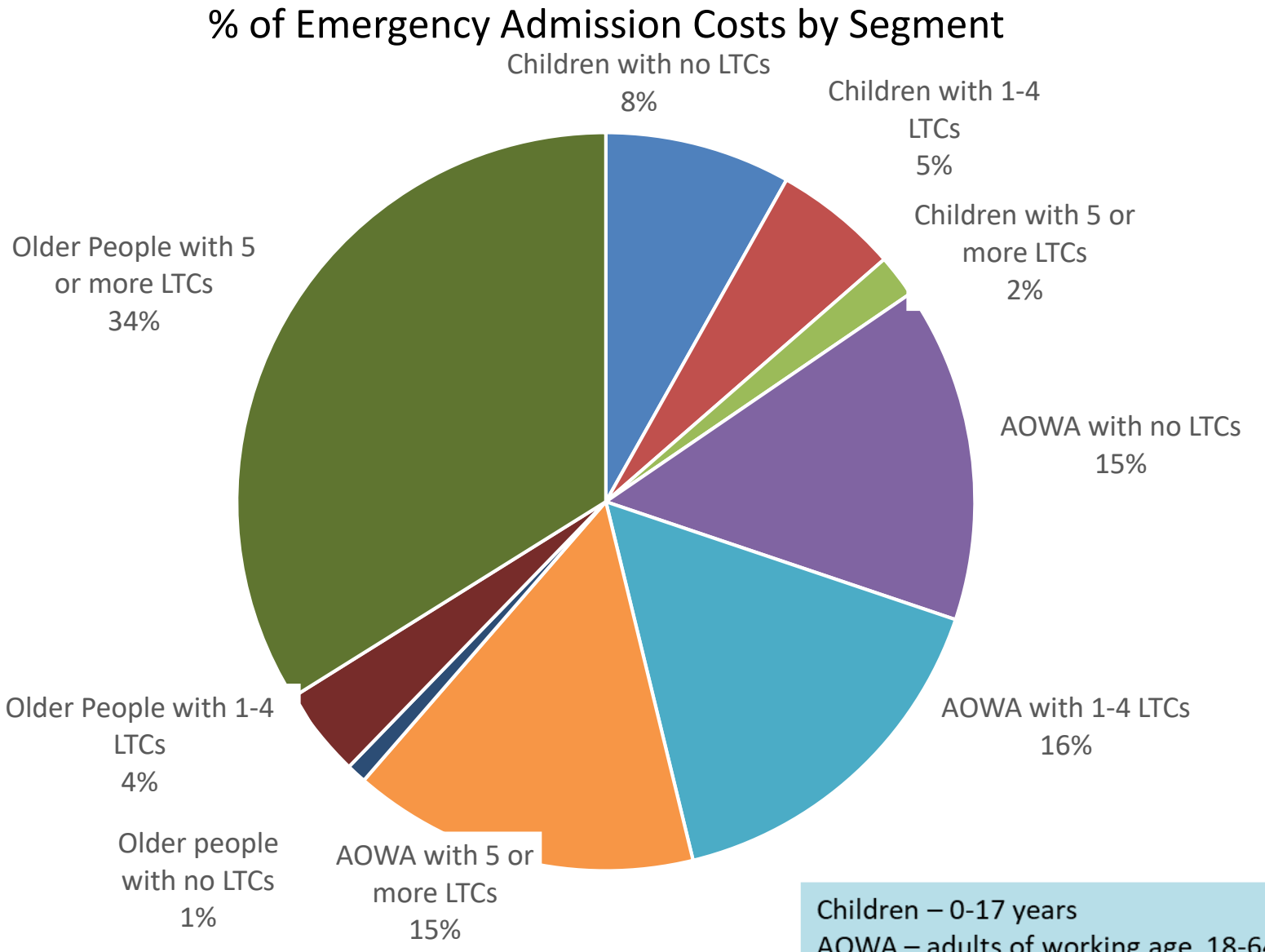
LTC Count	Age Band 00-04	05-11	12-17	18-34	35-44	45-54	55-64	65-69	70-74	75-79	80-84	85+	Total	% of Total
0	21,104	33,189	24,231	95,219	39,310	22,200	10,260	2,144	1,213	595	365	439	250,269	61.7%
1	2,301	4,200	3,755	18,766	12,142	12,395	9,395	2,614	1,640	879	555	423	69,065	17.0%
2	343	686	660	5,307	4,411	6,712	7,443	2,879	1,962	1,107	753	586	32,849	8.1%
3	88	162	175	1,766	1,724	3,281	4,933	2,316	1,798	1,294	827	703	19,067	4.7%
4	36	59	59	641	740	1,694	2,951	1,658	1,475	1,088	822	818	12,041	3.0%
5	13	36	17	265	327	802	1,659	1,113	1,046	916	791	754	7,739	1.9%
6	13	12	9	99	151	405	986	705	658	648	583	624	4,893	1.2%
7	6	3	9	63	73	217	539	404	457	472	495	551	3,289	0.8%
8+	4	12	9	68	95	302	865	711	871	1,030	1,109	1,376	6,452	1.6%
Total	23,908	38,359	28,924	122,194	58,973	48,008	39,031	14,544	11,120	8,029	6,300	6,274	405,664	100%

Segmenting Emergency Admissions – by ***Volume***



- Children – 0-17 years
- AOWA – adults of working age 18-64 years
- Older people- 65 years and older

Segmenting Emergency Admissions – by ***Cost***



Children – 0-17 years
AOWA – adults of working age 18-64 years
Older people- 65 years and older

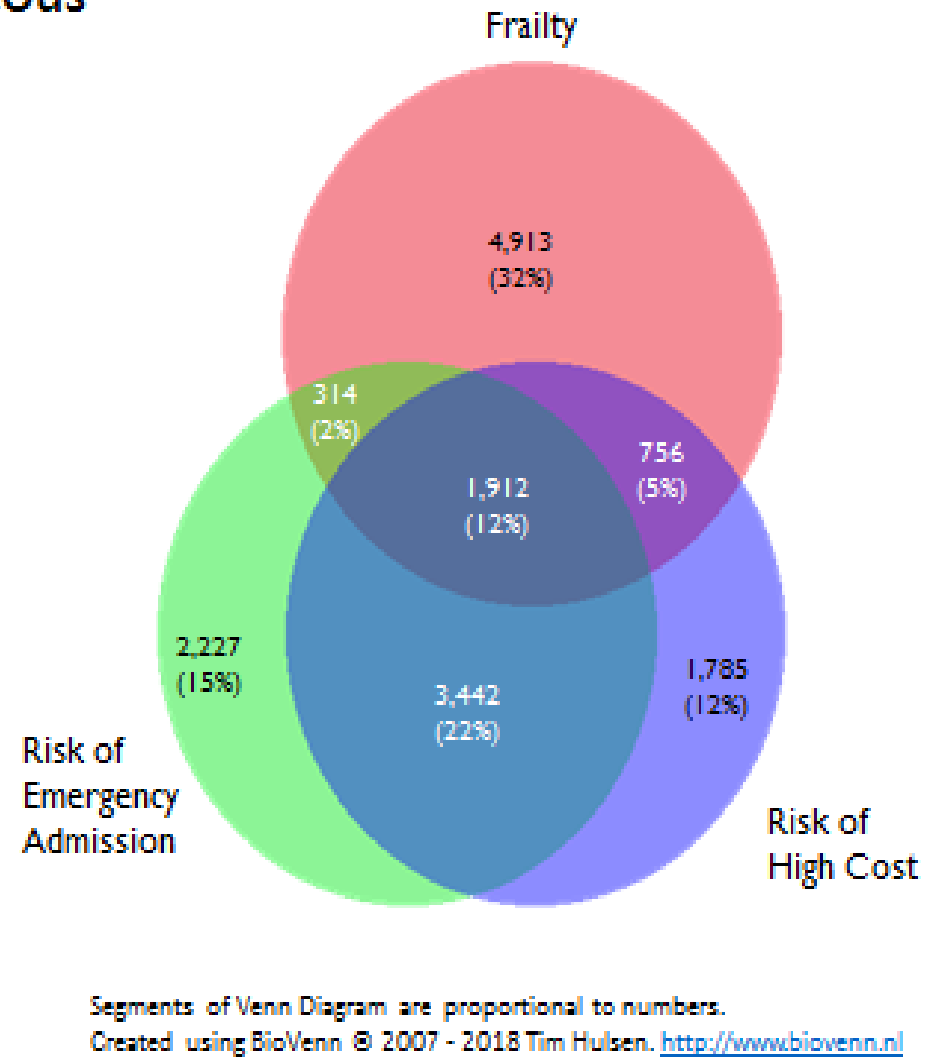
High Risk Groups are Not Homogeneous

Three cohorts of patients:

- Those who are flagged in the ACG System as having at least one condition associated with frailty (n=7,895)
- Those most at risk of an emergency admission in coming year (n=7,895)
- Those at risk of highest costs in coming year (n=7,895)

Total number of unique individuals = 15,349

- The degree of overlap between these different cohorts or segments isn't as great as people have traditionally thought.
- Therefore need to think about what cohort or segment of the population you are interested in and match the right predictive model or case finding technique to that segment.



Segments of Venn Diagram are proportional to numbers.
Created using BioVenn © 2007 - 2018 Tim Hulsen. http://www.biovenn.nl

Appendix D

LEICESTER CITY HEALTH AND WELLBEING BOARD

Theme of Meeting	Healthy Aging
Title:	Loneliness Prescription Service
Presented to the Health and Wellbeing Board by:	Troy Young: Assistant Director, Age UK Leicester Shire and Rutland
Date:	**28th November 2019**

EXECUTIVE SUMMARY:

Recognising that many older people visit their G.P. because of loneliness and other non-clinical issues, Age UK Leicester Shire and Rutland set up the Loneliness Prescription service in 2015.

Loneliness Prescriptions works with people who are over 50 years of age by supporting them to connect with local services and support including local social groups, educational courses, lunch clubs and exercise classes.
For older people who require on-going contact, the service offers a telephone befriending service.

The service is enhanced by a team of dedicated volunteers who have been trained to provide short term one to one support that that older people frequently need when they are re-engaging with their local community.
The service is funded by the National Lottery Community fund until March 2021.

Contributing to the objectives of the Joint Health and Wellbeing Strategy:

The Loneliness Prescription service recognises that social factors have a significant impact on the health of the population.

The Loneliness Prescription service promotes Healthy Ageing and Healthy Lives themes by connecting people to the services and support that they need.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

Note the content of the presentation and signpost people in need of the the Loneliness Prescription Service to their GP practice.

Age UK Leicester Shire & Rutland

Loneliness Prescription Service

Working with the 50+ group to overcome and prevent loneliness and social isolation

Troy Young
Assistant Director, Age UK
Leicester Shire and Rutland

- **50+ patients with non-clinical issues**
- **1 in 10 people who visit the GP do so primarily because they are lonely, presenting non-clinical needs**
- **Many patients are living with long term health conditions and have additional social needs**
- **Recognises that social factors have an impact on health**
- **Connecting people to services and support that will promote healthy ageing**

Leicester Shire & Rutland age UK

Phase 1: 2015- 2018

- **Launched as part of Leicester Ageing Together**
- **Worked in 5 specific wards: Belgrave, Spinney Hills, Evington, Thurncourt and Wycliffe.**
- **Received 499 referrals**
- **1300 referrals to other services**
- **1444 home visits**

Phase 2: April 2019- March 2021

- Funded by National Lottery Community Fund
- Working with all G.P practices across city
- Restructured to incorporate short term and ongoing support
- Target:
  Year 1: 160 people
- Year 2 : 200 people

- **Connecting people to services and support**
- **One to one support- using volunteer mentors**
- **Ongoing support delivered through telephone befriending**

Who are we connecting people to?

July Snapshot

- Caring for Carers
- Telephone befriending
- Call-in-time
- Mentoring support
- Information and Advice
- Charity Link
- Health Through Warmth
- Home Energy Checks
- Last Orders
- Housing

Next Steps

- Continue to work closely with G.Ps and Care Navigators
- Work with the Primary Care Networks in the city to support social prescribing
- Case Study

Appendix E

LEICESTER CITY HEALTH AND WELLBEING BOARD

Theme of Meeting	Healthy Aging
Title:	Social Value and Leicester Aging Together Pilot Project
Presented to the Health and Wellbeing Board by:	Kate Galoppi Head of Commissioning, Social care and Education Leicester City Council Ruth Rigby Programme Lead Leicester Ageing Together
Date:	**28th November 2019**

EXECUTIVE SUMMARY:

Loneliness and social isolation are significant risk factors for people's health and well-being. This presentation outlines a 12-month pilot that is taking place in 2 parts of the City. The pilot is using a community connector model, and utilising Social Value to connect isolated or lonely adults to activities and support within their communities.

