Public Document Pack

HEALTH AND WELLBEING BOARD

6th December 2021

Supplementary Information - Item 12 - Updated Appendix 1 & 2

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Leeds Better Care Fund

Narrative Plan 2021/22

Version	Final 30/11/2021
Health & Wellbeing Board	Leeds

Contents

Executive Summary

The key changes to the Better Care Fund (BCF) in 2021/22 are that we have met as a Health and Care System to consolidate the various schemes within the BCF so that they are more clearly aligned with existing System Governance structures. The schemes are broadly overseen by the Mental Health governance arrangements, the Frailty Programme Board, and the newly formed System Flow Programme Board. This means that the BCF funds are being deployed within a clear city-wide governance arrangement which has representation from key partners from all sectors

The key changes relate to the major system pressures linked to the ongoing impact of the Covid-19 pandemic and its impact on people's lives, health and the workforce required to deliver care. Hospital discharge and system flow remain a key priority, both for acute hospital patients but also for those patients in specialist mental health settings. We have had a considerable focus on improving the efficiencies of the Intermediate Tier beds in the City, which have an even greater part to play as the thresholds for 'no reason to reside' have tightened in response to Covid. We have also invested in the City reablement and equipment services, to maximise options for care at home wherever possible within workforce and supply constraints. Priorities and spend have to some extent been skewed by the availability of the Hospital Discharge Fund which has created additionality into the system. Key schemes in 21/22 include: additional social work capacity to reduce downstream delays, therapy supported discharge, maximising productivity in reablement, and enhancing care at home such as night sitters and additional home carers to support the increased numbers of people wishing to die at home.

We have included the Primary Care Frailty scheme within the BCF, believing its core purpose which is to optimise the care of frail people has a direct link into the ambitions of the BCF to reduce hospital admissions and lengths of stay. Alongside the community geriatricians and ensuring medical support to our intermediate care beds is robust, we are aiming to ensure that people can stay out of hospital for as long as possible, even if they have increased needs.

Our Mental Health services have had particular challenges this year, but we are clear that the 3rd sector partners whose contracts are included within our BCF envelope, have had an invaluable role in supporting the health and wellbeing of many people throughout the pandemic. We have used the complementary skills of our 3rd sector providers to ensure there is a range of options available to people with acute and enduring mental health needs, that is not only provided by registered staff and statutory organisations but can be more tailored to a non-clinical and more community responsive offer if appropriate. Key areas of focus include alternatives to statutory services for crisis, enhanced support for people in community mental health settings, and support to access employment.

Stakeholder Involvement

In 2021/22 we have simplified the groups of schemes within the BCF so that the BCF Plan for Leeds is overseeing work that is the business-as-usual work of a number of key system working groups. Partners are therefore well involved in this work via the work of those groups, which are all multi-agency and multi-partner. So, for example, the System Flow Programme Board has representation from all key NHS Providers and Local Authority commissioner and provider representatives, and the working groups feeding into this include 3rd sector partners including the Oak Alliance. We work closely with housing partners, particularly where patients need housing support on discharge, and have strong local schemes around support with adaptations on discharge, Telecare, and other support arrangements. In particular, our Housing Options team are closely connected to our work.

The Mental Health schemes within the BCF are overseen by the emergent Mental Health governance structures, which again have significant representation from across the City. In particular, during 2021/22 there has been significant engagement around the re-procurement of 3rd sector Mental Health provision, where colleagues have been consulted on the nature and shape of this provision and how to streamline the commissioning arrangements for this. Housing partners are key to all our mental health and LD work and we work closely with them around accommodation and accommodation support.

There are weekly system operational forums which cover all system partners which again provides an opportunity to ensure that all partners can highlight areas of concern which are then addressed through some of the BCF schemes. Healthwatch and user voice are engaged with these work plans at a number of levels and their findings are embedded into the service changes considered by the BCF delivery groups.

Governance

The Integrated Commissioning Executive (ICE) serves as the BCF Partnership Board. The main funds have been allocated to work programmes which fall under the oversight of our Mental Health governance arrangements (currently being developed alongside our place-based partnership arrangements, our Frailty Programme Board, and our System Flow Programme Board. The link between these groups and ICE is through lead officers from the NHS and Adults and Health, Leeds City Council. The Director of Pathway Integration, NHS Leeds CCG, and the Deputy Director of Integrated Commissioning (a joint appointment between LCC and the NHS) are the lead and supporting commissioners for all the schemes in the Fund. All the work areas have the input of colleagues across the system, including VCSE and user voice, although some of the user engagement requires further development and has been constrained by Covid and service pressures. We do not see the BCF as separate, but as a key enabler to our work programmes in the designated areas.

Overall Approach to Integration

We have an Integrated Commissioning Executive for the City chaired by the director of Adults and Health and the CCG Chief Officer. It has oversight of all joint and integrated commissioning agendas, which include out of hospital care, LD, MH, intermediate care, homelessness, and a variety of other areas where we commission in an aligned way. (The Executive includes lead directors from LCC and Leeds CCG as required, including the Director of Children's Services).

In accordance with our Integrated Commissioning Strategy, and through our commissioning arrangements, we continue to invest in community services which are based on promoting independence principles. Our strengths-based approach is embedded in our conversations with people who use health, care, and support services, with a focus on maximising the support provided by their families and unpaid carers, or through their local communities.

Joint priorities for 21/22:

- Intermediate Tier – a) Ensure sufficient capacity of out of hospital community bed-based Discharge to Assess provision Pathways 2 and 3; b) Market engagement and development of new models of Intermediate Tier provision); c) Maximise use of equipment/AT through Leeds Community Equipment Service

- Older people's care homes –increase dementia care provision including for complex needs; ensure high quality services including end of life care and avoidable admissions

- Home care – a) enhance in-house reablement provision to support hospital discharge and Home First strategy); b) continue development of Community Wellbeing Teams model of service to ensure home care is person-centred and flexible in meeting needs, including End of Life provision. Increase OT capacity to work with home care agencies to promote reablement principles, supporting people to regain or retain independence

- Mental Health – a) Review/maximise opportunities for commissioning services community MH services from the Third Sector, including focus on prevention and early intervention; b) Increase supported housing options, including wrap-around support for people with complex MH needs

<u>Approaches to collaborative commissioning</u>

We continue to review use of BCF to ensure our pooled resources are utilised to maximum effect and are targeted at reducing health inequalities and to support people to remain living independently in their home.

