BCF narrative plan template

Cover

Health and Wellbeing Board(s)

Leicester City

Bodies involved in preparing the plan (including NHS Trusts, social care provider representatives, VCS organisations, housing organisations, district councils)

Leicester City Council – Adult Social Care
Leicester City Council – Public Health Department
Leicester City CCG (now LLR ICB)
University Hospitals of Leicester Trust
Leicestershire Partnership Trust
Derbyshire Health United – provider of out of hours, emergency home visiting and Urgent Care Centre services

The BCF plan is co-developed with stakeholders and forms part of the wider Joint Health and Wellbeing Strategy delivery. Bodies involved in the preparation of this plan have been through a well-established, place-based infrastructure:

1. **Leicester City Integrated System of Care Group (ISOC).** This groups brings together representatives from the University Hospitals of Leicester, Leicester City Public Health Team, Leicester City Adult Social Care, Leicester City Place (ICB), Leicestershire Partnership Trust (MH and Community Health Services Provider), Derbyshire Health United (provider of out of hours medical services, out of hospital hubs and home visiting services), Health Watch, The City Primary Care Network Strategic Clinical Directors, Leicester City GP Lead for Population Health, Dr Raj Than, Leicester City Place clinical leads Dr Avi Prasad and Dr Fahad Rizvi. Voluntary Sector providers also attend to update on elements of BCF-funded provision. A sub-group of this Group drafted the initial 2022-23 City BCF budget. ISOC meets monthly to oversee operational delivery of BCF services and recommends any commissioning required to meet our objectives.
2. **Leicester City Joint Integrated Commissioning Board (JICB).** This monthly Board meeting is chaired alternately by the Director of Social Care, Education and Housing from Leicester City Council and the Chief Operating Officer for the ICB. It includes senior representatives from ICB, UHL, Public Health, Adult Social Care, Children's Services and Community Health Services. JICB has delegated authority from Leicester City Health and Wellbeing Board to develop BCF strategy and to sign off BCF plans pending HWB sign-off.

3. **Leicester City Health and Wellbeing Board:** Formal approval of the City 2022/23 BCF plans is expected at the scheduled meeting on 13th October. The chair of the Health and Wellbeing Board, is a member of the ISOC group, which has developed the 2022/23 plans.

Executive summary

Leicester City has adopted the Making it Real Framework. This ambition for this plan reflects our key 'I' and 'We' statements:

"I have care and support that is coordinated and everyone works well together and with me"

"We work in partnership with others to make sure that all our services work seamlessly together from the perspective of the person accessing services"

The BCF plan for Leicester City for 2022/23 reflects the established framework already in place for delivery of integrated working across the LLR system, whilst reflecting a high degree of continuity of strategic intent with our plans from previous years.

1. We will be focusing on delivery of the national metrics identified in the BCF Framework published in July 2022. (See Excel Template tabs 4,5,6,7)

2. We will continue to use the BCF monies and the partnerships and relationships to advance a broader range of culture, service improvement and quality-related agendas across the city health and care landscape as a whole:

    - Integration of services into an Integrated System of Care for people and their carers living with frailty or multimorbidity.
    - Reducing inequity of outcomes across health and care
    - Making Every Contact Count (MECC)
    - Promoting personalisation of care
    - Promoting parity of esteem for those with mental ill-health or neurodiversity
    - Improving the experience of care
    - Improving the experience of work for all our staff
    - Mobilising the voluntary sector as partners in a health and care system
    - Improving value (value for money and social value) for people and partners in our system
    - Embedding a population health approach to Improving health and care outcomes for the people of Leicester City (the Core20Plus5 approach)

The BCF pooled budget will fund the following key areas of place-based services in 2022/23:

- Care Navigation and coordination
- Home First Community Response Service including Integrated Hospital Discharge and Reablement Pathways
- Integrated Crisis Response Service
- Transforming Care and Learning Disability priorities
- Health and care data integration solutions
- Assistive technology developments (including community alarm call centre),
- Key services to support and sustain adult social care, (e.g. Care Act requirements
- residential respite, assessment and review teams, quality assurance team for care and nursing homes, mitigation of demographic growth and winter pressures).

Key changes in the 2022-23 plan

A tabletop review of City BCF investment in 2021/22 resulted in the following changes in the 2022/23 investment plan. These changes were made on the bases of emerging population need, strategic priorities at Place, and in some cases the identification of alternative (non-BCF) sources of funding for some services. For the 2022/23 plan, alternative funding sources (in full or part) were identified for some services, e.g. Dear Albert, Leicester Counselling Centre, VISTA and Warm Homes Services. This enabled new investments to be made in the GP Registration programme and the MDT Leader's post, as well as increases in other services as outlined below.