This work is being delivered by Leicester Ageing Together (LAT) over a one year period.

Contributing to the objectives of the Joint Health and Wellbeing Strategy:

This work supports the work of the Health and Wellbeing Strategy by addressing isolation and loneliness and helping people to form strong social connections with their local community.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

Note the content of the pilot.

Adult Social Care

Social Value and

Leicester Aging Together (LAT) Pilot Project

Kate Galoppi / Ruth Rigby
Leicester City Council/ Leicester Ageing Together

Why the need?

- loneliness and social isolation are significant risk factors for people's health and wellbeing
- lack of family, social or community connections, means people are less able to get support when they need it
- negative impact on health and social care

Leicester City Council

Project Aims

- Connect isolated or lonely adults to activities and support within their communities
- Test the community connector model
- Maximise the social value offered by our contracted providers
- Work in partnership to develop and support community groups and activities in the localities.

Leicester City Council

Why Leicester Aging Together (LAT)?

- **National Lottery *Ageing Better* Programme**
- **Partnership**
- **Community Focus**
- **Community Connectors**
  - connect people to sources of support
  - develop and support community groups and activities
- **Successful Outcomes around isolation**

Leicester City Council

Social Value

‘additional benefits generated by a service beyond its primary purpose’ (Public Services (Social Value) Act 2012)

- ASC tenderers are required to set out social value benefits
- Social Value Charter launched by council Nov. 2018
- SV includes: *employing locally and responsibly; sourcing locally and responsibly;* ***supporting and engaging local communities****; improving environmental sustainability; and doing business ethically*
- Examples: free venues hire, training for volunteers

Leicester City Council

The LAT Approach

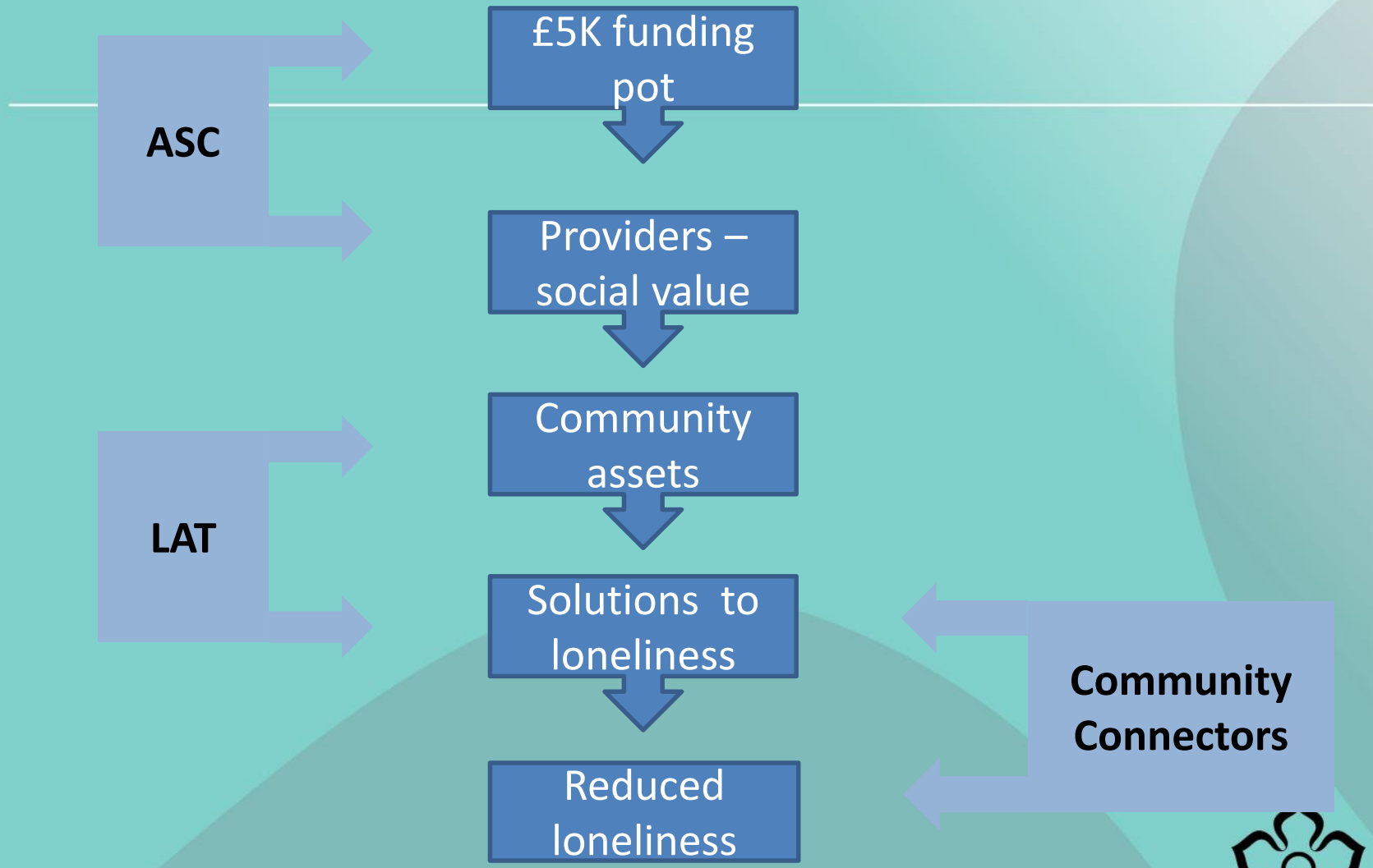
- Focus on 2 Wards, North Evington and Thurncourt
- Dedicated Community Connectors – finding local 'champions'
- Asset mapping – Tapping into local networks and partner organisations
- Generate community interest engagement using an **Asset Based Community Development (ABCD)** approach through:
  - Close Encounters (pop up tea parties) and the Cosy Bus
  - Listening Bench
  - Talking Tables
  - Establish new groups and activities

Leicester City Council

Summary

- 12 month pilot from 1st July 2019
- In two localities – Thurncourt & North Evington
- Partnership between ASC and LAT
- LAT Community Connectors key delivery mechanism
- ASC providers 'social value' offer to support the pilot.
- £5k funding pot from council to support community groups develop (max £200 per group)

Leicester City Council



Leicester City Council

Any Questions?

Kate.galoppi@leicester.gov.uk

Rebecca.hayward@leicester.gov.uk

Ruth@leicesterageingtogether.org.uk

Leicester
City Council

LEICESTER CITY HEALTH AND WELLBEING BOARD

Theme of Meeting	Healthy Aging
Title:	Steady Steps
Presented to the Health and Wellbeing Board by:	Lucy Baginskis (Leicester-Shire & Rutland Sport)
Date:	**28th November 2019**

EXECUTIVE SUMMARY:

Falls and related injuries are a common and serious problem for older people. In the UK, 30% of people older than 65 and 50% of people older than 80 fall at least once a year; those who fall once are two to three times more likely to fall again within the year.

In 2017/18, there were 752 falls related admissions in Leicester City with of an estimated cost of approximately three million pounds. National research and guidance suggest that the implementation of an integrated falls pathway can reduce activity by 25 to 30%.

The Steady Steps programme (Falls Management Exercise) will provide an opportunity for older people at risk of falling to increase their strength and balance and thus reduce their falls risk. The programme is based on best practice from the UK, current evidence base and operates to National Standards.

Contributing to the objectives of the Joint Health and Wellbeing Strategy:

<u>Healthy ageing</u>

- Support older people to have good wellbeing and feel safe in their own

homes.

- Support older people to utilise and engage with their local communities.
- Support older people to manage and protect their health and wellbeing.

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to:

To note this report for their information of a service that is currently being delivered in Leicester City

Falls Prevention- Steady Steps

Lucy Baginskis

Appendix G

History of Steady Steps/ community falls prevention

- Later Life led study- older adults (Falls and Management Exercise programme-FaME)
- PSI training
- Proact65+ Study
- Physical activity Implementation Study In Community-dwelling AduLts (PhISICAL) study
- Steady Steps

Physical activity Implementation Study In Community-dwelling AduLts (PhISICAL) study

LEICESTER-SHIRE & RUTLAND SPORT
PHYSICAL ACTIVITY & WELLBEING

Research aim

- To understand how best to implement the FaME strength and balance programme in order to develop an evidence-based toolkit for commissioners, to help increase availability of FaME across the UK.

Key Findings- summary

Research question	Summary
Does FaME still work when it is not part of a research study?	Yes – functional outcomes Yes – MVPA for those that complete Falls - Small decrease – provisional analyses
Is the fidelity and quality of FaME maintained outside of a research setting?	Fidelity – good 72-78% of fidelity criteria met Quality – very good 80-84% of quality criteria met Some elements missed off Band progression could be better Need to have QA systems
What are the barriers and facilitators to FaME implementation?	Commissioners - ££ and evidence Providers – complexity, confidence, practical issues Programme users – high drop out, social benefits

Falls Management Exercise (FaME) Implementation Toolkit

What is Steady steps?

- 24 week programme
- 65+
- Designed to help improve balance and stability.
- Delivered by Level 4 specialised Postural Stability Instructors
- Classes are tailored to each individual's abilities and will progress in difficulty throughout the programme
- People are eligible for the Steady Steps programme if they are aged over 65, are at risk of falling (e.g. have a high fear or falling or poor balance) or have fallen less than three times in the past 12 months.

Steady Steps process

- Referral (health professional or self referral)
- Local co-ordinator- mini triage
- Assessment
  - Past medical history, FRAT, functional assessment, confidence (confbal).
- Steady steps or referred on
- Steady Steps
  - TheraBand
  - Home exercises
- Steady Steps plus/ community provision

Delivery

LEICESTER-SHIRE & RUTLAND SPORT
PHYSICAL ACTIVITY & WELLBEING

Local update- Leicester City

Referrals

- 81 referrals
- 29 self-referrals

- Referrals from Health Professionals:

Majority from Falls clinic-(47)

Courses

5 courses- 30 attendees
7 courses due to start
26 courses- Public Health to co-ordinate

Lucy Baginskis

Sports Development Officer

LEICESTER-SHIRE & RUTLAND SPORT
PHYSICAL ACTIVITY & WELLBEING

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l.Baginskis@LRSport.org

www.lrsport.org

SportPark, 3 Oakwood Drive, Loughborough, Leics, LE11 3QF

lrsport.org LRSport LR_Sport LR_Sport_ LR_Sport Leicester-Shire & Rutland Sport

Appendix G

LEICESTER CITY HEALTH AND WELLBEING BOARD

Theme of Meeting	Healthy Aging
Title:	2019-20 Better Care Fund Plan
Presented to the Health and Wellbeing Board by:	Mark Pierce /Ruth lake
Date:	**28th November 2019**

EXECUTIVE SUMMARY: The Better Care Fund (BCF) is a programme spanning both the NHS and local government which seeks to join-up health and care services, so that people can manage their own health and wellbeing, and live independently in their communities for as long as possible. The BCF represents a unique collaboration between NHS England, the Ministry of Housing, Communities and Local Government (MHCLG), Department of Health and Social Care (DHSC) and the Local Government Association. The four partners work closely together to help local areas plan and implement integrated health and social care services across England, in line with the vision outlined in the Long Term Plan.

All Better Care Fund partnerships were required in 2019 to submit for government approval a revised version of the previous (2017-19) plan. The 2019-20 plan is attached in this instance for your information as the timelines this year meant that the plan had to be submitted, with the approval of the Chair of the HWB, outside of the scheduled cycle of HWB meetings. Attached is (a) the narrative paper outlining the key points of the planned investments and (b) the template giving details of the plan which was submitted and now awaits final government approval – expected in early December (Regional approval by a panel of Local Authority and NHS senior directors has already been given).

The plan details how the partnership between Leicester city CCG and Leicester City Council Adult Social Care plans to invest monies totalling £43,368,727 from four sources:

- The CCG BCF contribution
- The Improved Better Care Fund (iBCF) direct Grant to Local Authorities
- The Disabled Facilities Grant
- The NHS Winter Pressures Grant to Local Authorities

Contributing to the objectives of the Joint Health and Wellbeing Strategy:

- Reducing social isolation and loneliness in older people
- Helping people to remain independent in their own homes
- Reducing the numbers of those over 65 admitted to permanent residential care
- Improving the health and care outcomes for residents of Leicester

RECOMMENDATIONS:

The Health and Wellbeing Board is requested to: Note the submission of the BCF 2019-20 Plan to NHSE/I.