The BCF is being used to enhance and develop further our out-of-hospital/community-based services, prioritising older people's services and mental health services which promote personalised care.

Examples of our BCF Schemes that support an integrated approach include carers support, intermediate tier beds, MH support services, services for people with dementia, Equipment Services, Age UK support for discharge, Neighbourhood Networks providing meals, social

support, befriending etc to reduce isolation and risk of admission. We also fund primary care support including additional schemes to support enhanced health in care homes, and support to our intermediate tier beds. These are all pivotal to maximise wellbeing for people in their own homes to prevent deterioration.

In terms of inequalities, we also fund step down support for people at risk of rough sleeping, including health and welfare support to reduce harms. Our 3rd sector mental health schemes include schemes focused on minority communities to maximise engagement in services that will support mental wellbeing. These also include employment support, and particular support to refugees and asylum seekers.

Supporting Discharge (National Condition 4)

Since March 2020 there have been some very significant changes to hospital flows, linked to the pandemic and to the updated Hospital Discharge Guidance. This has changed the threshold and approach to care, further driving a 'discharge to assess' model, and replacing an approach based on 'medically optimised for discharge' to one more strictly defined by nationally defined 'reasons to reside'. We have embedded a daily approach to considering reasons to reside across all our acute wards, which has created more visibility on the discussions as to whether or not a patient has a need for hospital care on that date.

BCF funded activity includes all of our Intermediate Tier beds and supporting medical workforce, and funds the LCC Reablement Service, and the Leeds Community Equipment Service. These are key enablers to care at home – the Intermediate Tier beds provide a chance for further rehabilitation and recuperation for those unable to go straight home and the reablement service for those who need a period of personal care support to readjust to care at home. We have seen increased pressure on all our care at home services and equipment services, linked to an increased wish for people to be cared for at home on discharge and also at end of life.

We have recently reformed our governance structures around hospital discharge/system flow and created a System Flow Programme Board chaired by the Director of Adults and Health and the Deputy Medical Director of the CCG. This provides oversight of a number of areas of improvement, which have at their heart a more person centred and asset-based approach to discharge planning, which involves people and their families at an earlier stage and better takes into account their prior circumstances on admission. The Chief Operating Officer of Leeds Teaching Hospitals Trust (LTHT) is a core member of the System Flow Programme Board and is overseeing a detailed work plan within the hospital. This includes work on increasing daily contact with patients and families, work on criterion led discharge, work on people awaiting tests in hospital, a new vision for MDT meetings and other key improvements. These have been reviewed by an ECIST colleague. These have been overseen not only by ECIST but by System Leaders and are subject to regular scrutiny by Chief officers.

We are also focusing on the creation of a new multi-agency transfer of care hub, enhancements to throughput in our reablement service, and work on people with complex needs such as cognitive impairment or housing issues which require more focus. We are

also looking at the administrative and informatics infrastructure for these services to see if we can simplify arrangements and improve tracking of system constraints. Our arrangements will ensure there is a named coordinator for people discharged with support needs, to help improve the continuity of care and provide a single point of contact for people and families if there are concerns.

The Chief Operating officer of LTHT is the SRO for improvements in discharge within LTHT and sits on the System Flow Programme Board. She and the Clinical Director for Specialty and Internal Medicine are leading on detailed work around to improve focus on discharge and multi-disciplinary working.

Workforce constraints remain a significant concern as of October 2021, but we are working as a system to try to maintain safe care in the most appropriate settings that we can. We have an active recruitment programme, and a detailed work plan to maximise work force which reports into our System Resilience Assurance and Reset Board. The work plan includes a frequent workforce taskforce looking at portability of staff to enable mutual aid; a detailed workforce pipeline, international recruitment of nursing staff, increasing our in house 'We Care Academy' to enable fast track training and looking at non-traditional recruitment methods including reaching out to students and through social media.

Disabled Facilities Grant (DFG) and wider services

The Health & Housing Service within Housing Leeds promotes independent living across all tenures for disabled and vulnerable people living in our city. The service processes disabled facility grants (DFG) in the private sector in accordance with Government legislation and guidance and provides adaptations to its public sector stock funded via the Housing Revenue Account.

The service runs a comprehensive programme of discretionary funding to promote independent living, engaging with a wide variety of public, private and 3rd sector organisations to financially support projects and initiatives which promote independent living in a variety of different settings.

For individuals needing to re-house, Health and Housing can allocate medical priority on re-housing applications, has a team of Occupational Therapists who advise on suitability of prospective housing and caseworkers that support and help individuals and families locate suitable new homes to move to. Care and Repair, and Careline are both key parts of our discharge planning. We are also simplifying a pathway for people needing a 'deep clean' so that these kinds of intervention can be initiated as early as possible when the need is identified.

The Health & Housing service is fully committed to ensuring that all disabled people live in a home that is in good condition and is safe for occupation for its inhabitants ensuring everyone has full access to the property and the facilities and amenities within it.

Leeds City Council and NHS Leeds CCG also commission handyperson schemes, housing related support schemes such as Careline and the Assisted Technology schemes and there

is extensive supported housing within the city however these are not contained within the BCF.

In addition, the DFG grant is increasingly being used on integrated technology projects that enable health and social care professionals in supporting local citizens to retain their independence and remain in their own homes for longer. These include the development and roll out of the Leeds Care Record. The fund is also being used to support the delivery of the Digital Roadmap for Leeds, and in improving public and professional digital information resources relating to health and care services and in enabling social activities in our local communities.

Equality and Health Inequalities

Leeds has developed an updated system delivery plan during 2020/21 which has at its heart a focus on reducing the gaps in life expectancy within our City. Covid-19 has increased this gap, and thrown into focus the differences in experience. We have not analysed the BCF indicators by ethnicity or deprivation but will look to do so in coming months. We have previously looked at ethnicity in our intermediate tier beds, which showed a lower length of stay for people from BAME communities. During Covid, we have been focused on overall safe flow and patient experience but have recently commissioned a Public health needs assessment around needs for intermediate care/care at home which will provide more granularity on the needs of individual populations and communities which will then be addressed through strategy development.

Our Mental Health Strategy has a focus on ensuring services are needs led and is focused on ensuring access to services for people in deprived communities and those people with complex mental health problems who often have physical as well as mental health needs and significantly reduced life expectancy. Within our work plans we have a key workstream looking at the variation in access between people from different communities, some of whom are underrepresented in our preventative services (outpatients and community) but overrepresented in acute beds, forensic beds, and detention under the mental health act. Our strategy also looks at the needs of older people with mental health problems whose conditions are often underdiagnosed and we have a focus also on people aged 14-25.