Iterations of 2022/23 BCF plans were debated at ISOC at which the chair of the Health and Wellbeing Board represents the views of the elected HWB members

- Additional investment in Care Co-ordination for Discharge to Assess
- Additional investment in Integrated Crisis Response Services
- Additional investment in Care Navigation
- Additional investment in Reablement and in digital inclusion for those with sight loss
- Additional investment in Breast feeding support for women from less advantaged groups
- New investment in support for those who are resident within Leicester City but are not registered with a GP practice
- New investment for support to day care for those with alcohol and other substance misuse issues

- For 2022/23, joint priorities and projected spend were planned and approved by partners and stakeholders during the planning phase which began in February 2022. This included alignment to the newly refreshed Joint Health and Wellbeing Strategy (JHWS) priorities for Leicester City. The strategy focuses on the life course approach, with specific integration focus on Living and Supported Well, and Dying Well priorities.

Metric targets have been jointly produced with each BCF "Place" in Leicester, Leicestershire, and Rutland (LLR) using the same methodology. This has been through a collaboration of representation from Midlands and Lancashire Commissioning Support Unit, the ICB and Local Authorities. These have been added to the performance framework across LLR for joint delivery of outcomes related to activity to support timely discharge.

Governance

Overall responsibility for sign-off of the BCF plan sits with Leicester City's Health and Wellbeing Board, to ensure that the plan is supporting the delivery of the (newly refreshed in 2022) Health and Wellbeing strategy for Leicester. The next meeting of the Health and Wellbeing Board will take place on 13th October 2022, at which the plan will be formally approved. The Chair of the Health and Wellbeing Board has approved submission of this current plan following a Lead Member briefing.

Strategic oversight of the development of the plan is delegated to the Joint integrated Commissioning Board (JICB), which includes senior representatives of the Local Authority and ICB across adults and children's services, housing, and Public Health. Earlier drafts of this plan were developed by a sub-group of The Integrated Systems of Care group (ISOC, see below), were revised in line with comments from JICB and ISOC, and the final plan approved by JICB and by the CCG Executive Management Team.

The operational delivery of the BCF plan in Leicester City is managed each year by the Integrated Systems of Care Group (ISOC). ISOC includes representatives from a range of organisations including healthcare providers, the ICB, Health and Wellbeing Board, Public Health, Adult Social Care, Strategic Clinical Leadership and Health Watch. This group meets every month under the chairmanship of Deputy Director of Integration and Transformation (previously a CCG Independent Lay Vice Chair) to review progress and performance of BCF-funded services in relation to national BCF metrics and the wider agenda of integration, personalisation of care and reduction of inequity.

Leicester's BCF investment plan is mutually supportive with those of its ICS partners in Leicestershire and Rutland. Given its focus on improving outcomes and experiences of care for adults living in Leicester, its strategic development is also influenced by LLR system-wide groups including the LLR Prevention and Health Inequalities Reduction Board, the LLR Population Health Management Advisory Group and the LLR Frailty collaborative.

Overall BCF plan and approach to integration

Leicester's vision for health and care integration is '*Working together to enable everyone in Leicester to have opportunities for good health and wellbeing' (Leicester Health, Care and Wellbeing Strategy 2022-27)* Our jointly agreed priorities for delivering models of care are to:

- Access a range of preventative and proactive services
- Deliver more care outside of hospital and closer to home
- Provide integrated, personalised, and holistic services.
- Help citizens, carers and professionals work together to maintain health, wellbeing and independence, for as long as possible.

Our approach to joint commissioning for 2022/23 has been to re-align the BCF into key sections of delivery against emerging priorities in order to make it clear how BCF investment aligns to person-centred care and maintaining independence wherever possible

Many chronic conditions are preventable, yet the NHS remains, at heart, a treatment service for people when they become ill, and lacks a comprehensive approach to keeping people well. To address this, there is a need to move away from a system focused on diagnosing and treating illness towards a partnership that is based on promoting wellbeing and preventing ill health. To do this, our ICS will reach beyond the NHS to work alongside local authorities and other partners to address social, economic, and environmental determinants of health within an integrated system of care.

Evidence consistently shows that it is the wider conditions of people's lives – their homes, financial resources, opportunities for education and employment, access to public services, and the environments in which they live that exert the greatest impact on health and wellbeing. These 'wider determinants of health' require partners to work together to consider how they all combine to affect our wellbeing and health.

Our LLR 'Home First' Collaborative brings together clinical and managerial leadership across the system and aims to deliver optimal outcomes for our complex/ frailty patients through design and delivery of an integrated system of complex care across the Leicester, Leicestershire & Rutland health and care system. Over the years many great services have been developed through BCF funding to support people to remain at home as independently, and as safely, as possible. We are now looking

to opportunities to ensure our offer fits together without gaps in provision for all frail and complex patient groups.