NHS
Leicester City
Clinical Commissioning Group

Name of meeting	Integrated Systems of Care Group (ISOC)	**Date**	15.10.2019	**Paper**	
Report title	**Better Care Fund Annual Plan 2019-20**				
Lead Director	Sarah Prema, Director of Strategy and Implementation, Leicester City CCG.	**Tel/Email**	Sarah.Prema@Leicestercityccg.nhs.uk		
Report Author	Mark Pierce, Senior Strategy and Implementation Manager, Leicester City CCG.	**Tel/Email**	Mark.Pierce@leicestercityccg.nhs.uk		
Clinical Lead	Dr Raj Than, CCG GP Clinical Lead for Integrated Care.	**Tel/Email**	Tun.Than@gp-c82033.nhs.uk		
Links to CCG strategic objectives	☒ Through better commissioning, improve local and national health outcomes, particularly by addressing poor outcomes and inequalities; ☒ Balance the NHS budget and improve efficiency and productivity; ☒ Lead a step change in the NHS in preventing ill health and supporting people to live healthier lives;				
Purpose	**Note**	√	**Discuss and recommend**		**Approve**
Report summary	1. The purpose of this report is to inform Leicester City ISOC members of the details of the Leicester Better Care Fund (BCF) Plan for 2019/20, including the final expenditure plan submitted to NHS England on 27.09.2019 following the delayed publication of the BCF planning guidance and final CCG financial allocations into the BCF. 2. A full narrative plan is not required with the BCF submission this year. Instead, the template includes short sections to set out Leicester's approach to integration of health and care. The full template submission, including details of the investment plan submitted, has been provided as an appendix for reference. 3. The main thrust of the CCG minimum spend element of the plan – strategy, details of investments and targets for achievement on the four national BCF metrics – continues the strategic direction of the 2017-19 plan. The submission is overwhelmingly based upon the 2019-20 BCF investment plan already supported by ISOC earlier this year. Additional detail about investments from within Local Authority's IBCF, Disabilities Facilities Grant and Winter Pressure Grant are also included in the submission.				
Identified risks and risk management actions	The additional CCG investment in social care (5.9%) mandated by NHSE/I in this year's plan is not a risk as formal assurance has been given at national level that the additional monies required will be granted to the CCGs. The single biggest risk in terms of delivery lies in the area of non-elective admissions. This is a system-wide risk across LLR and mitigations are in place across a wide range of projects under the governance of the Leicester, Leicestershire and Rutland				

<table>
<tr><td></td><td>(LLR) Integrated Urgent and Emergency Care Board.</td></tr>
<tr><td>Resource and financial implications</td><td>The plan details a total investment of £43,368,727. This is made up of:
<table>
<tr><td>Better Care Fund CCG contribution</td><td>£23,936,545</td></tr>
<tr><td>Improved Better Care Fund (iBCF) (Local Authority)</td><td>£15,466,521</td></tr>
<tr><td>Disabilities Facilities Grant (local Authority)</td><td>£2,391,923</td></tr>
<tr><td>Winter Pressures Grant (Local Authority)</td><td>£1,573,738</td></tr>
</table></td></tr>
<tr><td>Conflicts of interest</td><td>None identified</td></tr>
<tr><td>Engagement and/or consultation considered?</td><td>Nationally, the 2019-20 plan is aimed at continuing the themes for delivery set out in the previous BCF 2017-19 plan. As the range of services funded through both elements of the BCF and the other grants are those commissioned partly in response to previous and on-going public engagement processes (e.g. findings from the carers' strategy work, feedback from patients accessing current BCF services) additional public engagement has not been sought at this point. MP has previously engaged with city patient representatives on the concept and constituents of our Integrated System of Care as funded though the BCF.

Mark Pierce and Ruth Lake collaborated on the contents of the submission. The allocation recommendations for use of the CCG minimum contribution, the details of system organisational redesign, and community services redesign, upon which much of this submission is based have been subject to consultation within and across partner organisations during 2018-19 as well as at ISOC meetings during the same period.</td></tr>
<tr><td>Clinical input assurance</td><td>Assurance on clinically orientated services funded (or part-funded) in the city though the BCF is via the GP members of ISOC on an ongoing basis.</td></tr>
<tr><td>Due regard/equality considerations?</td><td>Existing impact assessments will be reviewed to ensure that there have been no revisions are required.</td></tr>
<tr><td>Report history (audit trail)</td><td>The high-level principles and broad details of the submission have been approved for submission by Councillor Vi Dempster, Assistant Mayor for Health and Chair of the Leicester City Health and Wellbeing Board (HWBB) prior to submission. This is in line with national requirements. The submission will be taken as a paper to the November meeting of the HWB for formal approval. The gaining of retrospective approval from HWB is accepted in the guidelines.</td></tr>
<tr><td>Appendices</td><td></td></tr>
<tr><td>Recommendation</td><td>The Integrated Systems of Care Group is asked to:

a. Note the BCF Plan for 2019/20 for submission to NHS England by 27th September 2019.

b. Note that the Health and Wellbeing Board will receive the BCF Plan at the November meeting – the Chair, Councillor Dempster having given her approval in principle as per the national guidelines for submission.</td></tr>
</table>

Policy Framework and Previous Decisions

1. The 2019-20 BCF Policy Framework was published on 10th April 2019. This confirmed that the BCF policy framework provides continuity from the previous round of the programme. The delayed BCF Planning Requirements for 2019-20 were published on 18th July 2019, along with the final financial allocations for the BCF Plan.

2. The four national conditions set by the government in the Policy Framework remain the same and are:

    a. That a BCF Plan, including at least the minimum mandated funding to the pooled fund specified in the BCF allocations and grant determinations, must be signed-off by the Health and Wellbeing Board, and by the constituent local authorities and CCGs.

    b. A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution in line with the uplift to the CCG minimum contribution.

    c. That a specific proportion of the area's allocation is invested in NHS-commissioned out of hospital services, which may include seven-day services and adult social care.

    d. A clear plan on managing transfers of care (and improving DTOC), including implementation of the national high impact change model for managing transfers of care.

BCF Plan for 2019/20

3. The BCF Plan for 2019/20 is viewed as a continuation of the previous plan which covered 2017-19. Therefore materials for the national submission to NHS England were collected through a planning template, and we were not required to provide a detailed narrative report on this occasion.

4 The narrative section (available at Appendix A) sets out Leicestershire's approach to the integration of health and social care under the headings from the template:

    a. Joined up care around the person;

    b. Joint commissioning and delivery of health and social care at health and wellbeing board level;

    c. How the BCF plan and relevant elements of the STP/ICS plan aligns, including any jointly owned outcomes.

5 In terms of the CCG minimum contribution. The final figure (confirmed only in July 2019) increased by 5.3% against 2018/19 spend. NHS England have recognised that there will be a funding pressure on CCGs with the additional increase and have looked at ways to support CCGs with the social care element of this funding pressure. Further information has been received which shows how much additional allocation CCGs should receive to cover the

social care uplift. This confirmed that LC CCG should receive £551,000 to cover the social care cost pressure. The remaining pressures have been addressed from within the Performance Fund (now reduced) and the inclusion of existing recurrent CCG investment in community therapy within the BCF budget.

6 This amount will cover the funding pressure for the CCG relating to the social care spend. CCGs should receive formal confirmation from NHS England shortly. The additional funding should be released to CCGs following regional assurance that the BCF Plan meets the appropriate criteria.

7 The BCF expenditure plan, provided in Tab 6 of the submission spread sheet, sets out the line items/ service areas for each element of the BCF pooled budget.

8 The line items funded by the Improved Better Care Fund and Winter Pressures Grant are subject to Local Authority determination and associated grant conditions.

9. The Disabled Facilities Grant (DFG) allocation is automatically transferred to each District Council per the apportionment set out by government.

10 Tab 7 provides details on our priorities for embedding elements of the high impact change model (HICM) for managing transfers of care; which includes the current performance issues that need to be addressed and future changes planned for 2019/20. This section also sets out our current position of maturity for each of the eight changes in the model and the planned level of implementation by March 2020. The Discharge Working Group has oversight on the progress of the HICM for Leicester, Leicestershire and Rutland (LLR).

11. Tab 8 provides details on the proposed trajectory for the achievement of targets in the four national BCF metrics in 2019/20; a summary of the rationale for the level of performance being aimed for and an update on the current progress against the planned target.

12. The following table lays out the timetable for approval of the submitted plan:

BCF planning submission from local Health and Wellbeing Board areas (agreed by CCGs and local government).	By 27th September
Scrutiny of BCF plans by regional assurers, assurance panel meetings, and regional moderation	By 30th October
Regionally moderated assurance outcomes sent to BCST	By 30th October
Cross regional calibration	By 5th November
Assurance recommendations considered by Departments	5th – 15th

and NHSE	November
Approval letters issued giving formal permission to spend (CCG minimum)	Week commencing 18th November
All Section 75 agreements to be signed and in place	By 15th December

13 Work to update the BCF Section 75 agreement will now commence and will be submitted to the CCG Governing Body and Joint integrated Commissioning Board ahead of the deadline of 15th December for approval.

14 Leicester City ISOC is asked to support this plan acknowledging that this reflects the work reported upon to ISOC and JICB at regular intervals.

Better Care Fund 2019/20 Template

3. Summary

Selected Health and Wellbeing Board: Leicester

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£2,391,923	£2,391,923	£0
Minimum CCG Contribution	£23,936,545	£23,936,545	£0
iBCF	£15,466,521	£15,466,521	£0
Winter Pressures Grant	£1,573,738	£1,573,738	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	£43,368,727	£43,368,727	£0

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£6,802,087
Planned spend	£7,242,204

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£15,411,303
Planned spend	£15,426,324

Scheme Types

Assistive Technologies and Equipment	£313,580
Care Act Implementation Related Duties	£0
Carers Services	£650,000
Community Based Schemes	£1,299,389
DFG Related Schemes	£2,391,923
Enablers for Integration	£119,342
HICM for Managing Transfer of Care	£472,700
Home Care or Domiciliary Care	£11,745,886
Housing Related Schemes	£155,000
Integrated Care Planning and Navigation	£975,978
Intermediate Care Services	£5,888,157
Personalised Budgeting and Commissioning	£0
Personalised Care at Home	£74,832
Prevention / Early Intervention	£475,628
Residential Placements	£0
Other	£18,806,312
Total	£43,368,727

HICM >>

		Planned level of maturity for 2019/2020
Chg 1	Early discharge planning	Mature
Chg 2	Systems to monitor patient flow	Mature
Chg 3	Multi-disciplinary/Multi-agency discharge teams	Mature
Chg 4	Home first / discharge to assess	Mature
Chg 5	Seven-day service	Established
Chg 6	Trusted assessors	Mature
Chg 7	Focus on choice	Mature
Chg 8	Enhancing health in care homes	Established

Metrics >>

Non-Elective Admissions
Delayed Transfer of Care

Go to Better Care Exchange >>

Residential Admissions

		19/20 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	585.8158124

Reablement

		19/20 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	0.930434783

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: Implementation of the High Impact Change Model for Managing Transfers of Care	PR6	Yes
Agreed expenditure plan for all elements of the BCF	PR7	Yes
	PR8	Yes
Metrics	PR9	Yes

Better Care Fund 2019/20 Template

4. Strategic Narrative

Selected Health and Wellbeing Board: Leicester

Please outline your approach towards integration of health & social care:

When providing your responses to the below sections, please highlight any learning from the previous planning round (2017-2019) and cover any priorities for reducing health inequalities under the Equality Act 2010.

