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	^^ Link back to top
Remaining Word Limit:	895

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.

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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

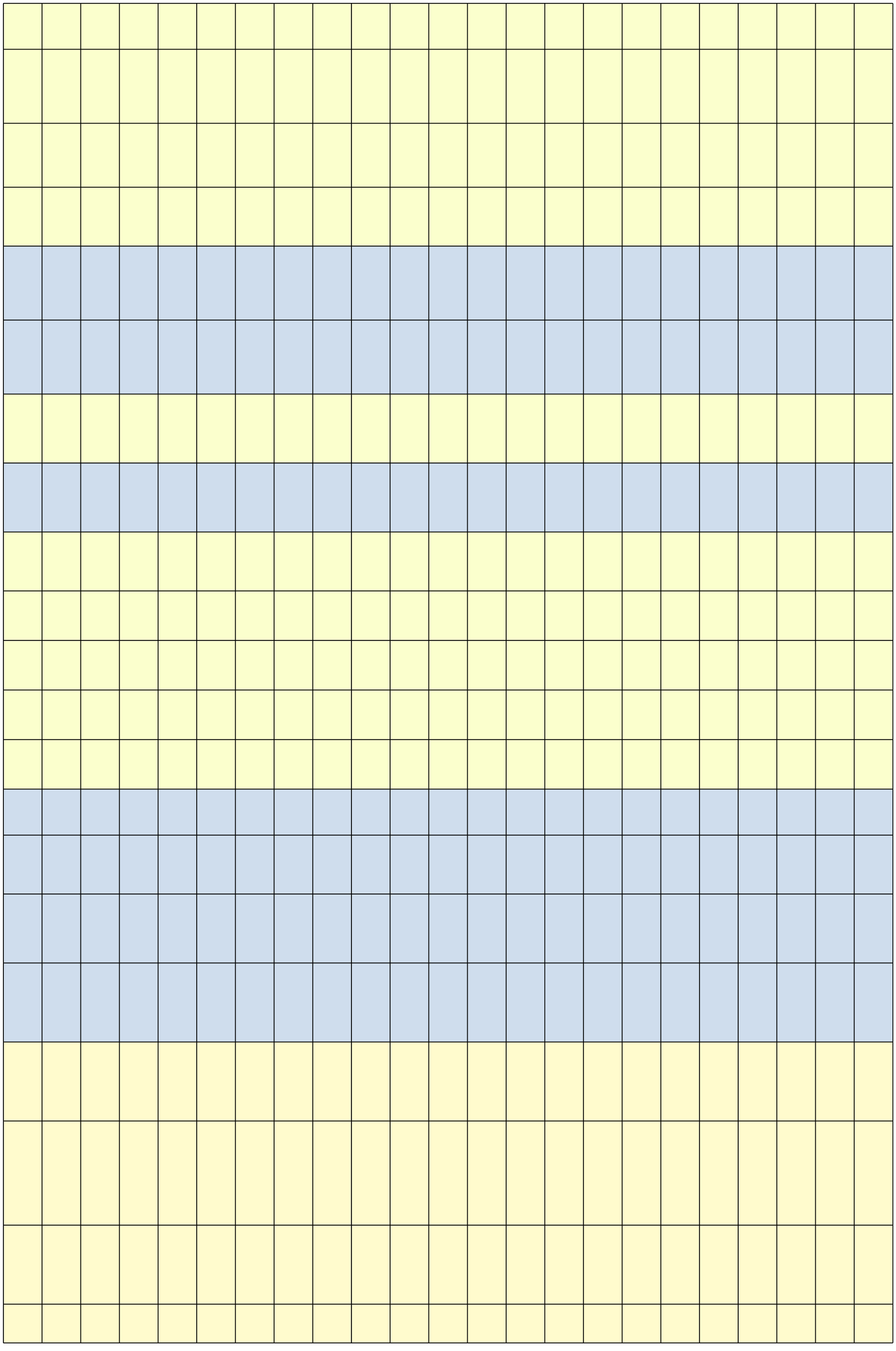