These are: Home First, Discharge to Assess, Transforming Care, Mental Health, and Health and Social Care protected services. Within these spheres, schemes are funded to deliver outcomes around proactive care, place-based models of care, personalised care, Dementia Strategy, Learning Disability pooled budget arrangements and "preablement" preparation for elective surgery. This has made it easier to determine overall commissioning activity within each key section. A desktop review of all BCF schemes by the Subgroup of ISOC helped to re-align BCF priorities for partners to new emerging models of care.

Summarised below are the some of the new key Home First programme priority schemes and developments that aim to meet the above priorities in addition to existing services described in previous years' plans, including any changes and additional investment to our Better Care Fund planning or spend.

For each scheme described in brief below, the appendix attached details key features, desired, outcomes, overall impact, challenges and mitigations to these areas of work.

Overall BCF Plan and approach

Transforming and building community services capacity through growing the LLR virtual ward model: £2.6 million initial investment – Start April 22 – completion Dec 23

A virtual ward is a team of professionals working to manage a group of patients in the community. It allows patients to get the care they need at home, safely and conveniently, rather than being in hospital. Using a combination of remote monitoring by healthcare professionals and home visits, virtual wards can help prevent hospital admissions or allow for an earlier, supported discharge. It has been shown that people make a better recovery in their own surroundings and that staying in hospital longer than necessary can have a detrimental effect on their condition and their independence.

By Winter it is hoped that 275 patients across LLR will be able to be looked after simultaneously across nine virtual wards including frailty, cardiology, acute respiratory and diabetes. The number of beds will increase to more than 440 by December 2023. (Leicester's population represents approximately 40% of the LLR population and would be using these services in a broadly proportionate way.)

The virtual ward service has been arranged by NHS LLR and will be provided by a collaborative of local organisations, including University Hospitals of Leicester NHS Trust, Leicestershire Partnership NHS Trust, Local Authorities and the local hospice, LOROS.

Among the priorities will be: to increase utilisation of existing virtual ward beds, ensuring appropriate use to avoid admission (where appropriate)/ facilitate earlier discharge; and to enhance our step up and step-down access to virtual ward beds through growing the development of the LLR unscheduled care coordination hub.

Impacts on equality and access to asset-based community approaches will be detailed for each ward in the EHIRA attached below. Phase 2 stages for the EHIRA are in development and further work is

underway to assess the ongoing requirements for this. E.g. whether impact assessments are required for each protected characteristic.

Paper D - Stage 1 EHIIRA questions MS '

Pathway 1: supporting reablement, rehabilitation and recovery intake model – initial health investment across LLR of circa £2.3 million recurrent funding (including non-BCF funding such as Ageing Well) – start implementation September 2022 – ongoing until September 2023

One of the major ambitions in our approach to integrated care has been the development of an overarching health and social care service that aims to support timely discharge and also to provide a step-up crisis model of care.

This will support the previous ambitions of the Ageing Well Programme by further integrating community models of care, to maximise independence, support people to remain in their own homes and reduce inequality of ability to remain at home particularly those with protected characteristics within the Equality and Diversity strategy. This will further ensure that Leicester City residents are receiving the right level of care in the right place at the right time, supporting delivery of recommendations received in the LLR system-wide review conducted by Dr Ian Sturgess, Urgent and Emergency Care Improvement Expert, during July and August 2022. The recommendations relating to this piece of work are being fed into a programme plan (currently in development) which will include risks to delivery and a breakdown of individual task-related timescales.

Changes from 2021/22 -

- Further investment in recruitment (recurrent) of staff to support the model
- Aligning the locality model of delivery to LPT hubs to incorporate community nursing and therapy
- Re-assessment (post-pandemic) of demand and capacity modelling
- Incorporating community response services with reablement

Embedding integrated neighbourhood working and delivering anticipatory care: **Additional £200k investment across LLR– this phase of implementation to last until April 2023**

Integrated Neighbourhood Teams aim to provide proactive and integrated care to communities of 30,000-50,000. They aim to keep local people well and out of hospital and are built on the base of primary care networks. They bring all parts of the workforce together and put the people at the centre of the care they receive. The cornerstone of each Integrated Neighbourhood is a Primary Care Network.

