Leeds Better Care Fund Narrative Plan 2022/23

Version	Final 19/08/2022

Cover

Health and Wellbeing Board(s)

Leeds

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

Plans reflect the ongoing work with NHS Trusts, Home care providers, care home providers, VCSE colleagues through our multiple local forums within the Leeds Health and Care Partnership (LHCP)

How have you gone about involving these stakeholders?

System Flow improvement plan, System resilience assurance board, weekly system coordination group and operational groups, care home and home care provider meetings etc

Executive summary

Overall BCF plan and approach to integration

Our joint priorities for 22/23 include strengthening our home-based care offers and continuing to work collaboratively around the management of home care and care home markets, recognising the significant challenges they bring. We are refreshing our needs assessment for people with dementia and our integrated commissioning approach to this population, mindful of their particular needs and the growth of this population.

We also have an integrated approach to mental health commissioning and a fully integrated service for people with a Learning Disability. All of our work around Intermediate Care and support to people on discharge/prevention of admission has health and care representation embedded within it as well as 3rd sector representation.

The key change in services commissioned through the BCF is that we are jointly commissioning a further 12 beds for people with complex dementia related needs. We are also embarking on a joint Intermediate Care Strategy which will review our investment and outcomes across our intermediate care beds and our home-based services to identify further opportunities for investment and reinvestment.

Implementing the BCF Policy Objectives (national condition four)

The Leeds Health and Care Partnership has a strong population health approach, which is now being further embedded through population boards focusing on the needs of key populations including those living with frailty, those living with long term conditions and those at the end of life. We already have a LES focused on anticipatory care for people who are frail, so are ahead of the national approach to anticipatory care. This scheme has encouraged identification of those who are most at risk of losing their independence/deterioration, and provision of support to these people. We have a strong VCSE presence in all our planning and are currently working on a scheme with 10 VCSE providers called 'Enhance', providing own support in communities for those without family to improve self-care and asset-based approaches. We have a self-management team who are actively engaging across our services to support people and their families to better manage their own conditions. This complements our strength based social work approach and our Asset Based Community Development approach. We have a long history of working in this way in Leeds. Our Local Care Partnership model aligns local third sector organisations with primary care networks and other statutory providers to ensure we maximise the use of community assets to enable people to remain safely in their own homes with community support. Not all of these schemes are currently commissioned through the BCF but the LA and NHS commissioning and delivery are fully aligned via our local decision making and service development fora.

We have heavily invested in extending our discharge facilitation and transfer of care arrangements in recent months to help ensure we embed a home first approach more thoroughly. While home care staffing was a major barrier in the first months of the year, we have increased our payments to home care providers, and have seen an improving position in recruitment and retention although fuel costs remain a concern. We have strong relationships with the local home care market and are working with them on innovative models of care. We are in the process of developing further integration between our local authority reablement service and our community health service therapy and intermediate care offers, to ensure we obtain best value and outcomes from these services. We are committed to a strong focus on people being enabled to stay at home as well as facilitation of discharge. We have strong links between our Same Day Emergency Care (SDEC) work and our community response, increasingly identifying opportunities to return people to their own homes from ED or SDEC rather than admissions. We have embedded a mental health worker into these teams too, to pay particular attention to the needs of people with MH problems on the verge of admission to see if we can maximise their discharges/admission avoidance, recognising the particular challenges that an inpatient setting can place on a person with mental health needs or cognitive impairment. Our SRO for Transfer of Care also leads on our Enhanced Community Response, so we are completely joined up in our approaches. We have recently increased our funding for care at home including additional night sitters and therapy staff in advance of the full findings of an Intermediate Care Redesign programme to determine how we reduce our reliance on bed-based care .

Alongside our ICS partners, we have carried out a self-assessment of implementation of the High Impact Change Model for managing transfers of care and embedded the actions within our System Flow change programme. This includes a further focus on 7 day discharge, maximising home first options and embedding further improvements within our acute trust settings.

Supporting unpaid carers

We recognise the critical contribution made by unpaid carers in supporting the achievement of our health and wellbeing priorities in Leeds We commission Carers Leeds to provide information, advice and support for adult and parent carers in Leeds – the focus in 22/23 is reaching more carers from our culturally diverse communities; taking an asset-based approach; engaging earlier and working preventively; supporting carers through hospital discharge, influencing others to act to benefit the lives of carers**.** We will be testing out our co-produced Carer Friendly Primary Care Resource Pack which includes key messages, links to online carer awareness training, practical steps, 'how to' guides and information about local support – the aim is to enable primary care to identify, record and appropriately support more carers. We continue to build on our digital offer for carers and will be working in partnership with Carers Leeds and Carers UK to offer additional support through the digital resource for carers. We are working with third sector colleagues to develop a new offer for carers from diverse Black, Asian and Minority Ethnic communities which will lead to more BAME carers being identified, being supported via information and advice, and being supported to have a short break from caring. We plan to introduce new arrangements which support more carers to put in place contingency/emergency plans. Our short breaks and sitting services enable carers to have a regular and planned break from caring and, in addition, we continue to provide small grants to carers to enable them to take a break.

Disabled Facilities Grant (DFG) and wider services

Through our transfer of care work we have improved our interactions between housing, NHS and social care providers to think more creatively about how we can support people to leave hospital.

In accordance with statutory instrument legislation, the Council provides a full range of support in providing adaptations for people that apply for financial support through the DFG. The bulk of the DFG funding is targeted at providing housing solutions for disabled people and people who have health care needs. Each year, an element of the budget is used to provide a programme of discretionary work. For 2022/23, the discretionary funding is being used for a variety of purposes including:

- Paying for the salaries of Occupational Therapists undertaking DFG assessments in ASC
- Jointly funding heating improvements for disabled people with LCC Climate Control and Sustainability team
- Joint venture with Care & Repair (Leeds) Ltd to give grants for disrepair and insulation improvements to the homes of disabled/vulnerable people (means tested)
- Funding adaptations in a number of residential buildings run by local charities
- Assessing applications for discretionary funding from external bodies/agencies
- Assessing applications for discretionary funding from individual disabled people for grant aid to secure independent living (each application subject assessment of household accounts). Grants awarded for a wide variety of purposes to enable disabled people to continue to live in their home and avoid going into residential care
- Provision of disabled equipment (slings and hoists) for disabled children in their homes
- Provision of funding for a handypersons scheme run by Care & Repair (Leeds) Ltd

Equality and health inequalities

We have not made any specific changes to our BCF plan in relation to health inequalities. Our population health approach is creating a stronger data set for us to look at in terms of resource utilisation across both our areas of deprivation and our populations with protected characteristics. This is an area we will be taking forward more thoroughly within our Intermediate Care review and our other work on proactive care and discharge. We will be looking at unwarranted variation in both resource utilisation and outcomes.