Better Care Fund 2021-22 Template

1. Guidance

Overview

Note on entering information into this template

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

Data needs inputting in the cell

Pre-populated cells

Note on viewing the sheets optimally

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

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

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

1. This section helps identify the sheets that have not been completed. All fields that appear as incomplete should be completed before sending to the Better Care Fund Team.
2. The checker column, which can be found on the individual sheets, updates automatically as questions are completed. It will appear 'Red' and contain the word 'No' if the information has not been completed. Once completed the checker column will change to 'Green' and contain the word 'Yes'
3. The 'sheet completed' cell will update when all 'checker' values for the sheet are green containing the word 'Yes'.
4. Once the checker column contains all cells marked 'Yes' the 'Incomplete Template' cell (below the title) will change to 'Template Complete'.
5. Please ensure that all boxes on the checklist are green before submission.

2. Cover (click to go to sheet)

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

4. Income (click to go to sheet)

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

5. Expenditure (click to go to sheet)

This sheet should be used to set out the schemes that constitute the BCF plan for the HWB including the planned expenditure and the attributes to describe the scheme. This information is then aggregated and used to analyse the BCF plans nationally and sets the basis for future reporting and to particularly demonstrate that National Conditions 2 and 3 are met.

The table is set out to capture a range of information about how schemes are being funded and the types of services they are providing. There may be scenarios when several lines need to be completed in order to fully describe a single scheme or where a scheme is funded by multiple funding streams (eg: iBCF and CCG minimum). In this case please use a consistent scheme ID for each line to ensure integrity of aggregating and analysing schemes.

On this sheet please enter the following information:

1. Scheme ID:
- This field only permits numbers. Please enter a number to represent the Scheme ID for the scheme being entered. Please enter the same Scheme ID in this column for any schemes that are described across multiple rows.

2. Scheme Name:
- This is a free text field to aid identification during the planning process. Please use the scheme name consistently if the scheme is described across multiple lines in line with the scheme ID described above.

3. Brief Description of Scheme
- This is a free text field to include a brief headline description of the scheme being planned.

4. Scheme Type and Sub Type:
- Please select the Scheme Type from the drop-down list that best represents the type of scheme being planned. A description of each scheme is available in tab 5b.
- Where the Scheme Types has further options to choose from, the Sub Type column alongside will be editable and turn "yellow". Please select the Sub Type from the drop down list that best describes the scheme being planned.
- Please note that the drop down list has a scroll bar to scroll through the list and all the options may not appear in one view.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside. Please try to use pre-populated scheme types and sub types where possible, as this data is important to our understanding of how BCF funding is being used and levels of investment against different priorities.
- The template includes a field that will inform you when more than 5% of mandatory spend is classed as other.

5. Area of Spend:
- Please select the area of spend from the drop-down list by considering the area of the health and social care system which is most supported by investing in the scheme.
- Please note that where 'Social Care' is selected and the source of funding is "CCG minimum" then the planned spend would count towards National Condition 2.
- If the scheme is not adequately described by the available options, please choose 'Other' and add a free field description for the scheme type in the column alongside.
- We encourage areas to try to use the standard scheme types where possible.

6. Commissioner:
- Identify the commissioning body for the scheme based on who is responsible for commissioning the scheme from the provider.
- Please note this field is utilised in the calculations for meeting National Condition 3.
- If the scheme is commissioned jointly, please select 'Joint'. Please estimate the proportion of the scheme being commissioned by the local authority and CCG/NHS and enter the respective percentages on the two columns.

7. Provider:
- Please select the 'Provider' commissioned to provide the scheme from the drop-down list.
- If the scheme is being provided by multiple providers, please split the scheme across multiple lines.

8. Source of Funding:
- Based on the funding sources for the BCF pool for the HWB, please select the source of funding for the scheme from the drop down list. This includes additional, voluntarily pooled contributions from either the CCG or Local authority
- If the scheme is funding across multiple sources of funding, please split the scheme across multiple lines, reflecting the financial contribution from each.

9. Expenditure (£) 2021-22:
- Please enter the planned spend for the scheme (or the scheme line, if the scheme is expressed across multiple lines)

10. New/Existing Scheme
- Please indicate whether the planned scheme is a new scheme for this year or an existing scheme being carried forward.

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

6. Metrics (click to go to sheet)

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

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

For each metric, systems should include a narrative that describes:
- a rationale for the ambition set, based on current and recent data, planned activity and expected demand
- how BCF funded schemes and integrated care will support performance against this metric, including any new or amended services.

1. Unplanned admissions for chronic ambulatory sensitive conditions:
- This section requires the area to input a planned rate for these admissions, per hundred thousand people for the year. This is the current NHS Outcomes Framework indicator 2.3i.
- The numerator is calculated based on the expected number of unplanned admissions for ambulatory sensitive conditions during the year.
- The denominator is the local population based on Census mid year population estimates for the HWB.
- Technical definitions for the guidance can be found here:
https://files.digital.nhs.uk/A0/76B7F6/NHSOF_Domain_2_S.pdf

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

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

- The narrative should set out the approach that has been taken to agreeing and aligning plans for this metric

3. Discharge to normal place of residence.
- Areas should agree ambitions for the percentage of people who are discharged to their normal place of residence following an inpatient stay.

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

4. Residential Admissions (RES) planning:
- This section requires inputting the information for the numerator of the measure.
- Please enter the planned number of council-supported older people (aged 65 and over) whose long-term support needs will be met by a change of setting to residential and nursing care during the year (excluding transfers between residential and nursing care) for the Residential Admissions numerator measure.
- The prepopulated denominator of the measure is the size of the older people population in the area (aged 65 and over) taken from Office for National Statistics (ONS) subnational population projections.
- The annual rate is then calculated and populated based on the entered information.

5. Reablement planning:
- This section requires inputting the information for the numerator and denominator of the measure.
- Please enter the planned denominator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (or from hospital to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home).
- Please then enter the planned numerator figure, which is the planned number of older people discharged from hospital to their own home for rehabilitation (from within the denominator) that will still be at home 91 days after discharge.
- The annual proportion (%) Reablement measure will then be calculated and populated based on this information.