Our Making it Real model of care is shown in the diagram below:

Model-of-care-Leicestershire.pdf

Some of the key deliverables include:

- Embedding operational Multi-Disciplinary Teams (MDTs) and an anticipatory care/population health management (PHM) approach to jointly manage frail, complex and high-risk patients, ensuring that all neighbourhood teams have well-functioning MDTs in place by October 2022 ;

- Ensuring consistent use of care co-ordinators, care navigators and social prescribers to maximise use of the Voluntary and Community Sector and other wellbeing offers in order to ensure the issues related to the wider determinants of health as well as purely clinical or functional capacity issues are addressed;
- Developing high-performing Integrated neighbourhood leadership teams consistently across LLR with full engagement, clear governance and shared purpose, underpinned by a local PHM plan by March 2023.
- Increasing the identification of carers enabling support to be offered;
- Developing an Integrated Neighbourhood Team maturity matrix;
- Increasing care planning to 95% of vulnerable patients;
- Recruiting additional care co-ordinators and finalising an MDT draft framework; and
- Recruiting MDT Facilitator roles through LAs (underway).
- community services, care homes and acute; and, planning and delivering a public awareness campaign.

Transforming and building community services through Home First Urgent Crisis Response and reablement

The aim of this priority is to deliver an urgent community response within two hours for more patients than in 2021-22 and achieve this target at least 80% (we are exceeding our target) of the time for the system.

Urgent crisis response referrals will be increased through: Emergency Department front door diversion; expanding pendant alarm referral routes; diverting appropriate calls from EMAS alignment to other local offers; continuation of the falls crisis response offer; and maintaining delivery of rehabilitation and reablement within two days of referral to at least 80% of cases across LLR. (Again a target that is being achieved)

Strengthening the community palliative and end-of-life care response

LLR partners will support more people to die in their place of choice through:

- Increased identification of people in their last year of life via increased use of risk predictive modelling markers within the ACG system (MRS) and ReSPECT planning;
- Improved access to end-of-life care provision through the design and mobilisation of a 24/7 advice line for patients, carers and professionals;
- Enhancing the end-of-life discharge pathway by testing an integrated end of life social care bridging and co-ordination offer and undertaking quality and co-production reviews of patient and carer experiences at the end of life.
- Ensuring end-of-life care remains everyone's business through appropriate training and support to staff of all disciplines
- Refreshing place-level JSNAs and the LLR all-age end of life strategy

Implementing the enhanced health in care homes (EHCH) model

- Ensuring full and consistent delivery of all parts of the EHCH PCN Direct Enhanced Service, including allocating named GPs for all care homes and residents;

- Piloting the use of a care home virtual ward with remote monitoring for patients with a frailty score of seven or above or a higher risk of admission, and developing a plan for further roll out by September 2022;
- Embedding comprehensive geriatric assessments and effective MDTs across all care homes by August 2022;
- Determining the ongoing model of care for bed based reablement care;
- Implementing the National Early Warning Score (NEWS) which is a tool for identifying and responding to acute illness. When used in care homes, staff measure residents' vital signs and record them on a tablet computer, which calculates a NEWS to share with health partners; and
- Complementing this by piloting WHZAN and Spirit digital technologies in care homes to support the identification of deterioration using NEWS2. The Whzan Blue Box is an all-in-one telehealth case. It measures vital signs, records photos, and performs multiple assessments and questionnaires including NEWS2. Signs of deterioration or illness are identified earlier, for a clinical response or carer support.

Implementing equitable falls prevention and management across LLR

- Evaluating and developing longer term plans for the falls crisis response model to maintain an equitable response across LLR by August 2022;
- Developing a plan for early identification and support for people at risk of falls by October 2022; and
- Embedding a consistent falls management offer across LLR.

Implementing an integrated therapy model that maximises shared resources

The Integrated Therapies Vision is to best utilise LLR therapy resources across LLR where services provided are similar or across patient pathways where there are key therapy interfaces. This will support seamless and effective patient care, efficiencies, flow, admission avoidance, and a single model of care within certain pathways with agreed standards and ways of working. This needs to be underpinned by a robust LLR Therapy workforce plan. Among the changes are:

- Maximising the use of LLR's integrated therapy workforce across ICS shared roles, a single leadership model, a single clinical model and shared waiting lists across each pathway;
- Development of a single clinical model and pathway for stroke therapy;
- Development of an integrated therapy model for community health and social care.

Growing community capacity through the workforce

- Engaging with independent providers of care home and domiciliary care, through provider forums, to support system resilience and the integration agenda;

- Co-design of a responsive system-wide Home First career pathway encouraging more effective integration and sharing of future workforce capacity by collectively developing a pipeline by championing of new roles and shared training and development; and
- Further exploration of Multi-Professional Teams/ co-location/ collaborative working to ensure consistent working practices and to promote better integration of the LLR workforce as well as care pathway delivery improvements.

Implementing the BCF Policy Objectives (national condition four)

Below are examples of investment in schemes to support enable people to stay well, safe and independent at home for longer and to provide the right care in the right place at the right time. All schemes are jointly agreed and approved with partners including Hospital Trusts and joint processes and resources are agreed in all cases. This is done both formally through the agreed governance structure and also through joint forums such as the Strategic Discharge Cell. We believe that these services which are funded through both BCF and national and local funding streams will help us deliver successfully against the high-impact change metrics and the other national BCF metrics.