Link to Scheme Type description

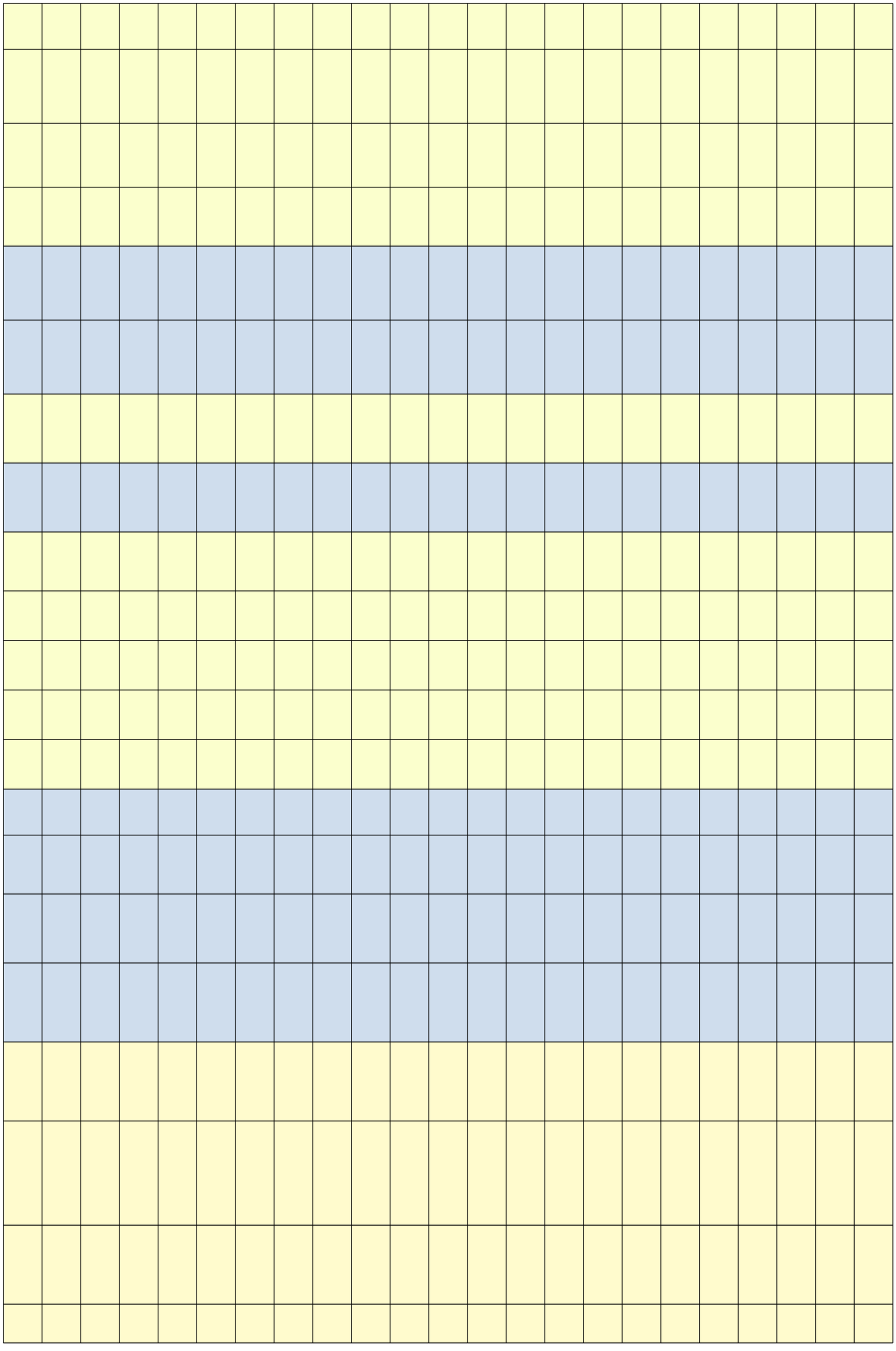
						Planned Outputs		Metric Impact				Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Planned Output Unit	Planned Output Estimate	NEA	DTOC	RES	REA	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% 