7. Planning Requirements (click to go to sheet)

This sheet requires the Health & Wellbeing Board to confirm whether the National Conditions and other Planning Requirements detailed in the BCF Policy Framework and the BCF Requirements document are met. Please refer to the BCF Policy Framework and BCF Planning Requirements documents for 2021-22 for further details.

The sheet also sets out where evidence for each Key Line of Enquiry (KLOE) will be taken from.

The KLOEs underpinning the Planning Requirements are also provided for reference as they will be utilised to assure plans by the regional assurance panel.

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

Better Care Fund 2021-22 Template

2. Cover

Version 1.0

HM Government

NHS

Please Note:

- You are reminded that much of the data in this template, to which you have privileged access, is management information only and is not in the public domain. It is not to be shared more widely than is necessary to complete the return.

- Please prevent inappropriate use by treating this information as restricted, refrain from passing information on to others and use it only for the purposes for which it is provided. Any accidental or wrongful release should be reported immediately and may lead to an inquiry. Wrongful release includes indications of the content, including such descriptions as "favourable" or "unfavourable".

- Please note that national data for plans is intended for release in aggregate form once plans have been assured, agreed and baselined as per the due process outlined in the BCF Planning Requirements for 2021-22.

- This template is password protected to ensure data integrity and accurate aggregation of collected information. A resubmission may be required if this is breached.

Health and Wellbeing Board:	Leeds
Completed by:	Helen Lewis, Caroline Baria, John Crowther, Richard Huskins, Lesley Newlove
E-mail:	lesley.newlove@nhs.net
Contact number:	0113 2217767

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

Job Title:	Chair Leeds Health & Wellbeing Board
Name:	Councillor Fiona Venner
Has this plan been signed off by the HWB at the time of submission?	Delegated authority pending full HWB meeting
If no, or if sign-off is under delegated authority, please indicate when the HWB is expected to sign off the plan:	Mon 06/12/2021

<< Please enter using the format, DD/MM/YYYY
Please note that plans cannot be formally approved and Section 75 agreements cannot be finalised until a plan, signed off by the HWB has been submitted.

	Role:	Professional Title (where applicable)	First-name:	Surname:	E-mail:
***Area Assurance Contact Details:**	Health and Wellbeing Board Chair	Councillor	Fiona	Venner	fiona.venner@leeds.gov.uk
	Clinical Commissioning Group Accountable Officer (Lead)		Tim	Ryley	tim.ryley@nhs.net
	Additional Clinical Commissioning Group(s) Accountable Officers		N/A	N/A	N/A
	Local Authority Chief Executive		Tom	Riordan	tom.riordan@leeds.gov.uk
	Local Authority Director of Adult Social Services (or equivalent)		Cath	Roff	cath.roff@leeds.gov.uk
	Better Care Fund Lead Official		Helen	Lewis	helen.lewis5@nhs.net
	LA Section 151 Officer		Victoria	Bradshaw	victoria.bradshaw@leeds.gov.uk
*Please add further area contacts that you would wish to be included in official correspondence -->	Better Care Fund Lead Official (Leeds City Council)		Caroline	Baria	caroline.baria@leeds.gov.uk

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

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

Please see the Checklist below for further details on incomplete fields

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

<< Link to the Guidance sheet

^^ Link back to top

Better Care Fund 2021-22 Template

3. Summary

Selected Health and Wellbeing Board: Leeds

Income & Expenditure

Income >>

Funding Sources	Income	Expenditure	Difference
DFG	£8,286,057	£8,286,057	£0
Minimum CCG Contribution	£60,996,586	£60,996,586	£0
iBCF	£30,710,369	£30,710,369	£0
Additional LA Contribution	£2,637,000	£2,637,000	£0
Additional CCG Contribution	£0	£0	£0
Total	**£102,630,012**	**£102,630,012**	**£0**

Expenditure >>

NHS Commissioned Out of Hospital spend from the minimum CCG allocation

Minimum required spend	£17,333,500
Planned spend	£33,041,544

Adult Social Care services spend from the minimum CCG allocations

Minimum required spend	£17,655,042
Planned spend	£17,655,042

Scheme Types

Assistive Technologies and Equipment	£5,707,000	(5.6%)
Care Act Implementation Related Duties	£1,900,000	(1.9%)
Carers Services	£2,133,445	(2.1%)
Community Based Schemes	£0	(0.0%)
DFG Related Schemes	£8,286,057	(8.1%)
Enablers for Integration	£467,050	(0.5%)
High Impact Change Model for Managing Transfer of	£25,527,294	(24.9%)
Home Care or Domiciliary Care	£0	(0.0%)
Housing Related Schemes	£0	(0.0%)
Integrated Care Planning and Navigation	£0	(0.0%)
Bed based intermediate Care Services	£13,374,704	(13.0%)
Reablement in a persons own home	£2,807,000	(2.7%)
Personalised Budgeting and Commissioning	£0	(0.0%)
Personalised Care at Home	£0	(0.0%)
Prevention / Early Intervention	£10,690,555	(10.4%)
Residential Placements	£30,710,369	(29.9%)
Other	£1,026,538	(1.0%)
Total	**£102,630,012**	

Metrics >>

Avoidable admissions

20-21 Actual	21-22 Plan

Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	815.0	810.0

Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	LOS 14+	13.5%	13.0%
	LOS 21+	7.0%	7.0%

Discharge to normal place of residence

	0	21-22 Plan
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	0.0%	76.0%

Residential Admissions

		20-21 Actual	21-22 Plan
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	461	550

Reablement

		21-22 Plan
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	82.0%

Planning Requirements >>

Theme	Code	Response
NC1: Jointly agreed plan	**PR1**	Yes
	PR2	Yes
	PR3	Yes
NC2: Social Care Maintenance	**PR4**	Yes
NC3: NHS commissioned Out of Hospital Services	**PR5**	Yes
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	Yes

Agreed expenditure plan for all elements of the BCF	**PR7**	Yes
Metrics	**PR8**	Yes

Better Care Fund 2021-22 Template

4. Income

Selected Health and Wellbeing Board: Leeds

Local Authority Contribution	
Disabled Facilities Grant (DFG)	Gross Contribution
Leeds	£8,286,057
DFG breakerdown for two-tier areas only (where applicable)	
Total Minimum LA Contribution (exc iBCF)	**£8,286,057**

iBCF Contribution	Contribution
Leeds	£30,710,369
Total iBCF Contribution	**£30,710,369**

Are any additional LA Contributions being made in 2021-22? If yes, please detail below	Yes