As in the previous section, for each scheme described in brief below, the appendix attached details key features, desired, outcomes, overall impact, challenges and mitigations to these.

Implementing BCF Policy Objectives ap|

Unscheduled Care Hub – pilot phase from April 2022. Ongoing development until April 2023
Our local health and care services will be taking responsibility for managing the needs of sub-acute patients who present to the Unscheduled Care Coordination Hub (UCCH). These are residents who are not seriously ill but are at immediate risk of unscheduled attendance at hospital or having an ambulance response.

The UCCH will co-locate a multidisciplinary team made of representatives from DHU Health Care, East Midlands Ambulance Service (EMAS), Adult Social Care (ASC), Leicestershire Partnership Trust (LPT), Integrated Care Board (ICB) and the Emergency Care Improvement Support Team (ECIST).

The UCCH can continue to take referrals from the Emergency Operations Centre (EOC) for EMAS calls waiting, however there will be a dedicated (Clinical Advice Team (CAT) clinician on site for a complete overview of LLR EMAS calls waiting (on EMAS stack), along with UCCH reviewing the Clinical Navigation Hub (CNH) and Home Visiting Service (HVS) calls waiting and EDs bed stack. This will provide UCCH with oversight of a substantial proportion of LLR's unscheduled care demand providing the ability to safely navigate patients to the most appropriate care setting for their needs.

Referrals from community teams in LPT and ASC will also be able to phone the UCCH to discuss patients presenting with non-emergency clinical presentations. This will be to guide a decision on whether an ambulance should be requested, or if the patient can be safely supported in their home environment.

Referrals to the UCCH from EMAS crews on scene is advised where a patient is at risk of admission and there is a view that a community-based alternative could be safely offered. This can be where there is no existing appropriate pathway, or the crew are not aware of an existing pathway. Where there is an community existing pathway, this should be utilised.

All patients referred or reviewed will receive a multi-disciplinary team discussion. This will support decisions being made within 15 minutes to ensure patients are placed into the most appropriate health or care setting and safely transferred into alternative pathways. Further considerations will include proactive support at home. The UCCH will take ownership of patients moved from all patient lists and the UCCH team will inform patients of any alternative plan/pathway identified.

The multidisciplinary unscheduled care team will have real time visibility of EMAS, DHU and LPT caseloads and the ability to interact with healthcare professionals on scene to provide viable alternatives to hospital admission and enabling appropriate support within the home environment.

The unscheduled care coordination hub will be supported by health and care colleagues ensuring the right skill set, experience and knowledge is in place to support the diverse needs of the patients being referred in. There will be clinical oversight by DHU throughout the hub's operation to ensure risks are monitored and patient safety is adhered to.

Integrated Discharge Hub and Case Management for Discharge - £313k – Completion October 2022
In 2020/21 Leicester, Leicestershire, and Rutland established an Integrated Discharge Hub with Hospital Trusts to streamline, coordinate and facilitate discharges for patients requiring ongoing support post discharge on pathways 1-3. In 22/23 this will be further developed and enhanced.

We have developed an electronic LLR Discharge Tracker that serves to provide system-wide assurance, across our single bed-base, of acute and community hospital inpatient beds, on key quality and performance metrics aligned to the national discharge guidance.

Multi-agency staff have access to all SystmOne electronic health records and can update and track patient activity in real-time.

Re-Commissioning of step-down D2A beds to support the 3 R model of care – commissioning to start October 2022 – completion for "go-live" July 2023
The introduction of the national discharge model to deal with COVID, and with it a more explicit onus on rehabilitation, reablement and recovery (RRR) as a core offer within the discharge process, is supporting a move to recovery and therapeutic interventions within a pathway 2 model. These services give our local system an opportunity to embed strength-based, outcome-focused care for people 'stepping down' from an acute care episode and, ideally, as a way of also avoiding admissions (step up) where a safe and effective alternative is available.

Previously commissioned bed-based models proved that 77% of patients returned to their usual place of residence with only a small percentage of people discharged into longer term residential care. The Care Co-ordination service has been enhanced to support this and offers links to ongoing community support and care. They work as part of the MDT alongside therapists to ensure that patients are effectively case managed and discharged with the appropriate levels of ongoing care for residual needs (if any).

The clear importance of a dynamic and comprehensive "RRR" offer in the LLR out-of-hospital landscape recognises that a shift from the provision of traditional care after discharge to one that is based on the principles of effective RRR, can maximise independence and wellbeing and potentially reduce the long-term costs of care. These services ensure dedicated capacity is available for people who would benefit from a RRR intervention as part of our Home First approach This supports the LLR vision for Home First and the key BCF priorities of the last several years relating to length of acute hospital stay, timely discharge and promoting independence for older people and those with disabilities.