Please note that there are 4 responses required below, for questions: A), B(i), B(ii) and C)

Link to B) (i)
Link to B) (ii)
Link to C)

A) Person-centred outcomes Your approach to integrating care around the person, this may include (but is not limited to): - Prevention and self-care - Promoting choice and independence	
Remaining Word Limit:	87

Leicester's BCF partnership has focused over the past three years on developing "An integrated system of care for frail and multimorbid patients". This acknowledges that each patient's experience of ill health and social care need will be different and that a solely medically focused approach will not be holistic or effective. Key learning points from 2017-19 have been:
(a) A system approach (not a service approach) to person-centred care is the most effective. We sum this up by constant reference to our "team of teams".
(b) Co-location is a very powerful tool for allowing distributed leadership to create holistic person-centred solutions - breaking down traditional service boundaries encourages teams to keep the person in the centre of planning rather than the traditional service parameters dictating the extent of integrated working.
(c) Much of the success in delivering effective personalised care comes from bringing non-medical teams and organisations togther to listen to the person and their carers's priorities.
(d) NHS services have a great deal to learn about strengths-based approaches to assessment from their social care colleagues - and they are willing to adapt practice to reflect new learning.
(e) A shared record between health and care, can greatly facilitate continuity of holistic, person-centred care.

The Leicester approach to person-centred care is summed up by one of our two BCF hashtags which we encourage staff to use on email footers and social media:(a) #moregooddays. We are having badges printed for staff across the patch with this hashtag. Essentially this refers to the ambition, agreed by BCF partnership leaders and being workshopped at front line level, that working collaboratively to deliver person-centred care will lead to the patient and their carers (AND staff) all having more "good days" - either in terms of wellbeing and health (or freedom from symptoms) or as busy health and care workers or volunteers. (b) #teamofteams: (see section B).
Integrating care around the person to reduce health inequalities in Leicester starts with risk stratification/population profiling to identify high risk and disadvantaged groups and has developed a suite of organisational and services responses funded through the BCF:
(a) Co-located teams jointly assessing patient needs: (1) We will continue the work of the Integrated Discharge team which co-locates ASC, Acute Hospital and Housing and voluntary sector (RVS and Alzheimer's Society) staff in one office at The Royal infirmary to holistically assess patient and carer need and develop joint approaches to facilitating discharge and follow up in the community. ASC Health Transfers team are now trusted assessors for city residential homes - one reason why 67% of discharges for city patients are achieved without a Discharge Notice being issued and our DToC performance has been strong. By focusing on those with most complex needs we aim to reduce the impact of health inequalities for those living in the most disadvantaged circumstances - our staff mix ensures culturally sensitive care. We will continue our BCF-funded Discharge Home to Assess model (subject of regional interest as innovative practice) aimed at getting those not suitable for immediate reablement home from hospital for two weeks of recuperation prior to assessment of ongoing need - a collaboration between ASC, CCG, LPT CHS and Dom care agencies(2) Integrated Mental Health Team - Co-located in health centre with GP and community nursing service and linked to all other BCF services. Focuses on home based assessment for those whose chronic physical illness is complicated by mental health issues such as anxiety, depression and potential cognitive decline. Aims to deliver parity of esteem for this often poorly served group of patients. Includes Occupational Therapist. Team using SystmOne to make communication with GPs, Care Navigators, community nursing and therapy more joined up. (3) Reablement service: Joint service offered by Leicester City Council and LPT Therapy services. Highly rated for outcomes in terms of independence and keeping people at home in latest Intermediate Care services review in England - despite highest Sunderland score on admission of all 51 services surveyed. (4) Integrated Crisis Response Service (ICRS) co-located with Community nursing, therapy and MH services. Conducts joint board rounds in co-located building each morning and carries out joint assessments Works closely also with UHL to bridge discharges, with EMAS and our Clinical Home Visiting service to share cases where people require health AND care assessments in urgent circumstances and joint planning. (5) Care Navigators - co-located with ASC neighbourhood teams. Have read/write access to SystmOne. Takes referrals from GPs and from other teams in the integrated system of care. Refer to over 50 different city clinical, local authority and voluntary/community services. Trusted assessors for Home Adaptations, ASC packages, continence and therapy services. Focusing on holistic solutions for those housebound, disabled and older patients, including those with MH problems. (6) Housing Enablement Team - specialist intensive support for those whose housing status is a barrier to hospital discharge - usually highly marginalised groups with severe health inequalities (e.g street homeless or insecurely housed, alcohol/drug dependent, Refugee/asylum seeking, those with severe MH problems). (7) NEW in 2019-20 Social worker focusing on Hoarding and addiction issues. Works closely with Local Authority, fire service, GPs and voluntary sector to develop individualised plans to reduce adverse outcomes in this marginalised group. (8) Expansion of Planning For Integrated Care in General Practice (PIC GP) Scheme to 5,000 patients: Uses risk stratification tool to identify high-risk patients and enhance personalised care by resourcing longer additional primary care appointments, MDT meetings and care planning. MH team, care navigators and community health staff attend the MDTs to tailor support to individual circumstances. Holistic frailty assessment tool now used as part of this process. Social Prescribing Coordinators will enhance the scope of this integrated working in 2019-20 and beyond as will the further development of Integrated Neighbourhood Teams around Primary Care Networks. (9) Personal budgets: Work started in Q4 2018-19 on developing a strategy on joint LLR-wide working on personal budgets. Led by Leicestershire BCF, and due in

B) HWB level

(i) Your approach to integrated services at HWB level (and neighbourhood where applicable), this may include (but is not limited to):
- Joint commissioning arrangements - Alignment with primary care services (including PCNs (Primary Care Networks)) - Alignment of services and the approach to partnership with the VCS (Voluntary and Community Sector)

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The 2019-20 BCF plan builds upon the very strong partnerships which have been developed via the BCF collaborative work since the inception of the Fund. Leicester city BCF work is planned and delivery is overseen by a city-wide partnership body which meets monthly; the Integrated Systems of Care Group (ISOC). Regular representation is from the CCG, Local Authority, Leicestershire Partnership Trust, University Hospitals of Leicester, GPs, Derbyshire Health United (provider of Home Visiting Service) with periodic attendance from Fire and Rescue, Police, Voluntary sector partners such as VISTA, The Centre Project (Day Centre providing range of service for vulnerable adults) and the Royal Voluntary Service. Chair is the CCG Independent Lay Vice Chair and Vice Chair is the Director of Adult Social Care and Safeguarding. The group's title reflects the City BCF partnership's long-term emphasis on creating a systems approach to collectively managing complexity at place level. ISOC Delivery Groups are formed pro tem to take ownership of delivery of specific work - reporting back to ISOC. Each January a sub-group of ISOC meets to review performance of BCF-funded services and agree a proposed budget for consideration by the CCG's Integrated Governance Committee and Joint Integrated Commissioning Board (JICB). The budget is truly co-produced by partners.

The ISOC itself reports to both the monthly JICB, chaired by the CCG Accountable Officer or Strategic Director of Social Care and Education which consists of senior CCG and Adult Social Care management and to the CCG's Integrated Governance Committee (IGC) through the ISOC Chair. The Health and Wellbeing Board Chair reviews and signs off the BCF plan and quarterly submissions on behalf of the Board and will request occasional updates on topics of interest from the BCF work - on profile of frailty and multi-morbidity in Leicester for September 2019, for example.

The systems approach means that ISOC places a high premium on the ability of funded services to integrate with all other services in the system (Make Every Contact Count) to deliver personalised care.

The 2019-20 BCF budget will fund services in adult social care, carers support, mental health services and training, hospital discharge, community rapid response in health and care, reablement, risk stratification and population profiling, assistive technology and home adaptations, care home staff training and clinical input, health and care staff training, health and social care protocol and clinical assessment training, care navigation services, data processing to examine variation, services for those with sight and hearing loss, for those with problems related to addiction or hoarding and for those with housing issues and in several areas related to primary and secondary prevention. Parity of esteem and the reduction of health inequalities are themes running right through the range of investments.

New investments in 2019-20 (a) Motivational Interviewing training (b) Increase in Integrated MH team staffing (c) New social worker post for hoarding and addiction (d) Extension of SystmOne access to ICRS (e) New data processing using Risk stratification (Investment in Mental Health First Aid training (f) Creation of Hearing Loss Support Service.

Alignment with Primary Care Networks (PCNs): Ten PCNs have been authorised in Leicester City. Neighbourhood teams from Adult Social Care, Community Health and Voluntary sector are now being aligned to these footprints - building on current strong integrated working with GP localities . ISOC has already hosted a "Grand Round" session for the ten Accountable Clinical Directors (PCN ACDs) to showcase the services within the system which will be available to align to Neighbourhood level in various configurations (police beat teams, Fire Stations, nursing and social work teams e.g.). For Home First services(Step up/down integrated teams) the Community Services Redesign will create a centralised single "front door" through a co-located Locality Decisions Unit (LDU) staffed by health and local authority. This will ensure that the right neighbourhood resources are mobilised to manage PCN work in a timely fashion. The BCF-funded risk stratifcation/population health work is being refreshed to create a PCN profile and a JSNA for frailty/multi-morbidity has been produced for the city. The MyChoice Community Asset Register will support Care Navigation and Social Prescribing at neighbourhood-level.
The Leicester Place-level investment in VCS has been very successful and we plan for this to continue.
Joint Commissioning at Place: Domicillary Carecommisioning already in place in the city. We undertake some additonal system level joint commissioning at system level which has a place-specific delivery model - e.g. Richmond Fellowship for MH care.

(ii) Your approach to integration with wider services (e.g. Housing), this should include:
- Your approach to using the DFG to support the housing needs of people with disabilities or care needs. This should include any arrangements for strategic planning for the use of adaptations and technologies to support independent living in line with the

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The Leicester Integrated System of Care for Frail and Multi-morbid Patients is based on a high level of integration between front line social care and health services and a range of wider services. The 2019-20 BCF budget invests in the following services:
Housing Enablement Team - Works with those where accommodation issues are a barrier to timely discharge from hospital. Case management for up to 6 weeks following discharge to ensure stability of tenure and financial arrangements and re-engagement with community.
Home Adaptation Service: Minor home adaptations to support step up and step down (Home First). Care Navigators are trusted assessors for this service.
Specialist social worker for those with hoarding and addiction issues - speciaist and individualised case management for highly complex cases - often linked to other health inequalities so this approach is a way of bringing the whole suite of person-centred solutions to bear in a way that promotes individual choice and optimises use of community assets and personal strengths.

New referral pathways developed with Fire and Rescue Service on hoarding and home fire safety. Care Navigators, community health staff and MH Integrated Team can now refer directly to the Leicestershire Fire Service Home Safety team for joint follow up.
Assistive Technology Service - serves about 5,000 clients. Provides a mixture of stand-alone and linked devices with support from a call centre which can interact with clients to check on wellbeing and can summon community support when necessary.
Development of a strategic implmentation plan for the delivery of additional supported living and Extra Cre Housing in partnership with statutory housing provider and social landlord partners.
People with disabilities, living in their homes often encounter difficulties completing activities of daily living such as - getting on an off the toilet, bathing, negotiating the stairs, getting into and out of the property and accessing essential facilities.
One way in which People are supported is by adapting their environment. This allows for the Person to increase their independence, sustain their abilities and delay any further deterioration, leading to a reliance on other services. By enabling these adaptations to take place they can create a safe and suitable environment for care to be provided (if needed) it can enable people to feel safe and secure and prevent dependency on the health and social care system.
For example DFG funding is accessed to enable the provision of adaptations such as:
- stair lifts
- through floor lifts
- step lifts
- level access showers
- wash dry toilets
- ramped access
- automatic door entry systems
- kitchen adaptations
- rare but a ground floor bedroom or bathroom

DFGs are accessed in circumstances of significant change in peoples lives such as a life changing road traffic accident or living with a life limiting condition. DFGs are provided for Children and Adults.

DFGs are used to support people when they are coming out of residential care or moving environments for example living with family/ carers, or in supported living too. The nature of the provision remains the same but the way on which the service is provided or the outcome is achieved for the person will differ.

C) System level alignment, for example this may include (but is not limited to):	
- How the BCF plan and other plans align to the wider integration landscape, such as STP/ICS plans - A brief description of joint governance arrangements for the BCF plan	
Remaining Word Limit:	895

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The transformation and integration of health and care is being addressed at System (across Leicester,Leicestershire and Rutland) (LLR), place (Leicester city) and Neighbourhood (localities or geographical areas, and now, PCNs). See (B)i and (B)ii for more information on the approach to delivery of models of integrated health, care, prevention and housing and the specific focus on areas of investment aimed at reducing inequalities of health. Since 2014 partners across LLR have been collaborating on the transformation of health and care via the "Better Care Together" programme - now known as the LLR Better Care Together Sustainability and Transformation Partnership (STP) The LLR STP has several clinical and enabling workstreams (see diagram and list on supplementary sheet). Many of the BCF-funded services and deliverables feed into the delivery plans of the LLR STP (see NHS System Operation plan 2019-20).
For example:
Workplan of the Discharge Working Group and the HICM feeds into the A&E Delivery Board
Workplans for falls, care homes, community services redesign, and Neighbourhood teams feed into the LLR Integrated Community Services Board
Work plans on data integration, business intelligence, and technology enabled care feed into the IM&T Board, which oversees delivery of the Digital Roadmap for LLR.