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

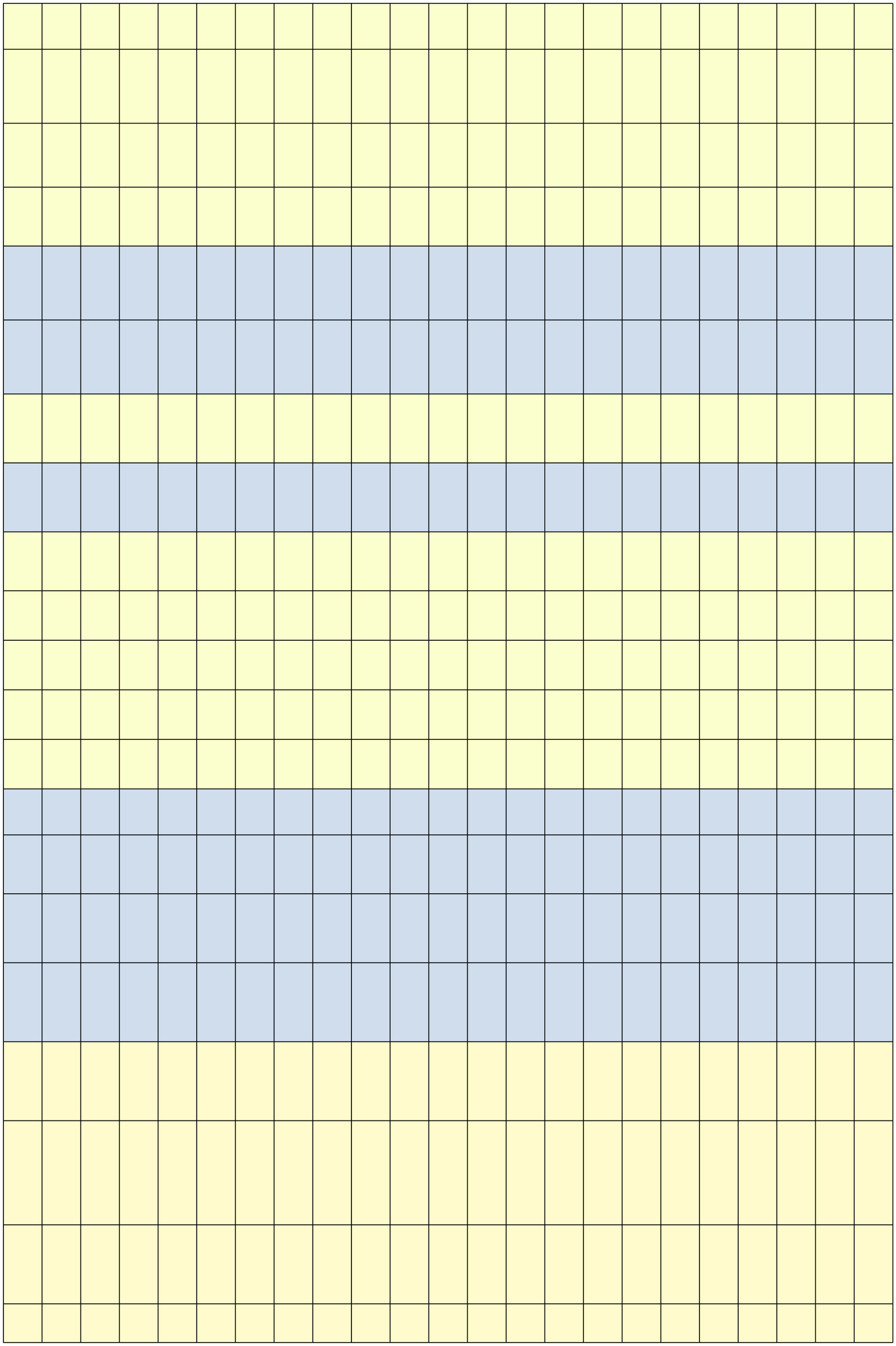
15	LPT - Unscheduled Care Team	Additional funding to CHS to resource left shift	Intermediate Care Services	Rapid / Crisis Response				High	Not applicable	Medium	High	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£519,815	Existing