These services have at their core, the principles and values of personalisation and community-based support, this is central to improving outcomes for people transferring from hospital into these settings. This specification borrows from Think Local Act Personal's "Making it Real" framework which is a set of 'I' and 'We' statements that describes what good care and support looks like from a person's perspective.

Integrated Personalised Care Framework - £81k for training packages – go live Nov 22

A review of the LLR Health and Social Care Protocol (2014) began in 2019 in a context of growing demand, with increasing complexity of need across all health and social care partners and against a backdrop of ongoing budgetary pressures and significant challenge in relation to capacity across all parts of the system.

The protocol listed and enabled partners to have a mandate for health and care providers to deliver a set of shared tasks on behalf of each other linked to the personalisation of deliveries of care models. The Integrated Personalised Care Framework aims to:

- Identifies the Principles, Statutory duties and National guidance that underpin and inform decision making around the delegation of support tasks between Health and Social Care.
- Identifies the elements required to support appropriate delegation and aims to help registered practitioners and commissioning workers understand the decision-making process involved in safe and effective delegation of a task from one provider /organisation to another.

In addition to this, there has been an ongoing drive towards integration across Health and Social Care, including the development of Primary Care Networks, Integrated Neighbourhood Teams, Home First and the effective utilisation of the voluntary sector and wider community assets.

Training and launch events are scheduled for September to roll out the new framework to the health and care workforce within Leicestershire.

Demand and Capacity modelling

The Demand Capacity modelling template has been completed in line with the guidance issued. The pattern of BCF investments in the range of services included in the 'intermediate care' descriptions is a continuation of the approach which has proved successful in Leicester City in previous years and which we believe best ensures that City capacity matches demand. (Still at home after 91 days after discharge = 93%. 60% requiring no package of care, 25% requiring same package of care as before) The BCF investment in this sphere on non-bed based services is £5,203,519. The sum of £494,077 spent on the city bed based services comes from a non-BCF source.

High Impact Change Model – self-assessment

Leicester City has undertaken a self-assessment against the high impact change model of care for 22/23. Attached is the summary of the assessment conducted and the work to progress through the levels of maturity.

High Impact Model

Supporting unpaid carers.

Leicester has a comprehensive offer that supports carers within our community. There are various schemes and services for unpaid carers and ways for them to access funds and short-breaks.

Details of the BCF finances used to support carers is detailed below. The last two bullets points represents the investment by the NHS in the delivery of the care act duties in relation to supporting unpaid carers (total = £764,025) (see row 2 in the Expenditure tab of the template):

- Provision for enhanced carer support services - £223k
- LD Short Breaks - £929k
- Residential Respite Service - £874k
- Care Act Enablers - £158k
- Care Act Support Pathway - £522k

Help is available through the customer service centre in Adult Social Care, with the BCF funding two carer champions to help carers access support initiatives shown below. In addition, Leicestershire has worked with the community and voluntary sector to commission VASL to support carers in the following ways:

- a dedicated telephone advice line Monday to Friday
- a telephone befriending service specifically for carers
- local carers groups and events
- support to complete Leicestershire County Council's online carer's assessment form

Carers support grants of £250 and personal budgets for carers are accessed through a carer assessment. This looks at existing support networks for example, family or friends. It considers the things a carer wants or need to achieve outside of your caring role and the impact this has on their ability to carry out those activities and affects their wellbeing.

Support to young carers is also included in the support offer and includes:

- help with school and college work
- training to get a job
- help to get a job
- activities
- spending time away from your caring responsibilities

In 2020 we signed up to become a partner organisation to Carefree which offers al breaks away listed on Carefree's Breaks Hub. Unpaid carers can browse available options and submit a request for a specific hotel on specific dates.

Respite at home (sitting service / time with)
Carers can find providers by using our online information and support directory and the Leicester, Leicestershire and Rutland Care Directory. The website also informs carers on NICE guidance on what to expect from a good service.

Short term care
This is available for carers to take a short break or holiday, this can be arranged by contacting any residential home and asking for availability and pricing for respite care.

Disabled Facilities Grant (DFG) and wider services

The Council administers a programme of DFGs with OT and housing staff working in partnership. A range of initiatives are deployed to create flexible and creative solutions for people requiring major adaptations, including a cost equivalent scheme, stair lift scheme, and bespoke solutions for people using the exceptional circumstances flexibility in the DFG policy. A funding pool is being explored to

support adaptations beyond the DFG cap, where this will maintain people living within their own home.