Local Authority Additional Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Leeds	£2,637,000	Equipment service contribution
Total Additional Local Authority Contribution	**£2,637,000**	

CCG Minimum Contribution	Contribution
NHS Leeds CCG	£60,996,586
Total Minimum CCG Contribution	**£60,996,586**

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

Additional CCG Contribution	Contribution	Comments - Please use this box clarify any specific uses or sources of funding
Total Additional CCG Contribution	**£0**	
Total CCG Contribution	**£60,996,586**	

	2021-22
Total BCF Pooled Budget	**£102,630,012**

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

Better Care Fund 2021-22 Template

5. Expenditure

Selected Health and Wellbeing Board: Leeds

<< Link to summary sheet

Running Balances	Income	Expenditure	Balance
DFG	£8,286,057	£8,286,057	£0
Minimum CCG Contribution	£60,996,586	£60,996,586	£0
iBCF	£30,710,369	£30,710,369	£0
Additional LA Contribution	£2,637,000	£2,637,000	£0
Additional CCG Contribution	£0	£0	£0
Total	**£102,630,012**	**£102,630,012**	**£0**

Required Spend

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

	Minimum Required Spend	Planned Spend	Under Spend
NHS Commissioned Out of Hospital spend from the minimum CCG allocation	£17,333,500	£33,041,544	£0
Adult Social Care services spend from the minimum CCG allocations	£17,655,042	£17,655,042	£0

Checklist

Column complete:

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

Sheet complete

						Planned Expenditure								
Scheme ID	Scheme Name	Brief Description of Scheme	Scheme Type	Sub Types	Please specify if 'Scheme Type' is 'Other'	Area of Spend	Please specify if 'Area of Spend' is 'other'	Commissioner	% NHS (if Joint Commissioner)	% LA (if Joint Commissioner)	Provider	Source of Funding	Expenditure (£)	New/ Existing Scheme
400	Reablement Services	Reablement services	Reablement in a persons own home	Preventing admissions to acute setting		Community Health		CCG			Local Authority	Minimum CCG Contribution	£2,807,000	Existing
401	Community beds	The community beds service provides intermediate care in the community	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			Private Sector	Minimum CCG Contribution	£11,968,219	Existing
402	Community beds	The Green	Bed based intermediate Care Services	Step down (discharge to assess pathway-2)		Community Health		CCG			Local Authority	Minimum CCG Contribution	£1,406,485	Existing
418	Supporting carers	A range of services to support carers	Carers Services	Other	Carer advice and support	Mental Health		CCG			NHS Mental Health Provider	Minimum CCG Contribution	£1,501,709	Existing
403	Supporting carers	A range of services to support carers	Carers Services	Respite services		Continuing Care		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£278,126	Existing
404	Supporting carers	A range of services to support carers	Carers Services	Respite services		Community Health		CCG			Local Authority	Minimum CCG Contribution	£353,610	Existing
405	Leeds Equipment	Leeds Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		Community Health		CCG			Local Authority	Minimum CCG Contribution	£3,070,000	Existing
406	Leeds Equipment	Leeds Community Equipment Service	Assistive Technologies and Equipment	Community based equipment		Community Health		LA			Local Authority	Additional LA Contribution	£2,637,000	Existing
419	3rd Sector prevention	Mental Health Prevention Services	Prevention / Early Intervention	Other	Mental Health Prevention Services	Mental Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£5,443,440	Existing
420	3rd Sector prevention	Community Health Prevention Services	Prevention / Early Intervention	Other	Community Healt Prevention Services	Community Health		CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£505,911	Existing
407	Admission avoidance	Crisis support/diversion from hospital	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning	Service to ensure people who are admitted to hospital are managed appropriately on discharge to support them to live at home and avoid re-admission	Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£2,800,000	Existing
408	Community Matrons	Health Care in the community	Prevention / Early Intervention	Other	Health care in the community	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£2,600,000	Existing
409	Homeless Accommodation Leeds Pathway (HALP)	To provide transitional accommodation for homeless patients after a stay in hospital	Other		To provide dedicated beds at St George's Crypt to provide transitional accommodation for homeless patients to facilitate timely discharge after a stay in hospital	Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£303,790	Existing
410	Interface Geriatricians	Community Geriatrician service to deliver a consultant led; community facing service for frail elderly patients providing direct patient care to patients and, direct clinical advice and support to the Neighbourhood Teams, and Primary Care.	High Impact Change Model for Managing Transfer of Care	Home First/Discharge to Assess - process support/core costs		Community Health		CCG			NHS Community Provider	Minimum CCG Contribution	£195,000	Existing

411	Disabled Facilities Grant	Means-tested grant to cover the cost of housing adaptations that help disabled people to live independently in their own homes	DFG Related Schemes	Adaptations, including statutory DFG grants		Social Care		LA			Local Authority	DFG	£8,286,057	Existing
412	Social Care to Health Benefit	Social care to health benefit	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning	Funding for social care to benefit health services	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£15,032,294	Existing
413	Contingency	Contingency fund	High Impact Change Model for Managing Transfer of Care	Early Discharge Planning	Contingency set aside for any NEA shortfall	Acute		CCG			NHS Acute Provider	Minimum CCG Contribution	£7,500,000	Existing
414	Care Bill	To cover the financial costs associated with the Care Act	Care Act Implementation Related Duties	Other	To cover the financial costs associated with the Care Act	Social Care		LA			Local Authority	Minimum CCG Contribution	£1,900,000	Existing
415	Enhancing Primary care	Primary care developments with the top 2% high risk and vulnerable patients on their practice registers. In order to develop services around these patients this funding is used to enhance services to support the management of this patient cohort.	Prevention / Early Intervention	Risk Stratification		Primary Care		CCG			CCG	Minimum CCG Contribution	£2,141,204	Existing
416	Information Technology	Initiatives include the Leeds Care Record, Person Held Record, collaboration tools, pathway assistance, system and data sharing improvements.	Enablers for Integration	System IT Interoperability	Initiatives include the Leeds Care Record, Person Held Record, collaboration tools, pathway assistance, system and data sharing improvements.	Other	Charity	CCG			Charity / Voluntary Sector	Minimum CCG Contribution	£467,050	Existing
417	Former local reform and Community voices	Former local reform and community voices grant	Other	Former local reform and community voices grant	A former social care grant transferred into the BCF	Social Care		LA			Local Authority	Minimum CCG Contribution	£150,000	Existing
421	Contribution to social care demand pressures	Contribution to social care demand pressures	Residential Placements	Other	Contribution to social care demand pressures	Social Care		LA			Local Authority	iBCF	£30,710,369	Existing
500	Social Care to Health Benefit	Social Care to Health Benefit	Other		Additional contribution	Social Care		LA			Charity / Voluntary Sector	Minimum CCG Contribution	£572,748	New