The Leicester BCF investment strategy has been to align investments towards (a) attainment of the BCF national Metrics and (b) to align with the work plans for the LLR STP in such areas as Discharge, Frailty, End of Life, Care Homes and Prevention.
The introduction of the iBCF and Winter funding allocations to the local authority added further non-recurrent elements to the pooled budget. These have been carefully managed (a) to ensure we meet the conditions of use such as DTOC and (b) to ensure that some of the funding is used to generate transformational change such as trusted assessor training and transformation work in the local authority to create a more strengths-based approach to practice in adult social care. (the training in motivational interviewing is a good example here). This should lead to a model where patient choice is more readily identified and honoured.
The LLR STP leadership is currently assessing the steps required to achieve ICS staus along the lines laid out in the NHS Long Term Plan - using the national maturity matrix to identify milestones. The STP and its system level workstreams will now need to be examined and refreshed in light of the overall ICS requirements. Within this context, new governance structures may emerge under our newly appointed single Accountable Officer to ensure the alignment between BCF investments at place level and the agreed pathway towards achievement of ICS status as a system. This work has begun with the introduction of a new Partnership Board comprised of CCG Lay Members and council representatives - the latter being the Chairs of the three HWB Boards. In this regard the history of positive partnerships and willingness to engage across boundaries in Leicester City will ensure that we are well placed to deliver on system-wide strategic commissioning models at place level but also to adopt good practice from across LLR and beyond.

Achievement of ICS status will require not just strategic commissioning partnerships within the sphere of social care and health but alignment at place and, where appropriate, at Neighbourhood level, of the work of Public Health.
Joint Governance of the BCF Plan: The plan content will have input from all partners via the Integrated Systems of Care Group. Sign off of the plan on behalf of the HWB Board will be via the Chair - Assistant Mayor for Health, Councillor Dempster.

Better Care Fund 2019/20 Template

5. Income

Selected Health and Wellbeing Board: Leicester

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Leicester	£2,391,923
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£2,391,923**

iBCF Contribution	Contribution
Leicester	£15,466,521
Total iBCF Contribution	**£15,466,521**

Winter Pressures Grant	Contribution
Leicester	£1,573,738
Total Winter Pressures Grant Contribution	**£1,573,738**

Are any additional LA Contributions being made in 2019/20? 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**	

CCG Minimum Contribution	Contribution
NHS Leicester City CCG	£23,936,545
Total Minimum CCG Contribution	**£23,936,545**

Are any additional CCG Contributions being made in 2019/20? If yes, please detail below	No

Additional CCG Contribution	Contribution	Comments - please use this box clarify any specific uses or sources of funding
Total Addition CCG Contribution	**£0**	
Total CCG Contribution	**£23,936,545**	

	2019/20
Total BCF Pooled Budget	**£43,368,727**

Funding Contributions Comments Optional for any useful detail e.g. Carry over
None

Better Care Fund 2019/20 Template

6. Expenditure

Selected Health and Wellbeing Board: Leicester

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£2,391,923	£2,391,923	£0
Minimum CCG Contribution	£23,936,545	£23,936,545	£0
iBCF	£15,466,521	£15,466,521	£0
Winter Pressures Grant	£1,573,738	£1,573,738	£0
Additional LA Contribution	£0	£0	£0
Additional CCG Contribution	£0	£0	£0
Total	£43,368,727	£43,368,727	**£0**

Required Spend	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£6,802,087	£7,242,204	£0
Adult Social Care services spend from the minimum CCG allocations	£15,411,303	£15,426,324	£0

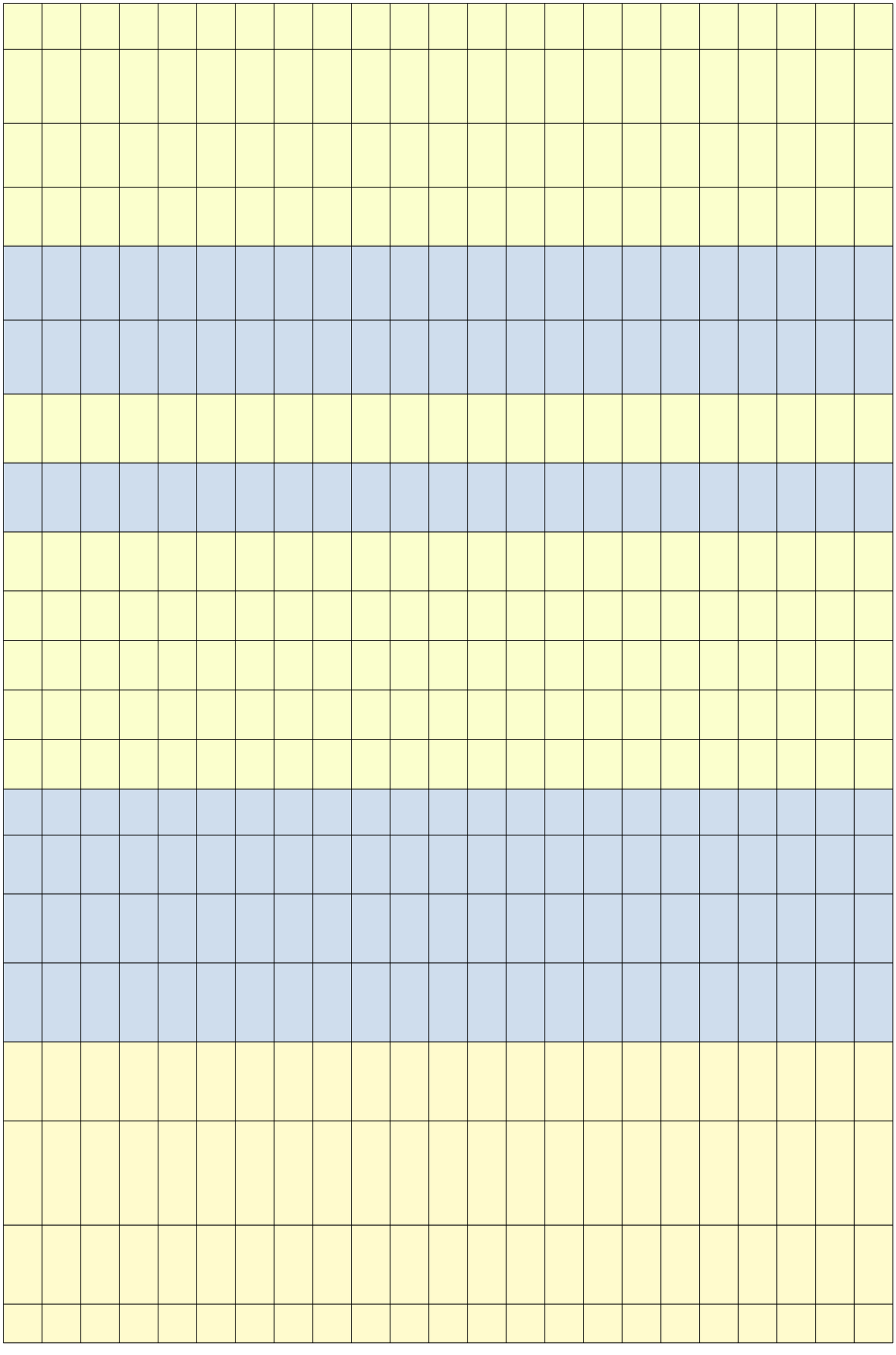
Link to Scheme Type description

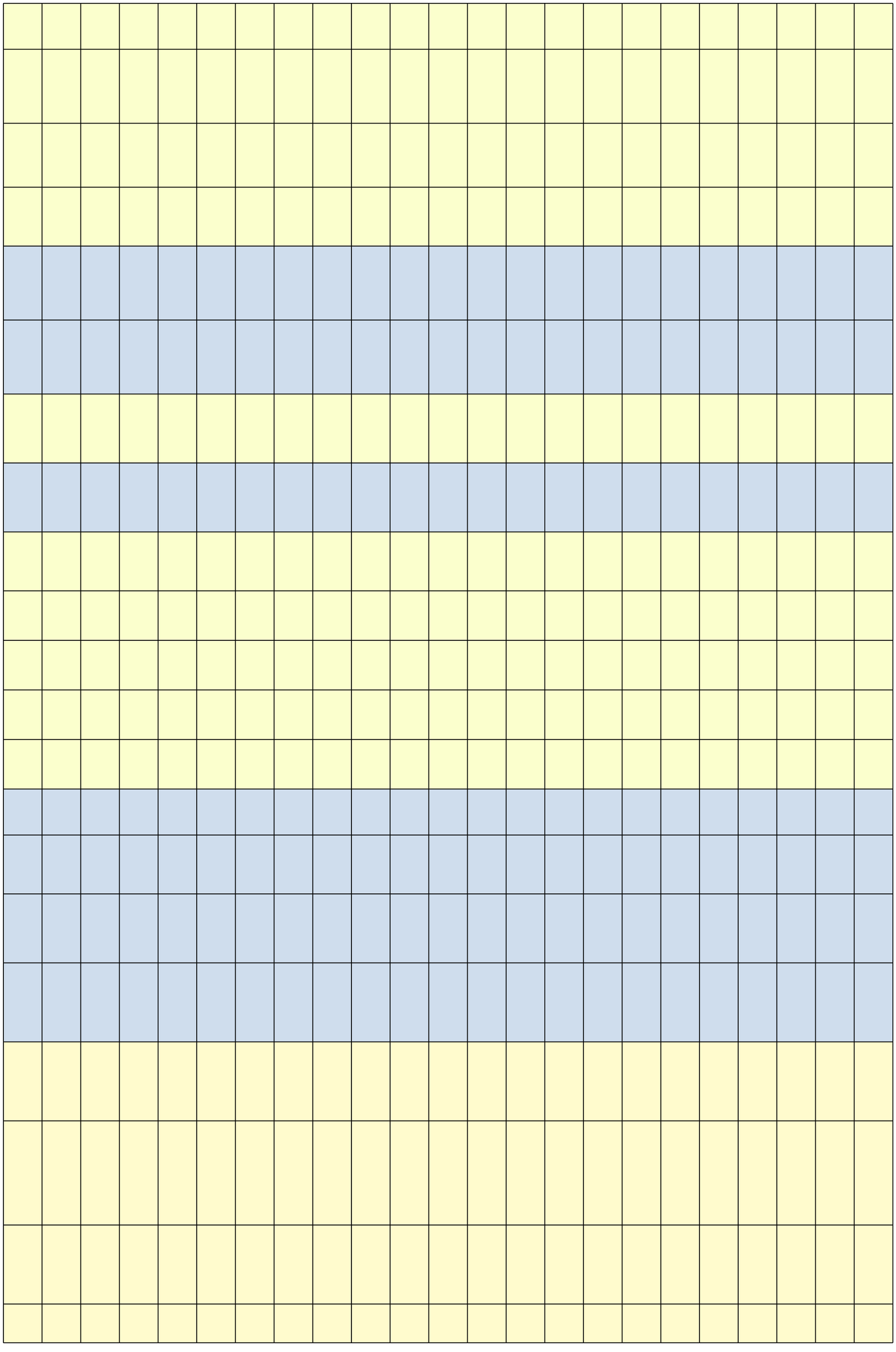
						Planned Outputs		Metric Impact				Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Planned Output Unit	Planned Output Estimate	NEA	DTOC	RES	REA	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
1	Existing ASC Transfer	Existing ASC transfer	Home Care or Domiciliary Care			Packages	1,074.0	Medium	High	High	Low	Social Care		LA			Local Authority	Minimum CCG Contribution	£6,007,613	Existing
2	Carers Funding	Range of services to support carers - fulfilling CCG's Statutory	Carers Services	Carer Advice and Support				Medium	Low	High	Medium	Social Care		LA			Local Authority	Minimum CCG Contribution	£650,000	Existing
3	Reablement funds - LA	Funds LA's in-house Reablement team	Intermediate Care Services	Reablement/Rehabilitation Services		Packages	1,200.0	Medium	High	High	High	Social Care		LA			Local Authority	Minimum CCG Contribution	£825,000	Existing
4	2016/17 ASC Increased Transfer	ASC increased transfer	Home Care or Domiciliary Care			Packages	1,000.0	Medium	High	High	Low	Social Care		LA			Local Authority	Minimum CCG Contribution	£5,738,273	Existing
5	Lifestyle Hub	Public Health commissioned hub for linking people to	Prevention / Early Intervention	Other	Physical health/wellbeing			Medium	Not applicable	Not applicable	Low	Community Health		CCG			Local Authority	Minimum CCG Contribution	£101,790	Existing
6	Assistive Technologies	Stand alone and Wireless devices to >5000 users	Assistive Technologies and Equipment	Telecare				Medium	Low	High	Medium	Social Care		LA			Local Authority	Minimum CCG Contribution	£203,580	Existing
7	Strengthening ICRS - LA	24/7 social care rapid response within 2 hours	Intermediate Care Services	Rapid / Crisis Response				High	Medium	High	High	Social Care		LA			Local Authority	Minimum CCG Contribution	£1,080,184	Existing
8	Health Transfers Team	On-site Social work team as part of integrated discharge team in acute	HICM for Managing Transfer of Care	Chg 3. Multi-Disciplinary/Multi-Agency Discharge				Low	High	Medium	Not applicable	Social Care		LA			Local Authority	Minimum CCG Contribution	£186,595	Existing
9	MH Discharge Team	Social worker onsite to support discharges from MH in patient wards	Personalised Care at Home			Placements	-	Low	High	Low	Low	Social Care		LA			Local Authority	Minimum CCG Contribution	£44,832	Existing
10	IT System Integration	SystmOne access for Care Navigators	Enablers for Integration	Shared records and Interoperability				Low	Not applicable	Low	Low	Social Care		CCG			NHS Community Provider	Minimum CCG Contribution	£7,125	Existing
56	It system integration	SystmOne access for ICRS	Enablers for Integration	Shared records and Interoperability				Low	Not applicable	Low	Low	Social Care		CCG			NHS Community Provider	Minimum CCG Contribution	£20,000	New
12	Falls (Steady Steps)	Strength & Balance programme in community to reduce	Prevention / Early Intervention	Other	Strength &balance training for falls			Medium	Not applicable	Medium	Medium	Community Health		CCG			Private Sector	Minimum CCG Contribution	£101,790	Existing
13	Home Visiting Service	24/7 clinical home assessment by Advanced practitioner	Intermediate Care Services	Rapid / Crisis Response				High	Not applicable	Low	Medium	Community Health		CCG			Private Sector	Minimum CCG Contribution	£1,255,073	Existing
57	Joint Integrated Commissioning Board Support	50% of 0.6WTE post to support joint Commissioning projects	Enablers for Integration	Integrated commissioning models				Low	Low	Low	Low	Social Care		CCG			Local Authority	Minimum CCG Contribution	£23,000	Existing