The BCF supports a wider range of housing needs including warm homes, small adaptations and equipment, additional capacity in the 24/7 community alarm scheme with direct access to UCR services. Work has taken place to explore how building links between the alarm scheme and CNS services might increase safe triage into non-acute services.

There are plans to increase OT capacity to support a review of people who are awaiting adapted rehousing, to inform the Housing Department's capital investment, creating suitable properties for people who have noy been able to secure suitable accommodation to date. This is challenging presently, as OT staff are proving difficult to recruit, which is a known national issue.

Housing Enablement Team

The Hospital Housing Enablement Team (HET) who provide a bedside service to patients and support flow through the UHL hospitals and the Bradgate Mental Health Unit continue to support the Integrated Discharge Hub.

A high volume of the work involves cases that fall outside of statutory duty for Local Authority Housing Options teams but fulfil the hospitals requirement to have a legal route for referral of homeless patients to the Local Authority. In addition, HET also supports patients with preventing evictions, accessing refuges, moving into new tenancies, provision of essential furniture items/white goods, support with adequate heating of homes, housing applications and benefit applications as just some of the work undertaken by HET that is outside the remit of statutory services but is otherwise necessary to secure safe, effective discharges for patients.

The additional support provided includes housing support for TB patients that access the TB centre for the East Midlands located in the Leicester hospitals, as well as extending support to patients with No Recourse to Public Funds but who are otherwise unable to be discharged from hospital safely. Most recently Lightbulb services and HET have been supporting therapy service patients with housing related issues by providing measures such as creating a downstairs-existences where possible and by undertaking small-scale cleans and clearances to make properties safe and accessible for discharges for patients and carers. In this way, patients are more likely to be able to return home in the first instance, rather than require interim placements or other high-cost interventions. Within mental health services, HET continues to work alongside Action Homeless to manage the Community Transitions Project, a step-down facility where patients who are ready to leave hospital can stay whilst they await long-term accommodation but who would otherwise be unsuitable for other temporary accommodation. This partnership allows vulnerable patients to be discharged safely from acute mental health beds, whilst still preventing readmissions as a result of unsafe discharges.

The team has expanded in a number of pilots to support the wider services and flow in the Mental Health Rehabilitation units and in all Community Hospitals. This is currently on a temporary basis to monitor demand. A similar pilot in MHSOP is also in discussion.
In 2021/22 the HET service undertook:

- 698 referrals from the UHL hospitals
- 173 referrals from the Bradgate Mental Health Unit
- 30 referrals from the MH Rehab units
- Managed 5 long-term TB cases in the community
- Achieved average resolutions times of just 2.61 days for UHL cases and 15.21 days for BMHU cases

Equality and health inequalities

The Leicester BCF plan is an enabler to all statutory organisations in our integration partnership in discharging their duties with respect to tackling and reducing inequalities. Reduction in health inequalities is informed by socio-economic data and woven into the design and prioritisation of interventions.

In this year's BCF, once again, we have further developed our approach to population health management particularly in light of inequalities highlighted during the covid pandemic. Partners have been provided with integrated sets of data to examine these issues which supported the development of the Joint Health and Wellbeing Strategy. One of the main aims of the strategy is to pinpoint health inequalities in order to design effective services to reduce these. This will be fed into current and future BCF planning.

Reducing health inequalities is a core priority for the LLR Integrated Care System (ICS) and its programme of work to reduce health inequalities will be guided by the 12 principles within the LLR Health Inequalities Framework with a focus on addressing the five priorities in the 21/22 & 22/23 NHS Operational Planning Guidance and the Core20Plus5 approach.
Attached is a report that was presented to the HWBB in July 2022, for Leicester and includes further details on the LLR approach to delivery of the core principles of the Core20Plus5.

LC HWBB CORE20PLUS5

Examples of continuous investment to reduce health inequalities in the city through the 2022-23 BCF investments, once again, include:

- The Centre Project
- VISTA
- Dear Albert
- Leicester Mammas
- Integrated Mental Health Team
- Royal National Institute for the Deaf (formerly known as Action on Deafness)
- Care Navigators
- Specialist support for those with Hoarding Disorder
- Live Well
- Smoke Free App
- GP registration team – New investment for 2022/23

All newly commissioned schemes, including those funded through the BCF, are subject to EHIRA's which form part of the overall development of business cases and presented throughout the corresponding governance structure. Work is underway to ensure that timescales for the development of EHIRA's is consistent within the development of schemes.

Current (2022/23) strategic actions to reduce health inequalities at the Integrated Care System level and local level following systemwide adoption of principles and actions contained within the LLR

Health Inequalities framework, further progress is planned or has already been made in the following areas:

Action 1
Places will be expected to apply the principles, outlined in the LLR Health Inequality Framework, to their specific populations in the most appropriate way that meets their local needs. This is likely to embrace the various factors that can affect people's health – including the wider determinants of health. For example in 2022 the ICB has agreed to a £1.1m investment in Leicester City Public Health to help mitigate the impact of current fuel poverty crises, on the basis of the impact of fuel poverty on physical and mental ill health.