16	MH Planned Care Team - LPT	Specialist team 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

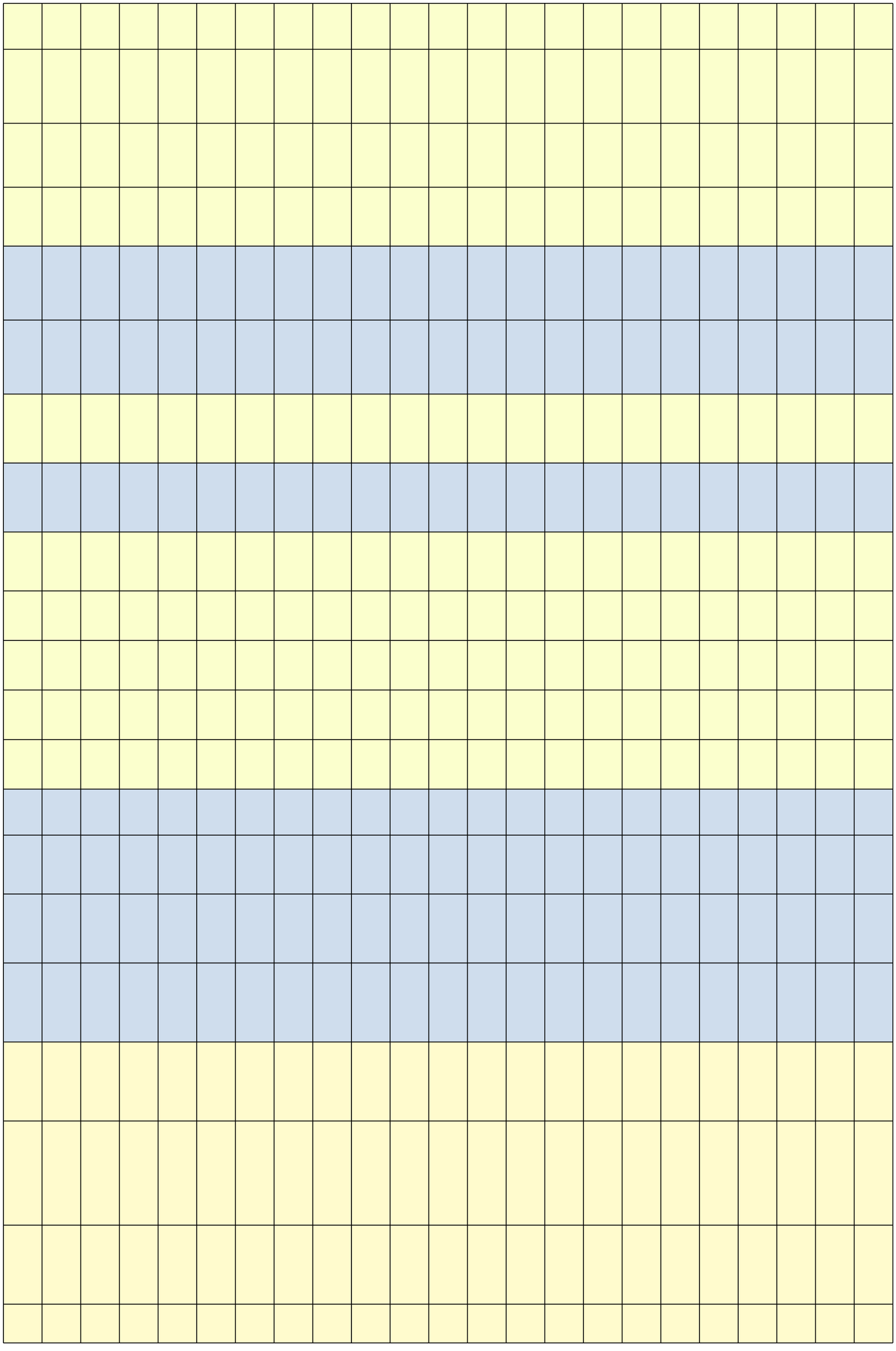
45	Identifying and managing frailty course for GPs	Bespoke course from LU Medical School on Managing frailty for	