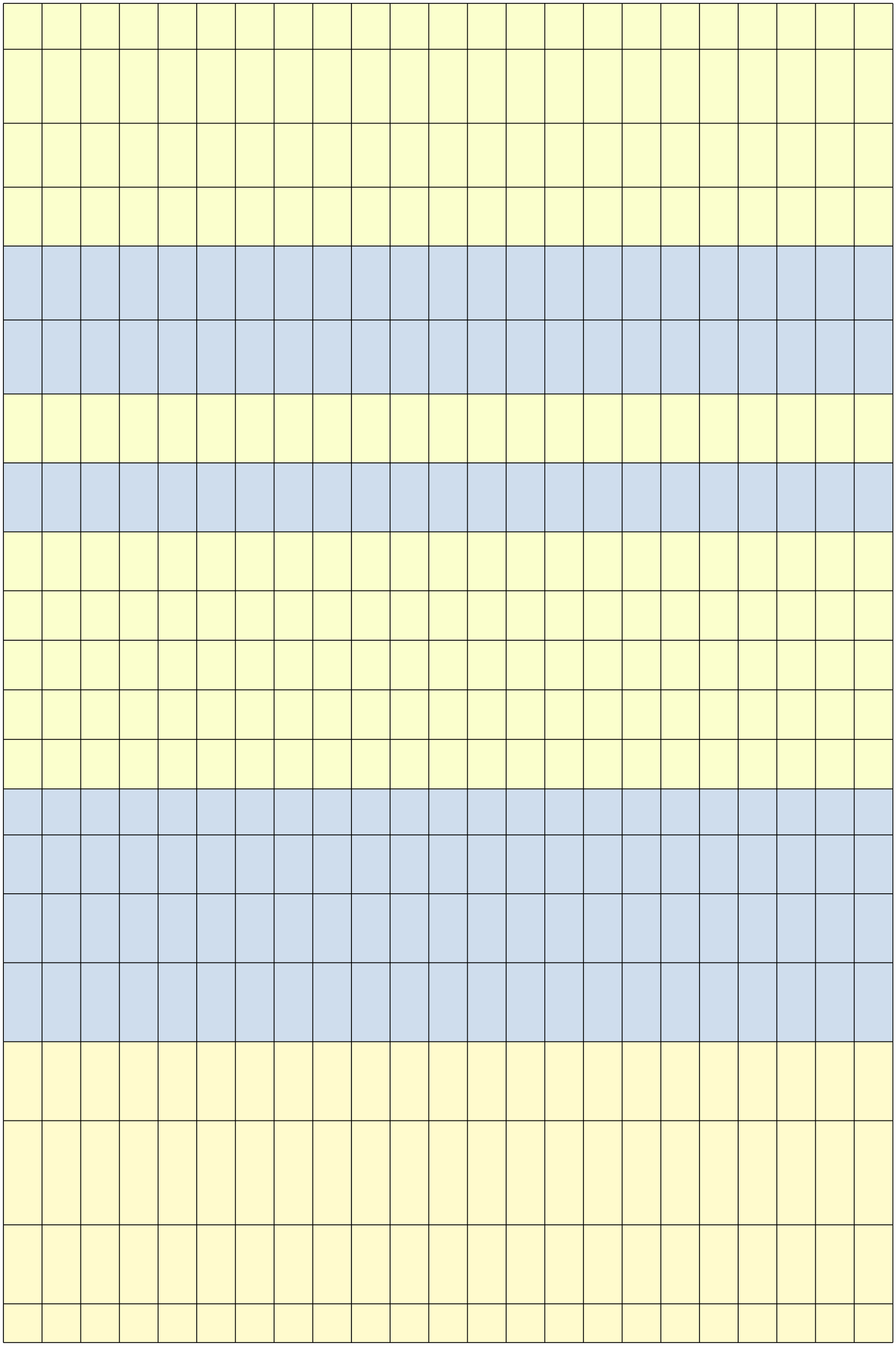
15	LPT - Unscheduled Care Team	Additional funding to CHS to resource left shift	Intermediate Care Services	Rapid / Crisis Response				High	Not applicable	Medium	High	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£519,815	Existing
16	MH Planned Care Team - LPT	Specialist team for those with LTCs AND fuunctional MH	Community Based Schemes					High	Not applicable	Low	Low	Mental Health		CCG			NHS Mental Health Provider	Minimum CCG Contribution	£388,253	Existing
17	Care Home Therapies Team - LPT	Dedicated therapy tream for city care homes - focus on falls	Prevention / Early Intervention	Other	Cinical therapy input for residents at risk			High	Not applicable	Not applicable	Not applicable	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£144,996	Existing
18	Intensive Community Support Beds -	"Virtual ward"	Intermediate Care Services	Rapid / Crisis Response				High	Medium	Medium	Low	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£954,032	Existing
19	Reablement - LPT	Clinical Therapy input to LA's Reablement service	Intermediate Care Services	Reablement/Rehabilitation Services		Packages	1,200.0	High	High	High	High	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£1,216,760	Existing
20	Risk stratification	Licence costs/data processing/analysis for risk stratification tool	Prevention / Early Intervention	Risk Stratification				Medium	Not applicable	Low	Low	Other	Data processing/licence costs	CCG			Private Sector	Minimum CCG Contribution	£66,163	Existing
23	Services for Complex Patients (Care Navigators)	Care Navigator service	Integrated Care Planning and Navigation	Other	Physical health/wellbeing			Medium	Not applicable	Medium	Low	Primary Care		CCG			Local Authority	Minimum CCG Contribution	£300,578	Existing
24	Hospital Housing Enablement Team	Specialist team aimed at homeless/insecurely housed needing hospital	Housing Related Schemes					Low	High	Low	Not applicable	Social Care		CCG			Local Authority	Minimum CCG Contribution	£155,000	Existing
26	Performance Fund	As per BCF guidance	Other		As per BCF guidance			Not applicable	Not applicable	Low	Not applicable	Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£1,704,053	Existing
28	Discharge Home to Assess	MDT partnership for those not eligible for reablement to discharge	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access				Low	High	Low	Not applicable	Social Care		LA			Local Authority	Minimum CCG Contribution	£188,322	Existing
29	H&SC Protocols - training	Training for ASC staff to undertake delegtated tasks under the protocol	Enablers for Integration	Integrated workforce				Low	Low	Medium	Low	Social Care		CCG			NHS Community Provider	Minimum CCG Contribution	£69,217	Existing
37	Care Home staff training	Training programme for residential Home staff in identifying and	Other		Training in how to communicate			Medium	Not applicable	Not applicable	Not applicable	Community Health		CCG			Private Sector	Minimum CCG Contribution	£23,000	Existing
38	LeicesterCare call centre Staffing increase	Additional staffing	Assistive Technologies and Equipment	Telecare				Medium	Not applicable	Medium	Medium	Community Health		CCG			Local Authority	Minimum CCG Contribution	£80,000	Existing
40	Action on Deafness	Access/engagement support to community and residential and	Assistive Technologies and Equipment	Wellness Services				Low	Low	Low	Low	Other	Support for people with disabilities	CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£30,000	New
41	Increase in funding to support packages	Additional packages of care to support the discharge of patients at	HICM for Managing Transfer of Care	Chg 3. Multi-Disciplinary/Multi-Agency Discharge				Low	High	Medium	Low	Social Care		CCG			Local Authority	Minimum CCG Contribution	£77,783	Existing
42	Eye Clinic Liaison Service	Advice, guidance & support for those with progressive sight loss	Other		Service from VISTA charity			Low	Not applicable	Medium	Medium	Other	Support for people with disabilities	CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£15,000	Existing
44	Centre Project	Day Centre for vulnerable people in city centre offering range of	Other		Vol. Sector Day Centre			Medium	Not applicable	Low	Low	Social Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£24,000	Existing

