BCF narrative plan template

This is an optional template for local areas to use to submit narrative plans for the Better Care Fund (BCF). These plans should complement the agreed spending plans and ambitions for BCF national metrics in your area's BCF Planning Template (excel).

Although the template is optional, we encourage BCF planning leads to ensure that narrative plans cover the headings and topics in this narrative template.

There are no word limits for narrative plans, but you should expect your local narrative plans to be no longer than 15-20 pages in length.

Although each Health and Wellbeing Board (HWB) will need to agree a separate excel planning template, a narrative plan covering more than one HWB can be submitted, where this reflects local arrangements for integrated working. Each HWB covered by the plan will need to agree the narrative as well as their excel planning template.

Cover

Health and Wellbeing Board(s)

Leeds

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

How have you gone about involving these stakeholders?

In 21/22 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 21/22 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.

Executive Summary

This should include:

- Priorities for 2021-22
- key changes since previous BCF plan

The key changes in 21/22 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 in 21/22 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 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. .

Governance

Please briefly outline the governance for the BCF plan and its implementation in your area.

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

Brief outline of approach to embedding integrated, person centred health, social care and housing services including

- Joint priorities for 2021-22
- Approaches to joint/collaborative commissioning
- Overarching approach to supporting people to remain independent at home, including strengths-based approaches and person-centred care.
- How BCF funded services are supporting your approach to integration. Briefly describe any changes to the services you are commissioning through the BCF from 2020-21.

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

Approaches to collaborative commissioning:

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.

Supporting Discharge (national condition four)

What is the approach in your area to improving outcomes for people being discharged from hospital?

How is BCF funded activity supporting safe, timely and effective discharge?

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. There is a detailed work plan within the hospital, the creation of a new multi-agency transfer of care hub, enhancements to 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 Leeds Teaching Hospitals 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 ..\..\..\..\..\..\..\Desktop\workforce update October.pptx .

Disabled Facilities Grant (DFG) and wider services

What is your approach to bringing together health, care and housing services together to support people to remain in their own home through adaptations and other activity to meet the housing needs of older and disabled people?

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.

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.

Briefly outline the priorities for addressing health inequalities and equality for people with protected characteristics under the Equality Act 2010 within integrated health and social care services. This should include

- Changes from previous BCF plan.
- How these inequalities are being addressed through the BCF plan and services funded through this.
- Inequality of outcomes related to the BCF national metrics.

Leeds has developed an updated system delivery plan during 20/21 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.