Prevention / Early Intervention	Other	Training course to improve quality of care			Medium	Not applicable	Medium	Medium	Primary Care		CCG			Private Sector	Minimum CCG Contribution	£5,000	New
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

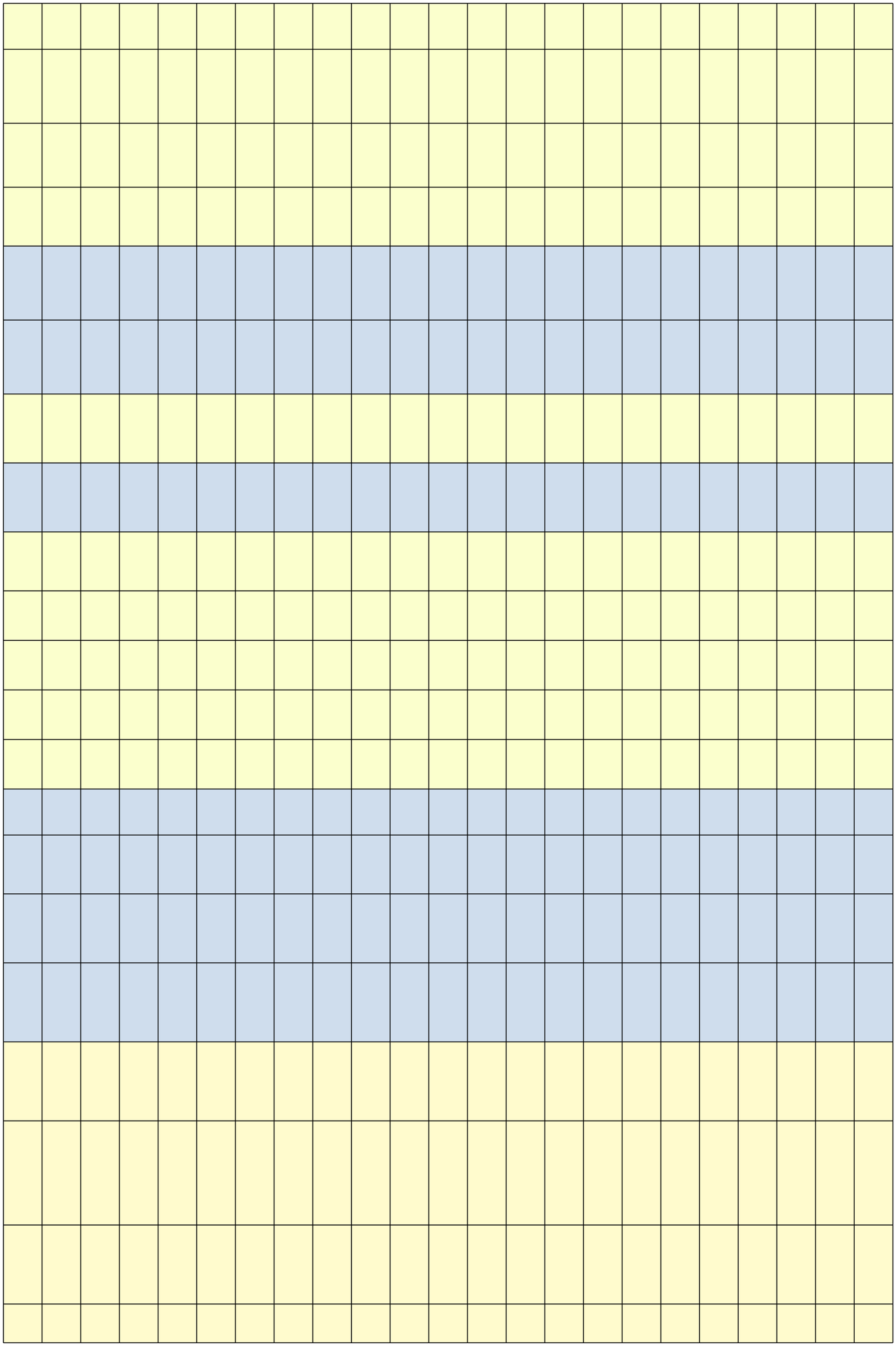