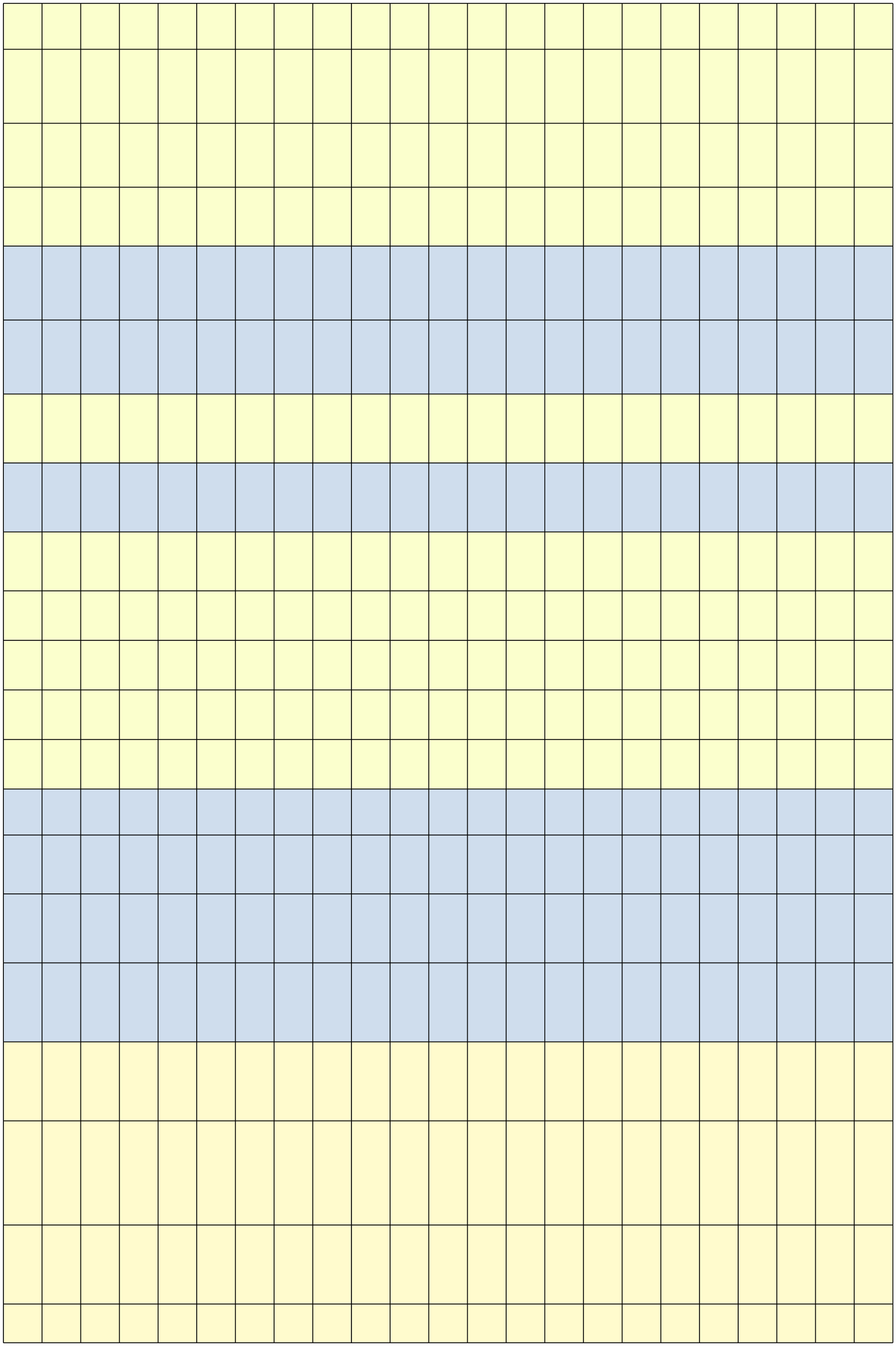
45	Identifying and managing frailty course for GPs	Bespoke course from LU Medical School on Managing frailty for	Prevention / Early Intervention	Other	Training course to improve quality of care			Medium	Not applicable	Medium	Medium	Primary Care		CCG			Private Sector	Minimum CCG Contribution	£5,000	New
46	Investment in community therapy to	Increase in ASC therapy staff	HICM for Managing Transfer of Care	Chg 4. Home First / Discharge to Access				Medium	Low	High	Medium	Social Care		CCG			Local Authority	Minimum CCG Contribution	£20,000	Existing
48	Pilot of Fire Service response to falls in Care	rapid response car to act as first responder to falls in care homes	Intermediate Care Services	Rapid / Crisis Response				Medium	Not applicable	Not applicable	Not applicable	Other	Out of hospital rapid response	CCG			Local Authority	Minimum CCG Contribution	£27,293	New
50	Royal Voluntary Service	6 week follow post hospital discharge to restore confidence and	Personalised Care at Home			Packages	480.0	Medium	Low	Medium	Medium	Other	Support to resume social activities post	CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£30,000	Existing
52	Stop Smoking clinics in hospital	Additional Stop Smoking support for people in hospital	Prevention / Early Intervention	Other	Physical health/wellbeing			Low	Not applicable	Low	Low	Acute		LA			Local Authority	Minimum CCG Contribution	£5,089	Existing
54	Mental Health First Aid	Funds places on MH First Aid Courses for ASC, CHS staff	Intermediate Care Services	Reablement/Rehabilitation Services		Packages	5.0	Medium	Not applicable	Low	Low	Social Care		LA			Private Sector	Minimum CCG Contribution	£10,000	Existing
55	Social worker for addiction/hoarding	Dedicated case management support for those with hoarding	Prevention / Early Intervention	Social Prescribing				High	Not applicable	Low	Low	Social Care		LA			Local Authority	Minimum CCG Contribution	£50,800	New
58	Community Therapy	Additional Physio and occupational therapy to support patients to	Community Based Schemes					Low	Not applicable	Not applicable	Not applicable	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£911,136	New
55	DFG Related Schemes	DFG Related Schemes	DFG Related Schemes	Adaptations				Low	Low	Medium	Medium	Social Care		LA			Local Authority	DFG	£2,391,923	Existing
56	iBCF	Meeting adult social care needs	Other		Variety of iBCF schemes			High	Medium	High	Medium	Social Care		LA			Local Authority	iBCF	£6,528,000	Existing
57	iBCF	Reducing pressures on the NHS, including supporting more people	Other		Variety of iBCF schemes			Low	High	Low	High	Social Care		LA			Local Authority	iBCF	£2,586,000	Existing
58	iBCF	Ensuring that the local social care provider market is supported	Other		Variety of iBCF schemes			Medium	High	Medium	Low	Social Care		LA			Local Authority	iBCF	£6,352,521	Existing
59	Winter Pressures	Meeting adult social care needs	Other		Variety of Winter pressures			Medium	High	Low	Low	Social Care		LA			Local Authority	Winter Pressures Grant	£677,619	Existing
60	Winter Pressures	Reducing pressures on the NHS, including supporting more people	Other		Variety of Winter pressures			Low	High	Low	Medium	Social Care		LA			Local Authority	Winter Pressures Grant	£289,000	Existing
61	Winter Pressures	Ensuring that the local social care provider market is supported	Other		Variety of Winter pressures			Low	Medium	Low	Low	Social Care		LA			Local Authority	Winter Pressures Grant	£607,119	Existing
21	Services for Complex Patients (GP PIC/Training)	Primary care/MDT prevention scheme for frail and multi-morbid	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				High	Low	Medium	Medium	Primary Care		CCG			NHS Community Provider	Minimum CCG Contribution	£630,000	Existing
39	Training in Motivational Interviewing for	Training for ASC in MI to promote strengths-based assessment.	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Low	Not applicable	Low	Low	Social Care		CCG			Private Sector	Minimum CCG Contribution	£45,000	Existing

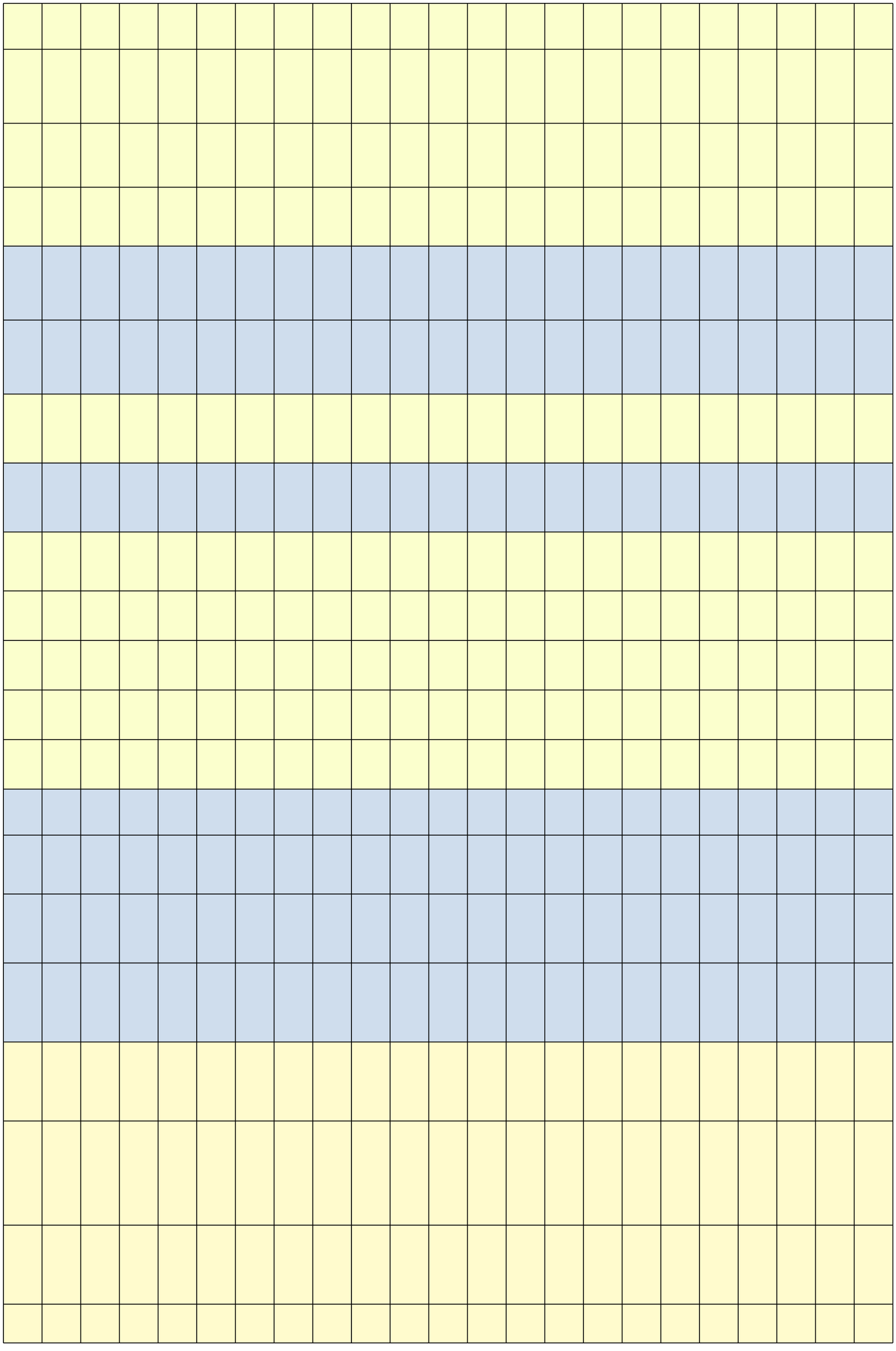
51	Printing costs for Care Navigator Leaflets	Print Care Navigator leaflets to support promotion of service to	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Low	Low	Low	Low	Primary Care		CCG			Private Sector	Minimum CCG Contribution	£400	New