Action 2
The ICS will make investment decisions for people across LLR that reflect the various needs of different communities - following the principle of proportionate universalism outlined in the Marmot reports. In this way, actions can be universal, but adjusted and made proportionate to the level of disadvantage. The aim of reducing health inequalities will be a high priority. Delivery of actions to reduce health inequalities locally, will be the responsibility of the Health and Wellbeing Board and the Leicester City Joint Integrated Commissioning Board. At system level across LLR, ensuring health and care equity through proportionately universal investment policies will be the responsibility of the LLR Prevention and Health Inequality Board, and of the ICB's Health Equity Committee. In 2022, Leicester City's BCF funded locally enhanced primary care scheme 'Planning for Integrated Care in General Practice' (PIC GP) allocated funding for a programme of enhanced primary and community care (including social care) on the basis of population health-based case mixed adjusted formula rather than simply on weighted list size. This model allocated larger sums of money to population with greater health inequalities and health care needs. This represents a proportionately universal approach to service provision.

Action 3
We will establish a defined resource to review health inequalities at this strategic level. This Health Inequalities Support Unit will be a virtual partnership between the NHS, local authorities and local universities. An enhanced ability to process and analyse data will support a better understanding of inequity across the area. We will gather and share best practice on effective interventions and provide teaching and training to all levels of staff in undertaking health equity audits. We will facilitate local research. Public health teams will deliver, with partners, the health inequalities support function at a place and neighbourhood level as part of the delivery of the Health and Wellbeing Strategy. The Health Inequalities Support Unit will be inaugurated during 2022-23. The directors of Public Health in Leicester, Leicestershire and Rutland have agreed the allocation of some Public Health analytical resource to commence an initial project on Cancer inequalities in Leicester City.

Action 4
All decision makers within the ICS will have expertise, skills, insight and understanding of health inequity and how to reduce it. Specifically, health inequity and inequality training will be mandatory for all executive decision makers in each organisation. In 2022 a sum of £20k was secured to fund the running of an initial health inequalities training course for LLR leaders, provided through the LLR Academy. The first cohort is expected to start in January 2023.

Action 5
Partner organisations continue to work together to understand the impact of Covid-19 on health inequalities across LLR, to allow effective and equitable recovery after the pandemic. We will be looking to:

- Identify groups and communities, across all ages and across protected characteristics, which have been most affected by the pandemic as a result of pre-existing vulnerabilities and disadvantages. In 2022 City BCF has funded GP Registration Programme to ensure marginalised groups, often the worst affected by Covid, has access to routine primary care and other public services.
- Undertake proportionate additional work to ensure vaccine uptake is equitable. LLR has been successful in applying to participate in the national Core20 Connectors Programme. The South Asian Health Alliance, SHAMA Women Centre and Equality Action Charnwood will be undertaking vaccine promotion activities this Autumn, specifically focusing on vaccine hesitant communities.
- Include consideration of the role of the wider determinants of health, such as education, employment, housing and poverty. For 2022/23 see comment on fuel poverty above.

Action 6

All partners will work to improve the completeness and consistency of their data to enable a better understanding of health inequity. This mainly relates to data collection on people with 'protected characteristics' under the Equality Act. Specifically, partner organisations will develop an action plan for having ethnicity, accessibility and communication needs of their population appropriately coded in records. In addition, we will make better use of our data sets in order to identify vulnerable groups and individuals to offer proactive, holistic care through Integrated Neighbourhood Teams. The BCF funded Care Co-ordination model is an example of how this will be addressed. In 2022, the GP IM&T Strategy group is developing a business case for funding access to the ARDENS electronic clinical software to support more consistent clinical coding in the primary care records.

Action 7

At the ICS level, we will obtain and use data to help us better understand where we can do more work to reduce health inequity. Specifically, each organisation will adopt a standard health equity audit tool and put training plans in place to use this tool, so that each 'place' area can compare their performance against other areas. In light of significant system pressures in other areas, action on rolling out this training is being deferred until the new year 2023.

Action 8

The NHS and public sector partner organisations within the ICS will seek to reduce health inequalities in respect of work opportunities, use of buildings and purchasing acting as "anchor institutions". The aim of doing this collaboratively, will increase purchasing power and commercial viability. From a workforce perspective in 2022/23, partner organisations across the LLR ICP have implemented a number of reverse mentoring programmes. Currently there are 25 participants across ICB, LPT, UHL and Local Authorities across LLR.