2021-22 Revised Scheme types

Number	Scheme type/ services
1	Assistive Technologies and Equipment
2	Care Act Implementation Related Duties
3	Carers Services
4	Community Based Schemes
5	DFG Related Schemes

6	Enablers for Integration
7	High Impact Change Model for Managing Transfer of Care
8	Home Care or Domiciliary Care
9	Housing Related Schemes

10	Integrated Care Planning and Navigation
11	Bed based intermediate Care Services
12	Reablement in a persons own home
13	Personalised Budgeting and Commissioning
14	Personalised Care at Home

15	Prevention / Early Intervention
16	Residential Placements
17	Other

Sub type
1. Telecare 2. Wellness services 3. Digital participation services 4. Community based equipment 5. Other
1. Carer advice and support 2. Independent Mental Health Advocacy 3. Other
1. Respite services 2. Other
1. Integrated neighbourhood services 2. Multidisciplinary teams that are supporting independence, such as anticipatory care 3. Low level support for simple hospital discharges (Discharge to Assess pathway 0) 4. Other
1. Adaptations, including statutory DFG grants 2. Discretionary use of DFG - including small adaptations 3. Handyperson services 4. Other

1. Data Integration 2. System IT Interoperability 3. Programme management 4. Research and evaluation 5. Workforce development 6. Community asset mapping 7. New governance arrangements 8. Voluntary Sector Business Development 9. Employment services 10. Joint commissioning infrastructure 11. Integrated models of provision 12. Other
1. Early Discharge Planning 2. Monitoring and responding to system demand and capacity 3. Multi-Disciplinary/Multi-Agency Discharge Teams supporting discharge 4. Home First/Discharge to Assess - process support/core costs 5. Flexible working patterns (including 7 day working) 6. Trusted Assessment 7. Engagement and Choice 8. Improved discharge to Care Homes 9. Housing and related services 10. Red Bag scheme 11. Other
1. Domiciliary care packages 2. Domiciliary care to support hospital discharge (Discharge to Assess pathway 1) 3. Domiciliary care workforce development 4. Other

1. Care navigation and planning
2. Assessment teams/joint assessment
3. Support for implementation of anticipatory care
4. Other

1. Step down (discharge to assess pathway-2)
2. Step up
3. Rapid/Crisis Response
4. Other

1. Preventing admissions to acute setting
2. Reablement to support discharge -step down (Discharge to Assess pathway 1)
3. Rapid/Crisis Response - step up (2 hr response)
4. Reablement service accepting community and discharge referrals
5. Other

1. Mental health /wellbeing
2. Physical health/wellbeing
3. Other

1. Social Prescribing 2. Risk Stratification 3. Choice Policy 4. Other
1. Supported living 2. Supported accommodation 3. Learning disability 4. Extra care 5. Care home 6. Nursing home 7. Discharge from hospital (with reablement) to long term residential care (Discharge to Assess Pathway 3) 8. Other

Description
Using technology in care processes to supportive self-management, maintenance of independence and more efficient and effective delivery of care. (eg. Telecare, Wellness services, Community based equipment, Digital participation services).
Funding planned towards the implementation of Care Act related duties. The specific scheme sub types reflect specific duties that are funded via the CCG minimum contribution to the BCF.
Supporting people to sustain their role as carers and reduce the likelihood of crisis. This might include respite care/carers breaks, information, assessment, emotional and physical support, training, access to services to support wellbeing and improve independence.
Schemes that are based in the community and constitute a range of cross sector practitioners delivering collaborative services in the community typically at a neighbourhood/PCN level (eg: Integrated Neighbourhood Teams) Reablement services shoukld be recorded under the specific scheme type 'Reablement in a person's own home'
The DFG is a means-tested capital grant to help meet the costs of adapting a property; supporting people to stay independent in their own homes. The grant can also be used to fund discretionary, capital spend to support people to remain independent in their own homes under a Regulatory Reform Order, if a published policy on doing so is in place. Schemes using this flexibility can be recorded under 'discretionary use of DFG' or 'handyperson services' as appropriate

Schemes that build and develop the enabling foundations of health, social care and housing integration, encompassing a wide range of potential areas including technology, workforce, market development (Voluntary Sector Business Development: Funding the business development and preparedness of local voluntary sector into provider Alliances/ Collaboratives) and programme management related schemes. Joint commissioning infrastructure includes any personnel or teams that enable joint commissioning. Schemes could be focused on Data Integration, System IT Interoperability, Programme management, Research and evaluation, Supporting the Care Market, Workforce development, Community asset mapping, New governance arrangements, Voluntary Sector Development, Employment services, Joint commissioning infrastructure amongst others.
The eight changes or approaches identified as having a high impact on supporting timely and effective discharge through joint working across the social and health system. The Hospital to Home Transfer Protocol or the 'Red Bag' scheme, while not in the HICM, is included in this section.
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.
This covers expenditure on housing and housing-related services other than adaptations; eg: supported housing units.

Care navigation services help people find their way to appropriate services and support and consequently support self-management. Also, the assistance offered to people in navigating through the complex health and social care systems (across primary care, community and voluntary services and social care) to overcome barriers in accessing the most appropriate care and support. Multi-agency teams typically provide these services which can be online or face to face care navigators for frail elderly, or dementia navigators etc. This includes approaches such as Anticipatory Care, which aims to provide holistic, co-ordinated care for complex individuals. Integrated care planning constitutes a co-ordinated, person centred and proactive case management approach to conduct joint assessments of care needs and develop integrated care plans typically carried out by professionals as part of a multi-disciplinary, multi-agency teams. Note: For Multi-Disciplinary Discharge Teams related specifically to discharge, please select HICM as scheme type and the relevant sub-type. Where the planned unit of care delivery and funding is in the form of Integrated care packages and needs to be expressed in such a manner, please select the appropriate sub-type alongside.
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.
Provides support in your own home to improve your confidence and ability to live as independently as possible
Various person centred approaches to commissioning and budgeting, including direct payments.
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.

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.
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.
Where the scheme is not adequately represented by the above scheme types, please outline the objectives and services planned for the scheme in a short description in the comments column.