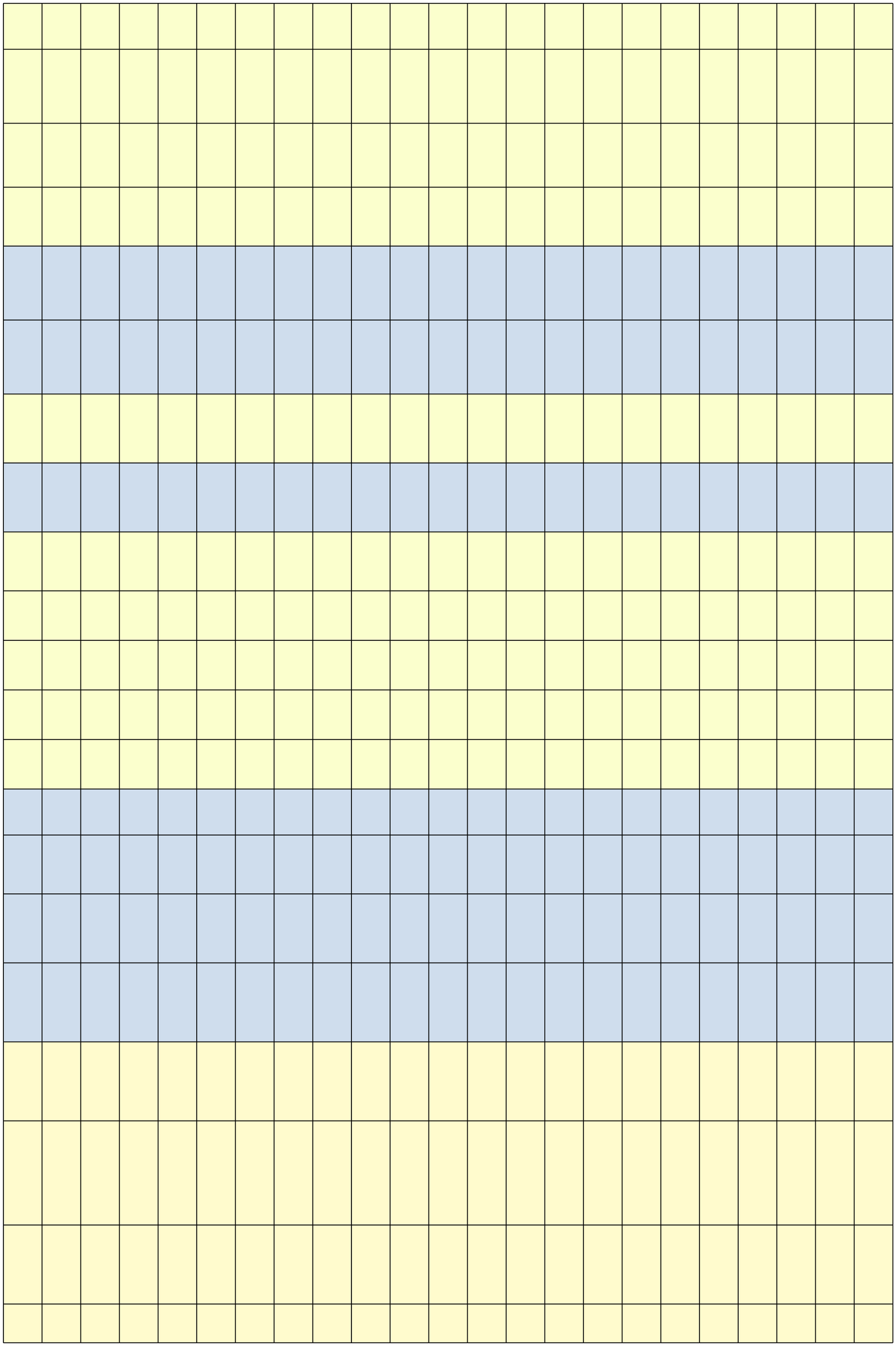


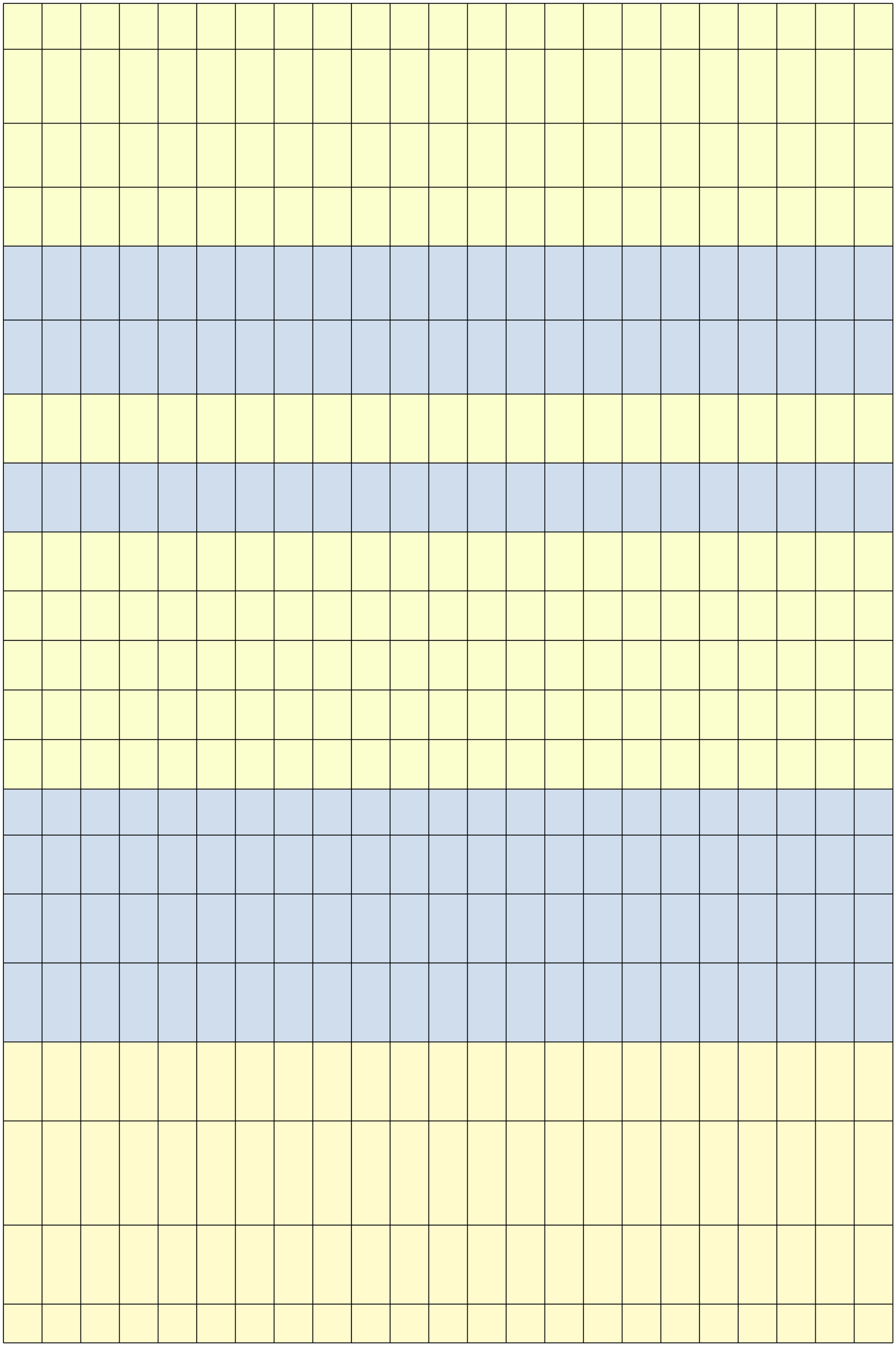


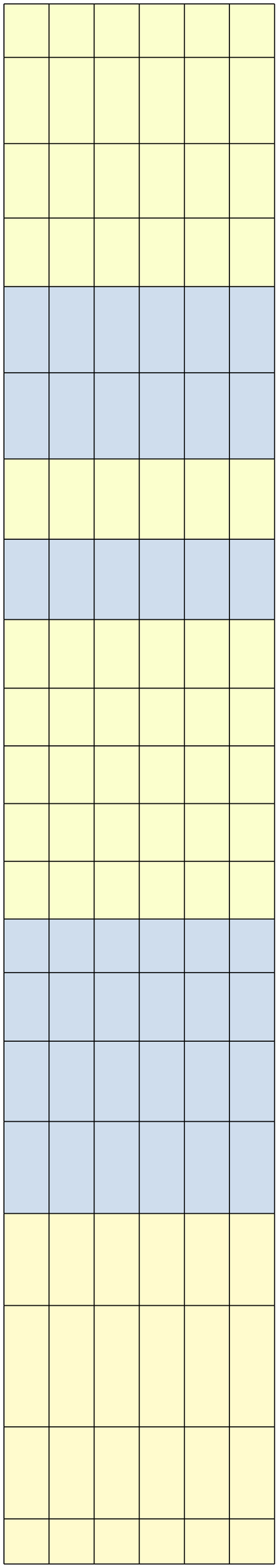












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Scheme Type	Description	Sub Type
Assistive Technologies and Equipment	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Digital participation services).	Telecare Wellness Services Digital Participation Services Community Based Equipment Other
Care Act Implementation Related Duties	Funding planned towards the implementation of Care Act related duties.	Deprivation of Liberty Safeguards (DoLS) Other
Carers Services	Supporting people to sustain their role as carers and reduce the likelihood of crisis. Advice, advocacy, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence. This also includes the implementation of the Care Act as a sub-type.	Carer Advice and Support Respite Services Other
Community Based Schemes	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 level (eg: Integrated Neighbourhood Teams)	
DFG Related Schemes	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.	Adaptations Other

Enablers for Integration	Schemes that build and develop the enabling foundations of health and social care 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.	
High Impact Change Model for Managing Transfer of Care	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 as such, is included in this section.	Chg 1. Early Discharge Planning Chg 2. Systems to Monitor Patient Flow Chg 3. Multi-Disciplinary/Multi-Agency Discharge Teams Chg 4. Home First / Discharge to Access Chg 5. Seven-Day Services Chg 6. Trusted Assessors Chg 7. Focus on Choice Chg 8. Enhancing Health in Care Homes Other - 'Red Bag' scheme Other approaches
Home Care or Domiciliary Care	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.	
Housing Related Schemes	This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.	

Integrated Care Planning and Navigation	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 like Single Point of Access (SPoA) and linking people to community assets. 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 and the HICM for managing discharges, 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.	Care Coordination Single Point of Access Care Planning, Assessment and Review Other
Intermediate Care Services	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.	Bed Based - Step Up/Down Rapid / Crisis Response Reablement/Rehabilitation Services Other

Personalised Budgeting and Commissioning	Various person centred approaches to commissioning and budgeting.	Personal Health Budgets Integrated Personalised Commissioning Direct Payments Other
Personalised Care at Home	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.	
Prevention / Early Intervention	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.	Social Prescribing Risk Stratification Choice Policy Other
Residential Placements	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.	Supported Living Learning Disability Extra Care Care Home Nursing Home Other
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.	

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Better Care Fund 2019/20 Template

8. Metrics

Selected Health and Wellbeing Board: Leicester

8.1 Non-Elective Admissions

	19/20 Plan	Overview Narrative
Total number of specific acute non-elective spells per 100,000 population	**Collection of the NEA metric plans via this template is not required** as the BCF NEA metric plans are based on the NEA CCG Operating plans submitted via SDCS.	Our BCF funded integrated system of care has been central to a relative containment in then growth of NEAs in Leicester - esp. in the over 65s. BCF funds a range of integrated health, local authority and vol.sector services in the community aimed at admission avoidance.2019-20 will build on previous successes We remain challenged in this area however with ED situated within easy access of all residents and the impact of health inequalities leading to multi-morbidity at an earlier age driving acute admissions. Our key target in 2019-20 is to focus on reducing admissions in adults of working age. See Section 4: A and B(i) and B(ii) and Winter

Please set out the overall plan in the HWB area for reducing Non-Elective Admissions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.

Plans are yet to be finalised and signed-off so are subject to change; **for the latest version of the NEA CCG operating plans at your HWB footprint please contact your local Better Care Manager (BCM)** in the first instance or write in to the support inbox:
ENGLAND.bettercaresupport@nhs.net

8.2 Delayed Transfers of Care

	19/20 Plan	Overview Narrative
Delayed Transfers of Care per day (daily delays) from hospital (aged 18+)	21.4	DTOCs in Leicester remain at a low rate. "Push" processes are via an integrated Discharge team at UHL made up of hospital staff, on-site social workers, Housing Enablement Team, RVS, and Dementia Support team. "Pull" function is via Reablement team, Discharge Home to Assess commissioned from Independent Sector domicilliary care, Discharge to Assess Care home beds and "bridging" from Integrated Crisis Response Service (ICRS). MH in-patients has an assigned on-site social worker and access to Housing Enablement Team. Post discharge phone call pilot via Care Navigators. Winter pressures grant - supports additonal capacity to reduce DTOC. For examp;le: Care Home Trusted Assessors and support to self funders.

Please set out the overall plan in the HWB area for reducing Delayed Transfers of Care to meet expectations set for your area. This should include any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric. Include in this, your agreed plan for using the Winter Pressures grant funding to support the local health and care system to manage demand pressures on the NHS, with particular reference to seasonal winter pressures.

Please note that the plan figure for Greater Manchester has been combined, for HWBs in Greater Manchester please comment on individuals HWBs rather than Greater Manchester as a whole.
Please note that due to the merger of Bournemouth, Christchurch and Poole to a new Local Authority will mean that planning information from 2018/19 will not reflect the present geographies.

8.3 Residential Admissions

		18/19 Plan	19/20 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	600	586	Carrying on successful work delivered in 2017-19. (a) Reablement Service (b) Discharge Home to Assess pathway. (c) Rapid response to fallers at home via ICRS (28 mins average). (d) Steady Steps strength and balance programme to reduce falls. (e) Care Navigator proactive assessment and intervention. (f) Integrated MH Team
	Numerator	254	254	
	Denominator	42,304	43,358	

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.

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 2016 based Sub-National Population Projections for Local Authorities in England;

Please note that due to the merger of the Bournemouth, Christchurch and Poole Local Authorities, this will mean that planning information from 2018/19 will not reflect the present geographies.

8.4 Reablement

		18/19 Plan	19/20 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 (%)	92.2%	93.0%	Carrying on successful work delivered in 2017-19. New Integrated Home First team launches with Locality Decisions Unit as single front door in December 2019 following earlier pilot in July- see Section 4 B (i). Medical support model to be piloted this year to resource explicit addional primary care support.
	Numerator	212	214	
	Denominator	230	230	

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.

Please note that due to the merger of the Bournemouth, Christchurch and Poole Local Authorities, this will mean that planning information from 2018/19 will not reflect the present geographies.