51	Printing costs for Care Navigator Leaflets	Print Care Navigator leaflets to support promotion of service to	Integrated Care Planning and Navigation	Care Planning, Assessment and Review				Low	Low	Low	Low	Primary Care		CCG			Private Sector	Minimum CCG Contribution	£400	New

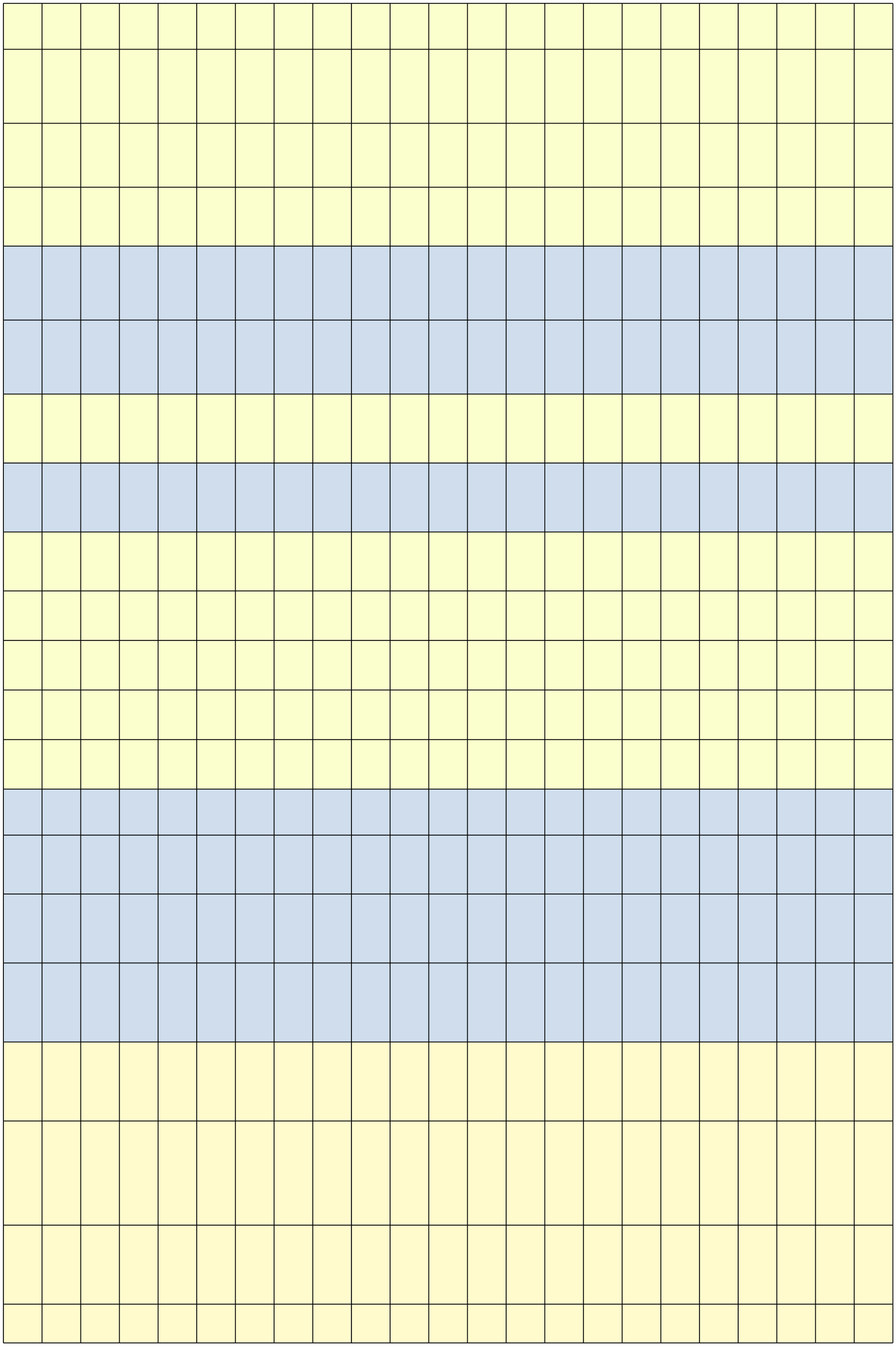