Better Care Fund 2021-22 Template

6. Metrics

Selected Health and Wellbeing Board: Leeds

8.1 Avoidable admissions

		19-20 Actual	20-21 Actual	21-22 Plan	Overview Narrative	
Unplanned hospitalisation for chronic ambulatory care sensitive conditions (NHS Outcome Framework indicator 2.3i)	Available from NHS Digital (link below) at local authority level. Please use as guideline only		815.0	810.0	No nationally updated data has been provided for the 2020 rates, and we do not have the ability locally to run reports based on local authority area rather than CCG from HES data. We are therefore assuming that our 2020 rate was in line with our 2019 rate. It may in fact have been lower, given the impact of Covid restrictions on non-Covid presentations but we do not have the detail on this, and do not think it is relevant for 2021 rates given the anomalous situation of 2020. Leeds rates are below national in 19/20 (816/100,000) compared to 862. They have declined steadily since 2015. We know 20/21 will be an anomalous year, but we expect a further small decline in 21/22 as we have enhanced our Medical Same Day Emergency Response offer from mid-year and expanded our Virtual Ward/urgent community response. Proactive care, and enhanced care in care homes should also further reduce admissions in this cohort. The data for 20/21 is not available, but is not considered to be relevant because it was such an anomalous year. Our current admission rate is tracking 20/21 admission rates, despite the growth in demand, which is showing the impact of our front door changes.	**Please set out the overall plan in the HWB area for reducing rates of unplanned hospitalisation for chronic ambulatory sensitive conditions, including any assessment of how the schemes and enabling activity for Health and Social Care Integration are expected to impact on the metric.**

>> link to NHS Digital webpage

8.2 Length of Stay

		21-22 Q3 Plan	21-22 Q4 Plan	Comments	
Percentage of in patients, resident in the HWB, who have been an inpatient in an acute hospital for: i) 14 days or more ii) 21 days or more As a percentage of all inpatients (SUS data - available on the Better Care Exchange)	Proportion of inpatients resident for 14 days or more	13.5%	13.0%	The BCF measure is place based, and measured on people discharged each month, whereas the weekly national Tableau report is provider based and based on incomplete pathways. While LTHT has a high proportion of people over 21 days LOS in its incomplete pathways, Leeds as a place is less of an outlier in completed pathways. Based on the BCF measure, we aim to reduce maintain our September levels of discharges over 14 days in Q3 and improve this by 0.5% in Q4 and to improve by 0.4% for 21 days plus in Q3 and then sustain that in Q4. We have some additional care home and community capacity opening in December, which should help improve Q3 overall, but we are mindful of the growth in no reason to reside patients we have seen during October and November. We are making some improvements in pathway which should reduce some of the avoidable delays in our transfer of care process. However, we are exceptionally aware that whatever process improvements we put in, the local social care workforce pressures are growing, which is likely in turn to increase the tip of some patients into the over 14 and over 21 day categories. The key actions to enable these improvements are: •Earlier discharge planning in hospital wards driven by the improvement work, which should help reduce overall length of stay for those patients not requiring support on discharge, and contribute to improvements for those requiring that support •Improvements in reablement ensuring that same day/next day capacity is available which should help minimise delays (if recruitment improves) •Improvements in transfer of care arrangements to ensure that there is earlier transfer to intermediate tier or care at home options once patients no longer have a reason to reside •Improved work between hospital and community therapies encouraging earlier transfers of people needing ongoing therapy/mobilisation •Improved staffing and engagement with the Intermediate Tier beds to enable care for more people with greater needs such as assistance of 2 Additional beds for winter (but likely to offset growth rather than improve numbers overall) Additional SW recruitment Removal of the stays within the Villa Care wards from the LTHT discharge data should also slightly reduce the numbers of discharges each month which are longer lengths of stay compared to historic volumes. We are also improving the way in which our Transfer of Care Hub communicates with the wards to increase the timeliness of transfers once packages/placements are confirmed. The major risks to delivering this ambition or going further are the significant workforce pressures now in the system, which have substantially reduced flow both to care at home and to care home placements. We have already seen two homes close/restrict admissions, which has added further pressure to a stressed system. While the system remains focused on workforce and recruitment, the significant pay and recruitment issues remain a major risk to delivery which will further impact on length of stay across all settings. The reduction in our short stay acute episodes (see below) via our admission avoidance work, also impacts on the proportions of people who require a longer length of stay or are delayed due to outflow issues as a proportion of the total. The ambitions around length of stays have been debated by our Silver Group of Chief Operating Officers from hospital, community trust and Adult Social Care, and we have debated closely the ability to influence these materially in the light of the local social care workforce market. We have been relatively cautious because we are very aware of the local context. However, we remain ambitious to drive out any delays that are not capacity dependent. Although the BCF measures only focus on length of stay in acute providers, we are equally mindful of delays in our mental health providers not only in older people but in working age adults, and continue to focus our resources and attention on these too.	**Please set out the overall plan in the HWB area for reducing the percentage of hospital inpatients with a long length of stay (14 days or over and 21 days and over) including a rationale for the ambitions that sets out how these have been reached in partnership with local hospital trusts, and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**
	Proportion of inpatients resident for 21 days or more	7.0%	7.0%		

8.3 Discharge to normal place of residence

	21-22 Plan	Comments	
Percentage of people, resident in the HWB, who are discharged from acute hospital to their normal place of residence (SUS data - available on the Better Care Exchange)	76.0%	We aim to return to 2019 levels of people discharged to their usual place of residence as our elective activity increases, and our deaths and intermediate tier discharges stabilise. Our ambition to reduce transfers to supported settings is tempered by an understanding of the home care staffing issues in the coming months which may require a reduction in 'home first' to enable flow. We are establishing a multi-agency transfer of care hub that is further supporting a 'home first' ethos, in conjunction with VCSE colleagues. All our trajectories are interlinked – any action that reduces length of stay will have a potential impact on any of the other measures. We remain committed to ensuring patients leave hospital as soon as possible, access reablement wherever possible, and avoid admission to long term care through intensive reablement, rehabilitation, appropriate equipment, home adaptations, good medical cover etc. All of these are within our BCF schemes – we are not focused on 'schemes' per se as we see these as a range of service offers, geared to meet the needs of individuals. We have, for example, provided additional funding to change the skill mix in our Community Care Beds to enable people with more demanding behaviours to access a therapeutic environment. Our BCF also includes funding for primary care to ensure there are no avoidable readmissions to hospital, and to reduce the likelihood of declines requiring long term care admissions. We have significantly invested in night sitters and care at home more broadly, but some of this investment in 21/22 has been through hospital discharge fund rather than BCF.	**Please set out the overall plan in the HWB area for improving the percentage of people who return to their normal place of residence on discharge from acute hospital, including a rationale for how the ambition was reached and an assessment of how the schemes and enabling activity in the BCF are expected to impact on the metric. See the main planning requirements document for more information.**

8.4 Residential Admissions

		19-20 Plan	19-20 Actual	20-21 Actual	21-22 Plan	Comments	
Long-term support needs of older people (age 65 and over) met by admission to residential and nursing care homes, per 100,000 population	Annual Rate	564	561	461	550	2020/21 admission numbers were impacted upon by the COVID pandemic which led to lower than expected admission levels. It is expected that admission levels for 2021/22 will be more in line with levels seen in 2019/20.	**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.**
	Numerator	700	693	571	690		
	Denominator	124,017	123,516	123,784	125,529		

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

8.5 Reablement

		19-20 Plan	19-20 Actual	21-22 Plan	Comments	
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services	Annual (%)	85.0%	83.1%	82.0%	2021/22 performance is expected to be broadly in line with pre-pandemic levels in 2019/20. The service is seeing an increased volume of people which is shown in the activity levels.	**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.**
	Numerator	425	276	574		
	Denominator	500	332	700		

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

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

Better Care Fund 2021-22 Template

7. Confirmation of Planning Requirements

Selected Health and Wellbeing Board: Leeds

Theme	Code	Planning Requirement	Key considerations for meeting the planning requirement These are the Key Lines of Enquiry (KLOEs) underpinning the Planning Requirements (PR)	Confirmed through	Please confirm whether your BCF plan meets the Planning Requirement?	Please note any supporting documents referred to and relevant page numbers to assist the assurers	Where the Planning requirement is not met, please note the actions in place towards meeting the requirement	Where the Planning requirement is not met, please note the anticipated timeframe for meeting it
NC1: Jointly agreed plan	**PR1**	**A jointly developed and agreed plan that all parties sign up to**	Has a plan; jointly developed and agreed between CCG(s) and LA; been submitted? Has the HWB approved the plan/delegated approval pending its next meeting? Have local partners, including providers, VCS representatives and local authority service leads (including housing and DFG leads) been involved in the development of the plan? Where the narrative section of the plan has been agreed across more than one HWB, have individual income, expenditure and metric sections of the plan been submitted for each HWB concerned?	Cover sheet Cover sheet Narrative plan Validation of submitted plans	Yes	Supporting narrative. HWB Chair has signed off the plan with delegated authority from the HWB. The plan is to be ratified at a public HWB meeting on 6th December 2021. Single HWB. Plan developed by LCC and NHS Officers jointly and reviewed by Chief Officers		
	PR2	**A clear narrative for the integration of health and social care**	**Is there a narrative plan for the HWB that describes the approach to delivering integrated health and social care that describes:** • How the area will continue to implement a joined-up approach to integrated, person-centred services across health, care, housing and wider public services locally. • The approach to collaborative commissioning • The overarching approach to support people to remain independent at home, and how BCF funding will be used to support this. • How the plan will contribute to reducing health inequalities and inequalities for people with protected characteristics? This should include - How equality impacts of the local BCF plan have been considered, - Changes to local priorities related to health inequality and equality, including as a result of the COVID 19 pandemic, and how activities in the BCF plan will address these	Narrative plan assurance	Yes			
	PR3	**A strategic, joined up plan for DFG spending**	**Is there confirmation that use of DFG has been agreed with housing authorities?** • Does the narrative set out a strategic approach to using housing support, including use of DFG funding that supports independence at home? • In two tier areas, has: - Agreement been reached on the amount of DFG funding to be passed to district councils to cover statutory Disabled Facilities Grants? or - The funding been passed in its entirety to district councils?	Narrative plan Confirmation sheet	Yes			
NC2: Social Care Maintenance	**PR4**	**A demonstration of how the area will maintain the level of spending on social care services from the CCG minimum contribution to the fund in line with the uplift in the overall contribution**	Does the total spend from the CCG minimum contribution on social care match or exceed the minimum required contribution (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC3: NHS commissioned Out of Hospital Services	**PR5**	**Has the area committed to spend at equal to or above the minimum allocation for NHS commissioned out of hospital services from the CCG minimum BCF contribution?**	Does the total spend from the CCG minimum contribution on non-acute, NHS commissioned care exceed the minimum ringfence (auto-validated on the planning template)?	Auto-validated on the planning template	Yes			
NC4: Plan for improving outcomes for people being discharged from hospital	**PR6**	**Is there an agreed approach to support safe and timely discharge from hospital and continuing to embed a home first approach?**	• Does the BCF plan demonstrate an agreed approach to commissioning services to support discharge and home first including: - support for safe and timely discharge, and - implementation of home first? • Does the expenditure plan detail how expenditure from BCF funding sources supports this approach through the financial year? • Is there confirmation that plans for discharge have been developed and agreed with Hospital Trusts?	Narrative plan assurance Expenditure tab Narrative plan	Yes			

Agreed expenditure plan for all elements of the BCF	**PR7**	**Is there a confirmation that the components of the Better Care Fund pool that are earmarked for a purpose are being planned to be used for that purpose?**	• Do expenditure plans for each element of the BCF pool match the funding inputs? (auto-validated) • Is there confirmation that the use of grant funding is in line with the relevant grant conditions? (see paragraphs 32 – 43 of Planning Requirements) (tick-box) • Has funding for the following from the CCG contribution been identified for the area: - Implementation of Care Act duties? - Funding dedicated to carer-specific support? - Reablement?	Expenditure tab Expenditure plans and confirmation sheet Narrative plans and confirmation sheet	Yes			
Metrics	**PR8**	**Does the plan set stretching metrics and are there clear and ambitious plans for delivering these?**	• Have stretching metrics been agreed locally for all BCF metrics? • Is there a clear narrative for each metric describing the approach locally to meeting the ambition set for that metric, including how BCF expenditure will support performance against each metric? • Are ambitions across hospital trusts and HWBs for reducing the proportion of inpatients that have been in hospital for 21 days aligned, and is this set out in the rationale? • Have hospital trusts and HWBs developed and agreed plans jointly for reducing the proportion of inpatients that have been in hospital for 14 days or more and 21 days or more?	Metrics tab	Yes			