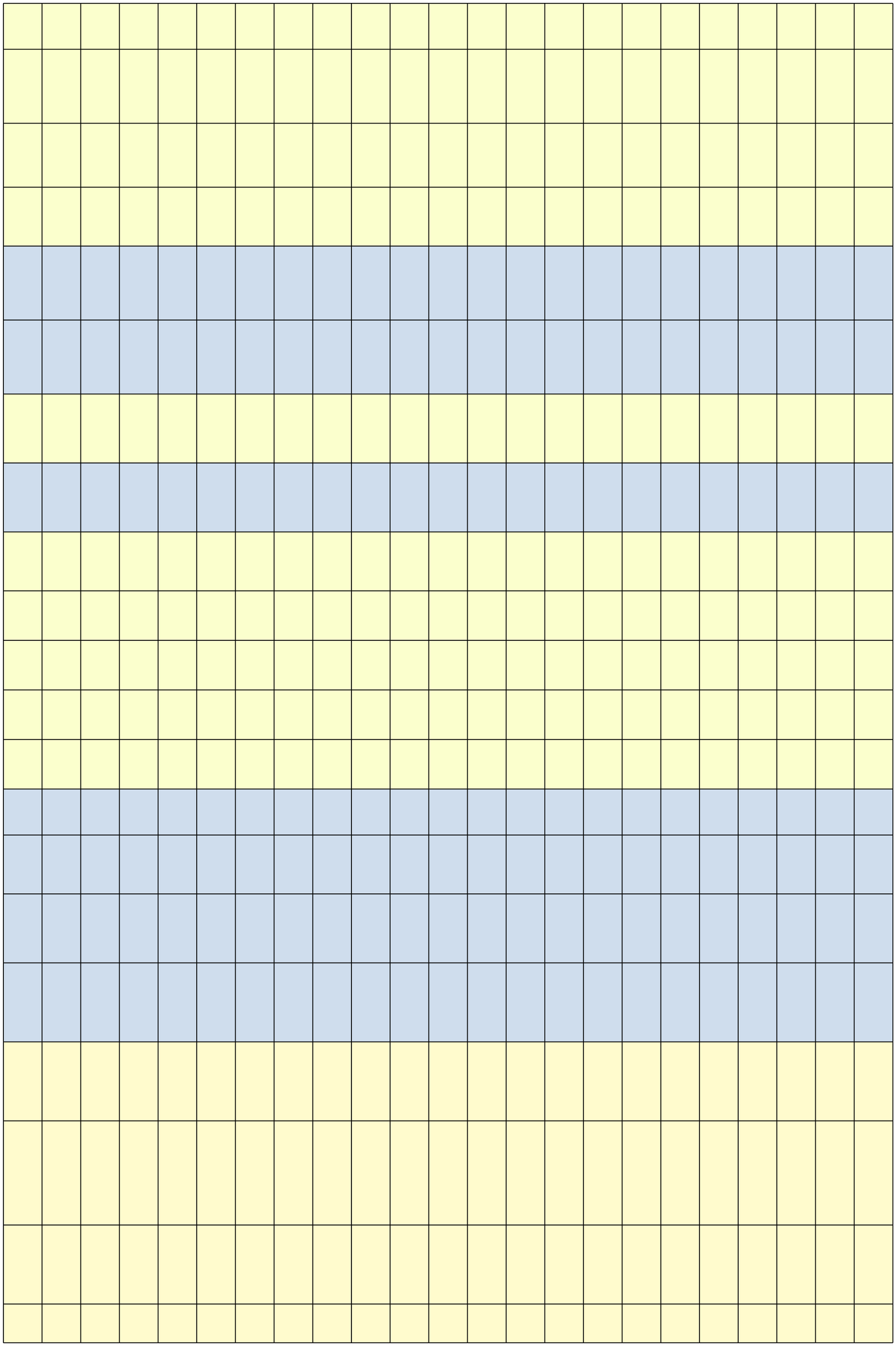












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Scheme Type	Description	Sub Type
Assistive Technologies and Equipment	Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, 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.